A.1 Proposal Certification Statement

Provide the Proposal Certification Statement (RFP Appendix # A) completed and signed, in the space provided, by an individual empowered to bind the Proposer to the provisions of the RFP and any resulting contract.

Enclosed, please find AmeriHealth Mercy of Louisiana, Inc.'s completed and signed Proposal Certification Statement. The statement has been signed by an individual empowered to bind AmeriHealth Mercy of Louisiana, Inc. to the provisions of this RFP and any resulting contract.

CNC-P PROPOSAL CERTIFICATION STATEMENT
RFP # 305PUR-DHHRFP-CCN-P-MVA

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including appendices and attachments.

OFFICIAL CONTACT: DHH requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. Identify the Contact name and fill in the information below: (Type or Print Clearly)

Date	June 29, 2010
Official Contact Name	Michael A. Rashid
Email Address	Michael.Rashid@amerihealthmercy.com
Fax Number with Area Code	215 - 937 - 8202
Telephone Number	215 - 937 - 8400
Street Address	100 Stevens Drive
City, State, and Zip	Philadelphia, PA 19113

Proposer certifies that the above information is true and grants permission to DHH to contact the above named person or otherwise verify the information I have provided.

By its submission of this proposal and authorized signature below, proposer certifies that:

1. The information contained in its response to this RFP is accurate;
2. Proposer accepts the procedures, evaluation criteria, contract terms and conditions, and all other administrative requirements set forth in this RFP;
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP;
4. Proposer's quote is valid for at least 120 days from the date of proposal's signature below;
5. Proposer understands that if selected as the successful Proposer, he/she will have seven (7) business days from the date of delivery of initial contract in which to complete contract negotiations, if any, and execute the final contract document. DHH has the option to waive this deadline if actions or inactions by the Department cause the delay.
6. Proposer certifies, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the internet at www.epls.gov).

Authorized Signature: _____

Typed or Printed Name: Michael A. Rashid

Title: President and CEO

Company Name: AmeriHealth Mecy of Louisiana

A.2 Ethics Code Signed Statement

Provide a statement signed by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract guaranteeing that there will be no conflict or violation of the Ethics Code if the Proposer is awarded a contract. Ethics issues are interpreted by the Louisiana Board of Ethics.

Enclosed, please find AmeriHealth Mercy of Louisiana, Inc.'s signed statement guaranteeing that there will be no conflict or violation of the Ethics Code if AmeriHealth Mercy of Louisiana, Inc. is awarded a contract pursuant to this RFP. The statement has been signed by an individual empowered to bind AmeriHealth Mercy of Louisiana, Inc. to the provisions of this RFP and any resulting contract.

LOUISIANA ETHICS CODE GUARANTEE

Undersigned, AmeriHealth Mercy of Louisiana, Inc., hereby guarantees that there will be no conflict or violation of the Louisiana Ethics Code if AmeriHealth Mercy of Louisiana, Inc. is awarded a contract pursuant to RFP #305PUR-DHHRFP-CCN-P-MVA. AmeriHealth Mercy of Louisiana, Inc. acknowledges and understands that ethics issues are interpreted by the Louisiana Board of Ethics.

Dated this 21st day of June, 2011

M. A. Rashid 6/21/11

Signature Date

Michael A. Rashid

Print Name

President and CEO

Title

Section B – Qualifications and Experience

B.1: Business Organization

Indicate your organization's legal name, trade name, dba, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name of your organization's ultimate parent (e.g. publicly traded corporation).

The AmeriHealth Mercy Family of Companies ("AmeriHealth Mercy") is responding to this request for proposal through its company, AmeriHealth Mercy of Louisiana, Inc. ("AML"). We will provide services using the name "LaCare," a trade name duly registered with the Louisiana Secretary of State.

AmeriHealth Mercy of Louisiana's physical offices are located at, and its mailing address is:

EXECUTIVE SUITES OF BR
Two United Plaza
8550 United Plaza Blvd., Suite 702
Baton Rouge, Louisiana 70809
Phone: (225) 922-4652

AmeriHealth Mercy of Louisiana, Inc. is a wholly-owned subsidiary of AmeriHealth Mercy Health Plan ("AMHP").

AmeriHealth Mercy Health Plan is a Pennsylvania general partnership whose ultimate controlling organizations are Mercy Health System and Independence Blue Cross.

- AMHP's address and phone number are:
  200 Stevens Drive
  Philadelphia, PA 19113
  (215) 937-8000
- Independence Blue Cross is a Pennsylvania non-profit hospital plan corporation. It is a non-stock/non-member corporation and its address is 1901 Market Street, Philadelphia, PA 19103
- Mercy Health System is a 501(c)(3) non-profit corporation. Its address is One West Elm Street, Conshohocken, PA 19428

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing addresses, and telephone number of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) individual interest in your organization, and the type of financial interest.

AmeriHealth Mercy of Louisiana, Inc. is a Louisiana corporation; it is wholly-owned by AmeriHealth Mercy Health Plan ("AMHP"), a Pennsylvania general partnership. No health professional has an individual interest in AmeriHealth Mercy of Louisiana, Inc.

The officers and directors of AmeriHealth Mercy of Louisiana, Inc. are as follows:

Table 1: Officers and Directors of AmeriHealth Mercy of Louisiana, Inc.

Name	Title	Address
Steven H. Bohner*	Senior Vice President and CFO, AmeriHealth Mercy Family of Companies *Treasurer of AML*	200 Stevens Dr. Philadelphia, PA 19113 Ph: (215) 937-8276
Robert H. Gilman, Esq.	Senior Vice President and	200 Stevens Dr.

Name	Title	Address
	General Counsel, AmeriHealth Mercy Family of Companies *Secretary of AML*	Philadelphia, PA 19113 (215) 937-8560
J. Michael Jernigan	Regional President, Southern Division AmeriHealth Mercy Family of Companies *Vice President of AML*	200 Stevens Dr. Philadelphia, PA 19113 (215) 937-8000
Anne M. Morrissey*	Executive Vice President and Chief Operating Officer, AmeriHealth Mercy Family of Companies *Vice President of AML*	200 Stevens Dr. Philadelphia, PA 19113 (215) 937-8425
Michael A. Rashid*	President & CEO, AmeriHealth Mercy Family of Companies *President of AML*	200 Stevens Dr. Philadelphia, PA 19113 (215) 937-8400
Robert E. Tootle, Esq.	Senior Counsel, AmeriHealth Mercy Family of Companies *Assistant Secretary of AML*	200 Stevens Dr. Philadelphia, PA 19113 (215) 937-8561

* Member of Board of Directors of AmeriHealth Mercy of Louisiana, Inc.

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

- AmeriHealth Mercy of Louisiana's Federal taxpayer ID: 27-3575066
- AmeriHealth Mercy of Louisiana's Louisiana taxpayer ID: 5877931001

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if not, so state.

AmeriHealth Mercy of Louisiana, Inc. is incorporated in the State of Louisiana. AmeriHealth Mercy of Louisiana maintains offices in Baton Rouge, Louisiana.

The corporate headquarters for the AmeriHealth Mercy Family of Companies is located in Philadelphia, Pennsylvania. AMHP has been registered with the Louisiana Secretary of State's office as a non-Louisiana partnership for some time, and in this capacity, AMHP's local representative is CT Corporation, with offices at 5615 Corporate Blvd. #400B, Baton Rouge, LA 70808-2536 [Ph: (225) 922-4490].

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

Neither AmeriHealth Mercy of Louisiana, Inc. nor its parent or any of its affiliates has been engaged by DHH within the past twenty-four (24) months.

B.2: Mergers, Acquisitions or Sales

Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. Include your organization's parent organization, affiliates, and subsidiaries.

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AmeriHealth Mercy of Louisiana, Inc. has not had any mergers, acquisitions, or sales within the last ten years. Its parent organization, AmeriHealth Mercy Health Plan, has had one acquisition within this timeframe. On January 31, 2008, AmeriHealth Mercy Health Plan acquired all of the outstanding equity interest of Community Behavioral Healthcare Network of Pennsylvania (CBHNP). CBHNP, which operates outside of Pennsylvania under the trade name, PerformCare, is a wholly-owned subsidiary of AmeriHealth Mercy Health Plan. CBHNP is a behavioral health care and human services company that currently provides services in Pennsylvania and New Jersey.

At the date of this proposal, there is no definitive agreement related to a change in ownership of AmeriHealth Mercy of Louisiana or AmeriHealth Mercy Health Plan.

B.3: Statement of Felony and/or Medicaid Offenses

Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled nolo contendere to any felony and/or Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. Include your parent organization, affiliates, and subsidiaries.

It is the policy of AmeriHealth Mercy of Louisiana, Inc. and its parent organization, affiliates and subsidiaries (collectively, "AmeriHealth Mercy") to not employ or do business with employees, agents, independent contractors, or subcontractors that have been convicted of, pled guilty to or pled nolo contendere to any felony and/or any Medicaid or health care related offense or that have ever been debarred or suspended by any federal or state governmental body. We accomplish this through various mechanisms, including but not limited to, execution of Code of Conduct certifications, review of federal and state debarment/suspension lists and contractual requirements:

- Upon hire, and annually thereafter, employees, agents and independent contractors are required to complete a Code of 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.
- AmeriHealth Mercy routinely checks federal and state debarment/suspension lists published by the relevant governmental bodies. Individuals and entities that appear on such lists are disqualified from engaging in business with AmeriHealth Mercy. If they appear on such lists after commencing business with AmeriHealth Mercy, we cease conducting business with them.
- AmeriHealth Mercy, through its provider credentialing process, identifies whether a provider has been debarred or suspended from participation in Medicaid/Medicare, or has been convicted of a felony and/or healthcare-related criminal offense. If through this process it is identified that a provider has been debarred or suspended from participation in Medicaid/Medicare, or if the

provider has been convicted of a felony and/or healthcare-related criminal offenses, the provider is disqualified from contracting with AmeriHealth Mercy and the contracting process is terminated; if such is identified through recredentialing, the provider is terminated from the AmeriHealth Mercy network in accordance with AmeriHealth Mercy policies and procedures. 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.

- 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. Upon receipt of such notification, as appropriate, AmeriHealth Mercy terminates the contract with the vendor.

B.4: Pending or Recent Litigation

B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. Include your organization's parent organization, affiliates, and subsidiaries.

There is no pending or recent (within the past five years) litigation against AmeriHealth Mercy of Louisiana, Inc. This includes, but is not limited to litigation involving failure to provide timely, adequate or quality physical behavioral health services. A list of for pending or recent (within the past five years) litigation against AmeriHealth Mercy of Louisiana, Inc.'s parent organization, affiliates and subsidiaries is provided below.

Keystone Mercy Health Plan

Pending or Recent Litigation Since 2006

- The Nemours Foundation v. Keystone Mercy Health Plan, U.S.D.C. DEL-CA#: 11-343. This is a breach of contract action brought by a network provider seeking reimbursement of claims it alleges were improperly denied and/or underpaid for 2008-2010. Damages requested are in excess of $500,000 plus applicable statutory interest. (In-house reserves established.)

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- Karen Coleman v. Keystone Mercy Health Plan, et al., Court of Common Pleas, Philadelphia County, October Term 2010, No. 0648. Slip and fall accident involving a third party who apparently fell on premises – housing Keystone Mercy Health Plan's Philadelphia operations – but which are the responsibility of either the property owner or the snow removal contractor – both of whom are parties to the lawsuit. Keystone Mercy Health Plan has no liability in this matter and defense counsel is working on a timely dismissal of Keystone Mercy Health Plan. (Insurance coverage available.)
- Medevac MidAtlantic, LLC v. Keystone Mercy Health Plan, Court of Common Pleas, Philadelphia County, February Term 2010, No. 1141. Plaintiff provides emergency ambulance aircraft services to patients requiring transport to hospitals. Plaintiff is not a Keystone Mercy Health Plan participating provider, but it has provided transportation services to Keystone Mercy Health Plan members. Plaintiff's complaint alleges a breach of implied contract in law as well as in fact along with unjust enrichment and is seeking the difference between billed charges and the Pennsylvania Medical Assistance fee-for-service rate paid by Keystone Mercy Health Plan. This case was filed in the Philadelphia County Court of Common Pleas and was subsequently removed to the U.S.D.C. Eastern District of Pennsylvania.
- Medstar-Georgetown Medical Center, Inc. d/b/a Georgetown University Hospital and MGMC, LLC d/b/a Georgetown Physicians Group v. Keystone Mercy Health Plan, Independence Blue Cross and Mercy Health System, U.S.D.C., Eastern District of PA, Civil Action No. 09-75. Keystone Mercy Health Plan is one of the Defendants in this breach of contract action arising out of transplant surgery performed on a Keystone Mercy Health Plan member. Plaintiffs are alleging that Keystone Mercy Health Plan, and the other Defendants, breached their agreement to fully reimburse both the hospital and physicians who provided care and treatment to Keystone Mercy Health Plan's member. The case was settled in February 2009.
- Philadelphia Hand Center v. Michael Smith v. Thomas Jefferson University Hospital and Keystone Mercy Health Plan, Court of Common Pleas, Philadelphia County, October Term 2009, No. 0111 (Arbitration). Keystone Mercy Health Plan joined to an underlying action brought against a Keystone Mercy Health Plan member by the Philadelphia Hand Center seeking reimbursement for services rendered to Defendant who was not enrolled with Keystone Mercy Health Plan at the time of treatment. Defendant is seeking contribution and/or indemnity from Keystone Mercy Health Plan. Case was voluntarily discontinued by Plaintiff in 2010.
- Donna McKnight v. Keystone Mercy Health Plan, U.S.D.C., E.D. Pa., CA No. 09-4827. Plaintiff is a former Keystone Mercy Health Plan employee who filed a Complaint in Philadelphia Federal Court alleging violations of Title VII of the Civil Rights Act of 1964; the Americans with Disabilities Act; the Family and Medical Leave Act; and the Pennsylvania Human Relations Act. Plaintiff was terminated in March 2008 for insubordination arising out of incidents with co-employees which were deemed inappropriate and unprofessional. This case was settled in February 2011.
- Terri McFadden v. Keystone Mercy Health Plan, U.S.D.C., E.D. Pa., CA No. 09-1744. Plaintiff is a former Keystone Mercy Health Plan employee who filed a Complaint in Philadelphia Federal Court in April 2009 alleging violations of the Family and Medical Leave Act (FMLA). Plaintiff was terminated for her failure to comply with reporting requirements under the FMLA. This case was settled in May 2010.

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- Peter Onu d/b/a Messiah Pharmacy v. Keystone Mercy Health Plan, Philadelphia Court of Common Pleas, November Term, 2007, No. 3292. Breach of contract action brought by a Keystone Mercy Health Plan network pharmacy regarding a dispute over reimbursements to pharmacy for medications furnished to Keystone Mercy Health Plan members. This case was settled in 2008.
- Akilah Barbee v. Keystone Mercy Health Plan. Delaware County Court of Common Pleas, No. 07-09604. Plaintiff, a former employee of Keystone Mercy Health Plan, filed a complaint in Pennsylvania State Court alleging race and pregnancy discrimination under Title VII and Pennsylvania Law. The Federal cause of action was dismissed. Plaintiff is seeking damages in excess of $50,000.
- Malisa L. Alexander v. Keystone Mercy Health Plan, et al., Civil Action No. 06-5599. Plaintiff, a former employee of Keystone Mercy Health Plan, filed a complaint in Philadelphia Federal Court alleging race discrimination and retaliation which resulted in her termination in October 2004. The suit named Keystone Mercy Health Plan and several employees who Plaintiff contends were responsible for her unfair treatment and ultimate dismissal from the company. The case was eventually settled in December 2007.
- Pennsylvania Medical Transport, Inc. d/b/a Medevac Ambulance, et. al. v. Keystone Mercy Health Plan, et al., Allegheny County No. GD-06-018902. Plaintiffs are allegedly ambulance services that have provided and do provide emergency transportation. Plaintiff's Amended Class Action Complaint asserts separate counts of unjust enrichment against all of the Pennsylvania Medicaid managed care organizations. Plaintiffs seek the difference between billed charges and the amount paid by the Medicaid plans. This case has been coordinated by the Allegheny County Court of Common Pleas with several other cases involving similar issues of law.
- Robert Knobler, M.D. v. Keystone Mercy Health Plan, Montgomery County Court of Common Pleas, No. 05-23717 (filed September 2005). Defamation action brought by a non-participating physician who alleged damage to his reputation arising out of comments made by Keystone Mercy Health Plan employees indicating that Dr. Knobler was placed on a restricted prescribing list due to his license being revoked and related issues. This case was settled in April 2010.
- BLM Group v. Keystone Mercy Health Plan and Mercy Health System Corporation, Court of Common Pleas, Montgomery County, Docket No. 04-32294. BLM filed a Complaint against Keystone Mercy Health Plan and Mercy Health System in December 2004 alleging breach of contract and failure to remit the amount of $348,981, plus interest and costs, owed in connection with the development of the Company's property at 101 Elm Street, Conshohocken, Pennsylvania. On January 15, 2009 the Court entered judgment in favor of the Defendants.

Vincent Reilly, Esquire, Senior Counsel, AmeriHealth Mercy Family of Companies, Ph: 215-937-8593, Email: Vincent.Reilly@amerihealthmercy.com, is the contact person available to discuss the above-referenced litigation.

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AmeriHealth Mercy Health Plan

Pending or Recent Litigation Since 2006

- Avrum Baum vs. Keystone Mercy Health Plan and AmeriHealth Mercy Health Plan, Philadelphia Court of Common Pleas, January Term 2011, No. 003876. Putative Class Action alleging negligence and breach of Pennsylvania unfair trade practice/consumer protection law for alleged disclosure of personal health information (PHI). Case was recently removed to Federal Court (U.S.D.C., E.D. Pa, Case Number 2:11-CV-01261-AB) and a Motion to Dismiss the Complaint was filed on March 2, 2011. (In-house reserves established.) Complaint seeks statutory damages (based upon Pennsylvania Law) as well as compensatory damages in excess of Fifty Thousand Dollars ($50,000).
- Teresa Sims v. Passport Health Plan, Jefferson Circuit Court, Kentucky. Plaintiff is a former AmeriHealth Mercy Health Plan employee hired to support Passport Health Plan, a Kentucky Medicaid health plan for which AmeriHealth Mercy Health Plan provides certain administrative and management services pursuant to an administrator agreement. Plaintiff is claiming she was unlawfully terminated due to her disability and that AmeriHealth Mercy Health Plan failed to accommodate her disability under Kentucky law. She is seeking compensatory damages along with front and back pay and benefits. (In-house reserves established.)
- PharmMD v. Denise Kehoe and PerformRx, LLC, Davidson County, Tennessee, No. 11-331-IV. This Complaint was filed in Tennessee State Court (it was subsequently removed to Federal Court - Middle District of Tennessee) by the former employer of Denise Kehoe. Ms Kehoe was a PerformRx employee at the time the suit was initiated. The suit seeks to enforce an employment agreement Ms. Kehoe signed with PharmMD which contained non-disclosure, non-solicitation and non-competition covenants. The Complaint seeks equitable remedies and unspecified damages. (In-house reserves established.)
- Cindy Mitchell and Edward Mitchell, Individually and as Co-Administrators of the Estate of Stephen Mitchell, a minor v. Community Behavioral HealthCare Network of Pennsylvania, Inc. and AmeriHealth Mercy Health Plan, et al., Philadelphia County, Court of Common Pleas, May Term 2009, No. 2126. On January 12, 2010 Defendants filed a Judgment of Non Pros against Plaintiffs for failure to file a timely Complaint.
- Children's Hospital of Pittsburgh of UPMC v. Mercy Health Plan and AmeriHealth Integrated Case Management, Inc. t/d/b/a AmeriHealth Mercy Health Plan, Court of Common Pleas of Allegheny County, Pennsylvania No. GD 09-22133. Plaintiff and Defendants entered into a Rate Agreement on April 25, 2008 wherein defendants agreed to pay certain sums for medical services rendered to Infant. A dispute arose between Plaintiff and Defendants regarding payment of medical services rendered. On or about March 12, 2010 Plaintiff and Defendants agreed to a settlement of any and all claims pertaining to this dispute.
- Skilled Care Pharmacy v. AmeriHealth Mercy Health Plan d/b/a PerformRx, Court of Common Pleas, Warren County, Ohio. (Filed in June 2008) Breach of contract action brought by participating pharmacy seeking reimbursement for failure to properly reimburse the pharmacy for claim payments resulting from prescriptions supplied to AmeriHealth Mercy Health Plan/PerformRx members. This case settled in October 2009.

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- City of Allentown v. AmeriHealth Mercy Health Plan, et al., Lehigh County, No. 2006-C-3271. Plaintiff allegedly provided emergency services and transportation in Pennsylvania. Plaintiff's complaint asserts three separate counts for unjust enrichment against three managed care organizations (MCOs) who provide managed health care benefits to recipients of Pennsylvania's Medical Assistance (MA) Program pursuant to written agreements with the Pennsylvania Department of Public Welfare (DPW). Each unjust enrichment count is asserted against a different MCO defendant. Plaintiff alleges they have billed the defendant MCOs for non-contract emergency services provided to their MA enrollees, and the MCOs have improperly limited their payment for these services to the fee-for-service rates established by DPW within the MA program. Plaintiff seeks from AmeriHealth Mercy Health Plan a greater amount of reimbursement than the amount paid for the non-contract emergency services. AmeriHealth Mercy Health Plan has filed an Answer and New Matter denying liability. Discovery is ongoing.

Vincent Reilly, Esquire, Senior Counsel, AmeriHealth Mercy Family of Companies, Ph: 215-937-8593, Email: Vincent.Reilly@amerihealthmercy.com, is the contact person available to discuss the above-referenced litigation.

B.5: Statement of Bankruptcy or Insolvency Proceedings

B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent organization, affiliates, and subsidiaries.

AmeriHealth Mercy of Louisiana, Inc. and its parent organization, affiliates and subsidiaries have not, within the last ten years, filed (or had filed against them) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. There is/was no predecessor company to AmeriHealth Mercy of Louisiana, Inc.

B.6: 10K Annual Report and 10-Quarterly Report

B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.

AmeriHealth Mercy of Louisiana, Inc., and its parent organization, affiliates and subsidiaries are not publically-traded and therefore, do not file the United States Securities and Exchange Commission SEC Form 10K Annual Report or 10-Q Quarterly Report.

Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses.

AmeriHealth Mercy of Louisiana, Inc. and its parent organization, affiliates and subsidiaries are not publically traded and therefore, are not subject to the jurisdiction of the Securities and Exchange Commission.

Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in

progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. Include your organization's parent organization, affiliates, and subsidiaries.

AmeriHealth Mercy of Louisiana, Inc. and its parent organization, affiliates and subsidiaries are not publically traded, and therefore, are not subject to the jurisdiction of the Securities and Exchange Commission.

B.7: Parent Organization/Other Owners

B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

See Attachment B.31 for the most recent detailed financial reports for AmeriHealth Mercy Health Plan, the parent organization for AmeriHealth Mercy of Louisiana, Inc.

Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.

See Attachment B.7 for a signed statement from AmeriHealth Mercy Health Plan, AmeriHealth Mercy of Louisiana, Inc.'s parent organization, unconditionally guaranteeing AmeriHealth Mercy of Louisiana, Inc.'s performance of each and every obligation, warranty, covenant, term and condition in the contract executed by AmeriHealth Mercy of Louisiana, Inc. and DHH pursuant to this RFP.

B.8: Employees, Client Base and Office Location(s)

B.8 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company.

AmeriHealth Mercy traces its roots back to Dublin, Ireland. Catherine McAuley, an heiress who used her inheritance to serve the poor, especially women and children, founded the Sisters of Mercy in 1831. In Catherine's "House of Mercy," Sisters of Mercy cared for the poor, sick and uneducated. Before she died in 1841, Catherine established 12 Mercy foundations throughout Ireland and two in England, the first convents built in that country following the protestant Reformation.

Some of the sisters expanded their service to the United States during the Civil War. They immediately began visiting the sick in their homes and setting up schools for the instruction and care of children and adults. The Sisters of Mercy founded Mercy Hospital in Philadelphia in 1831.

In the late 1970's and early 1980's the hospital witnessed a troubling increase in the number of people, mostly on Pennsylvania's Medicaid program, using the emergency room to seek primary care. This was not a good solution, as the critical pace of an emergency room is not intended to foster a patient/physician relationship, and engenders high costs and poor stewardship of resources.

Thus the concept of Mercy Health Plan was born: a voluntary Medicaid managed care plan. In 1983, the leaders of Mercy Hospital persuaded the state government to let them start a pilot capitated health plan to give 300 Medicaid recipients a "medical home" to reduce dependence on the emergency room for primary care. The Plan would work to connect each member with a Primary Care Physician, to encourage consistent and proactive health care, to extend benefits beyond the state fee-for-service model and to encourage the use the emergency room for emergencies only.

Mercy Health Plan grew rapidly, and in 1996, the Mercy Health Plan elected to expand. AmeriHealth Mercy Health Plan ("AMHP") was formed in 1996 as a general partnership between Mercy Health Plan and AmeriHealth Integrated Case Management, Inc. (AICM). The ultimate controlling persons of Mercy Health Plan and AICM are, respectively, Mercy Health System and Independence Blue Cross. Keystone Mercy Health Plan, AMHP's sister company (and its largest affiliate), is also under the ultimate control of Mercy Health System and Independence Blue Cross. Mercy Health System and Independence Blue Cross are both non-profit organizations, which serves as the foundation for the non-profit mission and culture of AMFC.

Drawing upon the strengths of both Mercy Health System and Independence Blue Cross, AmeriHealth Mercy's mission and values were forged from our history of connecting the most vulnerable among us to primary care while providing efficient medical management and provider services.

Today AmeriHealth Mercy comprises one of the largest Medicaid managed care plans in the United States, employing 2,441employees and touching more than 4 million Medicaid, SCHIP, Medicare and commercial lives nationwide through our managed care, behavioral health, and pharmacy programs. We are one of the nation's experts and industry leaders in the delivery of quality health care to low-income populations covered by publicly-funded programs, especially Medicaid. Our mission and values are constructed from our history of connecting the most vulnerable citizens to primary care while providing health care through our network providers and our own health management programs. Our family of companies includes: AmeriHealth Mercy Health Plan (Pennsylvania); Keystone Mercy Health Plan (Pennsylvania); Select Health of South Carolina; PerformRx (pharmacy benefit management); PerformCare (behavioral health services); and MDwise Hoosier Alliance (Indiana).

"In the care of the sick, have great tenderness in all things."
Sister Catherine McAuley

Simply stated, we help people:

- Get care
- Stay well
- Build healthy communities

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

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

AmeriHealth Mercy's programs include Medicaid risk and non-risk, Medicare Advantage Prescription Drug plans (MA-PDs), Medicaid at-risk and non-risk Behavioral Health Organizations (BHOs), State Children's Health Insurance Programs (SCHIP), and an uninsured program. Our mission is the foundation upon which we build all of our programs and products and enables us to meet the special medical, pharmaceutical, and behavioral health needs of these vulnerable populations, while satisfying complex state and federal requirements. Our programs are sensitive to the multiplicity of needs in the diverse regions and populations we serve.

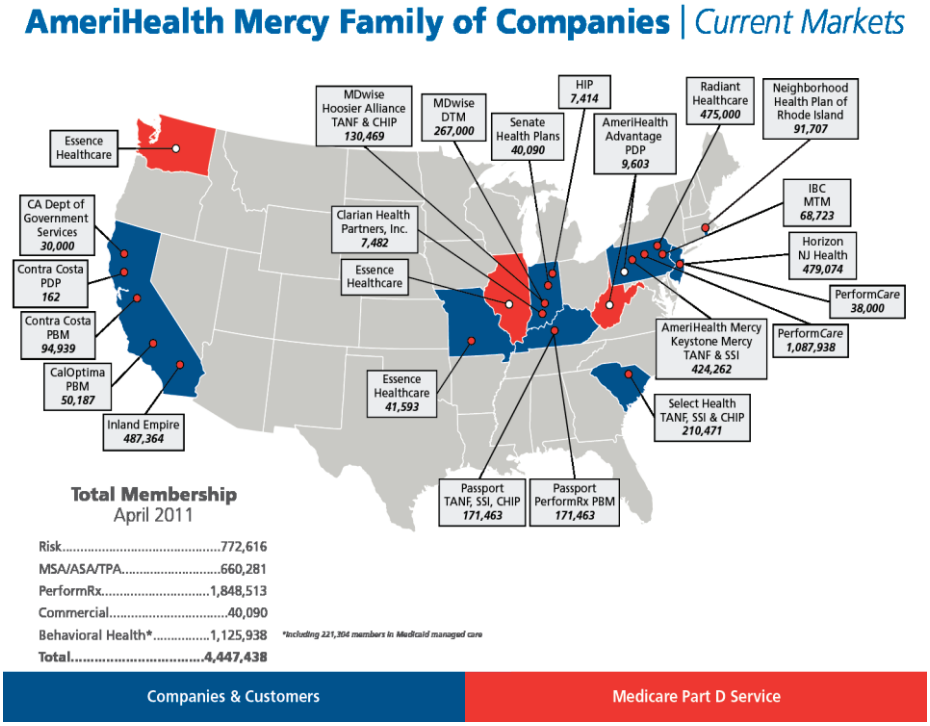
NCQA has awarded an excellent accreditation to Keystone Mercy Health Plan, AmeriHealth Mercy Health Plan and Select Health of South Carolina. In addition, NCQA has awarded excellent accreditation to the plan that AmeriHealth Mercy administers in Kentucky, and awarded excellent accreditation to MDwise, Inc. in Indiana for which MDwise Hoosier Alliance serves as a delivery system.

URAC has accredited both Keystone Mercy and AmeriHealth Mercy for their respective programs in case management, disease management, asthma, diabetes, heart failure, and COPD.

Both of the plans in Pennsylvania, as well as our plan in South Carolina were among the first group of plans to apply for and achieve NCQA Multicultural Health Care Accreditation. This is a new accreditation offering from NCQA. AmeriHealth Mercy health plans were three of the six nationwide early adopters of the standards. Based on preliminary results, all scores for all the AMFC health plans exceeded the NCQA passing requirement.

The map below illustrates the markets served by AmeriHealth Mercy:

Figure 1: AMFC Current Markets



- **AmeriHealth Mercy Health Plan** (AMHP) is one of Pennsylvania's most experienced Medicaid managed care health plans, serving approximately 109,000 Medicaid recipients in 15 counties in northeastern and central Pennsylvania and has achieved an accreditation status of Excellent from NCQA. Headquartered in Harrisburg, Pennsylvania, the company employs 91staff.

- **Keystone Mercy Health Plan** (KMHP) is the largest of AmeriHealth Mercy's affiliates and is headquartered in Philadelphia, Pennsylvania. Combined with its predecessor Mercy Health Plan, KMHP has served more than 300,000 Medicaid recipients in southeastern Pennsylvania since 1983, making it Pennsylvania's largest managed Medicaid health plan. The company has achieved an accreditation status of Excellent from NCQA, and employs 1,349 employees.
- **Select Health of South Carolina** is a wholly owned subsidiary of AmeriHealth Mercy Health Plan. Select Health has more than 40 percent market share in South Carolina, providing Medicaid managed care services to more than 210,000 members. The company has achieved an accreditation status of Excellent from NCQA. Headquartered in Charleston, South Carolina, Select Health has operated for 15 years and employs 219 employees.
- **MDwise Hoosier Alliance,** in partnership with MDwise Inc., provides care for members in the Hoosier Healthwise and Healthy Indiana programs, Indiana's health coverage programs for low-income families and children. The organization is headquartered in Indianapolis and serves approximately 138,000 members. MDwise Hoosier Alliance employs 104 employees and has earned NCQA accreditation through MDwise, Inc.
- **PerformCare** is a complete behavioral health care and human services company that supports approximately 1 million members. PerformCare specializes in providing superior, innovative solutions to support behavioral health, human services, and integrated health programs that are outcome-focused and customized for:
  - Medicaid and Medicare Plans
  - Commercial Health Plans
  - Wellness, Employee Assistance, and Specialty Products
  - Systems of Care Programs to Support Human Services Management Challenge
  - Operating under the name CBHNP in Pennsylvania, PerformCare was founded in 1994 by service providers. Also headquartered in Harrisburg, Pennsylvania, the company employs 310 employees and is NCQA accredited.
- **PerformRx** provides innovative, cost-effective pharmacy benefit management services for Medicaid, Medicare and commercial health plans for more than 1.8 million covered lives nationwide. PerformRx is mission-driven organization, dedicated to the delivery of quality pharmacy benefits with special attention to low-income populations. PerformRx programs include network management, audit service, utilization management, formulary design, rebate management, prior authorization, call center, mail pharmacy, and specialty pharmacy. PerformRx is among the first companies to have received accreditation under URAC's Pharmacy Benefit Management Standards. Headquartered in Philadelphia, Pennsylvania, the company employs 157 employees
- **Administrative Agreements.** AMFC has Medicaid Managed Care administrative agreements in New Jersey and Kentucky.

An organizational chart depicting the structure of the organization, parent organization and affiliates is enclosed as Attachment B8 and labeled a Chart A.

B.9: Narrative Description of CCN Project Team

Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level. If proposing for more than one (1) GSA, include in your description and organizational chart if: 1) the team will be responsible for all GSAs or 2) if each GSA will differ provide details outlining the differences and how it will differ.

Louisiana Medicaid Coordinated Care Network (CCN) Project Team

AmeriHealth Mercy's exclusive focus for nearly 30 years has been on Medicaid beneficiaries and other low income populations. We have been providing Medicaid services in risk based and other programs that cover 4 million Medicaid members in a variety of models including Medicaid Managed Care, Pharmacy Benefits Management and Behavioral Health Managed Care. Our experience serving adults and children in urban and rural areas is based on principles and disciplines that enable timely program implementations and a well-organized operational structure.

AmeriHealth Mercy has planned to expand its mission into Louisiana for many years. In 1994 Tom Lyman, Senior Vice President, Market Expansion started our journey. He and others have followed the changing Louisiana Medicaid environment beginning with discussions with Rose Forrest who was at DHH during the administration of Governor Edwards. We have continued to monitor the Louisiana Medicaid environment throughout Governor Foster, Governor Blanco and Governor Jindal's administrations and have worked with DHH staff whenever a coordinated care or similar initiative was under consideration.

Our primary goals for implementing a successful CCN-P in Louisiana are simple but important. They are:

- Pay claims accurately and timely—on the first day of operations
- Successfully exchange data and reports with DHH and designees—on the first day of operations
- Work with members to improve their health though our integrated care management programs—on the first day of operations, and
- Provide value to providers by giving them information to help them improve their patients care—on the first day of operations.

In addition to developing relationships with the DHH, our team has developed relationships with the "providers" of care to the Medicaid population: hospitals, primary care physicians, specialists and others. We understand that a successful CCN program depends on true collaboration with traditional providers of care to our targeted population, not just a traditional, commercial style managed care contract. As a result, we have invested years of relationship building with some of the largest provider entities in the State including conversations that began in 1994 and resulted in special collaborations with LSU and FMOL (Lady of the Lake) Health Systems as well as strong relationships with CHRISTUS, Woman's Hospital, Ochsner and Tulane Medical group among others as described in Section G. Due to the leadership of Ms. Jocelyn Bayliss, and her network development team, we have received almost 7000 signed letters of intent or contracts.

John Finan, President & CEO of FMOL Health System (left), and Fred Cerise, M.D., President & CEO of LSU Health System, discuss their collaboration with LaCare at a meeting in New Orleans in the spring of 2011

Clinical leadership for the implementation will be supplied by Dr. Andrea Gelzer, our Corporate Chief Medical Officer. Dr. Gelzer is responsible for oversight of all clinical quality and medical management activities as well as corporate medical informatics and provider network strategy. She previously provided strategic clinical leadership for the Medicaid managed care plan that has been ranked #2 by U. S. World News and Report for Medicaid managed care plans. Dr. Gelzer will ensure that both Dr. Fred Volkman, the Regional Medical Director, and the Louisiana Medical

Director, receive the benefit of the experience and technical capabilities of the clinical resources of all of the AmeriHealth Mercy affiliates. Also working with Dr. Gelzer, is Karen Michael, Vice President of Corporate Medical Management. Ms. Michael will oversee the implementation of clinical operations for the LaCare program. Ms. Michael's knowledge of Louisiana's health care delivery challenges is based on her first-hand experience working in collaboration with Louisiana healthcare providers and organizations in 2009, in preparation for AmeriHealth Mercy's proposal to support the Louisiana Chronic Care Management Program.

Louisiana Medicaid Coordinated Care Network (CCN) organizational structure

AmeriHealth Mercy's Louisiana organizational structure is illustrated below. This structure highlights the functions that will be performed at the local, regional and corporate levels within the AmeriHealth Mercy organization. This team will be responsible for all three GSAs.

Local Office

Sonia Madison, who has had a distinguished, three-decade career in health plan administration in Louisiana and other parts of the country, will lead our LaCare local office and will be focused on the hands-on approach to managing our CCN Program across all three GSAs. Functions managed at the local level will include administration, integrated care management, provider network management, community outreach, human resources, finance, service operations and compliance. The organizational chart below depicts the assignment of resources at the local level for these functions.

Figure 2: Organizational Structure – Local Office

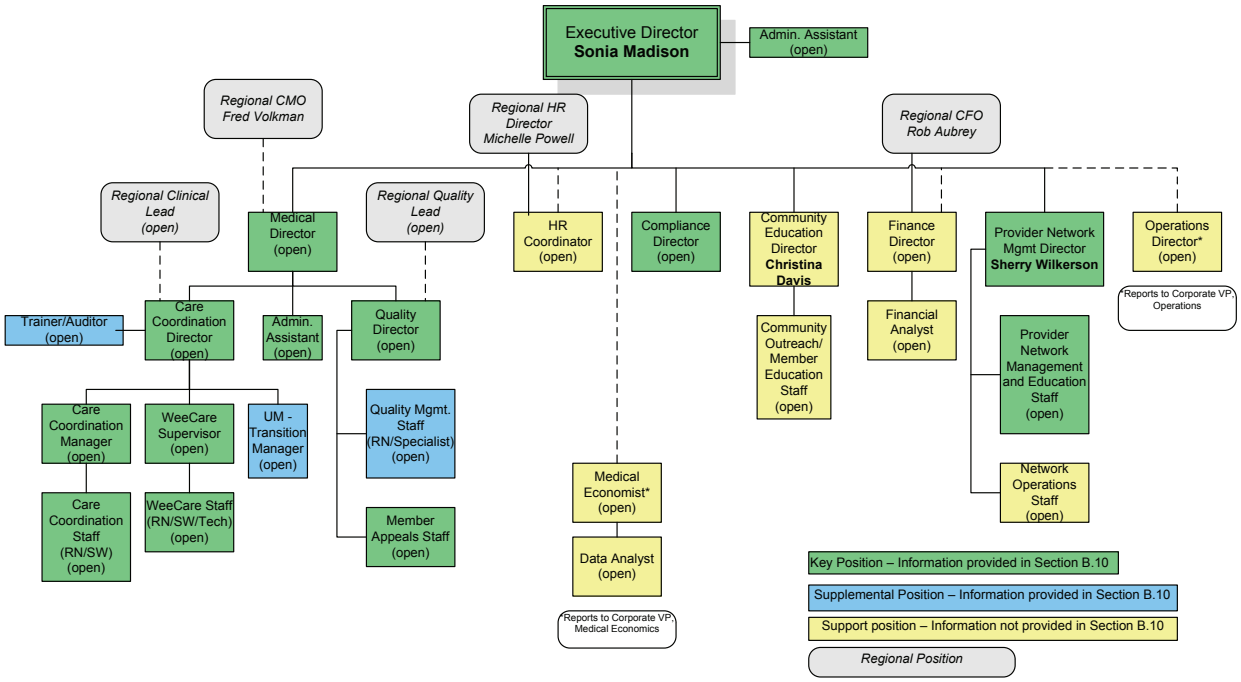


Table 2: Functions to be performed at the Louisiana Office

Administration	Human Resources
▪ Plan oversight and management ▪ P&L responsibility	▪ Local recruiting, hiring, orientation and training

▪ State contract compliance ▪ Government relations	▪ Associate relations
Finance	**Compliance**
▪ Budget development and analysis ▪ Financial analysis ▪ Rate analysis and negotiation support	▪ Fraud, waste and abuse program ▪ Compliance program
Community Outreach	**Integrated Care Management**
▪ Member outreach and education ▪ Community relations	▪ Telephonic case management ▪ Intensive case management ▪ Condition-specific disease management ▪ Maternity management (prenatal and postpartum) ▪ Population management ▪ Onsite transition management ▪ Onsite concurrent review ▪ Embedded care management ▪ Member grievance processing ▪ Quality program implementation, process improvement efforts
Provider Network Management	**Data Management**
▪ Network development and oversight ▪ Provider relationship management ▪ Provider education and communication ▪ Provider performance oversight and incentive program management ▪ Provider issue resolution ▪ Liaison with Operations for translation of provider contracts into claims payment system configuration; testing of configured contracts	▪ State data requests ▪ Provider network analytics ▪ State fee schedule analytics ▪ State benefit change analytics ▪ Plan-specific analytics
Service Operations	
Service Operations ▪ State contract compliance – operational components (e.g., service level agreements) ▪ Provider contract implementation ▪ System maintenance ▪ Operational performance monitoring ▪ Local vendor relations	

Regional Office

The second part of our Louisiana organizational structure is our Southern regional office. The regional office is led by J. Michael Jernigan who has over 30 years in health care experience and founded our South Carolina Medicaid managed care plan, SelectHealth in 1995. Headquartered in Charleston, South Carolina, our Southern Region team has an in-depth understanding of the needs of each group we serve, with a special focus on access to quality care for recipients in both urban and rural areas. AmeriHealth Mercy's leadership in the Southern Region has extensive experience with Medicaid populations and is

dedicated to the success of Louisiana's CCN Program. The organizational chart below highlights the regional assignment of responsibilities for this program.

Figure 3: Organizational Structure – Southern Regional Office

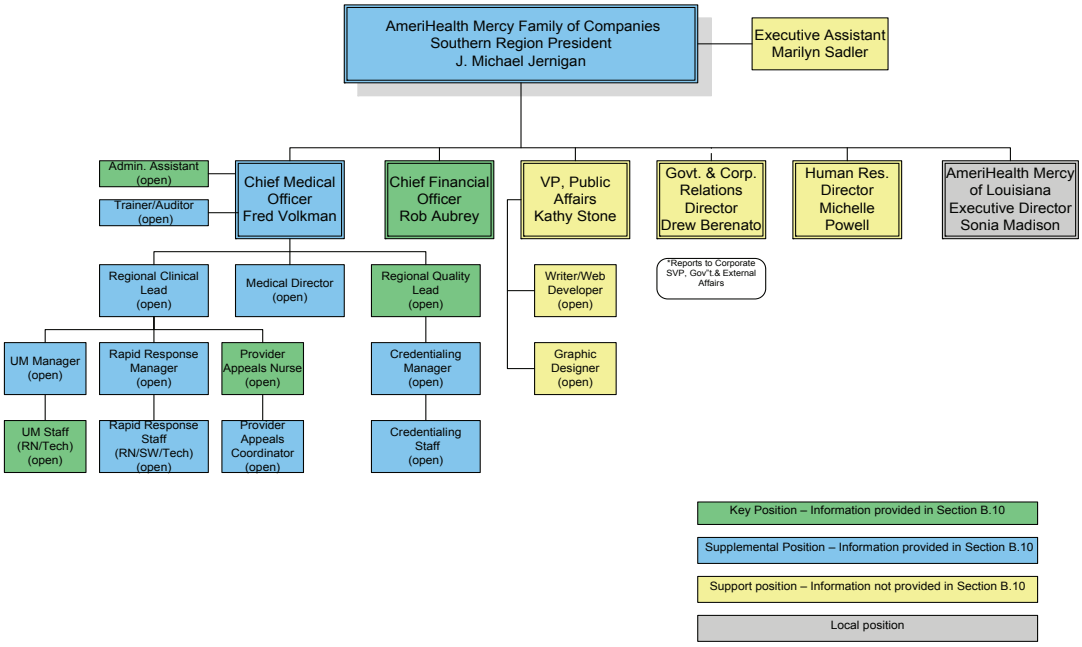


Table 3: Functions to be performed at the AmeriHealth Mercy Southern Regional Office

Administration	Human Resources
▪ Regional oversight and management ▪ Regional P&L responsibility ▪ Government relations – state and federal	▪ Regional recruiting and hiring ▪ Associate relations
Finance	**Integrated Care Management**
▪ Regional budget analysis and oversight ▪ Financial planning and analysis ▪ Revenue management	▪ Utilization management ▪ Prior authorization ▪ Concurrent review ▪ Retroactive review ▪ Provider appeal processing ▪ Rapid response unit ▪ Quality program oversight, outcomes reporting ▪ Credentialing
Public Affairs	**Government & Corporate Relations**
▪ Regional oversight of community outreach, education and marketing functions	▪ Regional liaison with local, state and federal regulatory and legislative bodies

Corporate Office

The last part of our Louisiana organizational structure is our corporate office. Under the leadership of Michael A. Rashid, our corporate leadership team has over 175 years of combined experience in Medicaid. We look forward to applying this knowledge and commitment to Louisiana's CCN Program.

The following organizational charts illustrate the assignment of leadership and resources across the levels of the company, from senior management to key functions such as claims processing, member services, and information systems.

As a young boy, Michael spent many summers in Shreveport, Louisiana with his grandfather, David Raines. Mr. Rashid said,

My roots run deep in Louisiana. The David Raines Health Center in Shreveport is named for my grandfather. I spent the summers of my youth in that town. With that said, AmeriHealth Mercy has been working to find a way to be involved in a managed care solution for the Medicaid population in Louisiana for more than 16 years, long before your state was seen as a business opportunity by other health plans

Michael Rashid, President and CEO
AmeriHealth Mercy Family of Companies

Figure 4: Organizational Structure – Corporate Office

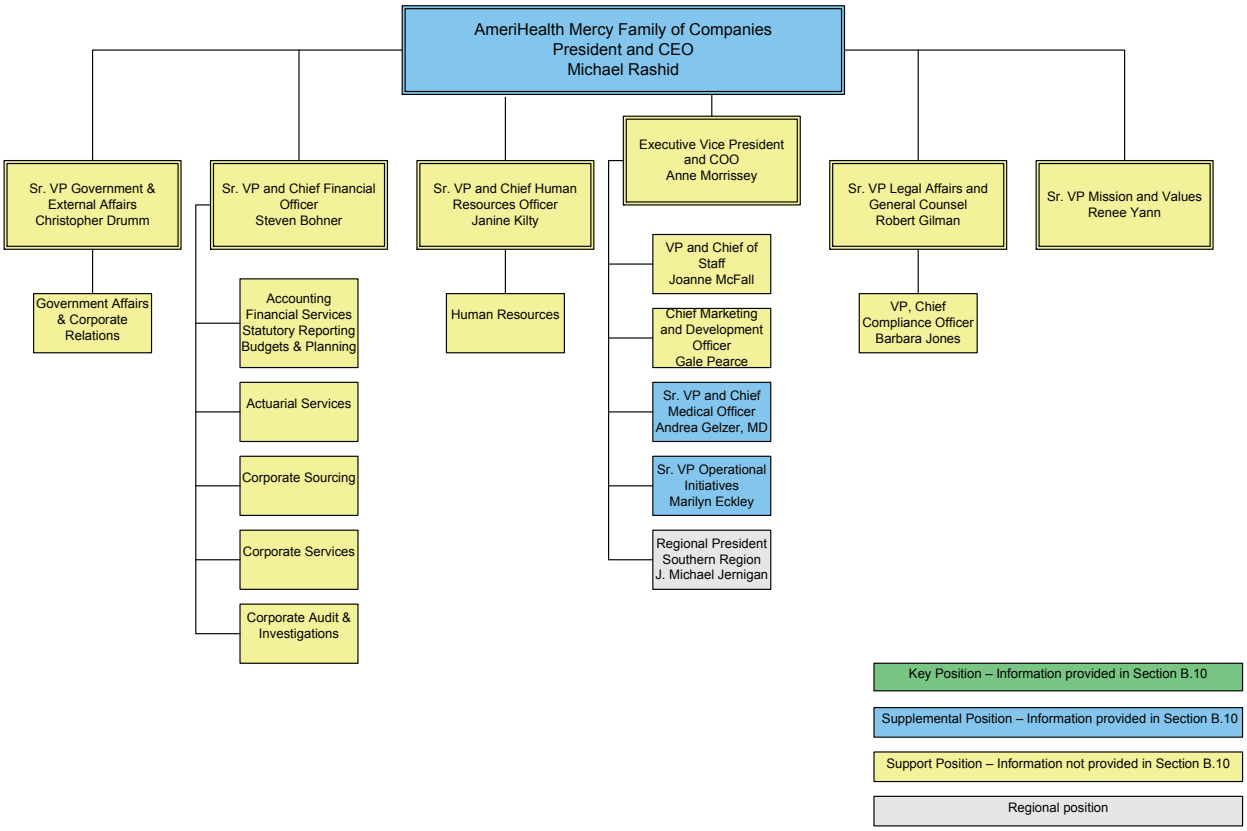


Figure 7: Organizational Structure – Corporate Operations and Technology

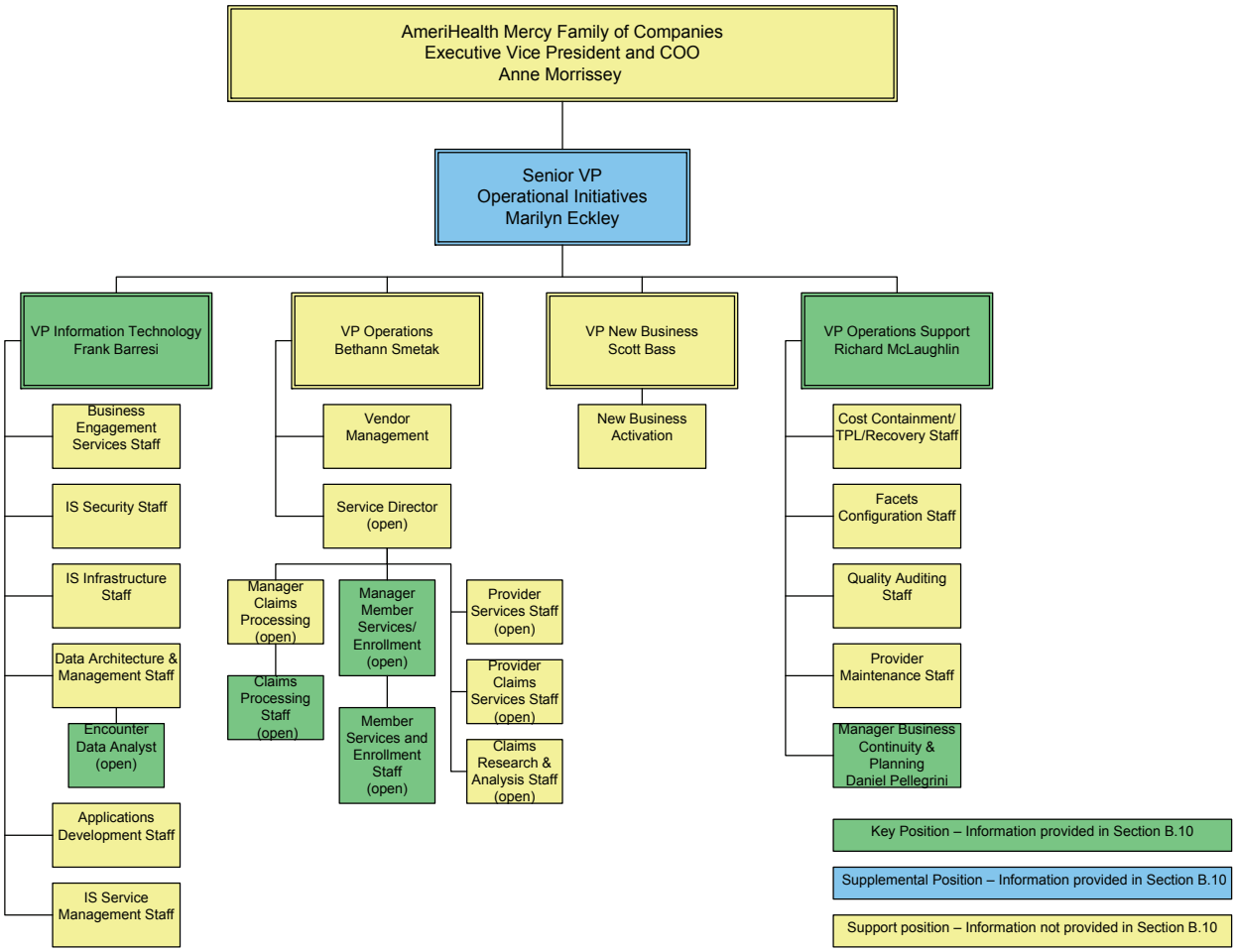


Table 4: Functions to be performed at the AmeriHealth Mercy Corporate Office

Administration	Human Resources
▪ Corporate oversight and management ▪ Corporate P&L responsibility ▪ Government relations – state and federal ▪ Mission and values ▪ Strategy implementation ▪ Operational oversight and risk management ▪ Portfolio Management (PMO) ▪ New business activation	▪ HR strategy ▪ HR policies and procedures ▪ Compensation and benefits ▪ HR systems ▪ Talent management – recruiting, hiring, staff development ▪ Associate relations and business support ▪ Learning and organizational effectiveness
Finance	**Integrated Care Management**
Finance ▪ Accounting ▪ Financial services and systems	**Integrated Care Management** ▪ Integrated care management strategy development

▪ Statutory reporting ▪ Budgets and planning ▪ Actuarial services ▪ Corporate sourcing ▪ Corporate services ▪ Corporate Audit and Investigations - fraud, waste and abuse program	▪ Clinical quality oversight ▪ Medical policy development and oversight ▪ Utilization management strategy and oversight ▪ Medical loss review ▪ Care management systems
Legal & Compliance	**Mission and Values**
▪ Corporate legal oversight ▪ Corporate compliance program	▪ Integration of the AmeriHealth Mercy mission and values into all aspects of the business
Provider Network Management	**Data Management**
▪ Provider Network Management strategy and systems ▪ Payment policy development and oversight ▪ Network management policies and procedures ▪ National contracting ▪ Provider incentive program strategy	▪ Production reporting ▪ Data management and governance ▪ Strategic business intelligence ▪ Quality and medical analytics ▪ Network and ancillary analytics ▪ Data management systems
Service Operations/IS	**Government Affairs**
▪ Service level oversight, reporting and monitoring ▪ Member and provider services – contact center ▪ Claims processing, research and analysis ▪ Enrollment and eligibility ▪ Operations support ▪ Facets configuration and testing ▪ Cost containment, TPL and recovery ▪ Quality auditing ▪ Provider data maintenance ▪ Business continuity and planning ▪ Vendor management ▪ Information systems ▪ Business engagement ▪ Security ▪ Infrastructure delivery ▪ Data architecture and management, e-business ▪ Encounter data management ▪ Applications development ▪ Service management	▪ Liaison to federal and state legislators and regulators for legislative affairs, policy development, and regulatory affairs
Marketing and Development	
▪ Market expansion ▪ Product development ▪ Health care reform/regulatory oversight ▪ Marketing and communications	

▪ Strategic planning	

B.10 Personnel Rosters and Resumes

Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.

- *If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.*
- *If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.*
- *For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.*

Personnel Roster

In alignment with the organizational charts presented in section B.9, please find personnel rosters attached to this section as Attachment B.10. These rosters include an overview of the local, regional, and corporate positions that will be responsible for the successful implementation and ongoing operations. Resumes and job descriptions for positions identified as Key Personnel and Supplemental Personnel have also been provided as Attachment B.10.

Local Responsibilities: AmeriHealth Mercy of Louisiana (LaCare)

All local positions are located in the LaCare office in Louisiana and are fully allocated to the contract.

Regional Responsibilities: AmeriHealth Mercy Family of Companies, Southern Region

All regional positions are located in the AmeriHealth Mercy Southern Division office in Charleston, South Carolina. The time and responsibilities of senior leadership and management positions are allocated equally among the three lines of business in the region. The positions of supervisors and below are fully allocated to the Louisiana DHH contract.

Corporate Responsibilities: AmeriHealth Mercy Family of Companies, Corporate Office

All corporate positions are located in the AmeriHealth Mercy corporate office in Philadelphia, Pennsylvania. Senior leadership and management time and responsibilities are allocated equally among all lines of business in the family of companies. The positions of supervisors and below are fully allocated to the Louisiana DHH contract.

B.11: Subcontractors

B.11 Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than $100,000 annually. Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located.

LaCare intends to use one affiliated and various non-affiliated major subcontractors as further detailed in the chart below.

Table 5: Subcontractor Information

Vendor	Legal Name	Mailing Address	Description of Work	Monitor	Evaluate	Currently Providing Services	Where are they located
ACS	ACS Commercial Solutions, Inc., a division of Affiliated Computer Services, Inc.	2828 North Haskell Avenue, Dallas, TX, 75204	Claims Data Entry	We will monitor the performance of our subcontractors through a formal contract-based quality oversight program and through ongoing day-to-day oversight and monitoring performed by staff dedicated to this function. Subcontracts include performance measures that are typically monitored through monthly reports which are also presented to the appropriate quality committee. In addition, as required by our oversight policies and procedures, annual onsite audits are conducted of subcontractors during which regulatory compliance and performance is reviewed. More information on monitoring subcontractors can be found in	Identified quality subcommittees routinely review and monitor any required monthly and ad-hoc reports prepared by subcontractors based on contract performance indicators. These subcommittees also review the results of any comprehensive annual audits of subcontractors, including the results of any on-site audits of. The annual audit includes in-depth file reviews against contract standards. The results of the annual audit and recommendations for any necessary corrective action plan, along with the target completion date(s), are presented to the appropriate quality committee. Based on the committee's decision, the subcontractor is approved or disapproved for continued operation. If a corrective action plan is imposed, the results of the corrective action and subsequent monitoring are brought back to the committee. All subcontractor agreements contain provisions	AmeriHealth Mercy Family of Companies	2828 North Haskell Avenue, Dallas, TX, 75204
SironaHealth	SironaHealth, Inc.	500 Southborough Drive, Ste. 105, South Portland, ME, 04106	24/7 Nurseline			Not currently providing services	500 Southborough Drive, Ste. 105, South Portland, ME 04106
Access2Care*	Access2Care, LLC	6200 S Syracuse Way, Greenwood Village, CO. 80111	NEMT			Not currently providing services	6200 S Syracuse Way, Greenwood Village, CO, 80111
MTM*	Medical Transportation Management, Inc.	16 Hawk Ridge Drive, Lake St. Louis, MO 63367	NEMT			Not currently providing services	16 Hawk Ridge Drive, Lake St. Louis, MO 63367
LogistiCare	LogistiCare Solutions LLC	1275 Peachtree Street NE, 6th Floor, Atlanta, GA 30309	NEMT			Not currently providing services	1275 Peachtree Street NE, 6th Floor, Atlanta, GA 30309
VSP*	Vision Service Plan (VSP)	**Corporate Headquarters:** 3333 Quality Drive, Rancho Cordova, CA, 95670. **Eastern Operations Center:** 3400 Morse Crossing, Columbus, OH, 43219. 614-471-7511 or 800-462-7009.	Vision			Not currently providing services	26 additional regional sales offices across the country to provide local service

Vendor	Legal Name	Mailing Address	Description of Work	Monitor	Evaluate	Currently Providing Services	Where are they located
eyeQuest*	DentaQuesat	465 Medford St., Boston, MA 02129	Vision	section G.	permitting us to terminate the agreement for non-performance of contract requirements and/or the inability of the subcontractor to meet established performance standards. For more information on LaCare's subcontractor evaluation processes and procedures, please see section G.	Not currently providing services	Does not currently have local representation.
AmeriHealth Mercy Health Plan (AMHP)	AmeriHealth Mercy Health Plan (AMHP	200 Stevens Drive, Philadelphia, Pennsylvania 19113	Corporate functions and support services. A detailed description is available bellow.			AmeriHealth Mercy Family of Companies	200 Stevens Drive, Philadelphia, Pennsylvania 19113
*Designated subcontract with whom AmeriHealth Mercy of Louisiana, Inc. has a Letter of Agreement							

In addition, as part of the response to this item, for each major subcontractor that is not your organization's parent organization, affiliate, or subsidiary, restate and respond to items B.1 through B.7, B10 and, B.16 through B.27

In the event of an award of a CCN contract, LaCare will execute the appropriate contract documents with ACS Commercial Solutions, Inc. for claims imaging and claims data entry and with SironaHealth, Inc. for 24/7 Nurse Call Line services. More detailed information regarding both of these non-affiliated subcontractors is further detailed below. We also intend to use non-affiliated subcontractors to perform Non-Emergency Medical Transportation (NEMT) and Vision Care services. LaCare has executed Letters of Intent with various vendors and is in the process of evaluating which vendors it will select to provide NEMT and Vision Care Services; upon selection, we will provide DHH with the vendor information requested in items B. 1 through B. 7, B. 10, and B. 16 through B. 27 of the RFP.

SironaHealth

Name and Mailing Address of your Company.		
B.1 Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (*e.g.* publicly traded corporation). Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.	Legal Name: Trade Name: Prior Company Name: Physical and Mailing Address: Corporate phone: Corporate fax: Form of Business: State of incorporation:	**SironaHealth, Inc.** SironaHealth IntelliCare 500 Southborough Drive, Suite 105 South Portland, ME 04106 888 674 7662 207 773 1857 **url:**www.sironahealth.com Privately held, S Corporation Delaware

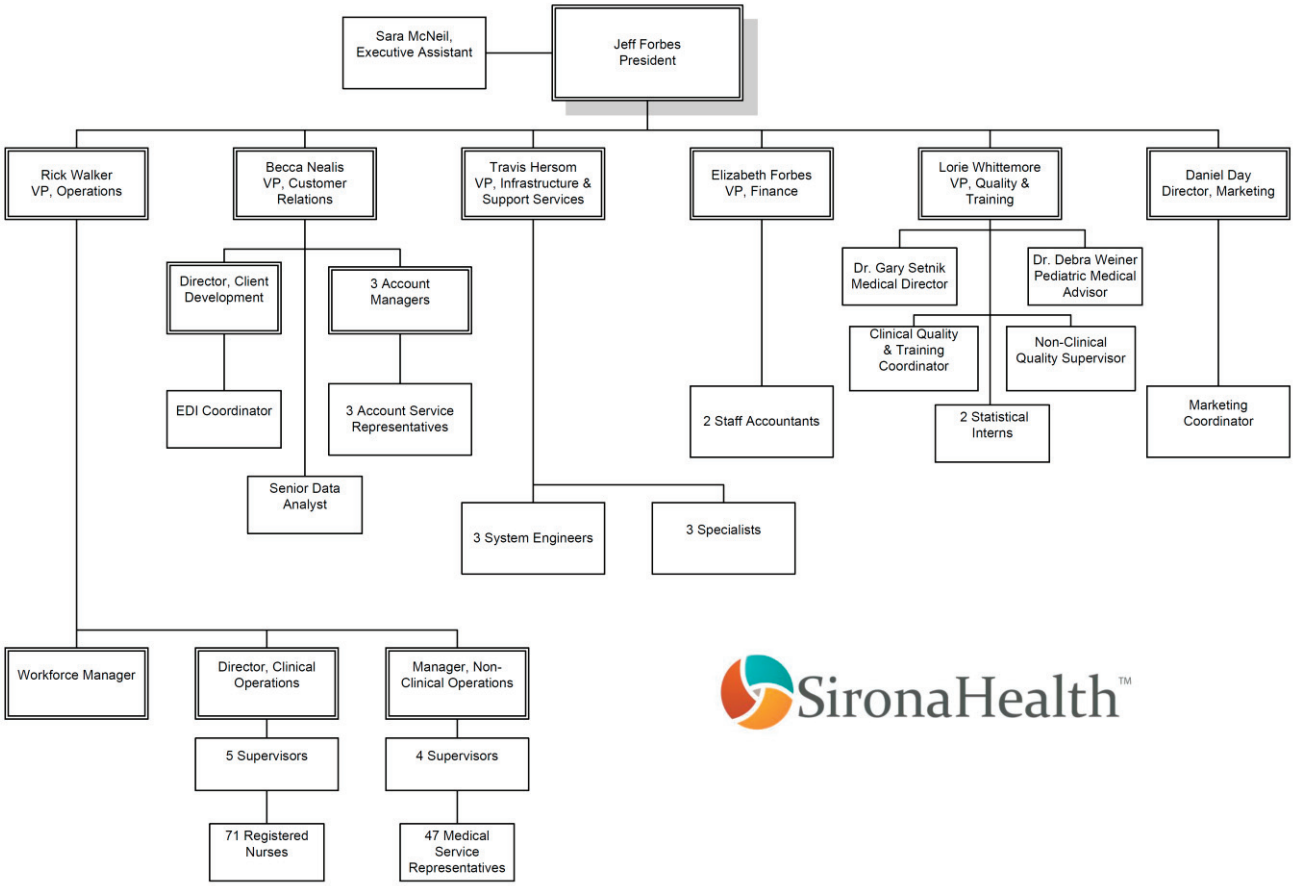
Provide your federal taxpayer identification number and Louisiana taxpayer identification number. Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provider the name and address of the local representative; if none, so state. If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.	DUNS#: 829169510 TIN#: 26-3734240 SironaHealth Contacts: Jeff Forbes President 207 771 2953 jforbes@sironahealth.com Rebecca Nealis Vice President, Customer Relations 207 253 2126 rnealis-albee@sironahealth.com SironaHealth is owned by a group of fourteen key manager and employees. None of the owners with at least a 5% interest in the organization are healthcare professionals. SironaHealth has not held a direct contract of DHH within the past 24 month period. SironaHealth served as a nurse advice line subcontractor for ACS Care and Quality Solutions for services provided to the state of Louisiana from July 2009 through April of 2010.
B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. **Include your organization's parent organization, affiliates, and subsidiaries.**	SironaHealth is a privately held company with no parent organization. There are no planned changes in ownership. The SironaHealth management and operation teams have provided healthcare call center services since 1997 under the brand names of SironaHealth and IntelliCare. On March 1, 2009, SironaHealth launched as a healthcare call center and successfully transitioned the operations and book of business of IntelliCare. Formed by the former management of IntelliCare, SironaHealth maintains the same vision and guiding principles of providing complete medical call center programs that are focused on engaging the health consumer and influencing healthy behaviors. The management, operations, and software development teams of SironaHealth have been providing medical call center solutions since 1997.
B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have **ever** been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. **Include your organization's parent organization, affiliates, and subsidiaries**.	No SironaHealth employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled nolo contendere to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body.
B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. I**nclude your**	There is no pending or recent litigation against SironaHealth.

organization's parent organization, affiliates, and subsidiaries.	
B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	SironaHealth has not filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.
B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report. Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	SironaHealth is not a publically traded organization.
B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner. Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.	SironaHealth is not wholly owned by another corporation.
B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience. If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.	

If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.

For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.

SironaHealth Exhibit A: Organizational chart



SironaHealth's proven effective business model focuses on cross-training techniques, supported by a sophisticated technology platform. SironaHeatlh currently handles over 310,000 triage calls per year and anticipates that LaCare will make up approximately 8% of its total nurse triage business. When employees are not actively serving LaCare members, they will be serving within the same function, but simply with other clients throughout the United States. The 24/7 Nurse Call Line staff will be trained to assist members and meet the requirements set forth in this RFP.

MANAGEMENT SUMMARIES

The senior management staff has significant experience in emergency and pediatric medicine, technology and process management.

Jeff Forbes ● *President, SironaHealth*

Prior to joining SironaHealth, Mr. Forbes was responsible for Medco's IntelliCare business unit. Over the last seven years, Mr. Forbes has served IntelliCare as CIO, COO, and most recently as General Manager. In his various roles at IntelliCare, Mr. Forbes has played a leadership role in the development and deployment of quality programs, new products, sales initiatives, operations improvement, and new technology. Before joining IntelliCare, he served as Vice President of Information Services at Barber Foods, where he turned IT into a strategic component by his early adoption of Internet technologies deploying a Nation-wide Internet Promotion Management System for food service and retail brokers. Mr. Forbes also held various management positions at Unum Life Insurance, where he deployed customer management and knowledge-based underwriting systems, and National Semiconductor/Fairchild, where he implemented a global ERP system for manufacturing. He holds a bachelor's degree in computer science from the University of Maine in Orono and a bachelor's of arts degree from University of Maryland, College Park and is certified in Total Quality Management (TQM). Jeff has been with IntelliCare/SironaHealth since 2001 and does not have Medicaid Managed Care experience.

Gary S. Setnik MD, FACEP ●*Medical Director*

Dr. Setnik is responsible for all aspects of clinical quality and risk management for SironaHealth. He has served as medical director for Health Front Educational Services, a Boston-based medical call center company, since its inception in 1991. Dr. Setnik has practiced and taught emergency medicine for 26 years. He is chair of the emergency department at Mount Auburn Hospital in Cambridge, Massachusetts, and since 1977 he has been an Assistant Professor in the Division of Emergency Medicine at Harvard Medical School, where he has chaired several committees on emergency medicine. He has also served on the board of directors for the Regional EMS Advisory Council. Dr. Setnik holds a bachelor's degree from Miami University in Oxford, Ohio, and an M.D. from Ohio State University College of Medicine in Columbus. Dr. Setnik has serviced as IntelliCare/SironaHealth's Medical Director since 1997.

Debra Weiner, MD ● *Pediatric Medical Director*

Dr. Weiner is the pediatric advisor for SironaHealth. Dr. Weiner is responsible for providing guidance regarding phone triage care of pediatric patients. Dr. Weiner is a board certified pediatrician and pediatric emergency medicine physician at Children's Hospital Boston (CHB), where she has practiced for 15 years since completing Pediatric Emergency Medicine Fellowship training at CHB. Dr. Weiner is also an Assistant Professor at Harvard Medical School (HMS), and is Director of the HMS Pediatric Emergency Medicine clerkship. Dr. Weiner has served as the Pediatric Emergency Medicine consultant for CHBs telephone triage service. She serves on multiple CHB committees that have developed clinical practice guidelines for patient care at CHB. Dr. Weiner has authored numerous articles and chapters related to Pediatric Emergency Care. Dr. Weiner earned her MD at University of Southern California, her PhD in Human Genetics at Medical College of Virginia and received residency training in Pediatrics at University of Colorado Health Sciences.

Lorie Whittemore, RNBC, BSN, CCM ● *Vice President, Quality and Training*

Ms. Whittemore is responsible for the oversight of all Quality and Training activities for SironaHealth, including compliance with URAC accreditation standards, quality monitoring, risk management, process improvement, and training throughout the organization. She brings over 20 years of healthcare experience to this position, including both clinical and management experience. Prior to her work at SironaHealth, Ms. Whittemore worked at IntelliCare as a Telehealth Nurse Consultant and Nursing Team Manager. As a Manager she assisted with the development, implementation, and oversight of new programs along with striving for quality and excellence within her nursing team. Most recently, Lorie served as IntelliCare's Quality Coordinator.

Ms. Whittemore holds a Bachelors of Science degree in Nursing from the University of Southern Maine and active certifications in Medical/Surgical Nursing and Case Management. She also holds a leadership position within a local service organization in her community. Lorie has been with IntelliCare/SironaHealth since 2002 and does not have Medicaid Managed Care experience.

Caroline White, BSN, RNC ● *Director of Clinical Operations*

Caroline is a 34-year veteran in the heatlh care industry. She brings over 20 years of ambulatory care experience to her current role with 12 of those years specific to telehealth. Caroline is responsible for the management of 24-hour clinical services -- leading her nursing teams toward operating efficiency while ensuring quality caller care. In addition to her role as a management leader, Caroline participates in corporate wide process improvement teams and task forces to promote the development of an empowered nursing team at SironaHealth. She is also an active member of the AAACN as well as Texas Nurses Association. Prior to joining SironaHealth, Caroline served as Director of Clinical Operations,

Clinical Quality and Training Coordinator, and staff nurse for IntelliCare, Inc. She has also held clinical management positions in Critical Care, Oncology/Hospice, School Nursing, and Community Health.

Ms. White holds a Bachelor of Science degree in Nursing from the University of Texas and has active certification in Telehealth Nursing. Caroline has been with IntelliCare/SironaHealth since 2001 and does not have Medicaid Managed Care experience.

Rick Walker ● *Vice President, Operations*

Mr. Walker is responsible for SironaHealth's clinical and non-clinical outsource services business units, disease management support services, enrollment outreach services, and workforce management. Throughout his tenure with SironaHealthhe has served in many capacities including the management of: acquisition assimilation, client services, financial forecasting, finance, and human resources. Prior to joining SironaHealth, Mr. Walker was the Senior Vice President at Medaphis Physician Services Corporation (PerSe), where he managed the Northeast Division Operations that included 21 sites, 500 employees and more than $25 million in annual revenue. His 20 years of revenue cycle and physician practice management experience includes the operational responsibilities of large multi-location process centers, call center integration, client management, and strategic consulting responsibilities. He has extensive experience in mergers, acquisitions, due diligence, and operations assimilation. Prior to Medaphis, Mr. Walker was a senior manager with Ernst and Young. Mr. Walker received a bachelor's degree in management from Babson College. Rick has been with IntelliCare/SironaHealth since 2001 and does not have Medicaid Managed Care experience.

Elizabeth Forbes ● *Vice President, Finance*

Ms. Forbes (no relation to Jeff Forbes) joined IntelliCare in 2001 and is responsible for directing all financial and accounting functions at IntelliCare. During her tenure with IntelliCare, Elizabeth has been a key contributor to the organization serving as Staff Accountant, Senior Accountant, Manager of Finance and Accounting, and now as Vice President of Finance. Prior to IntelliCare, Ms. Forbes was a Fund Accountant with Philo Smith & Co. in Stamford, CT and a Staff Accountant for HOP Energy, LLC, formerly Heating Oil Partners, LLC, in Darien, CT. She received her bachelor's of science in accounting from the University of Southern Maine. Elizabeth has been with IntelliCare/SironaHealth since 2001 and does not have Medicaid Managed Care experience.

Rebecca Nealis ● *Vice President, Customer Relations*

Ms. Nealis is responsible for Account Management and Project Management services for SironaHealth. As a Project Manager and VP of Customer Relations with IntelliCare, Ms. Nealis managed a multitude of large scale call center services implementations for health plans, research organizations, and disease management organizations. Prior to joining IntelliCare, Ms. Nealis worked as an Operation Manager for a Maine-based telephone company and as a Human Resources Manager for the Portland Press Herald in Portland, Maine. Ms. Nealis holds an MBA from the University of New Hampshire and a BS in Management from Boston College. Rebecca has been with IntelliCare/SironaHealth since 2004. She has experience providing account management services to Medicaid health plan clients.

Travis Hersom ● *Vice President, Infrastructure*

Mr. Hersom had been with SironaHealth for eight years and is responsible for the development, deployment, and maintenance of SironaHealth's technology infrastructure including network, telephony, server, and desktop infrastructure. Mr. Hersom also oversees SironaHealth Support Services team. Prior to SironaHealth, Mr. Hersom served as a technical deployment engineer at UNUM Provident and was responsible for deploying the organization's enterprise systems. Travis has been with IntelliCare/SironaHealth since 2000 and does not have Medicaid Managed Care experience.

Daniel Day ● *Director, Strategic Marketing & Communications*

Daniel is responsible for the development and management of marketing strategy, communications, and brand development for SironaHealth. In addition to his integrated marketing responsibilities, he is directly involved in new product development for current and emerging markets. Daniel received his bachelor's degree in Business Administration with a focus in marketing from Endicott College, Beverly, MA. Dan has been with IntelliCare/SironaHealth since 2004 and does not have Medicaid Managed Care experience.

SIRONAHEALTH
POSITION PROFILE/JOB DESCRIPTION

Position Title: Senior Project Leader

Reports To: Vice President Customer Relations

POSITION SUMMARY

The Senior Project Leader is responsible for planning, executing, and finalize projects according to quality, timing, and budget goals. This includes identifying resources and coordinating the efforts of team members, third-party contractors, and/or consultants in order to deliver projects according to plan. The Senior Project Leader works with customers and business process owners to define the project's objectives. The Senior Project Leader oversees quality control throughout its life cycle.

PREFERRED QUALIFICATIONS

- Business, Technical or Liberal Arts degree or equivalent experience and education
- Excellent oral and writing skills
- 3 - 5 years direct work experience in a project management capacity, including all aspects of process development and execution.
- Strong familiarity with project management techniques,
- Technically competent with software programs, such as Microsoft Excel, and Word.
- Self Directed with strong team and collaborative skills
- Persuasive, encouraging, and motivating yet a good listener
- Effectively communicate with all organizational levels within and outside the corporation
- Ability to read communication styles of team members and contractors who come from a broad spectrum of backgrounds.
- Reacts to project adjustments and shifting priorities promptly and efficiently.
- Ability to defuse tension among project team and customers if needed
- Ability to bring project to successful completion with political sensitivity
- Must be able to learn, understand, and apply new technologies
- Ability to effectively prioritize and execute tasks in a high-pressure environment

BASIC MINIMUM QUALIFICATIONS

- 5-10 years project management responsibility
- □-10 years project management responsible

PHYSICAL REQUIREMENTS

SironaHealth is often a fast paced work environment requiring an ability to prioritize and work effectively and efficiently with members of the organization regardless of pressure. Sedentary work requiring good manual dexterity with repetitive motions of wrists, hands, and fingers. Must have vision sufficiently correctable to work with a computer monitor. Must have excellent listening skills to receive detailed information through oral communication.

SERVICE DELIVERY EXPECTATIONS

- Team player.
- Ability to focus and complete tasks
- Effective problem solving skills.
- Excellent customer service skills.
- HIPPA Compliant.
- Demonstrate leadership skills.
- Adhere to SironaHealth's "Code of Conduct" philosophy

KEY JOB RESPONSIBILITIES AND TASKS

- Direct and manage project entire project life cycle.
- Define project scope, goals and deliverables that support business goals in collaboration with all customers
- Develop full-scale project plans and associated communications documents.
- Effectively communicate project expectations to team members and all customers in a timely and clear fashion.
- Provide candid updates to project with all customers on an ongoing basis.

- Estimate the resources and participants needed to achieve project goals.
- Draft and submit budget proposals, and recommend subsequent budget changes
- Where required, negotiate with other department managers for the acquisition of required personnel from within the company.
- Determine and assess need for additional staff and/or consultants and make the appropriate recruitments if necessary during project cycle.
- Set and continually manage project expectations with team members and all customers
- Delegate tasks and responsibilities to appropriate personnel.
- Identify and resolve issues and conflicts within the project team.
- Identify and manage project dependencies and critical path.
- Plan and schedule project time lines and milestones using appropriate tools.
- Track and report project milestones and deliverables.
- Develop and deliver progress reports, proposals, requirements documentation and presentations.
- Determine the frequency and content of status reports from the project team, analyze results, and troubleshoot problem areas.
- Pro-actively manage changes in scope, identify potential crises, and devise contingency plans.
- Define project success criteria and disseminate to involved parties throughout project life cycle.
- Coach, mentor, motivate and supervise project team members and contractors to influence them to take positive action and accountability for their assigned work.
- Build, develop, and grow any business relationships vital to the success of the project.
- Conduct post project assessments to drive process improvement
- Continuously improve practices and tools for project execution and management.

SIRONAHEALTH
POSITION PROFILE/JOB DESCRIPTION

Position Title: Nurse Consultant - Triage
Reports To: Nursing Team Supervisor/Manager - Triage

POSITION SUMMARY

The Nurse Consultant (NC) practices computer assisted expert nursing through inbound and outbound telephone contacts with patients whose physicians, hospitals, insurers, employers or other sponsors/providers are SironaHealth clients. Utilizing clinical software and guideline/information databases, the NC is responsible for assessing, triaging, and advising patients/callers who present with symptom-based problems or general health questions. This includes facilitating referrals to primary providers, specialists, healthcare facilities, and community resources as appropriate. The NC assists patients/callers to improve their health status via participation in client-sponsored disease management programs as well. Provides support to Medical Service Representatives (MSRs) through clinical monitoring, oversight and immediate availability for clinical issues that arise during coordination of client medical communications. Involvement with the SironaHealth Quality Improvement program is essential, and may incorporate involvement with surveys to define and measure client services or other process improvement activities.

QUALIFICATIONS

Current active RN license in the state where the nurse resides with no disciplinary action restriction. Nurse may be requested to obtain licenses in multiple states, but will be required to obtain CA license for this position. Home state license must not have restrictions preventing obtaining a license outside of their home state. Minimum of 3 years clinical experience in acute or ambulatory care setting. Superior nursing process skills and patient service drive. Positive, enthusiastic, helpful, fun-seeking personality. Organized, able to set priorities and work effectively under pressure with minimum supervision. Works well as a team member. Must have or quickly develop an ability to think, talk, and type simultaneously while utilizing excellent telephone communication skills and customer focused interpersonal relationship skills. Must have basic PC skills, proficiency in typing, ability to pass a Clinical proficiency test and a comfort with Windows Operating Systems. Membership in a professional organization or certification in a specialty is highly desired.

PHYSICAL REQUIREMENTS

SironaHealth is often a fast paced work environment requiring an ability to prioritize and work effectively and efficiently with patients/callers regardless of pressure. Sedentary work requiring good manual dexterity with repetitive motions of wrists, hands, and fingers. Must have vision sufficiently correctable to work with a computer monitor. Must have excellent hearing and listening skills to receive detailed

information through oral communication.

WORK ENVIRONMENT

Remote site office with a locked door. Special attention is given to assure ergonomically correct facilities that are compliant with ADA regulations.

NURSE CONSULTANT KEY JOB RESPONSIBILITIES AND TASKS

1. Promptly, answers telephone inquiries regarding caller needs through effective listening and asking open-ended questions. Demonstrates positive customer relationship skills with all encounters.
2. Utilizes expert nurse software to conduct sound nursing assessments, triage, and advice to patients/callers who have symptom- based problems. This includes uses of databases or approved reference material to provide health counseling and resource information to those who may not be experiencing any symptom based problems.
3. Thorough, concise documentation of all calls for medical/legal/statistical purposes with adherence to confidentiality agreements and policy and procedures.
4. Performs outbound patient contacts as part of SironaHealth's Quality Program. This may include utilizing special protocols to assess and advise patients who are participating in wellness or disease management programs or are being monitored during post-discharge or preadmission phases of care.
5. Meets outlined quality benchmarks and quality indicators as monitored. Accepts responsibility to correct any pattern of deficiency identified through quality audits, monitoring, or recordings. Demonstrates quality by documenting the application of the nursing process in a responsible, accountable and ethical manner.
6. Reports unusual calls or variances to established policies and procedures to Nursing Team Manager or Directors of Nursing.
7. Assists with medical communications coordination as needed in support of the MSR team.
8. Successfully completes annual competencies and a self -performance evaluation with outlined goals and objectives.
9. Maintains current knowledge base regarding practice issues and records educational activities
10. Participates willingly in committees, orientation and/or staffing processes as part of his/her professional growth.
11. Promotes sense of pride in call center and positive interpersonal relations among all team members. Exhibits commitment to effective problem solving techniques when issues arise.
12. Independently seeks out guidance/assistance as needed. In the absence of a Nursing Team Manager, assures that shift team members have completed all routine operations/communications functions.
13. Continuously acts to maintain a safe, clean, healthy and fun work environment consistent with SironaHealth's professional patient/caller service vision, values and endeavors. Ensures a work environment that meets with HIPPA regulations.
14. Demonstrates flexibility in providing coverage and/or availability for the call center via scheduling adjustments for unexpected absences, events or call volume variances.
15. Attends or reviews recording of 80% of team meetings annually. Assumes responsibility for staying current with call center changes via various communication tools.
16. Remains current with content knowledge of computer –assisted expert clinical nursing guidelines, reference material, and call center technologies.
17. Practices according to current practice standards, nurse practice act, laws and regulations.

Reference: AAACN Standard III.1; HCC Standard 5.6,20

SIRONAHEALTH
POSITION PROFILE/JOB DESCRIPTION

Position Title: Medical Service Representative
Reports To: Supervisor, Non-Clinical Operations

POSITION SUMMARY

This is an entry-level Medical Service Representative (MSR) position responsible for professionally responding to telephone inquiries from callers (client patients / members) as they relate to various health services provide by SironaHealth. MSR's must have excellent verbal and written communication, customer service and organizational skills, and the ability to multi task~~s~~.

BASIC MINIMUM QUALIFICATIONS

- High School Diploma ~~(~~or the equivalent~~)~~,
- 1-year experience in a customer service environment.
- Basic computer skills
- At least six months phone experience in a previous job or volunteer position.

PHYSICAL REQUIREMENTS

SironaHealth is often a fast paced work environment requiring an ability to prioritize and work effectively and efficiently with patients/callers regardless of pressure. Sedentary work requiring good manual dexterity with repetitive motions of wrists, hands, and fingers. Must have vision sufficiently correctable to work with a computer monitor. Must have excellent hearing and listening skills to receive detailed information through oral communication.

KEY JOB RESPONSIBILITIES AND TASKS

- Promptly answers, screens and processes medical service requests and telephone inquiries with strict adherence to confidentiality agreements and policies and procedures.
- Provide information on SironaHealth's customers' programs, policies and procedures.
- Collect and enter patient intake information into the appropriate medical service software system to initiate the transaction. Documentation is to be concise, thorough and accurate.
- Refer patients to the SironaHealth's nursing team for triage and medical advice.
- Responds to Crisis/Red Flag calls and refer to nursing staff until resolution.
- Utilizing automated (or if unavailable, manually) computer software to schedule appointment, take messages for physician visits and services and effectively communicating such information to the appropriate party per established protocols or rules of client.
- Participates in internal and external educational opportunities relevant to the call center or customer service environment.
- Attends or reviews 100% of team meetings annually.
- Respond to irate callers in a professional manner.
- Meets outlined SironaHealth QCare benchmarks and/or quality indicators as monitored through audits or recordings.
- Supports organizational changes. Demonstrates flexibility in providing coverage and/or availability for the call center via scheduling adjustments for unexpected absences, events or call volume variances.
- Other duties and special projects that are assigned by management.

B.16 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. I**nclude your organization's parent organization, affiliates, and subsidiaries.**

Contracted Entity	Scope of Work	Duration of Contract	Contact Name	Contact Phone Number	Number of Members	Population Type	Annual Contract Payments	Form of Payment	Role of Subcontractors

Contracted Entity	Scope of Work	Duration of Contract	Contact Name	Contact Phone Number	Number of Members	Population Type	Annual Contract Payments	Form of Payment	Role of Subcontractors
ACS Care and Quality Solutions	Nurse Advice Line	January 2009 - Present	Kathy McCormick	414-325-3990	Currently no clients with this entity	Varies	$30,000.00	Transaction Based	Outsource Translation Services to Certified Languages International
Boston Medical Center HealthNet Plan	Engagement Services (non-clinical)	January 2008 - Present	Rosemary Ajoku	617-748-6280	245,000	Medicaid	$75,000.00	Transaction Based	Outsource Translation Services to Certified Languages International
Care 1st Health Plan of Arizona	Nurse Advice Line, Transportation Coordination, Administrative Calls	February 2005 - Present	Rachel McDonald	602-778-1800	54,000	Medicaid	$210,000.00	Capitated - Per member, per month	Outsource Translation Services to Certified Languages International
Community Health Solutions of America	Nurse Advice Line	April 2010 - Present	Berta O'Leary	727-498-0019		Medicaid	$30,000.00	Transaction Based	Outsource Translation Services to Certified Languages International
Health Integrated	Nurse Advice Line	September 2010 - Present	Amber Steffenson	813-388-4028	170,000	Medicaid	$24,000.00	Transaction Based	Outsource Translation Services to Certified Languages International
Health Partners of Philadelphia	Nurse Advice Line	November 2009 - Present	Debra Kircher	215-849-9606	154,000	Medicaid, CHIP	$75,000.00	Capitated - Per member, per month	Outsource Translation Services to Certified Languages International
MDWise Inc.	Nurse Advice Line, Behavioral Health Line	June 2005 - Present	Maggie Moss	317-630-2831	300,000	Medicaid	$340,000.00	Transaction Based	Outsource Translation Services to Certified Languages International

Passport Health Plan	Nurse Advice Line	January 2006 - Present	Lennette Springfield	502-585-8359	161,000	Medicaid	$300,000.00	Capitated - Per member, per month	Outsource Translation Services to Certified Languages International
Texas Children's Health Plan	Nurse Advice Line	June 2006 - November 2009	Jan Scott	832-825-8703	230,000	Medicaid, CHIP	$600,000.00	Capitated - Per member, per month	Outsource Translation Services to Certified Languages International
Universal Health Care Group Inc.	Nurse Advice Line	September 2007 - Present	Cheryl Moss	727-456-2919	165,000	Medicaid and Medicare	$180,000.00	Capitated - Per member, per month	Outsource Translation Services to Certified Languages International

B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. **Include your organization's parent organization, affiliates, and subsidiaries.**	**Texas Children's Health Plan** 2450 Holcombe Blvd, Suite 34L Houston, TX 77021 Contract commenced June 1, 2006 and was terminated on November 30, 2009. Services Provided: Nurse Advice Line Services, Member Services Overflow Reason for Termination: Contract went out to bid according to regular schedule. Business was awarded to a call center located within Texas. Contact: Jan Scott, Vice President Government Programs Phone: 832-825-8703 E-mail: jbscott@texaschildrenshospital.org
B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. **Include your organization's parent organization, affiliates, and subsidiaries.**	The contract referenced in B.17 was not terminated based on performance.
B. 19 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following: • AM Best Company (financial strengths ratings); • TheStreet.com, Inc. (safety ratings); and • Standard & Poor's (long-term insurer financial strength.	SironaHealth does not have these ratings available.
B.20 For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found	This question is not applicable, as SironaHealth does not provide physical health services.

your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? I**nclude your organization's parent organization, affiliates, and subsidiaries.**	
B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.	SironaHealth is URAC accredited as a Health Call Center. The current accreditation went into effect on February 1, 2009 and expires on February 1, 2012, with intent to seek re-accreditation.
B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. **Include your organization's parent organization, affiliates, and subsidiaries.**	SironaHealth has never had its URAC accreditation status adjusted down, suspended or revoked.
B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	SironaHealth is not NCQA accredited.
B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (**including your organization's parent organization, affiliates, and subsidiaries**) in response to the report.	SironaHealth has not had an external quality review or corrective actions pursuant to Section 1932(c)(2) of the Social Security Act. However, SironaHealth is URAC accredited as a Health Call Center and must adhere to URAC standards.
B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	There has been no regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against SironaHealth within the last five (5) years. There has been no letter of deficiency issued to SironaHealth or any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts.
	SironaHealth has not been and is not currently the subject of a criminal or

B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. **Include your organization's parent company, affiliates and subsidiaries.**	civil investigation by a state or federal agency.
B.27 Submit name, phone number and address of client references (minimum of three, maximum of five) for your organization; with at least one reference from a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years.	References are enclosed as Attachment B.11.

ACS

Name and Mailing Address of your Company.	
B.1 Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (*e.g*. publicly traded corporation). Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest. Provide your federal taxpayer identification number and Louisiana taxpayer identification number. Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provider the name and address of the local representative; if none, so state. If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.	ACS, a Xerox Company, company headquarters are located: 2828 North Haskell Avenue Dallas, TX 75204 214-841-6111 (office) 214-823-5746 (fax) info@acs-inc.com Our parent company, the Xerox Corporation corporate headquarters are located: 45 Glover Avenue PO Box 4505 Norwalk, CT 06856-4505 1-203-968-3000 (office) ACS is a corporation. Our parent company, Xerox, is also a corporation. There are no individuals including health professionals who own more than 4% interest in our company. We have several employees and offices in the State of Louisiana. There is no single local representative. The contact name for this response content is: Rob Levy, ACS Sales Director Commercial Healthcare ACS, Inc. A Xerox Company Tel: 770-558-4378 Rob.levy@acs-inc.com 721 Hambledon Bend Alpharetta, GA 30022-8514 Affiliated Computer Services, Inc. was incorporated in Delaware in 1988. ACS Commercial Solutions, Inc. division was incorporated in 1990 in Nevada and acquired by ACS in 1998. ACS was acquired by Xerox in February, 2010. Xerox was founded in 1906 and became the Xerox Corporation in 1961.

ACS, a Xerox Company, is the world's largest diversified business process outsourcing and information technology services firm supporting client operations in more than 160 countries. ACS Commercial Solutions, Inc., a division of Affiliated Computer Services, Inc., is proposing services in response to the RFP. The following information is being provided for the parent company, and the division in which services will be performed:

	Parent Company	ACS	Division
Name of Company	Xerox Corporation	Affiliated Computer Services, Inc.	ACS Commercial Solutions, Inc.
Address of Company	45 Glover Ave. Norwalk, CT 06856-4505	2828 North Haskell Ave. Dallas, TX 75204	101 Yorkshire Blvd. Lexington, KY 40509
Telephone number	203-968-3000	214-841-6111 214-823-5746 (fax)	859-389-4000
Web site address	www.xerox.com	www.acs-inc.com	www.acs-inc.com
Dun & Bradstreet Number	04-959-1852	19-419-0609	61-760-8476
Tax identification number	160468020	51-0310342	87-0476606

B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. **Include your organization's parent organization, affiliates, and subsidiaries.**

Our parent company, the Xerox Corporation corporate headquarters are located:
45 Glover Avenue
PO Box 4505
Norwalk, CT 06856-4505
1-203-968-3000 (office)

ACS was acquired by Xerox in February, 2010. Xerox was founded in 1906 and became the Xerox Corporation in 1961.

Below outlines Xerox Corporation
Xerox announced May, 2011 the acquisition of NewField IT, a UK-based Managed Print Services (MPS) print consultancy and software solution provider. NewField IT is a best-in-class software solutions provider that helps companies implement and manage their MPS requirements more quickly and efficiently, utilizing their AssetDB® Software suite.

Xerox and ACS announced three important acquisitions during the first quarter of 2011. First, ACS will acquire CredenceHealth Inc., creating a simple way for healthcare providers to use patient information to predict and prevent patient medical complications. Through a cloud-based solution, CredenceHealth's clinical surveillance tools will be integrated with ACS' core suite of managed care solutions to deliver an extremely robust offering in the

	critical healthcare industry. In addition, ACS also will expand its capabilities in customer care services through the acquisition of Unamic/HCN, the largest privately-owned customer care provider in the Benelux. This agreement is ACS's first acquisition in the European customer care market and demonstrates the significant potential we envisioned when Xerox acquired ACS. Finally, Xerox Europe acquired Concept Group, a supplier of digital document solutions to more than 3000 customers in the UK. This acquisition delivers channel expansion and extends our reach to small and medium sized businesses. In October of 2010, ACS extended its pharmaceutical services with the acquisition of TMS Health from Private Equity firm Palm Beach Capital. TMS brings new offerings such as physician services and clinical trials as well as strong communications capabilities. With this acquisition, ACS becomes one of the largest providers of customer care services to the pharmaceutical and biotech healthcare industries. In May 2010, ACS announced an agreement to acquire ExcellerateHRO, LLP (EHRO), a global benefits administration and relocation services provider from Hewlett-Packard Company. This acquisition will establish ACS as one of the world's single largest pension administrators and will clearly demonstrate Xerox's commitment to invest in HR services. On February 8th, 2010, Xerox completed its acquisition of Affiliated Computer Services, Inc., transforming Xerox into the world's leader in business process and document management. The new Xerox provides the technology and services to help our customers reach new levels of efficiency and effectiveness, giving them the freedom to focus on what matters most: their real business ACS is the largest diversified business process outsourcing (BPO) firm in the world. Its expertise is in automating work processes and providing BPO and IT outsourcing services that range from processing over 1 million credit card applications and 12 million student loans each year to providing HR services for more than 4.4 million employees and retirees annually.
B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have **ever** been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. **Include your organization's parent organization, affiliates, and subsidiaries**.	ACS, Xerox is party to no litigation which will materially affect its ability to perform the services required by this RFP. However, in the normal course of operations, ACS becomes involved, from time to time, in general, commercial, or business litigation, as either a plaintiff or a defendant. The number of cases varies and involves disputes on matters of payment, breach of contract, negligence, employment, and similar matters common to employers doing business in the United States. No pending cases are, in ACS' judgment, material or likely to have an adverse impact on ACS' ability to perform services under this RFP. There has been no such litigation in the past three years. Our current annual report is available at www.acs-inc.com to view detailed information on any current or pending legal proceedings. ACS is not aware of any employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled nolo contendere to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body.
B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be	ACS is subject to certain legal actions and proceedings, claims, and disputes, which arise in the ordinary course of business. ACS Management and the ACS Legal Department do not believe that any of those actions or proceedings will have a materially adverse impact on ACS's financial position, results of operations, or liquidity. In October 2002, a former ACS subsidiary, ACS Defense, LLC, and several other government contractors received a grand jury document subpoena

covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	issued by the U.S. District Court for the District of Massachusetts. The subpoena was issued in connection with an inquiry being conducted by the Antitrust Division of the Department of Justice ("DOJ"). The inquiry concerns certain IDIQ (Indefinite Delivery – Indefinite Quantity) procurements and their related task orders, which occurred in the late 1990s at Hanscom Air Force Base in Massachusetts. In February 2004, ACS sold the contracts associated with the Hanscom Air Force Base relationship to ManTech International Corporation ("ManTech"); however, ACS has agreed to indemnify ManTech with respect to this DOJ investigation, which remains ongoing. ACS has cooperated fully with the DOJ's investigation, and until a decision is made by the government regarding any further action, the impact to ACS, if any, cannot be determined. On March 3, 2006, ACS received notice from the SEC that it was conducting an investigation into certain stock option grants made from October 1998 through March 2005. On June 7, 2006 and on June 16, 2006, ACS received requests from the SEC for information on all ACS stock option grants since 1994. ACS has been providing supplemental information to the SEC on a voluntary basis following the initial SEC requests. The SEC issued its formal order of investigation in August 2006. The investigation remains active and ACS has had ongoing discussions with the SEC regarding its resolution. Until a decision is made by the government regarding any further action, the impact to ACS, if any, cannot be determined. On April 4, 2008, JP Morgan Chase & Co. ("JPMorgan") filed a lawsuit against ACS and ACS SLS (collectively, "ACS") in U.S. District Court in Wilmington, Delaware. JPMorgan seeks certain declarations as well as unspecified monetary damages related to alleged violations by ACS of JPMorgan's lockbox, and check processing and imaging patents. ACS denies JPMorgan's allegations and is vigorously defending this lawsuit. In September and October 2009, nine lawsuits were filed in connection with the Merger Agreement with Xerox Corporation ("Xerox"). Seven lawsuits were filed in the District and County Courts of Dallas County, Texas and two lawsuits were filed in Delaware Chancery Court. The plaintiffs in each case allege that they are ACS stockholders, and they purport to bring a class action on behalf of all of ACS's stockholders. The lawsuits generally assert claims of breach of fiduciary duties against members of ACS's board of directors, allegedly aided and abetted by ACS and Xerox. The plaintiffs allege that the terms of the proposed acquisition are unfair to ACS's Class A stockholders, and plaintiffs seek recovery of unspecified monetary damages allegedly sustained by the stockholders. All of the litigation arising from the acquisition offer is being vigorously defended and ACS believes it has meritorious defenses to the plaintiffs' claims. Government contracts are subject to review and audit by various government agencies in the normal course of business. ACS Management believes that any such reviews and audits for subsequent fiscal years will not have a materially adverse impact on ACS's financial position or the results of operations. ACS Management and the ACS Legal Department do not believe that any of the actions or proceedings will have a materially adverse impact on ACS's financial position, results of operations, or liquidity. ACS has never been subject to debarment or felony conviction. Please also refer to recent SEC Form Proxy, 8-K and10-Q, filed by Affiliated Computer Services, Inc., also available on EDGAR website and on ACS's webpage at: www.acs-inc.com.

B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	ACS, our predecessors and our parent company have not filed or had filed against, any bankruptcy or insolvency proceeding in the last 10 years.
B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report. Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	See attachment B11 for our FY2010 10K and the last 10Q. There have not been any SEC investigations in the last 10 years.
B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner. Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.	Please see response to **B.6**. ACS does not generate stand-alone financial reports.

B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.

If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.

If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.

For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other

duties and the amount of time allocated to each.

Lance Hale, Managing Director, Commercial Healthcare

Lance Hale is a Managing Director for ACS. In this position, he has operational responsibility for domestic and international operations in the Healthcare Payer organization for BPO, Customer Care and Recovery Services centers providing these services to Fortune 500 clients. He is responsible for approximately $275M in annual revenue for ACS.

Lance began his career with ACS in 2001, drawing upon his expertise in Client, BPO, Call Center, Account, Sales, and Territory Management to successfully be a part of a team that has made ACS so successful in outsourcing today. He has 19 years of BPO experience.

Prior to joining ACS, Lance gained extensive experience in Fortune 500 client management services, including domestic and offshore services. His extensive experience allows him to consult with new and existing clients towards outsourcing solutions that will satisfy their company initiatives and whether it be a domestic, offshore or combined solution.

Lance continues to produce impressive results at ACS in his skillful direction of operational transition, account growth, and cost reduction strategies. Under his leadership, he has opened multiple facilities, both on and offshore to accommodate new and existing client growth, successfully transformed clients to an outsourcing relationship, and is a thought leader in the organization and to his clients.

Lance attended Weber State University, where he graduated with a bachelor degree in Business Management.

Mike Morrison, Senior Vice President, Healthcare Payer and Insurance
Mike Morrison began working for ACS in 2002 and has quickly made an impact with his leadership and quick thinking.

Morrison joined ACS as a Sales Executive for Payer immediately after college and soon signed business with a new client; a leading health insurance company. From 2002 to 2007 Morrison grew the account from basic transaction processing into a partnership that has since grown to include the entire claims processing cycle along with other services.

In 2008 Morrison was promoted to Director of Payer Sales. As a Director, Morrison had seven direct reports in the Healthcare Payer line of business (LOB).

After only a year as Director, ACS split the Healthcare Payer LOB into two groups and Morrison was promoted to Vice President of Business Development for the Commercial Healthcare LOB in 2009. He had seven direct reports and oversaw a team of 17 total Account Executives, Directors, and other Vice Presidents. He was the youngest Vice President in BPS' history.

Morrison again exceeded expectations and was promoted to Senior Vice President of Sales and Marketing for the Healthcare Payer and Insurance (HPI) group. In this role he now oversees all Sales, Marketing, and Business Development functions for over 40 total Account Executives, Directors, and Vice Presidents.

Morrison graduated from Ohio University with a Business degree in Management Information Systems.

Michael Potter, Senior Vice President, Commercial Health

Michael is the Senior Vice President of the East Region within the Commercial Health line of business. He is responsible for the overall operations, profit and loss accountability and customer relationship. The region projects include claim mailroom for medical and dental, enrollments, small group insurance, FSA, data entry and software application development. In addition ACS provides customer care and recovery services for several of the regions clients. Those customers represent over $150 million in revenues across all services.

Michael's career began in public accounting with a regional firm in Lexington, KY before moving into the manufacturing industry as a controller and then as a general manager of the facility. Before coming to ACS he worked as Operations Vice President for an audit and data entry firm in the freight industry.

At ACS he has worked as an SBU Manager and most recently as Division Vice President. In each instance his teams have achieved sustained improvement in operational performance, profitability and building partnerships with the client.

Michael graduated with distinction from the University of Kentucky with a Bachelor degree in Business Administration from the School of Accountancy.

Lori Bowling, currently Division Vice President, London Healthcare, ACS Shared Services, was previously an SBU Manager and Facility Manager at ACS.

With over 30 years' experience in BPO and over 20 years' experience in Healthcare Payer, she is responsible for successful new business implementation of Department of Labor OWCP. This effort eventually led to the DOL Outsource team receiving an "Exceptional Achievement Award" from the Secretary of Labor.

Lori also possesses over 25 years of management experience with over 10 years of international operations experience and over five years of division vice president experience.

She is an ACS President Club Award recipient as well.

Lori attended business classes including Principles of Management, Accounting, Sociology, Intro to Business, through Hazard Community College and Somerset Community College with continuing education classes including Dale Carnegie & Associates Human Relations Course, High Involvement Teams Leadership Training, Reengineering and Total Quality Management, Zenger Miller Leadership Training, Integrated Learning Systems and Crucial Conversations.

Joey Brandon Sasser, currently the SBU Manager at ACS for the Keystone line of business.

With 5 years' experience in BPO and 5 years' experience in Healthcare Payer, he is been responsible for the running the Keystone SBU day to day operation for over 2 years. This includes one domestic location and two offshore locations.

Before becoming part of the ACS organization Brandon background was retail which included 15 years of direct and indirect Management.

He is an ACS President Club Award recipient and has completed his ACS Six Sigma Green Belt training as well.

Brandon attended business classes at LCC Lexington Community College and finished up his two year degree at the University of Kentucky.

Eunice Peters is currently the Project Support Leader for the Keystone Strategic Business Unit under the London Healthcare Division.

Responsibilities include testing and implementation of all development requests; maintaining all documentation related to processing of transactions; and coordinating, establishing and maintaining appropriate controls related to internal and external audits.
During her tenure of 27 years with ACS she has held supervisory positions both for mailroom and data entry operations, application support positions and quality auditing positions. The last 7 years have been in current position.

ACS INC.
JOB DESCRIPTION
1. JOB IDENTIFICATION
TITLE: Transaction Processor LEVEL: TBD
FAMILY: Transaction Processing CODE: 320010
FLSA CATEGORY: Non-Exempt DATE: 04/30/03
2. POSITION PURPOSE

Provides data entry and verification support to a task, project, contract, or division by operating data entry equipment to code, format, and transcribe data from a source document and/or phone call into a form suitable for storing, retrieving, processing, and manipulating within an automated system. May enter data into formatted or unformatted screens and/or documents. An entry-level clerical support position requires familiarity with data entry and keyboard functions. The Data Management Assistant performs routine data entry functions and assists with simple formatting tasks following established policies. Works under immediate supervision and work is closely checked.

3. REPRESENTATIVE PRINCIPAL DUTIES AND RESPONSIBILITIES*

- Transcribes routine pre-coded and identifiable alphanumeric data from source document and/or phone call into an automated system.
- Operates phone system and/or alphanumeric keyboard for data entry.
- Verifies work to ensure accuracy and completeness.
- Record, post, log, enter, photocopies, and/or updates information or data.
- Creates and maintains files.
- May provide office support as necessary.

4. KNOWLEDGE, SKILLS AND ABILITIES REQUIRED

- High School diploma or equivalent.
- 0 - 1 year of related experience.
- Accurate typing of 30 words per minute.

- Manual dexterity.
- Ability to use PC, typewriter, calculator, and/or data entry devices.
- Ability to pay attention to details.

5. WORKING CONDITIONS

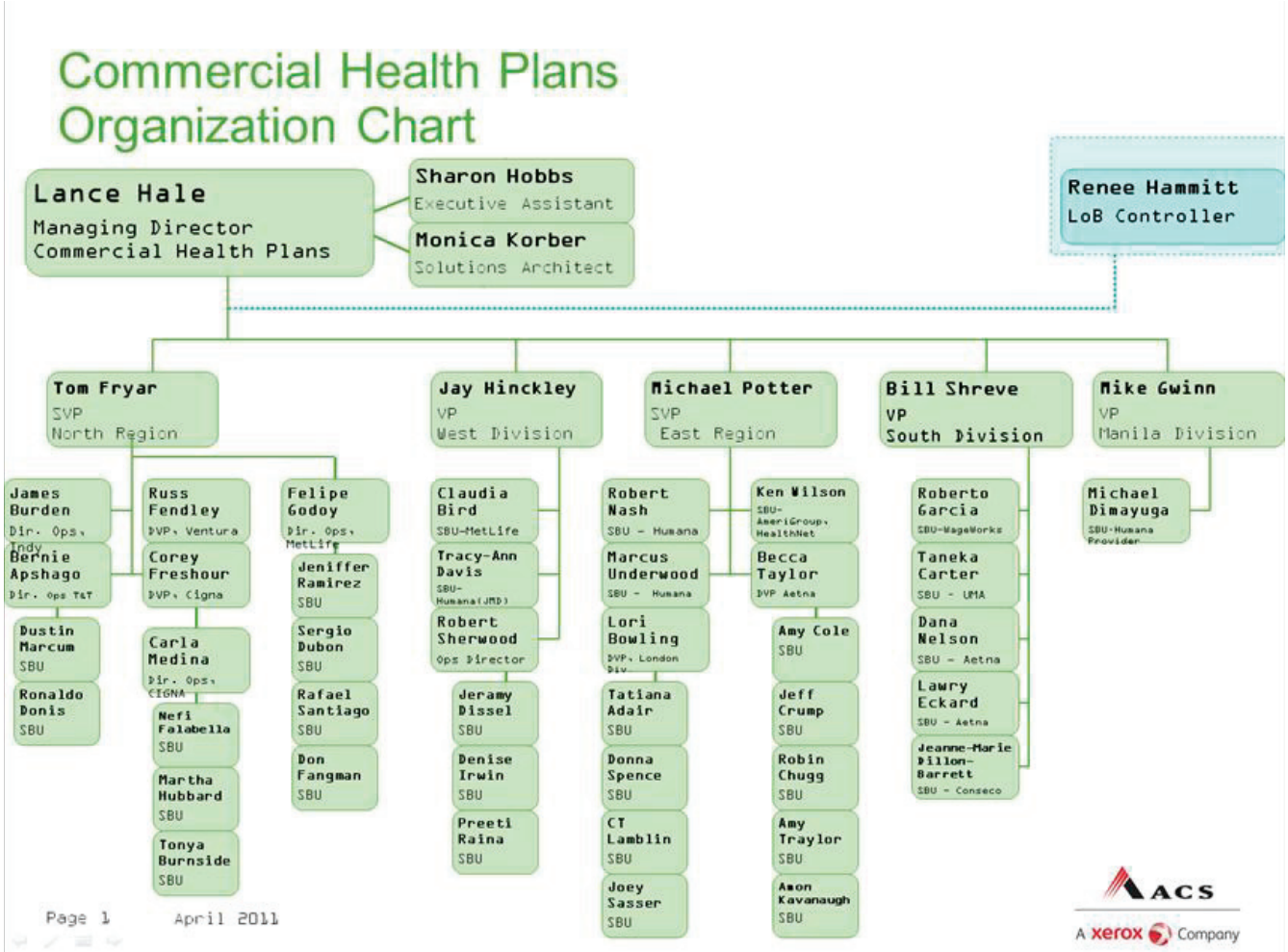
- Works in an office environment with production orientation.
- Uses PC, optical scanner, typewriter, calculator and other office equipment.

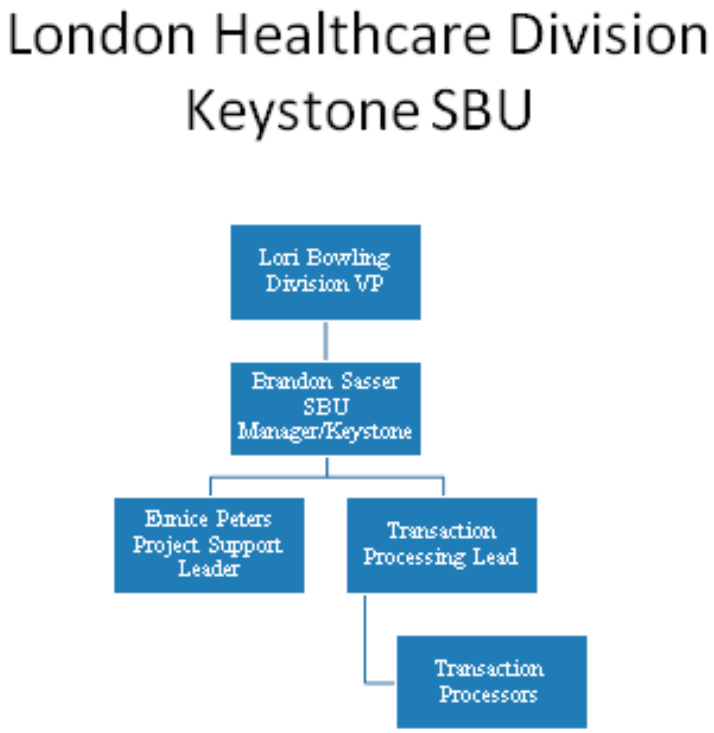
By: ISB
Revision: 12/2003
Transaction Processor

6. APPROVALS DATE

DATE

**The above information on this description has been designed to indicate the general nature and level of work performed by employees with this classification. It is not designed to contain or be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job.*





B.16 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. I**nclude your organization's parent organization, affiliates, and subsidiaries.**

Please see below ACS Medicaid/CHIP State clients and services provided.

Solutions >>>	Administrative and Fiscal Agent				Children's Health		PBM	Care Coordination & Mgmt	Health Information Analysis		
State	MMIS Fiscal	Other Administrative Consultative Services	Medicaid Managed Care Enrollment Services	Eligibility, Eligibility-related Services	CHIP Eligibility/ Enrollment	EPSDT	Rx Services	PCCM	Decision Support (DSS)	Informed Health - At least one Informed Health component in place	HIE Connectivity
Alabama										X	X

Alaska	X		X				X			X	
Arkansas							X			X	
California	X						X			X	
Colorado	X						X		X	X	
Connecticut			X	X	X						
District of Columbia	X						X			X	
Florida					X		X			X	
Georgia											
Hawaii	X		X				X			X	X
Indiana							X			X	
Kentucky										X	X
Louisiana		X									
Massachusetts							X			X	
Maryland		X					X			X	
Michigan										X	
Minnesota							X			X	
Mississippi	X			X	X		X		X	X	X
Missouri							X			X	X
Montana	X		X				X		X	X	
New Hampshire	X										
New Jersey			X	X	X						
New Mexico	X	X					X		X		
North Carolina							X			X	
North Dakota	X						X				
Ohio Medicaid							X		X	X	
Ohio BCMH							X				
Pennsylvania										X	
Rhode Island		X	X	X							
South Carolina		X									
Texas	X						X	X		X	
US DOL				X	X		X				
Virginia	X	X		X						X	
Wyoming	X								X	X	X
34	13	6	6	6	5	0	21	1	6	23	6

Medicaid Client	
B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. **Include your organization's parent organization, affiliates, and subsidiaries.**	Over the course of our history and with a customer base of more than 6,000 clients, ACS has on occasion terminated client relationships, however this is rare. The most common reasons for termination are excessive delinquent payments or business changes by the client which no longer necessitate our services. ACS and the client usually reach a mutual agreement that this is in the interest of both parties. In addition, ACS has had more than one client terminate the relationship. Typically this is due to an internal shift in their business processes such that they no longer require outsourced services even though they may not be at the end of a contract period. We have had no client terminations in the last 5 years that have had any significant financial impact on ACS. **We maintain the highest overall customer retention rate in the industry of 90%.** Due to confidentiality agreements, ACS does not release information about former clients.
B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. **Include your organization's parent organization, affiliates, and subsidiaries.**	ACS engages in partnerships with our clients. Our goals are long term and encompass the term of the contract focusing on growth potential or fulfilling the term length, if limited. Our solution architects engage in diligent risk assessment prior to engagement to ensure we work with our clients continually as business requirements evolve to shape and achieve their business goals. Communication with our clients is open and constant with staff dedicated to project success from inception to completion. On very few occasions, we have had projects terminated by our clients or ACS due to differing opinions on the ability to achieve the desired results e.g. in terms of cost savings or quality improvements within a defined scope. We do not consider these terminations failed projects. Failure to complete a project awarded would mean a failed partnership, and ACS is dedicated to only meeting and exceeding the expectations of our clients. Due to confidentiality agreements, ACS does not release information about former clients.
B. 19 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following: • AM Best Company (financial strengths ratings); • TheStreet.com, Inc. (safety ratings); and • Standard & Poor's (long-term insurer financial strength.	*Credit ratings for ACS, a Xerox Company*

Rating	FY 2011	FY 2010	FY 2009	FY 2008
Moody's	Baa3	Baa2	Baa2	Baa2
Standard & Poors ("S&P")	BBB -	BBB -	BBB	BBB
Fitch	BBB	BBB	BBB	BBB

B.20 For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to	No.

factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? I**nclude your organization's parent organization, affiliates, and subsidiaries.**	
B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.	ACS is not accredited by NCQA, AAAHC or JCAHO, as each of these organizations supports special health care facility-related certifications, rather than related administrative services. ACS does share a strong focus on quality of our operations and services. ACS applies industry standards to each service line (Business Process Outsourcing, IT Outsourcing and System Integration). For example, ACS currently applies the following industry standards: ▪ Six Sigma / Lean ▪ ISO 9001 certification ▪ ISO/IEC 20000 certification ▪ ISO 27001 certification ▪ BS 7799 certification - security ▪ BS 15000 ▪ SAS70 Type 2 Audits / SSAE 16 Audits ▪ SEI - CMM ▪ Support client and internal goals with respect to: (HEDIS, NCQA, BCBS MTM, etc.) ▪ IEEE and ISO standards incorporated in software engineering processes, procedures and practices ▪ Project Management Institute (PMI) compliant standards ▪ Auditing (security audits – per Federal and State guidelines, financial audits – Price Waterhouse Coopers, LLC). ▪ **URAC accreditation by our subsidiary Bowers** ▪ We are primarily IT focused, other certifications or standards such as CMS, HITSP, CDC, NSQIP and others that come from our clinical solutions like MIDAS+ LIVE that bring more clinical accreditation.
B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. **Include your organization's parent organization, affiliates, and subsidiaries.**	No.
B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	Not applicable.
B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees	ACS is not required to perform an EQRO audit, therefore this is N/A.

as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (**including your organization's parent organization, affiliates, and subsidiaries**) in response to the report.	
B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	Not applicable.
B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. **Include your organization's parent company, affiliates and subsidiaries.**	Please see our response to question B3, B4 and B6
B.27 Submit name, phone number and address of client references (minimum of three, maximum of five) for your organization; with at least one reference from a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years.	References are attached as attachment B11.

If the major subcontractor is your organization's parent organization, affiliate, or subsidiary, respond to items B.1, B.8 and B.9. You do not need to respond to the other items as part of the response to B11; note, however, responses to various other items in Section B must include information on your organization's parent organization, affiliates, and subsidiaries, which would include any major subcontractors that are your organization's parent organization, affiliate, or subsidiary.

Affiliated Subcontractor

Subcontractor: AmeriHealth Mercy Health Plan (AMHP)

Mailing Address/Location: 200 Stevens Drive, Philadelphia, Pennsylvania 19113

Scope of Work: AMHP will provide affiliate services to AmeriHealth Mercy of Louisiana, Inc. ("AML"), which will include corporate support for such functions as human resources, marketing and legal services, as well as operational support in the areas of information services, claims processing and contact/call center functions. In providing these subcontractor services, AMHP will employ resources from both its corporate offices in Philadelphia, PA and from its regional office located in Charleston, SC. AML and AMHP will memorialize this relationship by means of a subcontract, in the form of an Administrative Services Agreement.

AML and AMHP have established a CCN project team to ensure a smooth implementation. The project team includes individuals whose focus is primarily at the local level, such as AML's Executive Director,

and also a significant number of individuals from the corporate/AMHP level, where a great deal of planning and support are already underway to ensure an effective integration of the CCN program into the AmeriHealth Mercy Family of Companies. The Enterprise Portfolio Management Office provides the key linkage between the local and corporate functions.

The major functions and services that will be provided by AMHP are depicted in the following table. A detailed enumeration of the specific activities that these headings encompass is included in AML's response in item B.9 – specifically, in the table that is included in the "Corporate Office" portion of that response.

Table 6: Functions to be performed by AMHP

Corporate Functions	Operational Support Services

▪ Administration
▪ Human Resources
▪ Government Affairs
▪ Finance (Accounting, Financial Services, Actuarial Services, Accounts Receivable, Fraud, Waste & Abuse, Statutory Reporting)
▪ Legal Affairs & Corporate Compliance
▪ Mission & Values
▪ Corporate Sourcing
▪ Corporate Communications & Marketing
	▪ Integrated Care Management
	▪ Provider Network Management
	▪ Data Management
	▪ Information Services & Service Operations
	  ○ Claims Processing
	  ○ Member & Provider Services – contact centers
	  ○ Enrollment
	  ○ Information Systems

Name and Mailing Address of your Company.	
B.1 Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (*e.g.* publicly traded corporation). Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization,	AmeriHealth Mercy Health Plan ("AMHP") is a Pennsylvania general partnership. AMHP is a member of the AmeriHealth Mercy Family of Companies ("AMFC"), headquartered in Philadelphia, Pennsylvania. Its physical address (which is the same as its mailing address) is: 200 Stevens Dr. Philadelphia, PA 19113 Ph: (215) 937-8000 The ultimate controlling organizations of AMHP are Mercy Health System and Independence Blue Cross: ▪ Independence Blue Cross is a Pennsylvania **non-profit** hospital plan corporation. It is a **non-stock/non-member** corporation and its address is 1901 Market Street, Philadelphia, PA 19103 ▪ Mercy Health System is a 501(c)(3) non-profit corporation. Its address is One West Elm Street, Conshohocken, PA 19428 No health professional has an individual ownership interest or other financial interest in AmeriHealth Mercy Health Plan. The directors and officers of AmeriHealth Mercy Health Plan are as follows:

and the type of financial interest. Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provider the name and address of the local representative; if none, so state.

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

Table 7: AMPHP Board of Directors

Name	Title	Mailing Address and Telephone Number
H. Ray Welch, Jr.	President and Chief Executive Officer Mercy Health System	One West Elm St. Conshohocken, PA 19428 Ph: (610) 567-6000
Daniel J. Hilferty	President, Health Markets Independence Blue Cross	1901 Market St. Philadelphia, PA 19103 1-800-275-2583
Joseph H. Bradley	Chief Financial Officer Mercy Health System	One West Elm St. Conshohocken, PA 19428 Ph: (610) 567-6000
Mark T. Bullock, Esq.	Senior Vice President, Legal Affairs & Corporate Risk Management Mercy Health System	One West Elm St. Conshohocken, PA 19428 Ph: (610) 567-6000
Yvette D. Bright	Chief Administrative Officer & Senior Vice President Independence Blue Cross	1901 Market St. Philadelphia, PA 19107 1-800-275-2583
Paul A. Tufano, Esq.	Senior Vice President & General Counsel Independence Blue Cross	1901 Market St. Philadelphia, PA 19107 1-800-275-2583

Table 8: AMHP Executive Officers

Name	Title	Mailing Address and Telephone Number
Michael A. Rashid	President & Chief Executive Officer	200 Stevens Dr. Philadelphia, PA 19113 Ph: (215) 937-8400
Anne Morrissey	Executive Vice President & Chief Operating Officer	200 Stevens Dr. Philadelphia, PA 19113 Ph: (215) 937-8425
Robert H. Gilman, Esq.	Senior Vice President, Legal Affairs & General Counsel	200 Stevens Dr. Philadelphia, PA 19113 Ph: (215) 937-8560
Steven H. Bohner	Senior Vice President, Finance & Chief Financial Officer	200 Stevens Dr. Philadelphia, PA 19113 Ph: (215) 937-8276

Provide your federal taxpayer identification number and Louisiana taxpayer identification number. Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

	AmeriHealth Mercy Health Plan's FEIN: **23-2859523**. AmeriHealth Mercy Health Plan's Louisiana tax ID number: **5345939001** AmeriHealth Mercy Health Plan is a Pennsylvania general partnership. AMHP has been registered with the Louisiana Secretary of State, as a non-Louisiana partnership, since 2005; its charter number is 36081242L. AMHP's local agent in Louisiana is CT Corporation, whose address is 5615 Corporate Blvd., Suite 400B, Baton Rouge, LA, 70809. AmeriHealth Mercy Health Plan has been licensed as a third-party administrator by the Louisiana Department of Insurance since August 17, 2006. *If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.* AmeriHealth Mercy Health Plan has not been engaged by DHH within the past twenty-four (24) months.

B.8 Describe your organization's number of employees, client base, and location of offices. Submit an organization chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company

Drawing upon the strengths of both Mercy Health System and Independence Blue Cross, the AmeriHealth Mercy Family of Companies' mission and values were forged from our history of connecting the most vulnerable among us to primary care while providing efficient medical management and provider services. Our mission is straightforward – AMFC exists to provide quality and accessible health care services to our members, and is characterized by a special concern for the poor and disadvantaged.

Simply stated, we help people:

- Get care
- Stay well
- Build healthy communities

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

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

AmeriHealth Mercy has grown to become one of the largest Medicaid managed care organizations in the United States. We are one of the nation's experts and industry leaders in the delivery of quality health care to low-income populations covered by publicly funded programs, especially Medicaid. Currently, AmeriHealth Mercy touches more than four million Medicaid/SCHIP/uninsured recipients nationwide through its health plans, pharmacy benefit management services, behavioral health services, care management services, and administrative contracts.

AmeriHealth Mercy 's programs include Medicaid risk and non-risk, Medicare Advantage Prescription Drug plans (MA-PDs), Medicaid at-risk and non-risk Behavioral Health Organizations (BHOs), State Children's Health Insurance Programs (SCHIP), and an uninsured program. Our mission is the foundation upon which we build all of our programs and products and enables us to meet the special medical, pharmaceutical, and

behavioral health needs of these vulnerable populations, while satisfying complex state and federal requirements. Our programs are sensitive to the multiplicity of needs in the diverse regions and populations we serve.

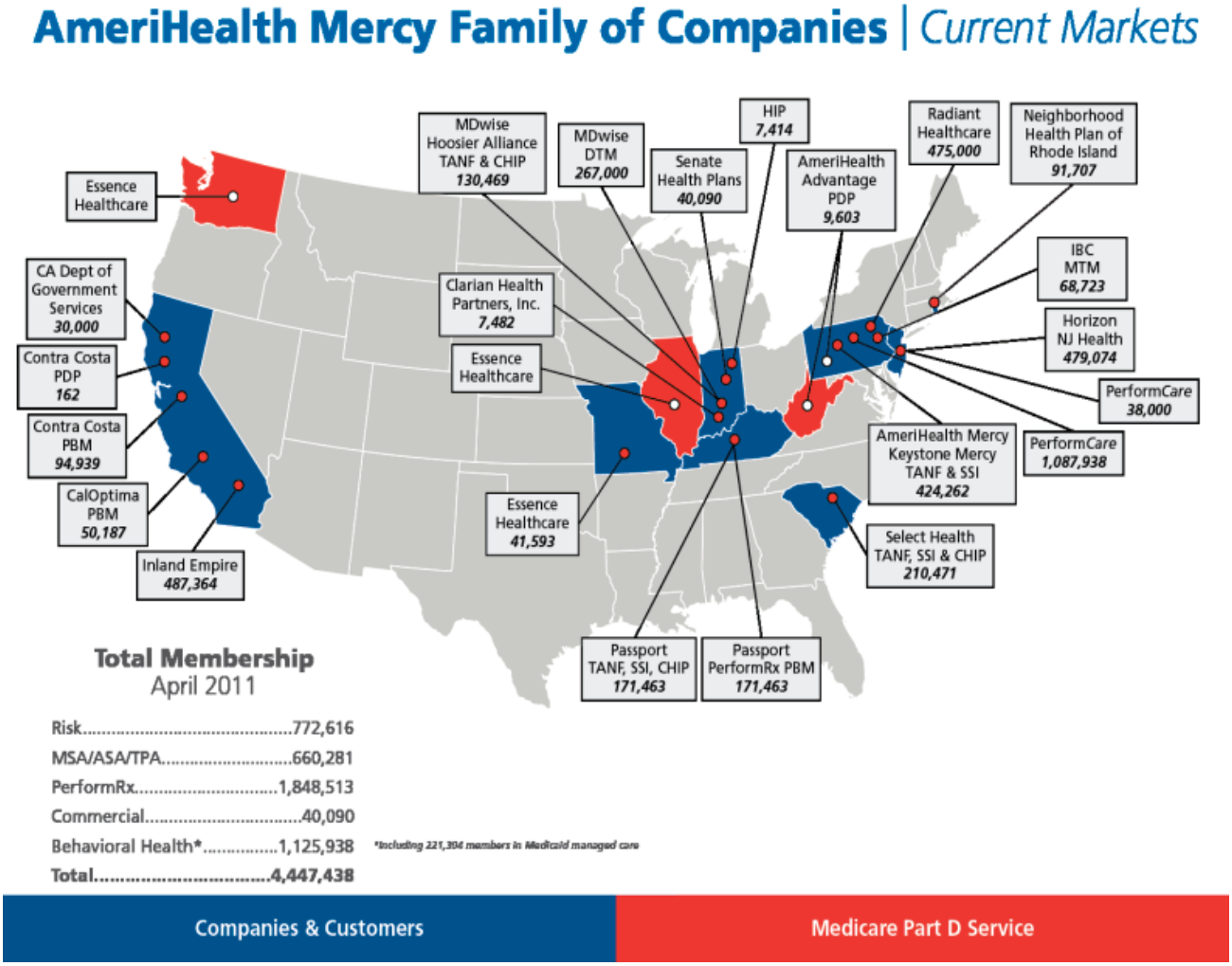
NCQA has awarded an excellent accreditation to Keystone Mercy Health Plan, AmeriHealth Mercy Health Plan and Select Health of South Carolina. In addition, NCQA has awarded excellent accreditation to the plan that AmeriHealth Mercy Health Plan administers in Kentucky.

URAC has accredited both Keystone Mercy Health Plan and AmeriHealth Mercy Health Plan for their respective programs in case management, disease management, asthma, diabetes, heart failure, and COPD. PerformRx, AMFC's pharmacy benefits manager, was one of the first PBMs in the country to be URAC-accredited.

Both of the plans in Pennsylvania, as well as our plan in South Carolina were among the first group of plans to apply for and achieve NCQA's Multicultural Health Care Accreditation. AMFC health plans were three of the six nationwide early adopters of the standards. Based on preliminary results, all scores for all the AMFC health plans exceeded the NCQA passing requirement.

The map below illustrates the markets served by AMFC

Figure 5: AMFC Current Markets



Driven by our mission and guided by careful planning for deliberate growth, AmeriHealth Mercy has continued

to expand, adding strategic and diverse lines of business to its full-risk Medicaid managed care products. Following is a brief description of the members of the AmeriHealth Mercy Family of Companies.

AmeriHealth Mercy Health Plan (AMHP) is one of Pennsylvania's most experienced Medicaid managed care health plans, serving approximately 109,000 medical assistance recipients in 15 counties of northeastern Pennsylvania. AMHP's operations are headquartered in Harrisburg, Pennsylvania, with 91 associates.

PerformCare is a complete behavioral health care and human services company that supports over one million members in the public and private sectors. PerformCare specializes in providing superior, innovative solutions to support behavioral health, human services, and integrated health programs that are outcomes-focused and customized for:

- Medicaid and Medicare plans
- Commercial health plans
- Wellness, employee assistance, and specialty products
- Systems of care programs to support human services management challenge

PerformCare (CBHNP in Pennsylvania), was founded in 1994 by service providers. Headquartered in Harrisburg, Pennsylvania, today the company has 170 associates.

Keystone Mercy Health Plan is the largest of AMFC's affiliates. Keystone Mercy and AMHP are sister companies, both being ultimately accountable to Mercy Health System and Independence Blue Cross. Keystone Mercy, headquartered in Philadelphia, Pennsylvania, serves more than 300,000 Medicaid recipients in five counties of Southeastern Pennsylvania, making it Pennsylvania's largest managed Medicaid health plan. The company employs 1,349 associates.

PerformRx is a pharmacy benefit manager that provides innovative, cost-effective pharmacy benefit management services for Medicaid, Medicare and commercial health plans. Headquartered in Philadelphia, Pennsylvania, PerformRx is a mission-driven organization, dedicated to the delivery of quality pharmacy benefits with special attention to low-income populations covered by publicly funded programs, directly reflecting the vision of AmeriHealth Mercy. The company's 157 associates serve over 1.8 million members.

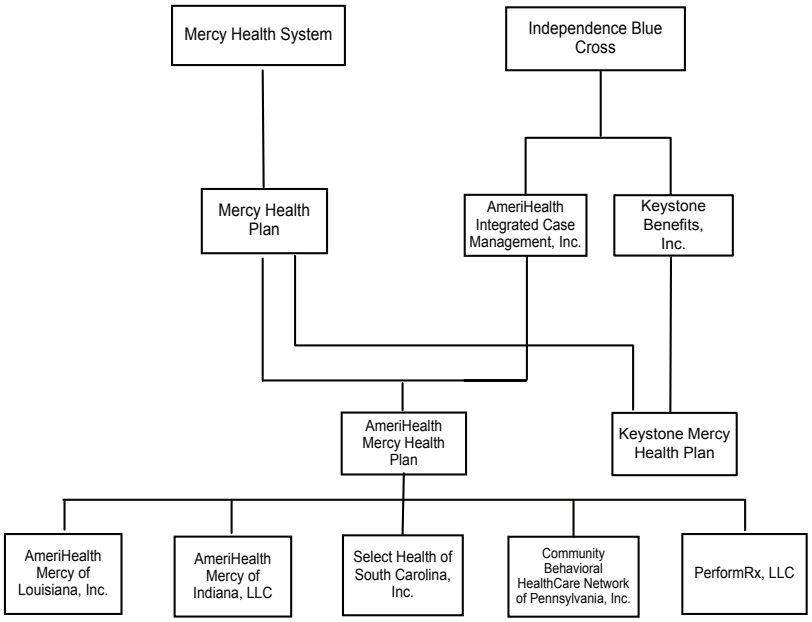
Select Health of South Carolina is a Medicaid managed care organization with 219 associates serving more than 210,000 members across the state of South Carolina. Select Health is licensed as an HMO by the South Carolina Department of Insurance. Headquartered in Charleston, S.C., Select Health has served the needs of South Carolina's Medicaid beneficiaries for 15 years. Select Health of South Carolina has been named one of the "Best Places to Work in South Carolina" for three consecutive years and is certified as a Gold Level Well Workplace by the Wellness Council of America.

AmeriHealth Mercy of Indiana, doing business as MDwise Hoosier Alliance provides care for members in the Hoosier Healthwise and Healthy Indiana programs, Indiana's health coverage programs for low-income families and children. The organization is headquartered in Indianapolis and today serves approximately 138,000 members. MDwise Hoosier Alliance employs 104 associates.

Administrative Agreements. AmeriHealth Mercy has Medicaid Managed Care administrative agreements in New Jersey and Kentucky.

In total, the 2,441 associates in the AmeriHealth Mercy Family of Companies serve more than four million members nationwide. See Chart A below for a corporate organization chart showing the relationship among the members of the AmeriHealth Mercy Family of Companies.

AmeriHealth Mercy of Louisiana, Inc.
Ownership Structure



**** Does not include other subsidiaries and affiliates of IBC and Mercy.***

Chart A: Structure of the Organization

See Figures 12 – 14 below for an organization chart showing the internal structure and lines of responsibility and authority in the AmeriHealth Mercy Family of Companies.

Figure 6: Organizational Structure – Corporate Office 1

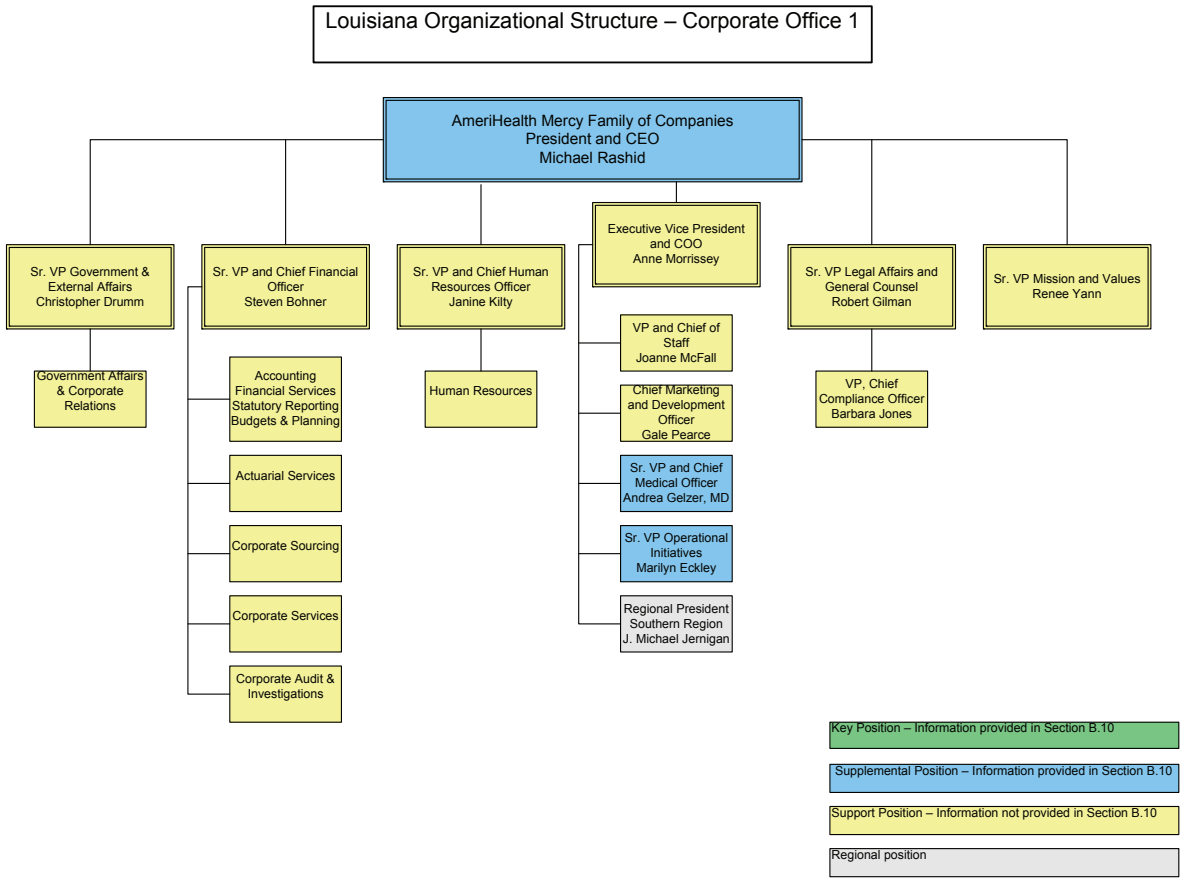


Figure 7: Organizational Structure – Corporate Office 2

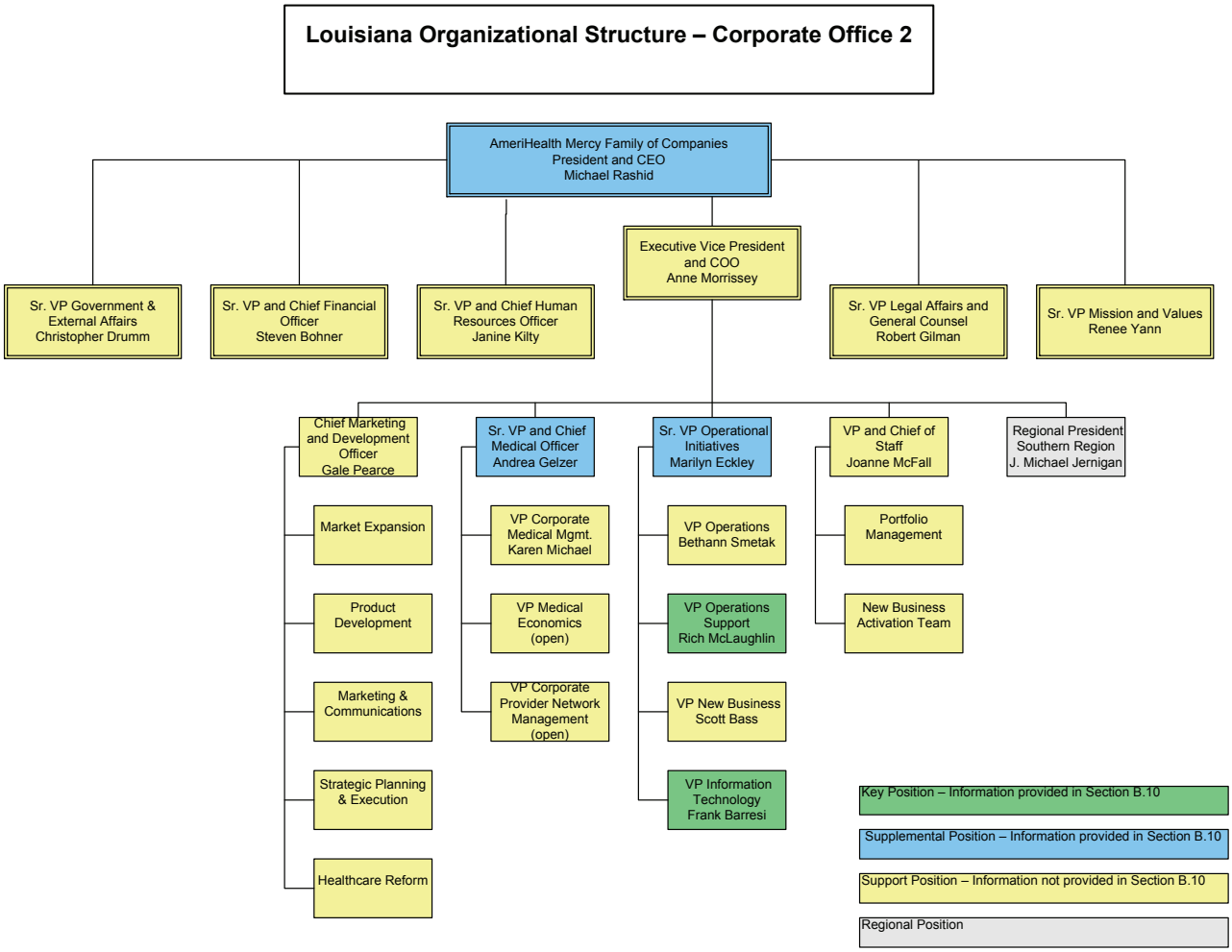
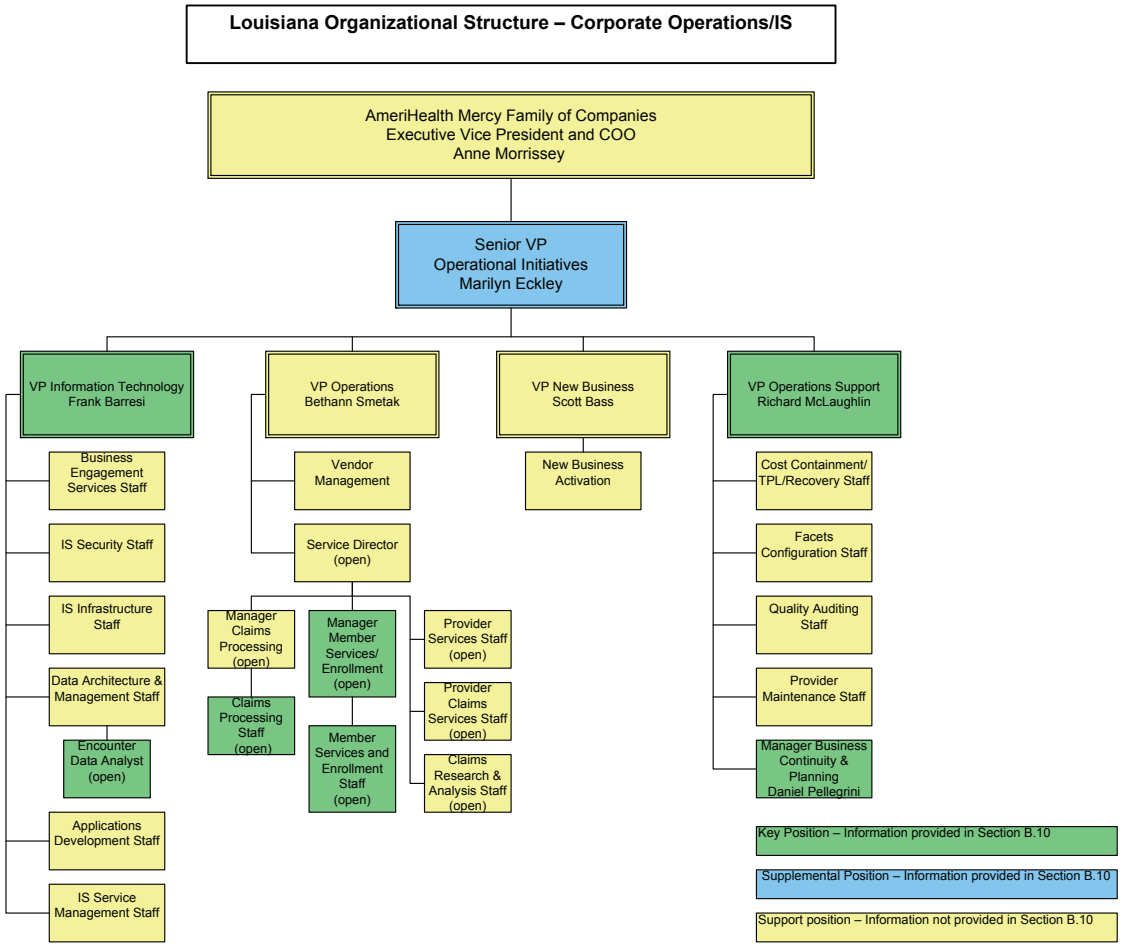


Figure 8: Organizational Structure – Corporate Operations



AMHP B.9 Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local	AmeriHealth Mercy of Louisiana, Inc. ("AML" or "LaCare") has the distinct advantage of having as one of its major subcontractors its parent organization – AmeriHealth Mercy Health Plan ("AMHP"). By contracting with AMHP for both back-office operations and corporate functions, LaCare will be able to concentrate its resources, energies and presence on ensuring a successful implementation of the CCN-P program at the local level. Figures 10 – 12 above are a comprehensive depiction of the relationship among members of the AmeriHealth Mercy Family of Companies, relative to the CCN-P program. Local and regional operations will be supported

level.	and complemented by the functions and services provided at the corporate level under the subcontract between AML and AMHP. AMHP will provide direct operational support for LaCare in the areas of: ▪ Integrated Care Management ▪ Provider Network Management ▪ Data Management ▪ Information Services & Service Operations ▪ Claims Processing ▪ Member & Provider Services – contact centers ▪ Enrollment ▪ Information Systems ▪ Fraud, Waste & Abuse ▪ Statutory Reporting These functions are performed at AMHP's headquarters in Philadelphia, PA. AMHP's decades-long experience in implementing and managing Medicaid managed-care programs throughout the country will provide solid support and synergy with and for the LaCare local operations team. AMHP's corporate support functions will also be available to LaCare through the subcontract between AML and AMHP. LaCare will, of course, ensure appropriate local staffing as required – for example, LaCare will employ a Finance Director and an HR Coordinator. At the same time, these positions will be an extension of their corporate (AMHP) counterparts. The Family of Companies' HR policies, for example, will be deployed locally at LaCare. One key to ensuring a seamless interaction between the Corporate (AMHP) and local (LaCare) staffs is the AMFC Southern Regional Office. LaCare staff members overseeing these corporate support functions have an indirect dotted-line reporting relationship to the Regional Office. Ultimately all reporting is to Michael Rashid, the President and CEO of the AmeriHealth Mercy Family of Companies. Various lines of business within the Family of Companies, including LaCare (through the Southern Regional Office), report to Mr. Rashid through the Executive Vice President & Chief Operating Officer, Anne Morrissey. In addition to the heads of each line of business, AMHP's Operations areas also report to Ms. Morrissey. This organizational structure helps to ensure a high degree of coordination within the Family of Companies; and in the case of the CCN-P program, will ensure that AMHP provides the requisite support to AML, not only in its role as a subcontractor, but also as a fellow member of the AmeriHealth Mercy Family of Companies.

Monitoring and Evaluation of Performance: We anticipate that AMHP's experience and expertise in implementing Medicaid managed care programs will allow us to quickly complete the subcontract and set up monitoring and evaluation systems. The subcontract will serve as the vehicle for establishing specific performance standards, around which AML will construct a formal oversight program. AMHP has extensive experience itself in monitoring performance by its delegates and other subcontractors; the monitoring processes and tools that AMHP employs to conduct oversight of its own subcontractors will similarly be applied in order to measure and evaluate AMHP's performance under the subcontract with AML.

The inter-family relationship between AML and AMHP will facilitate the oversight by AML of AMHP's performance under the subcontract. AML will have the advantage of access to real-time data and reporting from AMHP, as an adjunct to the formal oversight that will derive from the subcontract. The subcontract will define the specific reports and other monitoring vehicles that AMHP will be required to provide to AML, and the frequency of reporting, with respect to the functions performed by AMHP under the subcontract.

(As the parent to AmeriHealth Mercy of Louisiana, Inc. responses below are limited, as requested, to items B.1, B.8 and B.9. Responses specific to AmeriHealth Mercy Health Plan have the notation "AMHP" prior to the response number.)

B.12: Compliance

B.12 Provide a description your Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart B in your response) involved in compliance along with staff levels of authority.

Corporate Dedication to Compliance and Privacy Plan

AmeriHealth Mercy strives to ensure an ethical, compassionate, efficient and compliant approach to healthcare delivery and management for the benefit of members, providers, customers and employees. We are committed to conducting business in compliance with all applicable federal and state laws and regulations. AmeriHealth Mercy is also committed to maintaining a working environment that promotes these ideals and permits its employees and agents to demonstrate the highest ethical standards in performing their duties.

Compliance Program Elements

AmeriHealth Mercy has developed and maintains an effective and comprehensive corporate compliance program that incorporates the elements of an effective compliance program as outlined in guidelines established by the Office of the Inspector General, U.S. Department of Health and Human Services. To that end, the Corporate Compliance Program includes the following:

- Standards of Conduct and Written Policies and Procedures -- Company-wide distribution of written standards of AmeriHealth Mercy's commitment to corporate compliance.
- Chief Compliance Officer -- A corporate compliance officer who has primary responsibility for the development, implementation and monitoring of the corporate compliance program.
- Education/Training Programs -- Consistent and appropriate education and training programs for all employees to help ensure proper understanding of corporate compliance standards of conduct and policies and procedures.
- 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.
- Monitoring/Auditing Protocols -- The consistent use of audits and other evaluation mechanisms to monitor compliance and assist in the elimination of non-compliance. These mechanisms include the development of self-assessment tools within specific departments or operational areas.
- Investigation -- The utilization of formal evaluation and examination protocols, applied to all available and relevant evidence, to determine whether a violation of compliance standards and/or the law has occurred.
- Corrective Action -- The prompt and thorough implementation and monitoring of improvement activities to respond to compliance violations so as to prevent or reduce the risk of similar violations on a prospective basis.

- Disciplinary Action/Sanctions/HR Protocols -- The enforcement of appropriate disciplinary action or sanctions against any associate who violates applicable corporate compliance policies and procedures.
- Fraud, Waste and Abuse Plans - A comprehensive fraud, waste and abuse plan to detect, correct, and prevent fraud, waste and abuse.
- Document Retention – The distribution of consistent guidelines for the retention and destruction of company information and documents. These guidelines include company minimum retention periods as required by law and/or under the terms of specific contracts or customer directives.
- Confidentiality – The enforcement of policies and procedures safeguarding confidential information from inappropriate or unlawful disclosure or other handling by associates.

Privacy Program Elements

To meet the standards as outlined above of the Compliance Program, a portion of the overarching compliance program is AmeriHealth Mercy's Privacy Program, which has been created by incorporating the requirements promulgated by the Office of Civil Rights, U.S. Department of Health and Human Services, as part of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Privacy Program includes the following:

- Standards of Conduct and Written Policies and Procedures -- The company-wide distribution of written standards of conduct, as well as written policies and procedures that promote the organization's commitment to compliance with the HIPAA privacy regulation.
- Privacy Officer -- A corporate privacy officer who has primary responsibility for the development, implementation and monitoring of the privacy program
- Education/Training Programs --Consistent and appropriate education and training programs for all employees to help ensure proper understanding and compliance with the HIPAA privacy and security regulations and policies and procedures.
- Monitoring/Auditing Protocols -- The consistent use of audits and other evaluation mechanisms to monitor compliance and assist in the elimination of non-compliance. These mechanisms include the development of self- assessment tools within specific departments or operational areas.
- Investigation -- The utilization of formal evaluation and examination protocols, applied to all available and relevant evidence, to determine whether a violation of privacy standards and/or the law has occurred.
- Corrective Action -- The prompt and thorough implementation and monitoring of improvement activities to respond to compliance violations so as to prevent or reduce the risk of similar violations on a prospective basis.
- Disciplinary Action/Sanctions/HR Protocols -- The enforcement of appropriate disciplinary action or sanctions against any associate who violates applicable corporate compliance/privacy policies and procedures.
- Document Retention -- The distribution of consistent guidelines for the retention and destruction of company information and documents. These guidelines include company minimum retention periods as required by law and/or under the terms of specific contracts or customer directives.
- Confidentiality -- The enforcement of policies and procedures safeguarding confidential and protected health information from an appropriate or unlawful disclosure or other handling by associates.

Employee Responsibility for Compliance and Privacy

The Corporate Compliance and Privacy Programs are intended to be proactive and reactive with a goal toward ensuring that all employees understand what is expected of them in carrying out the Company's business. Employees must be confident that questions and concerns will be thoroughly investigated no matter what is at stake and who may be implicated.

AmeriHealth Mercy requires each employee to participate in the Corporate Compliance Program by learning and carrying out the Code of Ethics and Conduct, of which the Company provides training and education. Likewise, AmeriHealth Mercy requires each employee to participate in the Privacy Program by participating in regular, mandatory training; furthermore, all employees are required to sign the "Associate Confidentiality, Privacy, and Security Agreement" on an annual basis.

AmeriHealth Mercy also requires employees to report suspicion of fraud or misconduct. AMFC provides confidential mechanisms for such reporting of fraud or misconduct and investigates all reports. AmeriHealth Mercy maintains and publicizes its Corporate Compliance Hotline to receive confidential reports of fraud and misconduct. Employees are also encouraged to report fraud and misconduct to supervisors and managers and may do so orally or in writing. AMFC investigates all allegations of fraud and misconduct.

Retribution against an employee for good faith, truthful and prompt reporting is prohibited by any entity or individual. Any entity or individual involved in such retribution is subject to disciplinary action.

Compliance Officer's levels of authority and reporting relationships

The Compliance Offer holds a highly regarded position where she is also well positioned to discreetly share information with any and all key parties. Within this role, she is responsible for the following levels of authority:

Role of the Compliance Officer

- Designate delegates to carry out compliance and privacy responsibilities
- Ensure all employees acknowledge in writing that they will abide by the Code of Ethics and Conduct
- Develop and facilitate suitable training programs
- Investigate reports of wrongdoing; determine extent of appropriate investigation
- Report criminal activity internally, as appropriate
- Conduct compliance functions on confidential basis, wherever possible
- Maintain confidential fraud and compliance hotline
- Establish and maintain system to document corporate compliance functions
- In conjunction with Human Resources, create/promote consistent procedures for discipline
- Develop and institute programs to improve the plan
- Develop and implement monitoring and auditing protocols and tools to evaluate compliance
- Reports to the CEO, AmeriHealth Mercy Board of Directors and Board of Director's Audit Committee as warranted
- Responsible for routine meetings of the Corporate Compliance, Privacy and Security Committee
- Integration into the corporate program of the compliance functions at each of the plans or lines of business that comprise AmeriHealth Mercy, including the Compliance Office of LaCare.

Role of the Privacy Officer

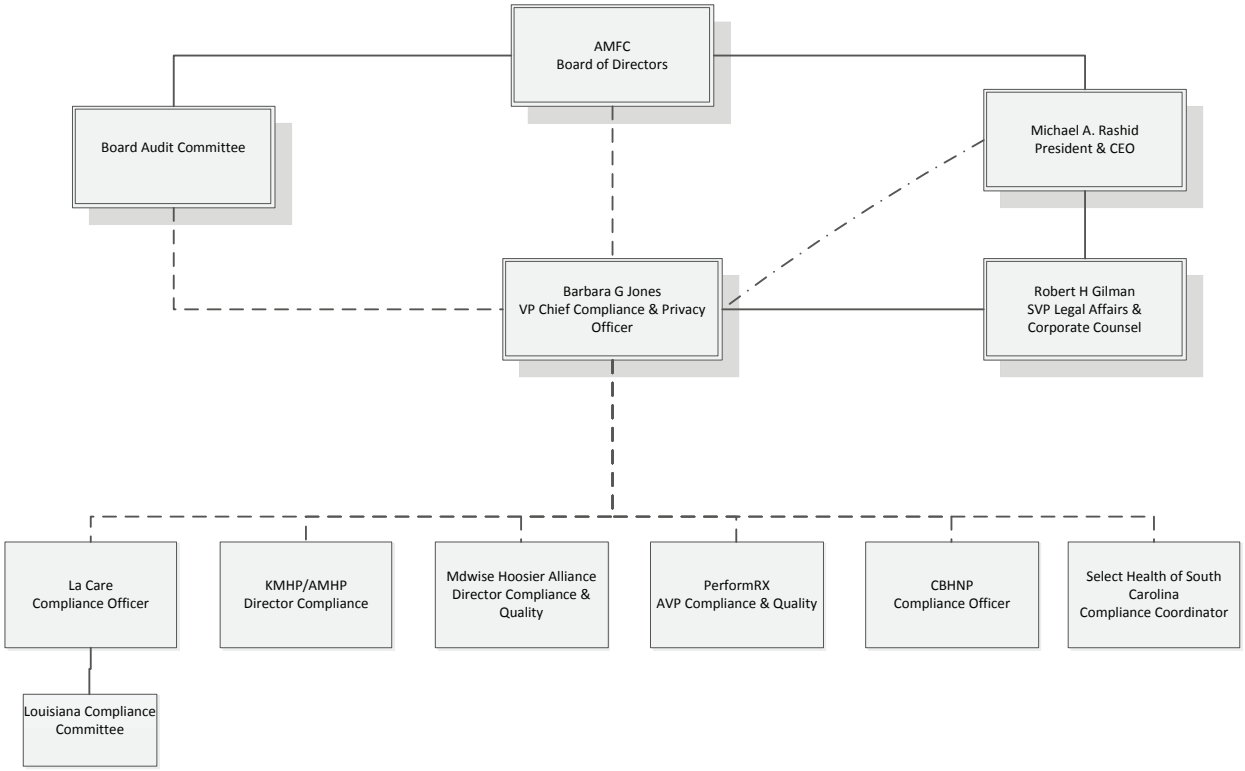
- Develops guidance and assists in the identification, implementation, and maintenance of organization information privacy policies and procedures
- Establish and direct an organization-wide privacy oversight committee

- Performs initial and periodic information privacy risk assessments and conducts related ongoing compliance monitoring activities in coordination with the organization's other compliance and operational assessment functions
- Ensure the organization has and maintains appropriate privacy and confidentiality consent, authorization forms, information notices, and materials reflecting current organization and legal practices and requirements.
- Oversees, directs, delivers, or ensures delivery of initial and annual
- privacy training and orientation to all associates and, in some cases, third parties, as appropriate
- Track access to, collection of and/or release of protected health information, within the purview of the organization and as required business activities
- Establishes and administers a process for receiving, documenting, tracking, investigating, and taking action on all complaints concerning the Company's privacy policies and procedures
- Oversees member rights to inspect, amend, and restrict access to protected health information when appropriate
- Ensures compliance with privacy practices and consistent application of
- sanctions for failure to comply with privacy policies
- Maintains current knowledge of applicable federal and state privacy laws and accreditation standards, and monitors advancements in information privacy technologies to ensure organizational adaptation and compliance
- Serves as information privacy consultant to the Company for all departments and appropriate entities

Compliance Officer's reporting relationships

The Chief Compliance Officer (CCO), Barbara Jones, reports directly to the AmeriHealth Mercy's General Counsel and answers to AmeriHealth Mercy's Chief Executive Officer and the Board's Audit Committee.

Figure 9: Compliance Program Reporting Structure



B.13: Press Releases

B.13 Provide copies of any press releases in the twelve (12) months prior to the Deadline for Proposals, wherein the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues. Do not include press releases that are primarily promotional in nature.

AmeriHealth Mercy manages the development and distribution of press releases through our Corporate Communications department. Working in collaboration with communicators in our affiliate plans, the Media Relations Manager has responsibility for the composition of releases and guides approvals to appropriate individuals, including responsibility for required regulatory approvals.

Please see Attachment B.13 for copies of press releases from the previous 12 months which mention or discuss "financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues" as requested.

B. 14: Performance Bond and Insurance Requirements.

Describe your plan for meeting the Performance Bond, other bonds, and insurance requirements set forth in this RFP requirement including the type of bond to be posted and source of funding.

Through its corporate insurance program, AmeriHealth Mercy of Louisiana, Inc. (AML) will, upon award of a CCN contract and prior to commencing work, secure the necessary bonds and insurance as required by the RFP. All such bonds and insurance will be filed with DHH for approval. AML will require its subcontractors to obtain similar insurance prior to commencing work.

Specifically, AML shall obtain the following types of insurance in the amounts and extents required by the RFP:

- Workers' Compensation Insurance;
- Commercial Liability Insurance (a copy of AML's current liability insurance certificate is provided in our response to Item B. 30);
- Errors and Omissions Insurance;
- Insurance Covering Special Hazards, as determined by DHH; and
- Insurance Covering Licensed and Non-Licensed Motor Vehicles

The policies will: (a) name AML as the insured; (b) be fully executed by the officers of the insurance company; and (c) state that the policies may not be canceled, permitted to expire, or be changed without 30 days advance notice to and consent from DHH.

AML is still evaluating whether it will purchase reinsurance coverage from a third party or whether it will self-insure. Whichever reinsurance arrangement AML ultimately decides to proceed with will comply with the applicable RFP reinsurance requirements.

In accordance with the RFP, AML will obtain and maintain a performance bond of ten (10) million dollars ($10,000,000), payable to the State of Louisiana, to guarantee the payment of AML's obligations to DHH and the performance of AML's obligations under the CCN contract. The surety company to provide the performance bond will be ACE/Westchester Fire Insurance, which is on the United States Department of Treasury's list of approved sureties.

AML shall insure against losses sustained through fraudulent or dishonest act or acts committed by employees of AML and its subcontractors pursuant to the corporate insurance program's crime and fiduciary insurance policy. To the extent that the coverage provided for in the crime and fiduciary policy is insufficient or not in compliance with the applicable requirements of the RFP, AML shall secure and maintain throughout the term of the CCN contract the required fidelity bond.

B.15: Table of Financial Measures

Provide the following information (in Excel format) based on each of the financial statements provided in response to item B:30: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio.

The table below contains the financial measures requested in Item B.15 for the latest three years, based on the audited financial statements for AmeriHealth Mercy Health Plan (AMHP). AMHP is the parent organization of AmeriHealth Mercy of Louisiana, Inc. as described in the response to item B.31. We have included the standard formulas for ease of reference.

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Table 9: Table of Financial Measures (Dollar Amounts in Thousands)

Financial Measure	Formula	2008 (from 2009 audited statement)	2009 (from 2010 audited statement)	2010 (from 2010 audited statement)
(1) Working Capital	Current Assets - Current Liabilities	$26,505	$56,450	$75,576
(2) Current Ratio	Current Assets ÷ Current Liabilities	1.11	1.20	1.22
(3) Quick Ratio	(Cash and Cash Equivalents + Investment Securities + Accounts Receivable) ÷ Current Liabilities	1.04	1.10	1.15
(4) Net Worth	Total Assets - Total Liabilities	$80,368	$104,614	$124,592
(5) Debt-to-Worth Ratio	Debt/Loans Outstanding ÷ Net Worth	0.28	0.15	0.12

B.16: Table of Financial Measures

Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identity, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly funded managed care contracts for the Medicaid/CHIP individuals within the last five (5) years, identify the Proposers ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. ***Include your organizations parent organization, affiliates and subsidiaries.***

AmeriHealth Mercy of Louisiana, Inc. (AML) is a newly formed organization so requested information is not available for AML. However, please see the below grid for information on all of the publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals for AML's parent organization, affiliates and subsidiaries (collectively, "AmeriHealth Mercy") for the last five (5) years.

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Table 10: Publicly-funded Managed Care Contracts

Trade Name	Work Performed	Contract Start Date	Contact Name & Phone Number	Membership as of 4/11	Population	Annual Payments (000's)	Payment Type	Role of Subcontractor
Health Choices - AmeriHealth Mercy Health Plan (Central & Northeast PA)	Medicaid Managed Care	1997-Present	Joanie Morgan, Director, Bureau of Managed Care Operation Dept. of Public Welfare (717) 772-6303	109,684	TANF, SSI with & without Medicare State and Fed GA and Medically Needy	$460,602	Capitated	Pharmacy claims processing, 24/7 nurse line, vision services, dental services, prescription benefit program, select radiology procedures, neonatal medical management, data imaging and limited TPL and recovery services
Health Choices - Keystone Mercy Health Plan (Southeastern PA)	Medicaid Managed Care	1996-Present	Joanie Morgan, Director, Bureau of Managed Care Operation Dept. of Public Welfare (717) 772-6303	314,578	TANF, SSI with & without Medicare State and Fed GA & Medically Needy; Presumptive Eligibility; and Uninsured Population	$1,596,867	Capitated	Pharmacy claims processing, 24/7 nurse line, vision services, dental services, prescription benefit program, select radiology procedures, data imaging and limited TPL and recovery services

CONFIDENTIAL AND PROPRIETARY

Trade Name	Work Performed	Contract Start Date	Contact Name & Phone Number	Membership as of 4/11	Population	Annual Payments (000's)	Payment Type	Role of Subcontractor
FirstChoice by Select Health of South Carolina (Statewide)	Medicaid Managed Care	1999-Present	Roy E. Hess, Interim Deputy Director, Managed Care Dept. of Health and Human Services (803) 898-	210,471	TANF, SSI without Medicare, CHIP	$600,560	Capitated	Pharmacy claims processing, prescription benefit program and inpatient behavioral health services
MDwise Hoosier Alliance (Statewide)	Medicaid Managed Care & Healthy Indiana Uninsured Program	2007-Present	Charlotte MacBeth, President, MDwise, Inc. (317) 822-7116	137,883	TANF, SSI with & without Medicare State and Fed GA & Medically Needy; Presumptive Eligibility; and Uninsured Population	$245,048	Capitated	Behavioral health services
MDwise Care Select (Statewide)	Care Mgmt. And Utilization Mgmt. including Prior Authorizations	2007-2010	Charlotte MacBeth, President, MDwise, Inc. (317) 822-7116	N/A	SSI w/out Medicare (average membership 39,627)	$630	Capitated	N/A
CBHNP an AmeriHealth Mercy Company (Health Choices)	Behavioral Health Medicaid Managed Care	2006-Present	Scott Suhring, CEO Capital Area Behavioral Health Collaborative (717) 671-7190	221,304	TANF, SSI with & without Medicare State and Fed GA & Medically Needy	$290,000	Capitated	N/A

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In addition to the above-referenced managed care contracts, AmeriHealth Mercy has, within the last five (5) years, provided administrative and management services to Medicaid/CHIP and/or other low-income populations through the administrative and management service contracts described in the below grid.

Table 11: Administrative and Management Services Contracts

Trade Name	Work Performed	Contract Start Date	Contact Name & Phone Number	Membership as of 4/11	Population	Annual Payments (000's)	Payment Type
Passport Health Plan (16 Counties in Kentucky)	Managed Services on behalf of health plan including Medical Mgmt., Prov. Network & all admin functions.	1997-Present	Mark Carter, Interim CEO, University Health Care d/b/a Passport Health Plan (502) 585-8351	171,463	TANF, SSI w/ and w/o Medicare, State & Fed GA and Medically Needy	$48,800	Capitated
Passport Advantage (16 Counties in Kentucky)	Managed Services on behalf of health plan including Medical Mgmt., Prov. Network & all admin functions.	2006-Present	Mark Carter, Interim CEO, University Health Care d/b/a Passport Health Plan (502) 585-8351	9,744	SSI w/ Medicare	$7,606	Capitated
Horizon NJ Health (Statewide)	TPA Services	1997 - Present	Karen L. Clark, President Horizon NJ Health (609) 718 - 9274	479,074	TANF, SSI w/ and w/o Medicare	$32,030	Capitated
PerformCare of NJ (Statewide)	TPA Services	2010 - Present	Jeffrey J. Guenzel, Director Division of Child Behavioral Health Services (609) 292-4741	39,936	TANF, SSI with & without Medicare State	$7,400	Capitated

CONFIDENTIAL AND PROPRIETARY

Trade Name	Work Performed	Contract Start Date	Contact Name & Phone Number	Membership as of 4/11	Population	Annual Payments (000's)	Payment Type
Pediatric Associates Provider Sponsored Network (PSN)	TPA and Mgmt. Services	2006-2009	Terry Fields, CEO, Pediatrics Association PSN	N/A	TANF, SSI w/o Medicare (average membership was 9,148)	$2,214	Shared Savings Model

AmeriHealth Mercy has not had any managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years.

B.17: Terminated Contracts

Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. Include your organization's parent organization, affiliates, and subsidiaries.

Except for the following non-renewed and terminated contracts, AmeriHealth Mercy of Louisiana, Inc. and its parent organization, affiliates and subsidiaries have not had any contract terminated or not renewed within the past five (5) years.

Table 12: Terminated Contracts

Affiliate	Contract Party (Client)	Reason for Nonrenewal or Termination	Termination Date	Client Address & Phone Number
PerformRx	APS Healthcare	PBM Agreement terminated as a result of the Plan Sponsor's termination of all Plan membership following State (Hawaii) determination to resume responsibility for management of behavioral health pharmacy benefit.	10/31/10	Art Fleury Vice President, Business Solutions (914) 288-4601
PerformRx	Carolina Crescent Health Plan, Inc.	No reason given by client.	6/30/09	Jennifer Marchant Executive Director (803) 748-8661
PerformRx	Humana AdvantageCare Plan, Inc. f/k/a Metcare Health Plans, Inc.	Humana acquired Metcare, a Medicare Part D plan for which PerformRx provided PBM services. PerformRx agreed to permit an early	12/31/08	Julie Dickinson Director, Corporate Pharmacy Management Humana Inc. (502) 580-1000

Affiliate	Contract Party (Client)	Reason for Nonrenewal or Termination	Termination Date	Client Address & Phone Number
		termination of the PBM Agreement in order to permit Humana to consolidate the lives covered under the Metcare Part D plan with another of Humana's Part D products.		
PerformRx	MDwise, Inc.	PBM contract terminated as a result of the State of Indiana carving out pharmacy from the Medicaid managed care program.	12/31/09	Chris Johnson Vice President, Medical Economics & Network Strategies (317) 822-7237
PerformRx	Optimum Healthcare	Client terminated PBM Agreement in order to in-source pharmacy benefit administration.	12/31/08	Mike Keilty Director of Pharmacy (727) 451-6800 Ext. 3206
PerformRx	Touchstone Health HMO, Inc.	Client exercised contractual no-cause termination right.	12/31/08	Cathy Neiman VP, Contracting/Network Development (212) 295-1040
PerformRx	Virginia Premier Health Plan, Inc.	No reason cited.	6/30/09	James S. Parrott Chief Executive Officer (804) 819-5151

B.18: Corrective Action

If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries.

AmeriHealth Mercy of Louisiana, Inc. and its parent organization, affiliates and subsidiaries have not had any contract terminated or not renewed within the past five (5) years on the basis of performance.

B.19: Current Ratings

As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following:

- *AM Best Company (financial strengths ratings);*
- *TheStreet.com, Inc. (safety ratings); and*
- *Standard & Poor's (long-term insurer financial strength.*

Not Applicable. AmeriHealth Mercy of Louisiana, Inc. and its parent organization, AmeriHealth Mercy Health Plan (collectively "AmeriHealth Mercy") have not been rated by the agencies listed above as they

are not publically traded. However, AmeriHealth Mercy's financial strength is demonstrated by the financial measures depicted in AmeriHealth Mercy's response to Item B.15.

B.20 Breach of Contract

For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? Include your organization's parent organization, affiliates, and subsidiaries.

AmeriHealth Mercy of Louisiana, Inc. and its parent organization, affiliates and subsidiaries (collectively, "AmeriHealth Mercy") has not, with in the last five (5) years, been notified by a party to which AmeriHealth Mercy is contractually obligated to provide physical health services that the party has found AmeriHealth Mercy to be in breach of the contract.

B.21: NCQA or URAC Accreditation Status

B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.

As a newly formed organization, AmeriHealth Mercy of Louisiana, Inc., is not yet NCQA accredited. However, in the event of an award of a CCN contract, AmeriHealth Mercy of Louisiana, Inc. will submit an application for NCQA accreditation at the earliest possible date allowed by NCQA and once achieved, maintain accreditation throughout the life of the CCN contract. The chart below lists the organization's current NCQA accreditation status.

Table 13: Current NCQA Accreditation Status

Health Plan	Effective Date	Current Accreditation Status (based on last rescore)
Keystone Mercy Health Plan	8/6/2010	Excellent
AmeriHealth Mercy Health Plan	8/6/2010	Excellent
Select Health of South Carolina	1/3/2011	Excellent
MDwise Hoosier Alliance	11/9/2009	Accredited*
	Accredited through MDwise, Inc.	

*MDwise applied for NCQA accreditation as a New Health Plan. NCQA's accreditation status for New Health Plan is limited to Accredited or Denied.

NCQA offers distinction to organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities. AmeriHealth Mercy and its affiliated plans are three (3) of only six (6) early adopters nationwide to earn NCQA's Multicultural Health Care Distinction. Additional information on our multicultural health care programs and successes can be found in Section L4.

Table 14: NCQA Multicultural Health Care Distinction Award Accreditation

Plan	Effective Dates
Keystone Mercy Health Plan	5/2011
AmeriHealth Mercy Health Plan	5/2011
Select Health of South Carolina	5/2011

The chart below lists the organization's current URAC accreditation status.

Table 15: URAC Accreditation Status

Plan	Accreditation type	Effective	Expires
Keystone Mercy Health Plan	Case Management (3.1) Disease Management (2.1) Asthma, Diabetes, Heart Failure COPD	11/1/2009 12/1/2008 1/9/2009	11/1/2012 11/1/2011 12/1/2011
AmeriHealth Mercy Health Plan	Case Management (3.1) Disease Management (2.1) Asthma, Diabetes, Heart Failure COPD	11/1/2009 12/1/2008 1/9/2009	11/1/2012 12/1/2011 12/1/2011
PerformRx	Pharmacy benefit management	10/2010	9/2013

*AmeriHealth Mercy/Keystone Mercy Health Plan has made a decision to allow our URAC accreditations to expire as these areas are now covered under the NCQA Health Plan Standards.

B. 22: Change to Accreditation Status

B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Include your organization's parent organization, affiliates, and subsidiaries.

As a newly formed organization, AmeriHealth Mercy of Louisiana, Inc. is not yet NCQA accredited. Accordingly, AmeriHealth Mercy of Louisiana, Inc. has never had its accreditation status adjusted down, suspended, or revoked. Furthermore, AmeriHealth Mercy Health Plan, the parent organization of AmeriHealth Mercy of Louisiana, Inc. and its affiliates and subsidiaries have never had their accreditation status (NCQA or URAC) adjusted down, suspended, or revoked.

B. 23: NCQA Health Plan Report Cards

B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. Include your organization's parent organization, affiliates, and subsidiaries.

As a newly formed organization, AmeriHealth Mercy of Louisiana, Inc. is not yet NCQA accredited. However, in the event of an award of a CCN contract, AmeriHealth Mercy of Louisiana, Inc. will submit an application for NCQA accreditation at the earliest possible date allowed by NCQA and once achieved, maintain accreditation throughout the life of the CCN contract.

The following NQCA report cards, certificates and website screen prints for AmeriHealth Mercy Health Plan ("AmeriHealth Mercy"), the parent organization of AmeriHealth Mercy of Louisiana, Inc., and its affiliated plans are provided for review. The table below is a summary of the documents to follow.

Table 16: Health Plan Awards

Health Plan	Report Card	Certificate	NCQA's Web Site Screen Print
AmeriHealth Mercy Health Plan	Health Plan	Health Plan	Multicultural Health Care Distinction
Keystone Mercy Health Plan	Health Plan	Health Plan	Multicultural Health Care Distinction
MDwise Hoosier Alliance*	New Health Plan	New Health Plan	Not Applicable
Select Health of South Carolina	Health Plan	Health Plan	Multicultural Health Care Distinction

* Accredited through MDwise, Inc. as one of eight (8) MDwise, Inc. Delivery Systems. Accordingly, we have attached the MDwise, Inc. report card and certificate. MDWise, Inc. applied for NCQA accreditation as a New Health Plan. NCQA's accreditation status for New Health Plan is limited to Accredited or Denied.

Health Plan NCQA Report Cards

Figure 10: AmeriHealth Mercy Health Plan NCQA Report Card

Health Plan Report Card

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AmeriHealth Mercy Health Plan

Print Close this window

General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	2404 Park Drive, 1st Floor, Harrisburg, PA, 17110
Number of members enrolled:	108,075
Website:	www.amerihealthmercy.com

This health plan serves members in the following state(s):
Pennsylvania

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Expiration Date:	08/06/2013
Date of Next Review:	05/15/2013
HEDIS measures included in results:	Yes
CAHPS measures included in results:	Yes

Performance Results

Accreditation Status: Excellent

Accreditation Star Ratings

Access and Service:	☆☆☆☆
Qualified Providers:	☆☆☆☆
Staying Healthy:	☆☆☆☆
Getting Better:	☆☆☆☆
Living with Illness:	☆☆☆☆

Other

For cost of benefits information, please contact this plan directly or speak with the benefits manager at your place of work.

Figure 11: Keystone Mercy Health Plan NCQA Report Card

Health Plan Report Card

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Keystone Mercy Health Plan

Print Close this window

General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	200 Stevens Drive, Philadelphia, PA, 19113
Number of members enrolled:	307,815
Website:	www.kmhp.com

This health plan serves members in the following state(s):
Pennsylvania

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Expiration Date:	08/06/2013
Date of Next Review:	05/15/2013
HEDIS measures included in results:	Yes
CAHPS measures included in results:	Yes

Performance Results

Accreditation Status: Excellent

Accreditation Star Ratings

Access and Service:	★★★★
Qualified Providers:	★★★★
Staying Healthy:	★★★☆
Getting Better:	★★★☆
Living with Illness:	★★★☆

Other

For cost of benefits information, please contact this plan directly or speak with the benefits manager at your place of work.

Figure 12: MDwise, Inc. Health Plan NCQA Report Card

Health Plan Report Card - Windows Internet Explorer provided by AMFC

http://reportcard.ncqa.org/plan/external/PlanSummary.aspx?WipsPlanId=871

MDwise, Inc.

Print Close this window

General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	Madison Plaza, 1200 Madison Ave., Suite 400, Indianapolis, IN, 46225
Number of members enrolled:	282,187
Website:	www.mdwise.org
Other Names:	Healthy Indiana Plan, Hoosier Healthwise, MDwise Community Munster, MDwise Healthy Indiana Plan, MDwise Hoosier Alliance, MDwise Hoosier Healthwise, MDwise Methodist, MDwise Select Health, MDwise St. Anthony's, MDwise St. Catherine, MDwise St. Margaret Mercy, MDwise St. Mary's, MDwise St. Vincent, MDwise Wishard

This health plan serves members in the following state(s):
Indiana

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Date of Next Review:	08/14/2012

Performance Results

Accreditation Status:	Scheduled
Accreditation Star Ratings	
Access and Service:	
Qualified Providers:	
Staying Healthy:	
Getting Better:	
Living with Illness:	

Other

For cost of benefits information, please contact this plan directly or speak with the benefits manager at your place of work.

[Close this window]

Done Internet 100%

Figure 13: Select Health of South Carolina, Inc. Health Plan NCQA Report Card

Health Plan Report Card

Page 1 of 1

Select Health Of South Carolina, Inc.

Print Close this window

General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	4390 Belle Oaks Drive, Suite 100, N. Charleston, SC, 29405
Number of members enrolled:	205,073
Website:	www.selecthealthofsc.com
Other Names:	First Choice

This health plan serves members in the following state(s):
South Carolina

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Expiration Date:	01/03/2014
Date of Next Review:	10/09/2013
HEDIS measures included in results:	Yes
CAHPS measures included in results:	Yes

Performance Results

Accreditation Status:	Excellent

Accreditation Star Ratings

Access and Service:	☆☆☆☆
Qualified Providers:	☆☆☆☆
Staying Healthy:	☆☆☆½
Getting Better:	☆☆☆☆
Living with Illness:	☆☆☆½

Other

For cost of benefits information, please contact this plan directly or speak with the benefits manager at your place of work.

Health Plan NCQA Certificates

Figure 14: AmeriHealth Mercy Health Plan NCQA Certificate

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

has awarded

AmeriHealth Mercy Health Plan

Medicaid HMO

HEALTH PLAN NCQA ACCREDITATION EXCELLENT

its highest accreditation status of

EXCELLENT

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.
This organization's HEDIS results are in the highest range of national performance.

CHAIR, BOARD OF DIRECTORS | PRESIDENT | CHAIR, REVIEW OVERSIGHT COMMITTEE

August 6, 2010 — DATE GRANTED
August 6, 2013 — EXPIRATION DATE

Figure 15: Keystone Mercy Health Plan NCQA Certificate

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

has awarded

Keystone Mercy Health Plan

Medicaid HMO

HEALTH PLAN NCQA ACCREDITATION EXCELLENT

its highest accreditation status of

EXCELLENT

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.
This organization's HEDIS results are in the highest range of national performance.

CHAIR, BOARD OF DIRECTORS | PRESIDENT | CHAIR, REVIEW OVERSIGHT COMMITTEE

August 6, 2010 — DATE GRANTED
August 6, 2013 — EXPIRATION DATE

Figure 16: MDwise, Inc. Health Plan NCQA Certificate

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

has awarded

MDwise, Inc.

the status of

New Health Plan Accreditation

for the development of a structurally sound managed health care delivery system which has as its primary objective the delivery of high quality member care and service.

NEW HEALTH PLAN NCQA ACCREDITATION ACCREDITED

CHAIR, BOARD OF DIRECTORS — PRESIDENT — CHAIR, REVIEW OVERSIGHT COMMITTEE

November 9, 2009 — DATE GRANTED

November 9, 2012 — EXPIRATION DATE

Figure 17: Select Health of South Carolina, Inc. Health Plan NCQA Certificate

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

has awarded

Select Health of South Carolina, Inc.

Medicaid HMO

its highest accreditation status of

EXCELLENT

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.
This organization's HEDIS results are in the highest range of national performance.

HEALTH PLAN NCQA ACCREDITATION EXCELLENT

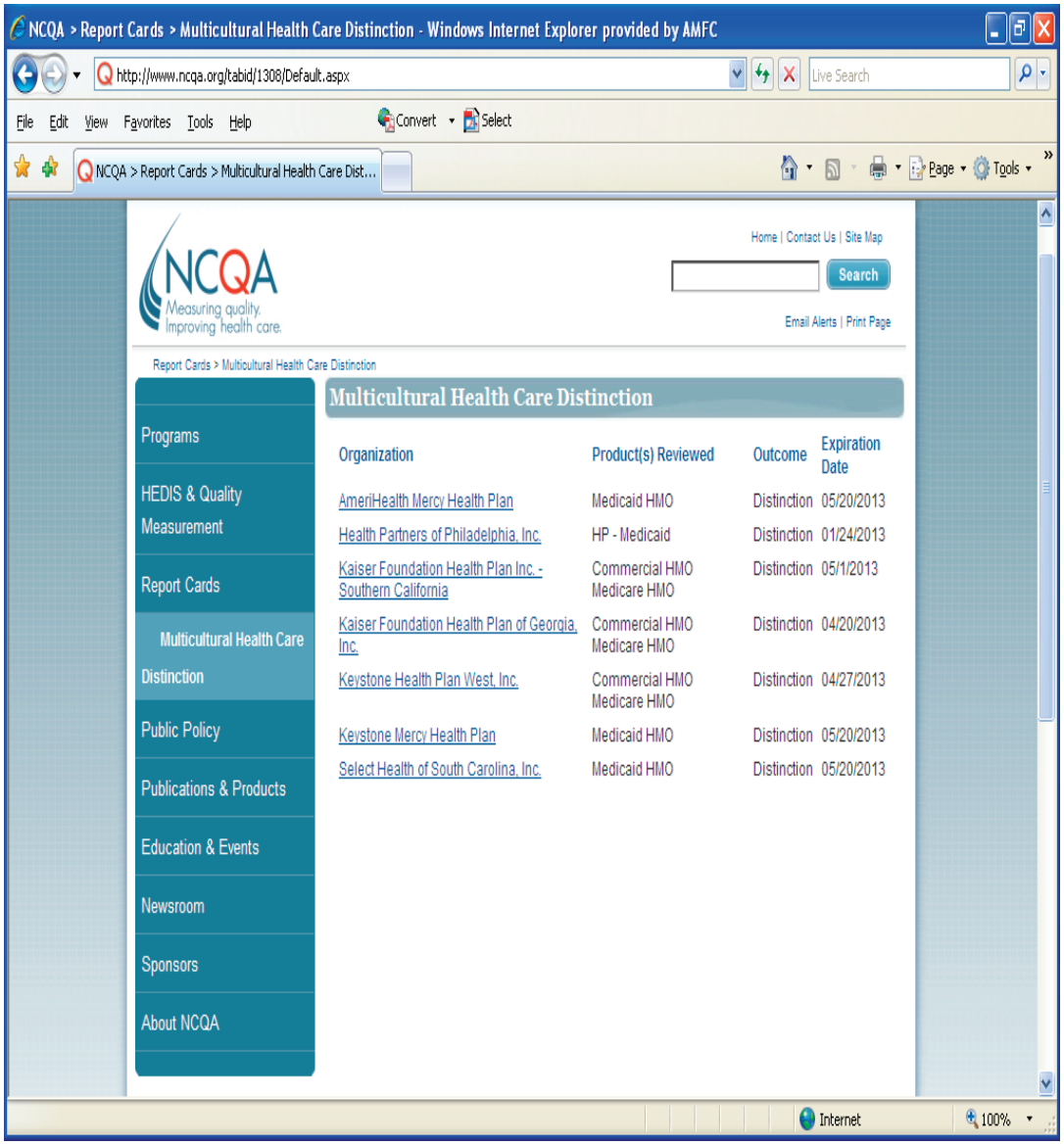
CHAIR, BOARD OF DIRECTORS | PRESIDENT | CHAIR, REVIEW OVERSIGHT COMMITTEE

January 3, 2011 — DATE GRANTED
January 3, 2014 — EXPIRATION DATE

Health Plan NCQA Multicultural Distinction Notification

As discussed above, NCQA offers distinction to organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities. AmeriHealth Mercy and its affiliated plans are three (3) of only six (6) early adopters nationwide to earn NCQA's Multicultural Health Care Distinction. Below is a screen shot of the announcements of award on NCQA's website for the three health plans affiliated with AmeriHealth Mercy of Louisiana, Inc.

Figure 18: Select Health of South Carolina, Inc. Health Plan NCQA Certificate



B. 24: External Quality Review Report

B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (including your organization's parent organization, affiliates, and subsidiaries) in response to the report.

Attached, as Attachment B.24, is the most recent external quality review report for the largest Medicaid contract as identified in B.16, Keystone Mercy Health Plan, which is operated as an affiliate organization to LaCare. The report is supplied in full.

Although the report is titled 2009 it is the most recent report as it was completed in April 2010. The report identified four HEDIS measures that had no significant change from HEDIS 2008 to HEDIS 2009 and were below the HEDIS 2009 Medicaid Managed Care weighted average. A root cause analysis with a plan of action was required. As part of Attachment B.24, we have enclosed the root cause analysis associates with the following four measures:

- Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Level Controlled (<100 mg/dL)
- Comprehensive Diabetes Care: LDL-C Level Controlled (<100 mg/dL)
- Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Received
- Prenatal and Postpartum Care: Timeliness of Prenatal Care.

B.25: Regulatory Action/Sanctions

Identify and describe any regulatory action or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries.

AmeriHealth Mercy of Louisiana, Inc. (AML) has not had any regulatory action or sanction imposed on it by any federal or state regulatory entity within the last five (5) years. Regulatory actions or sanctions imposed by a federal or state regulatory agency with the five (5) year timeframe against AML's parent organization, affiliates and subsidiaries are described below.

1. **Organization:** AmeriHealth Mercy Health Plan (AMHP)/Keystone Mercy Health Plan (KMHP)

   Regulatory Agency: Pennsylvania Department of Public Welfare (PADPW), Medicaid

   Regulatory Action/Sanction: For the months of January, March, September – December 2010, AMHP and KMHP were each sanctioned a total of $10,000 by the PADPW for non-compliance with the timeframe for mailing provider claim checks after the checks have been printed. The operational issues leading to this CAP have been corrected by both AMHP and KMHP.
2. **Organization:** Select Health of South Carolina, Inc. ("Select Health")

   Regulatory Agency: South Carolina Department of Health and Human Services (SCDHHS), Medicaid

   Regulatory Action/Sanction: In June 2008, the SCDHHS imposed a $100,500 monetary sanction for non-compliance with marketing requirements caused by two (2) Select Health associates who assisted a number of Medicaid beneficiaries with the enrollment process by faxing their applications to the SCDHHS enrollment broker. Select Health self-reported the incident to the SCDHHS after Select Health became aware of the actions of the two (2) associates.

No federal or state regulatory entity has, within the last five (5) years, issued a letter of deficiency to AML or requested or required corrective actions of AML related to a Medicaid or CHIP contract. This information as it pertains to AML's parent organization, affiliates and subsidiaries is described in the chart below. Notably, as a matter of practice, the Pennsylvania Department of Public Welfare (PADPW) issues corrective action plans for most compliance issues, regardless of the severity of the deficiency.

1. **Organization:** AmeriHealth Mercy Health Plan (AMHP)/Keystone Mercy Health Plan (KMHP)
   - **Regulatory Agency:** Pennsylvania Department of Public Welfare (PADPW), Medicaid
   - **Letter of Deficiency/Corrective Action Plan (CAP):** In November 2010, the PADPW requested a CAP as a result of a reportable privacy breach that occurred earlier in the year

when a thumb drive containing Protected Health Information (PHI) of members was lost. The CAP required AMHP and KMHP to address the following areas: 1) implementation of encryption software; 2) information security protocols; 3) policies and procedures regarding the use of removable media, the collection of PHI at community events, and notification of PHI breaches; 4) HIPAA training; 5) monitoring of utilization by affected members to detect fraud, waste and abuse; and 6) the logistics of member notifications, call center processes and the handling of complaints stemming from the breach. AMHP and KMHP have comprehensively responded to all items addressed in the CAP and the CAP has been closed by the PADPW.

2. **Organization:** AmeriHealth Mercy Health Plan (AMHP)/Keystone Mercy Health Plan (KMHP)
   - **Regulatory Agency:** Pennsylvania Department of Public Welfare (PADPW), Medicaid
   - **Letter of Deficiency/Corrective Action Plan (CAP):** In February 2010, the PADPW issued CAPs requiring AMHP and KMHP to implement a plan to ensure that expedited grievance decisions are consistently made within the required timeframe. The limited availability of staff on weekends and holidays to process expedited grievance review requests (which includes collecting the necessary data, notifying the members and providers of the review, conducting committee review, and notifying members and providers of the committee determination) impeded AMHP's and KMHP's ability to consistently meet the required timeframes for expedited grievance reviews. AMHP and KMHP implemented a plan to utilize on-call staff to process expedited grievance review requests received on weekends and holidays. The PADPW approved this plan and closed the CAP.
3. **Organization:** AmeriHealth Mercy Health Plan (AMHP)/Keystone Mercy Health Plan (KMHP)
   - **Regulatory Agency:** Pennsylvania Department of Public Welfare (PADPW), Medicaid
   - **Letter of Deficiency/Corrective Action Plan (CAP):** In September 2009, the PADPW issued a CAP requiring AMHP and KMHP to implement a plan to ensure that coverage determinations for home health aide services are made on the basis of medical necessity rather than for administrative reasons. AMHP and KMHP have comprehensively responded to all items addressed in the CAP and are awaiting closure of the CAP by the PADPW.
4. **Organization:** AmeriHealth Mercy Health Plan (AMHP)
   - **Regulatory Agency:** Pennsylvania Department of Public Welfare (PADPW), Medicaid
   - **Letter of Deficiency/Corrective Action Plan (CAP):** In June of 2009, the PADPW issued CAPs requiring AMHP to implement plans to ensure compliance with provider network access standards in two counties. The termination of a large health system from the AMHP provider network resulted in network access issues in two counties. AMHP has diligently worked to address the access issues - made extremely challenging by the limited number of available hospitals in the two counties and surrounding counties. AMHP executed a contract with a health system located in one of the two counties; the PADPW has closed the CAP for that county. Although the CAP remains in place with respect to the other county, AMHP is in active contract negotiations with a health system located in that county and is confident that the PADPW will close the CAP after the provider contract is executed. Until such time, AMHP continues to permit affected members to obtain services through out-of-network providers.
5. **Organization:** AmeriHealth Mercy Health Plan (AMHP)/Keystone Mercy Health Plan (KMHP)
   - **Regulatory Agency:** Pennsylvania Department of Public Welfare (PADPW), Medicaid
   - **Letter of Deficiency/Corrective Action Plan (CAP):** In August 2008, the PADPW issued a CAP requiring AMHP and KMHP to implement a plan to ensure submission of inpatient

encounters with the correct facility code/place of service. The systems issues leading to this CAP were corrected and the CAP closed.

6. **Organization:** AmeriHealth Mercy Health Plan (AMHP)/Keystone Mercy Health Plan (KMHP)
   - **Regulatory Agency:** Pennsylvania Department of Public Welfare (PADPW), Medicaid
   - **Letter of Deficiency/Corrective Action Plan (CAP):** In July of 2008, the PADPW issued a CAP requiring AMHP and KMHP to implement a plan to ensure compliance with a PADPW Operations Memorandum requiring delivery services to be reimbursed at a rate equal to at least the PADPW Medicaid fee-for-service rate. The AMHP and KMHP claims system is configured to reimburse delivery services at a rate at least as equal to the Medicaid fee-for-service rate unless the provider bills a lesser amount, in which case the provider is reimbursed the billed amount. AMHP and KMHP requested written confirmation from the PADPW that CMS and the PA Auditor General approved of reimbursing providers an amount greater than the amount billed by the provider. No further documentation was provided by the PADPW and the CAP was closed.
7. **Organization:** AmeriHealth Mercy Health Plan (AMHP)/Keystone Mercy Health Plan (KMHP)
   - **Regulatory Agency:** Pennsylvania Department of Public Welfare (PADPW), Medicaid
   - **Letter of Deficiency/Corrective Action Plan (CAP):** In April of 2008, the PADPW issued a CAP requiring AMHP and KMHP to implement a plan to ensure the submission of Institutional Long Term Care (LTC) encounters with the correct facility code. As a result of a PADPW systems change, all Medicaid managed care plans contracted with the PADPW were submitting LTC encounters with the incorrect facility code. The systems issues leading to this CAP were corrected and the CAP closed.
8. **Organization:** AmeriHealth Mercy Health Plan (AMHP)/Keystone Mercy Health Plan (KMHP)
   - **Regulatory Agency:** Pennsylvania Department of Public Welfare (PADPW), Medicaid
   - **Letter of Deficiency/Corrective Action Plan (CAP):** In April of 2008, the PADPW issued a CAP requiring AMHP and KMHP to implement a plan to ensure the generation of a monthly report to County Children and Youth Agencies identifying members in the custody of the agencies due for an Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening. A systems change inadvertently caused the report to stop generating. The systems issue was addressed and the CAP closed.
9. **Organization:** AmeriHealth Mercy Health Plan (AMHP)/Keystone Mercy Health Plan (KMHP)
   - **Regulatory Agency:** Pennsylvania Department of Public Welfare (PADPW), Medicaid
   - **Letter of Deficiency/Corrective Action Plan (CAP):** In October 2006, the PADPW issued a CAP requiring AMHP and KMHP to implement a plan to ensure the production of a report of dental hotline telephone call metrics. The reports were not produced because of a system configuration issue. The configuration issue was corrected and the CAP closed.
10. **Organization:** AmeriHealth Mercy Health Plan (AMHP)/Keystone Mercy Health Plan (KMHP)
    - **Regulatory Agency:** Pennsylvania Department of Health (PADOH), Medicaid
    - **Letter of Deficiency/Corrective Action Plan (CAP):** In February 2008 and in October 2010, the PADOH issued a CAP requiring AMHP and KMHP to implement a plan to ensure compliance with certain Pennsylvania utilization review requirements. The PADOH is required to audit all licensed utilization review entities for compliance with Pennsylvania utilization review requirements. All utilization review entities audited by the PADOH in the last two audits (Years 2007 and 2010) were found to have deficiencies and requested to implement a plan of correction. AMHP and KMHP comprehensively responded to all items addressed in the 2008 and 2010 CAPs and the CAPs were closed.
11. **Organization:** AmeriHealth Mercy Health Plan (AMHP)/Keystone Mercy Health Plan (KMHP)

- **Regulatory Agency:** Pennsylvania Department of Health (PADOH), Medicaid
- **Letter of Deficiency/Corrective Action Plan (CAP):** In March 2007 and in January 2009, the PADOH issued a CAP requiring AMHP and KMHP to implement a plan to ensure compliance with certain Pennsylvania member complaint and grievance appeal requirements. The PADOH is required to audit all licensed managed care organizations for compliance with Pennsylvania member complaint and grievance requirements. Most of the managed care organizations audited by the PADOH in the last two audits (Years 2006 and 2008) were found to have deficiencies and requested to implement a plan of correction. AMHP and KMHP comprehensively responded to all items addressed in the 2007 and 2009 CAPs and the CAPs were closed.

12. **Organization:** Community Behavioral Health Network of Pennsylvania, Inc. (CBHNP)
    - **Regulatory Agency:** Pennsylvania Department of Health (PADOH), Medicaid
    - **Letter of Deficiency/Corrective Action Plan (CAP):** In September 2009, the PADOH issued a CAP requiring CBHNP to implement a plan to ensure compliance with certain Pennsylvania utilization review requirements. The PADOH is required to audit all licensed managed care organizations for compliance with Pennsylvania member complaint and grievance requirements. The 2009 audit was the first audit conducted by the PADOH of the utilization review activities of behavioral health managed care organizations; all of the behavioral health managed care organizations that were audited by the PADOH were found to have deficiencies and requested to implement a plan of correction. CBHNP comprehensively responded to all items addressed in the 2009 CAP and the CAP was closed.
13. **Organization:** Community Behavioral Health Network of Pennsylvania, Inc. (CBHNP)
    - **Regulatory Agency:** Pennsylvania Department of Health (PADOH), Medicaid
    - **Letter of Deficiency/Corrective Action Plan (CAP):** In October 2008, the PADOH issued a CAP requiring CBHNP to implement a plan to ensure compliance with certain Pennsylvania member complaint and grievance appeal requirements. The PADOH is required to audit all licensed managed care organizations for compliance with Pennsylvania member complaint and grievance requirements. The 2008 audit was the first audit conducted by the PADOH of behavioral health managed care organizations. CBHNP comprehensively responded to all items addressed in the CAP and the CAP was closed.

No other letters of deficiency have been issued to or corrective actions requested or required of AML's parent organization, affiliates and subsidiaries related to Medicaid or CHIP contracts.

B.26: Criminal or Civil Investigation.

Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B. 6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. Include your organization's parent company, affiliates and subsidiaries.

AmeriHealth Mercy of Louisiana Inc. is not currently the subject or recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency. Furthermore, except as described below, AmeriHealth Mercy of Louisiana, Inc.'s parent company, affiliates and subsidiaries are not currently or recently been the subject of such investigation.

In 2010, the Kentucky Attorney General ("KYAG") investigated AmeriHealth Mercy Health Plan, AmeriHealth Mercy of Louisiana Inc.'s parent organization, regarding allegations that AmeriHealth

Mercy Health Plan employees had falsely reported one HEDIS score for a Kentucky Medicaid health plan for which AmeriHealth Mercy Health Plan serves as the administrator. Specifically, the KYAG investigated allegations that a few records were reported incorrectly as having had a PAP test for the Cervical Cancer Screening HEDIS measure reported in 2009.

As the administrator, AmeriHealth Mercy Health Plan is responsible for, among other things, developing and carrying out quality improvement programs and HEDIS reporting for the Kentucky plan. These programs and reporting are operated separately and autonomously from AmeriHealth Mercy Health Plan's other lines of business. Different policies and procedures are utilized and separate AmeriHealth Mercy Health Plan staff, located in Kentucky, carry out those functions under Kentucky local management.

AmeriHealth Mercy Health Plan fully cooperated in the investigation, which ultimately revealed that the errors were the responsibility of a few Kentucky-based employees who are no longer employed by AmeriHealth Mercy Health Plan. These errors increased the Cervical Cancer Screening score of the Kentucky plan.

Despite AmeriHealth Mercy Health Plan's belief that the incorrect reporting of the HEDIS score was not intentional, AmeriHealth Mercy Health Plan entered into a settlement with the KYAG, in January 2011, in an effort to expeditiously resolve the matter pursuant to which AmeriHealth Mercy Health Plan paid $2,032,758. A resolution of the same matter was subsequently entered into with federal authorities in May 2011, with no additional settlement payment.

To ensure that this type of situation does not occur again, AmeriHealth Mercy Health Plan implemented its own compliance plan to address the issues raised by the KYAG investigation. (No corrective action plan was required by the state or federal authorities.) The compliance plan provided for, among other things:

- Enhanced training of staff involved in HEDIS reporting and medical record abstractions
- More robust security of the HEDIS databases and completed HEDIS forms
- Electronic linkage of the medical record documentation supporting the HEDIS review to the member's data record
- Contracting with an independent reviewer to review medical record abstractions used in HEDIS scoring

AmeriHealth Mercy Health Plan completed all actions set forth in its compliance plan. This compliance plan will be part of the AmeriHealth Mercy of Louisiana operating model to further ensure that it does not happen in the CCN program.

B.27: References

Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:

AmeriHealth Mercy is pleased to provide five references from clients with whom we have shared long-term relationships.

Charlotte MacBeth, President and Chief Executive Officer of MDwise, a provider-sponsored managed care organization owned by Clarian and Wishard Hospital systems focused exclusively on government healthcare products in statewide contracts in Indiana that cover over a third of the TANF population. AmeriHealth Mercy has had a relationship with MDwise since 2005 when our affiliate, PerformRx was selected at their pharmacy benefits manager. In 2006, when Indiana Medicaid rebid their Medicaid Managed Care program for TANF, MDwise asked us to act as a partner to expand throughout the state in a full risk contract known as MDwise Hoosier Alliance where we currently provide all managed care operations, including claims processing, medical management, network development and management and a medical management call center to nearly 138,000 members. MDwise Hoosier Alliance is NCQA accredited under the MDwise contract. In addition, we support MDwise in a unique program for the previously uninsured called the "Healthy Indiana Plan". In the past, MDwise, using AmeriHealth Mercy's care management expertise, served the ABD population in an administrative contract known as Indiana Care Select. Our relationship with MDwise has prepared us for working closely with large, locally based provider systems that will benefit the LaCare program in Louisiana.

Emma Forkner was the Director of the South Carolina Department of Health and Human Services from 2007 to 2010. During that time, she was responsible for oversight of AmeriHealth Mercy's Select Health managed Medicaid Program. Select Health of South Carolina, Inc., established in 1996 in Charleston, is a wholly owned subsidiary of AmeriHealth Mercy providing Medicaid managed care services to more than 210,000 members state-wide in South Carolina comprising 40% of the total Medicaid market. Members under this contract include individuals in the TANF and TANF-related categories of assistance, who like the proposed Louisiana CCN program, are mandated to enroll in managed care. In addition, Select Health serves 17,362 SSI (ABD) recipients. Unlike the proposed Louisiana CCN Program, members in the SSI (ABD) category of assistance enroll in Select Health on a voluntary basis. Select Health of South Carolina has achieved an accreditation status of Excellent from NCQA. Our experience in both the urban and rural counties of South Carolina will benefit the medical management and outreach staff of the LaCare program as they work to achieve our goal of improving the clinical outcomes of our Louisiana members.

Mark Carter is Interim Executive Director of Passport Health Plan, owned by University Health Care Inc. a Louisville, Kentucky-based provider -sponsored health plan owned by the University of Louisville and other traditional Medicaid providers serving all Categories of Aid in a sole source contract in 16 counties with almost 172,000 Medicaid, Medicare and CHIP members. AmeriHealth Mercy and Passport have had a strategic partnership since 1997. AmeriHealth Mercy currently serves as a Third-Party Administrator for University Health Care Inc., Our experienced professionals primarily provide administrative services to Passport that include claims processing, medical management, marketing support and call center management. Passport has an Excellent Accreditation Status. For the past several years, Passport has been in the Top 15 Medicaid Health Plans in America as determined by NCQA and the US NEWS and WORLD Report. Our experience in dealing with this large entity owned by a variety of provider groups who often have conflicting agendas will help LaCare to develop a successful CCN throughout the State of Louisiana.

Mike Nardone had oversight for the Pennsylvania Medicaid managed care program in his role as Deputy Secretary, Medical Assistance at the Pennsylvania Department of Public Welfare (DPW) until January 2011.

David Kelley, MD, is the current Chief Medical Officer in the Office of Medical Assistance Programs in the Pennsylvania Department of Public Welfare. AmeriHealth Mercy has enjoyed a close working relationship with both Mr. Nardone and Dr. Kelley. AmeriHealth Mercy's Keystone Mercy and AmeriHealth Mercy Health Plans, members of the AmeriHealth Mercy Family of Companies, contract with the Pennsylvania Department of Public Welfare to provide voluntary and mandatory full-risk managed care services to more than 424,000 Medicaid recipients in all categories of Aid, including,

TANF and Aged, Blind and Disabled. AmeriHealth Mercy Health Plan is located in central and northeastern Pennsylvania and has an Excellent accreditation status from NCQA. Keystone Mercy Health Plan is located in the five counties around Philadelphia Pennsylvania and has an Excellent accreditation status from NCQA. AmeriHealth Mercy and its predecessor organization, Mercy Health Plan, have been operating Medicaid managed care programs in Pennsylvania since 1982. LaCare will benefit from this experience of operating in a fully mandated program similar to the Louisiana CCN initiative.

B. 28: Web sites

B.28 Indicate the website address (URL) for the homepage(s) of any website(s) operated, owned, or controlled by your organization, including any that the Proposer has contracted to be run by another entity as well as details of any social media presence (e.g. Facebook, Twitter). If your organization has a parent, then also provide the same for the parent, and any parent(s) of the parent. If no websites and/or social media presence, so state.

AmeriHealth Mercy of Louisiana, Inc. is a wholly-owned subsidiary of AmeriHealth Mercy Health Plan ("AMHP"); accordingly, AMHP is AmeriHealth Mercy of Louisiana's parent company.

- AMHP's Web site: http://www.amerihealthmercyhp.com
  AMHP is a general partnership whose ultimate parents are Mercy Health System and Independence Blue Cross.
- Mercy Health System's Web site: http://www.mercyhealth.org
- Independence Blue Cross' Web site: http://www.ibx.com.
  AmeriHealth Mercy of Louisiana, Inc. has established its Web site under its product's name, "LaCare."
- Our Web address is: http://www.lacarelouisiana.com.

LaCare is the newest member of the AmeriHealth Mercy Family of Companies, which is comprised of AMHP and its affiliates (including AmeriHealth Mercy of Louisiana). Our affiliates' Web sites and social media presence:

- http://www.amerihealthmercy.com (the AmeriHealth Mercy Family of Companies)
- http://www.hoosieralliance.com (MDwise Hoosier Alliance)
- http://www.keystonemercy.com (Keystone Mercy Health Plan)
- http://www.performcare.org (Community Behavioral HealthCare Network of Pennsylvania)
- http://www.cbhnp.org (Community Behavioral HealthCare Network of Pennsylvania – externally hosted and managed)
- http://www.performrx.com (PerformRx – externally hosted and managed)
- http://www.selecthealthofsc.com (Select Health of South Carolina)
- http://www.amerihealthmercyofkentucky.com (AmeriHealth Mercy of Kentucky)
- http://twitter.com/#!/lacarelouisiana
- http://www.facebook.com/help/?page=900#!/pages/LaCare/166359390085282

The AmeriHealth Mercy Family of Companies also hosts and operates the following Web sites, where users can learn more information about products and programs offered by AmeriHealth Mercy:

- http://www.healthyhoopsprogram.com (AmeriHealth Mercy's Healthy Hoops® program)
- http://www.performedhealth.com (AmeriHealth Mercy's PerforMED® care management program)

B.29: Certificate of Authority

Provide evidence that the Proposer has applied to Louisiana Department of Insurance for a certificate of authority (COA) to establish and operate a prepaid entity as defined in RS 22:1016 and in accordance with rules and regulations as defined by the Department of Health and Hospitals.

AmeriHealth Mercy of Louisiana, Inc. (AML) has applied to the Department of Insurance for a certificate of authority (COA) to establish and operate a prepaid entity as defined in RS 22:1016 and in accordance with the rules and regulations as defined by the Department of Health and Hospitals. See Figure 20 below for correspondence dated June 14, 2011 from Angelle Hayes, Insurance Specialist III, acknowledging the Louisiana Department of Insurance's receipt of AML's completed Health Maintenance Organization Application and commencement of the review process.

Figure 19: Correspondence Acknowledging Receipt of AML's Health Maintenance Organization Application

LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

June 14, 2011

Tom Clark
c/o Adams and Reese LLP
450 Laurel Street, Suite 1900
Baton Rouge, LA 70801

RE: Health Maintenance Organization Application of AmeriHealth Mercy of Louisiana, Inc.

Dear Mr. Clark:

The Louisiana Department of Insurance has received the application in association with the above captioned matter and it appears that the application is substantially complete at this time. We will now begin a more in-depth review of the application. You can expect the next step of our application process to take approximately thirty days. If during that review, additional questions arise or we find the need for additional information, we will contact you.

Should you have any additional questions regarding this matter, please do not hesitate to contact this office at (225) 219-7549 or via email to ahayes@ldi.state.la.us .

Sincerely,

Angelle Hayes
Insurance Specialist III
Company Licensing Division

P. O. BOX 94214 • BATON ROUGE, LOUISIANA 70804-9214
PHONE (225) 342-5900 • FAX (225) 342-3078
http://www.ldi.la.gov

B.30: Financial Responsibility and Stability

Provide the following as documentation of financial responsibility and stability:

- *a current written bank reference, in the form of a letter, indicating that the Proposer's business relationship with the financial institution is in positive standing;*
- *two current written, positive credit references, in the form of a letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by an accredited credit bureau within the last 6 months;*
- *a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate; and*
- *a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer's name) for a general line of credit in the amount of five-hundred thousand dollars ($500,000.00).*

The attached documents are submitted herewith in accordance with the requirements of Item B.30 and may be found at the end of this section as Attachment B.30.

AmeriHealth Mercy of Louisiana, Inc. (AML) is a newly formed organization. As such, a current written bank reference, in the form of a letter, is not available for AML. However, please see attached bank reference for AML's parent organization; AmeriHealth Mercy Health Plan (AMHP) is in a positive standing with the financial institution

AmeriHealth Mercy of Louisiana, Inc. (AML) is a newly formed organization. As such, two current written, positive credit references are not available for AML. However, please see attached positive credit references from vendors dealing with AML's parent organization, AmeriHealth Mercy Health Plan (AMHP).

AmeriHealth Mercy of Louisiana, Inc. (AML) has comprehensive general liability coverage, including broad form comprehensive general liability coverage, in the amount of $1,000,000 per occurrence and $8,000,000 in the aggregate. See Attachment B.30 for a copy of such valid certificate of insurance. AmeriHealth Mercy Health Plan (AMHP), AML's parent organization, has similar general liability coverage. AML will provide DHH with a copy of AMHP's certificate of general liability insurance upon request.

AmeriHealth Mercy of Louisiana, Inc. (AML) is a newly formed organization. As such, a letter of commitment from a financial organization is not available for AML. However, please see attached line of credit in excess of $500,000 for AML's parent organization, AmeriHealth Mercy Health Plan (AMHP).

B.31: Financial Strength and Resources

Provide the following as documentation of the Proposer's sufficient financial strength and resources to provide the scope of services as required:

- *The two most recent independently audited financial statements and associated enrollment figures from the Proposer. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be:*
  - *Prepared with all monetary amounts detailed in U.S. currency;*
  - *Prepared under U.S. generally accepted accounting principles; and*
  - *Audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor's opinion letter, financial statements, and the notes to the financial statements.*
- *The Proposer's four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to- Date), with preparation dates indicated. The statements must*

include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows.

- *Verification of any contributions made to the Proposer to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable*

The attached documents are submitted herewith in accordance with the requirements of Section B.31 and may be found at the end of this section as Attachment B.31.

AmeriHealth Mercy of Louisiana, Inc. (AML) is a newly formed organization so independently audited financial statements are not available for AML. However, please see audited financial statements for AML's parent organization, AmeriHealth Mercy Health Plan (AMHP) for the two most recent years.

AmeriHealth Mercy of Louisiana, Inc. (AML) is a newly formed organization so unaudited quarterly financial statements are not available for AML. However, please see attached the four (4) most recent internally prepared unaudited quarterly statements for AML's parent organization, AmeriHealth Mercy Health Plan (AMHP).

Regarding the last bullet, verification of any contributions to improve financial position, AmeriHealth Mercy of Louisiana, Inc. (AML) and AML's parent organization, AmeriHealth Mercy Health Plan (AMHP) have not received any contributions to improve its financial position after the most recent audit.

Section C – Planned Approach to Project

Describe how you will launch a network and set up operations capable of supporting its membership and meeting the requirements of the RFP by January 1, 2012 for GSA "A", March 1 of 2012 for GSA "B", and May 1 of 2012 for GSA "C".

The AmeriHealth Mercy Family of Companies ("AmeriHealth Mercy") has almost 7,000 signed letters of intent or provider contracts creating a foundation for a statewide provider network. The voluminous nature of our work plan is indicative of the specificity and detail of our plan and represents over 200,000 people hours. These two critical elements will support our goal of creating the best Medicaid managed care plan for the State of Louisiana.

Our project plans are designed to accomplish the following goals:

- Pay claims accurately and timely – on the first day of operations
- Successfully exchange data and reports with DHH and designees –on the first day of operations
- Work with members to improve their health through our integrated care management programs – on the first day of operations, and
- Provide value to providers by giving them information to help them improve their patients care – on the first day of operations

We have been actively engaged in developing a clear understanding of the Louisiana health care environment for over a decade. Through extensive dialogue and planning with key health care systems, providers, community organizations and public health officials, we have established a firm groundwork for the implementation of a successful managed Medicaid health plan. The following is a list of key relationships we have developed during the planning process, and who we will continue to partner with as we implement and operationalize our CCN-P Plan:

Table 1: Key Relationships

Providers and Associations		
Franciscan Missionaries of Our Lady Health System (FMOL)	Louisiana State Medical Society	Tulane Community Health Center
Louisiana State University (LSU)	Louisiana Hospital Association	ENT Associates of Lake Charles
LSU Health Sciences Center, New Orleans	HomeCare Association	The Ellis Clinic
Woman's Hospital	Lake Senior Care Center	Innis Community Health Center FQHC site
Christus Health Louisiana	Louisiana Primary Care Association	Surgical Hospital of Greater Baton Rouge
Louisiana Rural Hospital Association	Tulane University School of Medicine; Louisiana Quality Forum	Ochsner Health System/North Shore Medical Center
New Orleans Medical Association	Louisiana Medical Association	Louisiana Chapter, American Academy of Pediatrics
Lower 9th Ward Health Clinic	Neonatology Associates	Saint Thomas Community Health Center

Community and Religious Organizations		
Louisiana Association of Business and Industry	Louisiana Public Health Institute	Diabetes Association
Business Group on Health and Louisiana Health Care Alliance	Amistad Group	NAMI Louisiana
Catholic Charities	Local YMCAs	March of Dimes
Metropolitan Human Services	United Way	Louisiana Quality Healthcare

District, NOLA		Forum
Louisiana Association of School Based Health Clinics	Family Roads	Louisiana Quality Healthcare Forum

AmeriHealth Mercy will do business as LaCare and hopes to serve the Louisiana Medicaid members in all three GSAs.

Launching a Provider Network

Developing a comprehensive network of providers is a critical element in the success of any Medicaid program. Our organization is familiar with the intricacies and potential pitfalls of building and managing a network that supports the members we serve. AmeriHealth Mercy has demonstrated the ability to build managed care plans in multiple states, all within required – and often limited – timeframes; allowing our members to quickly and easily access the care they need.

With nearly 30 years of experience in building strong provider networks in multiple geographies, we have developed a proven process to ensure we can quickly implement a comprehensive provider network that not only meets but also exceeds Department of Health and Hospitals (DHH) requirements upon notification of a contract award.

Pre Recruitment Activity

In anticipation of working with the State of Louisiana, we formed a cross-functional team with two of our strategic provider partners (LSU Health Systems and Franciscan Missionaries of Our Lady) to identify provider data and develop a process to comply with requirements established by DHH. Our goal was to identify opportunities to reduce the administrative burden on our providers during both the recruitment phase and ongoing operations. With this information in hand, our Provider Network Management team began several months ago to collect DHH-required materials from providers, along with operational and credentialing information necessary to support implementation and other operational processes. We believe that our proactive approach in this area will enable us to bring the program into operation quickly and efficiently. As specified in Section G, we have almost 7,000 providers who have signed the provider contracts or a letter of intent.

Network Development Mail Campaign

AmeriHealth Mercy mailed provider recruitment packages to all potential network providers. Included in this packet was in-depth information about AmeriHealth Mercy's Louisiana operations, draft provider agreements, and comprehensive contact information including a toll-free provider services line and web address. We also distributed and accepting letters-of-intent (LOI) from area providers to accommodate the strict timeframes set forth in this RFP.

Network Development Outreach Campaign

Network Development begins by establishing open and personal lines of communication. To support our Network Development Outreach Campaign, AmeriHealth Mercy assembled teams of local representatives throughout Louisiana with the dedicated focus of identifying key providers and establishing points-of-contact. Since its inception, this team has become familiar to Louisiana providers and partnered with local associations through sponsorships and representation at community events.

"LSU is delighted to be collaborating with LaCare as a preferred partner during the upcoming CCN program implementation. LSU senior management and its associates see the importance that CCN development will bring to Louisiana and its Medicaid populations, and believe that LaCare's expertise will be a positive asset to the introduction of the program."

Patrick O'Connor, PhD
Director, Research & Development

Developing Operational Capabilities has been actively preparing to participate in the Louisiana CCN-P in anticipation of the program beginning on January 1, 2012. To show our commitment to the state, we have already hired several key LaCare employees including an Executive Director, a Community Education and Outreach Director and a Provider Network Management team, all of whom are located in our Baton Rouge office.

In addition, we have identified leaders with many years' experience in our Southern Region and Corporate office who have successfully implemented and managed services for the Medicaid population in many states. They have already begun to engage with the Louisiana health care community in order to refine their understanding of the State's unique needs. For example, AmeriHealth Mercy employees have met with and established relationships with several local and community organizations throughout the state including the United Way, March of Dimes, Catholic Charities, Family Roads, and St. Bernard Project. In addition, our Provider Network Management team has been active with organizations such as the Louisiana State Medical Society, Louisiana Rural Hospital Coalition, and the Louisiana Association of School Based Clinics (See Table 1 for additional details regarding established community and provider relationships). These groups will be critical to ensure a smooth implementation and ongoing success of the Louisiana CCN-P Program.

> *"FMOL is pleased to be working with LaCare as a preferred provider partner as it prepares for CCN program implementation. FMOL's provider community understands how important CCN development is to Louisiana's Medicaid population, and believes that LaCare's experience and approach will allow for a smooth transition regarding the introduction of the program."*
>
> ***Rene Ragas***
> *Director of Special Projects*

Upon notification of contract award, we will bring to bear the infrastructure and expertise of our health plans in the AmeriHealth Mercy Family of Companies to ensure we meet the requirements outlined in the CCN-P RFP. Our organization brings unparalleled expertise and experience in building and launching managed Medicaid plans nationwide. The implementation of the Medicaid health plan in Louisiana is an expansion of our core mission and will benefit from our considerable expertise.

Louisiana's CCN program has some similar features as the programs enacted in Florida. AmeriHealth Mercy managed a PSN for a group of pediatricians in Broward County, Florida. Terry Fields, President of the PSN said

> *"...Pediatric Associates developed a Provider Sponsored Network in response to Florida Medicaid Reform. We engaged AmeriHealth Mercy to administer managed care related services. They coordinated all implementation efforts on time, were professional and met all Florida Medicaid Agency requirements. We were up and running and with minimal complaints from providers, members, advocacy groups and other stakeholders."*

AmeriHealth Mercy will implement a similar program in Louisiana with the same type of commitment to the State of Louisiana, its Medicaid members and providers.

Experience – Proven Implementation Team

Effectively and efficiently implementing Medicaid managed care programs is a key component of our core business competency. AmeriHealth Mercy has identified a dedicated team to ensure the successful implementation of the Louisiana CCN Program. Our implementation team is led by experienced project management professionals and subject matter experts from core business areas such as Information Technology, Medical Management, Customer Services, Claims Payment, Provider Network Management, Data Analysis and local, regional and national AmeriHealth Mercy executive leadership. Using a comprehensive, cross functional implementation approach, this team will ensure completion of all activities necessary to the business startup, Readiness Review, and ongoing operations.

Seamless Transition and Implementation Plan

Our implementation approach has transitioned members from state sponsored fee for service models into full risk managed care programs across the nation. Over the years we have continuously improved this process to achieve one goal: smooth and seamless transition of our members and providers without disruption of needed medical care.

Scalable Core Information Systems

AmeriHealth Mercy's core system infrastructure can be scaled to meet the membership and business requirements for Louisiana (all three regions by January 1, 2012). The Information Solutions team has already completed a detailed review of the specific requirements for the Louisiana CCN-P Program and has identified actions necessary to meet all requirements in all service areas such as: inbound and outbound eligibility files, connectivity with the State and/ or any other State vendors (Enrollment Broker), and Louisiana Rural Hospital Coalition provider payment methodologies.

Strong Relationships with our Provider Partners

Our providers are a critical component in the successful implementation and operation of the AmeriHealth Mercy plans. We have developed strong relationships with critical providers who will be actively engaged in the implementation of our Louisiana operations. These strategic partners will be included on workgroups, advise the team on Louisiana specific provider issues and assist with systems testing and payment validation. For example: we will complete an entire payment cycle for the providers with some test claims and send them the output – Remittance Advice, etc. The providers will be asked to validate the payment and provide comments. Over the years this has proven to be one the most critical acknowledgment of system readiness.

Internal Readiness Review

In preparation of the State's on-site review, we will have started performing our own internal readiness review which is a major milestone in our project implementation process. This internal readiness review will include three components:

- Desktop review of all policies and procedures
- Extensive system readiness testing. The readiness testing will include: system access and navigation, running test scripts to ensure applications meet business requirements, loading of enrollment information, production of all outputs (i.e. claim remit, eligibility file, etc), connectivity with the State and vendors and load balance testing.
- Network adequacy

Strategic Vendor Relationships

Through the implementation and system readiness we will leverage existing vendor relations we have in place to provide support in the following areas:

- Information Solutions – Developers, system configuration analysts, EDI mappers
- Contact Center – Call overflow support
- Network Management – Network development and credentialing
- Medical Management – Clinical staffing including nurses, social workers and technicians

These strategic vendors will provide AmeriHealth Mercy with the ability to mobilize and add additional capacity as needed to ensure we keep the project on target to meet critical milestones.

Experienced Staff and Available Capacity

One of our strategic approaches to successful implementation is to leverage the experience and capacity of our existing operations. We will reassign key experienced staff from other regions to support our business for as long as necessary in order to meet all program implementation requirements. This approach reduces training time and provides DHH with a strong and experienced corps that can hit the ground running on day one. In addition, we have additional capacity in our other regions which we will

bring to bear to support implementation. Our Enterprise Service delivery model and experience put us in an unmatched position to meet the requirements of the Louisiana CCN-P RFP.

C.1: Implementation Requirements

C.1 Discuss your approach for meeting the implementation requirements and include:

- *A detailed description of your project management methodology. The methodology should address, at a minimum, the following:*
  - *Issue identification, assessment, alternatives analysis and resolution;*
  - *Resource allocation and deployment;*
  - *Reporting of status and other regular communications with DHH, including a description of your proposed method for ensuring adequate and timely reporting of information to DHH project personnel and executive management; and*
  - *Automated tools, including use of specific software applications.*

Project Management Overview

AmeriHealth Mercy has an established, innovative Enterprise-wide Program Management Office (EPMO) which incorporates methodologies enabling our organization to not only prioritize activities and execute implementation projects but to do so with key personnel focused exclusively on serving the needs of the CCN Program. As described in more detail in C.2, the EPMO is staffed by a large group of project management expertise with a combined 250 years of Medicaid experience.

AmeriHealth Mercy currently has a Louisiana project team, with support from the EPMO, working on a seamless and carefully thought-out implementation plan governed by leaders representing key functional areas. The project team and local management is led by Sonia Madison, who has had a distinguished, three-decade career in health plan administration in Louisiana and other parts of the country. Ms. Madison became well known to the health care community in Louisiana as a senior advisor to former U.S. Secretary of Health and Human Services Mike Leavitt in the aftermath of Hurricane Katrina. Ms. Madison is currently working from AmeriHealth Mercy's established office in Baton Rouge.

AmeriHealth Mercy's CCN project team and the PMO have constructed and begun executing itemized tasks in our detailed Work Plan (Section C.4) which includes preparing for the Readiness Review components of all three General Service Areas (GSAs). As we have done with our affiliated plans, certain core functions will be managed at the local level which includes administration, integrated care management, provider network management, community outreach, human resources, finance, service operations and compliance.

Governance

As a part of its charge, the EPMO maintains strong governance structure that allows for communication to all levels of the organization and with our DHH partners. This structure will be utilized for the AmeriHealth Mercy implementation plan and is critical to our success in serving CCN Program members in Louisiana:

Project Management Leadership – ensuring successful implementation through the close monitoring of requirements set out in the RFP, as well as rapid escalation and resolution of project issues.

Weekly Executive Summary Report – focusing on the status and issues of individual implementation activities.

Weekly Portfolio Review Meeting – focuses on discussing detail level concerns corporate and regional stakeholders and is a forum to escalate interdependencies as they arise between project teams, functional departments and business areas. This meeting is comprised of technical staff managers, business analyst, business stakeholders, project managers, program directors and EPMO Management.

Monthly Corporate Services Review – meetings to present information focusing on schedule, financial status, risk identification, and issue management along with other material issues.

Portfolio Stakeholders Committee – monthly meeting to review critical issues and changing operational and implementation priorities. This Committee is comprised of AmeriHealth Mercy's Executive Leadership and chaired by the EPMO management team.

Portfolio Executive Governance meets a minimum of six times a year and is also accountable to review and approve/reject recommendations from the Portfolio Stakeholder Committee. This Committee is comprised of AmeriHealth Mercy's Organizational Leadership, Executive and Business Sponsors and is chaired by the EPMO management team.

This structure, along with the experience and skills of the individuals, positions us for the successful implementation of the Louisiana plan. The EPMO provides the structure through its methodology, tools, techniques, and education to ensure that the organization adheres to repeatable processes, operates efficiently, maximizes resources, and produces quality end-results.

AmeriHealth Mercy's Project Management Methodology was built on the following principles:

- Consistent utilization of industry standard best practices in project management methodologies
- A dedicated project management team with more than 250 years of project management experience
- A stable and predictable implementation staffing model
- Effective and accurate communications by building strong relationships with DHH personnel
- Execution of a detailed implementation work plan

Our project management methodology provides a template for each of our Louisiana project deliverables, ensuring consistency and completeness. It also brings a discipline and standardization to each implementation project providing the tools, techniques, project leadership, training, and guidance necessary to maximize the use of time and resources. The ability to leverage this successful project management methodology provides a structure for an efficient, effective, and predictable quality outcome. The EPMO's methodology is based on industry standards of best practices and an established project management methodology made up of eight individual phases shown in Figure 1 below:

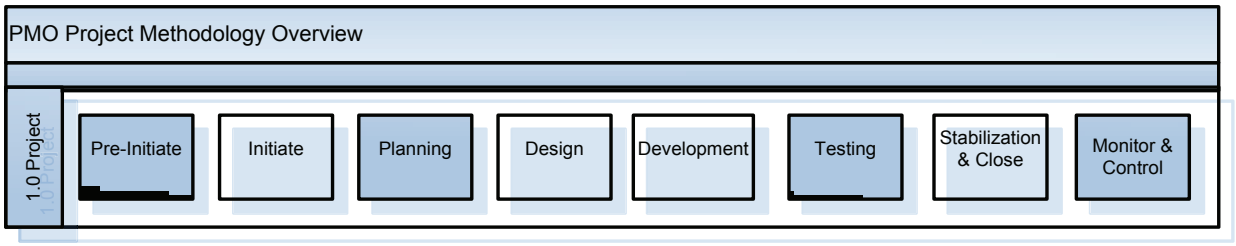


Figure 1: Project Management Methodology

The EPMO methodology offers the appropriate levels of control for monitoring throughout the lifecycle of our Louisiana business projects, especially our implementation of the CCN Program. Each phase builds on the previous work and can be completed in iterative, overlapping or functional phases based on the project team's assessment and recommendations.

Pre-Initiation: The Pre-Initiation Phase allows AmeriHealth Mercy to accept new requests into the portfolio in a structured manner. This phase of the methodology includes an assessment and estimation of project costs, resource needs and anticipated benefits. The EPMO methodology requires management of existing portfolio activities when re-prioritizing or re-balancing occurs. These activities are considered

key to assuring that prioritized work, such as the implementation of the CCN program for Louisiana continues without impact.

Initiation: The AmeriHealth Mercy Project Scope and Charter is approved, and the Communication, Resource and Project Management plans are developed. This phase also marks the formal start of Monitor and Control activities which will continue throughout the implementation lifecycle including Risk Management, Issue Management, and Change Management.

Planning: The Project Management plan is approved and baseline is created during the planning phase; this phase also includes the formal approval of business requirements, functional requirements and the development of the traceability matrix. This phase is critical to assure a successful, quality and timely implementation for the Louisiana CCN Program.

Design: System Architecture and Technical Designs are approved during the Design phase. The design phase allows the organization to be certain that the system requirements will meet the needs of Louisiana, its citizens and provider organizations without impediment due to systems issues.

Development: This phase encompasses the development effort which includes coding, unit testing and development of operations guidance for the operational teams.

Testing: The testing phase also known as QAT (Quality Assurance Testing) includes approval of the test plan, Systems Integration testing, Test Script Execution and User Acceptance Testing. Test script and execution, user training typically occurs during this phase along with the final stages of preparation for the deployment to production. This critical phase of the methodology assures that defects are discovered and corrected prior to any systems going into production. Business users are required to participate in the User Acceptance Testing and systems will not be deployed to production without formal acceptance and approval from appropriate authorities.

Stabilization & Close: The project team continues in place during the stabilization period of the project, any production issues are addressed and managed by the project management team during this phase. At the conclusion of the stabilization period, the project team conducts a "Lessons Learned" review for the project and project close activities commence. Formal turnover of the system to the operations departments occurs during this phase of the project prior to allowing the project close to occur.

Monitor and Control: Activities included in Monitor and Control phase are conducted throughout the implementation lifecycle. These activities include: risk management, issue management, and change management. Any material activity resulting from issue or risk management will cause change management processes to occur. Change management is also invoked by the project management team if a need arises from the business that causes scope, schedule, or requirements changes. This assures that the project team has documented all required deliverables throughout the implementation cycle.

Issue Management and Resolution

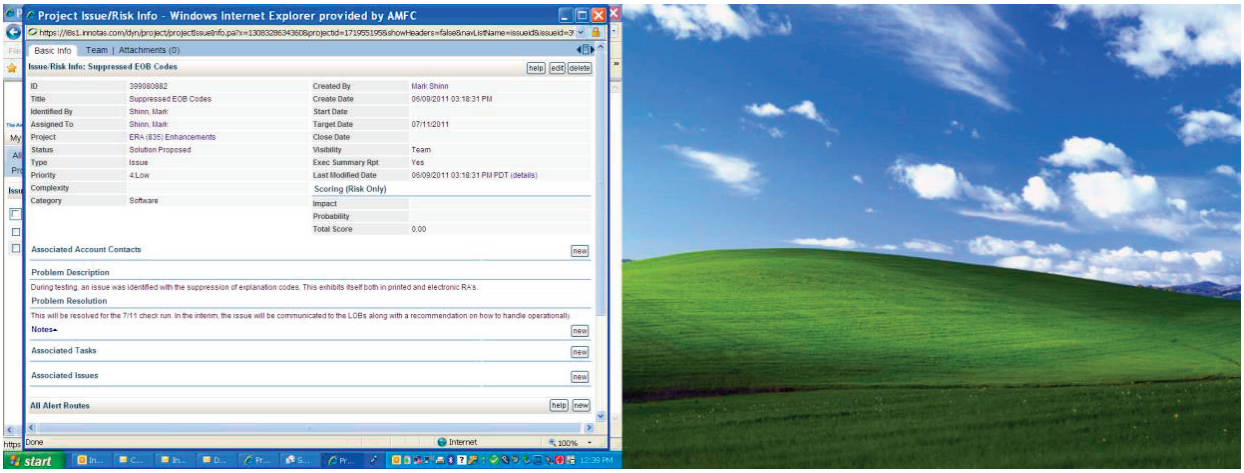
Timely, efficient and effective issue identification, assessment, alternatives analysis and resolution is a critical success factor for a successful implementation. AmeriHealth Mercy employs an Issue Resolution process that describes how issues will be identified and captured, assigned, and assessed during the course of the implementation.

This process defines the level of information that must be captured for each issue in each step of the process. Issues will be prioritized based on the level of potential impact and magnitude of the issue as it relates to the schedule, a specific region or level of functionality. An important part of the issue resolution process considers the effectiveness of careful coordination with the Risk Management Strategy, as certain risks can become an issue during the lifecycle of the implementation. The outcome of an issue may result in a change, which will follow the change management process for inclusion in the work schedule and scope.

As the DHH requirements are developed and resolved, the AmeriHealth Mercy issue log will document the concerns that have been assessed and closed for the implementation. The project management team will adhere to the issue resolution process to ensure consistent and best practice issue resolution practices are in place for all issues identified during the implementation.

Issue Identification

For example, several issues have been identified based on information supplied in the RFP as a result of the project management team's analysis of the RFP. These issues are identified and captured in an issue log.



Issue Assessment, Analysis and Resolution

As issues are identified, AmeriHealth Mercy's Project Management Team will perform an impact assessment and analysis of each identified issue to determine its downstream effects and severity on the implementation of our CCN Plan. We will document all issues that arise in our project management tracking system, which is outlined in more detail below. Any issues that could negatively impact the project will also be addressed in a timely manner using the following guidelines:

- Issues and other general questions that arise during the course of this implementation will be acknowledged and responded to within a 24 hour period.
- Response to general questions pertaining to activities will be directed to appropriate Workgroup(s)
- The expected resolution time for issues is 48 hours based on severity and priority
- All issues exceeding a 48-hour response timeline will be escalated to the Project Governance Committee for resolution.

In the event that the resolution of an issue results in a change to the project scope, schedule and/or budget, a formal change management process will be followed. The individual or party requesting the change is required to complete a change request document that includes documentation of a detailed reason for the change, associated costs, resources needs, internal and or external impact to the project or other projects and any new dependencies or assumptions. The request must be accompanied by a realistic mitigation and/or contingency plan(s). The Governance Committee will perform a preliminary review of the request and, if approved, forward the request to the appropriate member of senior management for final approval.

Resource Allocation and Deployment

Demand Management

Our EPMO has a well-defined, enterprise-wide, Demand Management Process that enables AmeriHealth Mercy to analyze the portfolio of project work including an assessment of our resources and a deployment of those resources across all of our lines of business. This includes projects already in progress as well as

new requests to determine the value and impact across the organization. Demand Management has been particularly effective in planning for the implementation of Louisiana's CCN RFP and Readiness Review components: AmeriHealth Mercy has established a project inventory, assigned priority levels for each task, and allocated resources to ensure:

- An understanding of the unique focus of Louisiana's CCN Program.
- A timely and seamless transition period for members, providers, and DHH from the current FFS Program to the CCN Model.
- AmeriHealth Mercy is prepared for go-live dates for each of the three GSAs.

As business needs and priorities change, Demand Management provides the framework to compare new requests against the existing body of work based on:

- Strategic value
- Risk assessment
- Cost/benefit
- Net gain
- Resource impacts to staff and infrastructure

As part of the Demand Management framework, each new project requires a documented business justification and resource analysis. And, as we identify growth opportunities, such as the LA CCN Program, our Demand Management Process ensures we have deployable resources available to respond to new business or product opportunities. The process will ensure that there will be an adequate supply of subject matter experts from across our business and operations areas, as well as technical experts available when needed during the course of the implementation.

Automated Tools

AmeriHealth Mercy has an unrivaled perspective on the most effective automated tools and software applications required to support a successful Medicaid program in Louisiana. Highly skilled employees and a focus on technology will be the key to AmeriHealth Mercy's implementation success.

The EPMO currently utilizes a Web-based third party software product for our Project Portfolio Management (PPM) tool to successfully manage projects to completion. The product is an industry-leading solution that streamlines the management of all of the strategic initiatives that are under the responsibility of the EPMO. The software provides the following critical elements:

- **Real-time analytics** to show the current status of each project
- **Prioritization** of tasks and resources
- **Project request management** to catalog and manage demand for new projects
- **Project and program management** to effectively manage projects from inception to completion while allowing for effective communication and report to organizational stakeholders
- **Portfolio management** to assure portfolio level governance and reporting
- **Resource management** to evaluate EPMO resource capacity
- **Financial management** to complete initiatives on time and on budget

The software allows us to maintain all project details within a centralized repository, improving access to standardized project information and overall efficiency. Our staff can easily view a one-stop snapshot of program and project details by quarter or by year. Each week, detailed information for every in-process project report is published on the EPMO website, allowing anyone in the organization to view the latest project and program details. Project managers can flag open issues, risks, or action items within the system, and the EMPO can quickly produce customized reports as needed for DHH review.

Microsoft Project, and other Microsoft Office tools are also used as needed, and artifacts produced by these tools can be stored in our PPM tool's repository. This ability greatly expands the functionality

available to the Louisiana project managers, and can be easily tailored to meet any unique CCN Program needs.

Communicating with DHH

AmeriHealth Mercy believes that effective communication is the cornerstone to building a strong collaborative relationship with Department of Health and Hospitals (DHH). AmeriHealth Mercy's history of establishing Medicaid programs in various states across the country will assist us in our efforts to communicate with DHH in an effective and timely manner regarding the implementation of the project.

The size and nature of this contract requires that formal communication protocols be established to ensure that the project is being managed appropriately and implementation is proceeding as planned. Although we will work with DHH to determine the specifics of a communication plan consisting of acceptable reporting structures and timelines, we recommend that we formally establish at least two weekly calls as soon as the awards are announced. The first call would be a conference call with all the selected CCN's. As we have implemented health plans in other states, we have learned that many of the managed care organizations had similar questions, and we all learned from each other. We would also recommend that we have a weekly one-on-one call between our organization and DHH to discuss specific issues not discussed on the call with all of the selected CCNs.

In addition to the communication calls recommended above, we recommend other reporting mechanisms such as regularly scheduled and ad-hoc reports as well as live, interactive meetings and site visits. Examples of such reporting mechanisms include, but are not limited to:

- **Detailed Implementation Plan Reporting***:* The implementation plan will be used to create a comprehensive management report, detailing project scope, status, staffing, and timelines. Areas of success and achievement will be highlighted along with any unforeseen setbacks or barriers.
- **Risk Management & Issue Reporting***:* This proactive process will be used to identify critical issues needing to be addressed in an escalated or expedited manner. Using a specially created database, AmeriHealth Mercy will be able to provide real-time updates to both internal and DHH staff.
- **Site Visits and Meetings**. While the Executive Director is designated as the primary contact for all operational matters related to this contract, the AmeriHealth Mercy Implementation Project Manager will also serve as a liaison to DHH during the implementation phase of this contract. In this point-of-contact role, the Implementation Project Manager is responsible for providing the most current and updated reports while also acting as a facilitator to bring together AmeriHealth Mercy staff and their DHH counterparts when the need arises. As always, AmeriHealth Mercy Executive Staff are available at the discretion of DHH.

To ensure a smooth transition between the implementation and operational phases of the contract, AmeriHealth Mercy will continue to provide any and all implementation reports until which time DHH deems it no longer necessary.

C.2: Implementation Work Plan

C.2. Provide a work plan for the implementation of the Louisiana Medicaid CCN Program. At a minimum, the work plan should include the following:

- *Tasks associated with your establishment of a "project office" or similar organization by which you will manage the implementation of the CCN Program;*
- *An itemization of activities that you will undertake during the period between the awarding of this procurement and the start date of the CCN Program. These activities shall have established deadlines and timeframes and as needed conform to the timelines established under this RFP for deliverables.*

  - *All activities to prepare for and participate in the Readiness Review Process; and(complete)*
  - *All activities necessary to obtain required contracts for mandatory health care providers as specified in this RFP.*
- *An estimate of person-hours associated with each activity in the Work Plan;*
- *Identification of interdependencies between activities in the Work Plan; and*
- *Identification of your expectations regarding participation by DHH and/or its agents in the activities in the Work Plan and dependencies between these activities and implementation activities for which DHH will be responsible. (In responding the CCN shall understand DHH shall not be obligated to meet the CCN's expectation.)*

AmeriHealth Mercy developed a detailed implementation plan for the Louisiana Medicaid CCN Program. This Work Plan provided in Section C.4 illustrates AmeriHealth Mercy's approach to the startup, monitoring, and ongoing management of a robust operating entity prepared to meet the needs of Louisiana's Medicaid members, providers and, communities.

Louisiana Medicaid Coordinated Care Network (CCN) Project Office

AmeriHealth Mercy has a Louisiana project team working on a seamless and carefully planned implementation for its CCN Program. The project office is governed by a team of leaders representing key functional areas and local management is led by Sonia Madison, who has had a distinguished, three-decade career in health plan administration in Louisiana and other parts of the country. Ms. Madison became well known to the health care community in Louisiana as a senior advisor to former U.S. Secretary of Health and Human Services Mike Leavitt in the aftermath of Hurricane Katrina. Ms. Madison is currently working from AmeriHealth Mercy's established office in Baton Rouge.

AmeriHealth Mercy's Project Management Office is a team consisting of over 35 employees. All of the program directors and project managers are certified as Project Management Professionals (PMP) through the Project Management Institute (PMI), a global professional project management organization. Our business analysts are certified as Certified Business Analysis Professionals through the International Institute of Business Analysis (IIBA).

LaCare's project team has constructed a detailed Work Plan, included in C.4, and has begun execution of the itemized tasks in that Plan. Our Louisiana project office is responsible for the development and implementation of all components covered by the Readiness Reviews for ***all three General Service Areas (GSAs)***.

In recognition of the unique nature of the Louisiana market (and the differences between specific regions within the state), AmeriHealth Mercy will also benefit from dedicated key personnel and operations focused exclusively on serving the needs of the CCN Program. As we have done with our affiliated plans, certain functions will be managed at the local level including administration, integrated care management, provider network management, community outreach, human resources, finance, service operations and compliance.

AmeriHealth Mercy is committed to providing strong, comprehensive, local leadership for Louisiana's CCN Program as shown by our strategic placement of key individuals who have substantial experience with both managed care and Medicaid. The AmeriHealth Mercy team will bring DHH the depth of resources needed to successfully implement the program as well as to provide innovative enhancements to the program in the future.

Governance Team:

The AmeriHealth Mercy CCN project team is governed by AmeriHealth Mercy leadership representing all areas of operation. This governance team is responsible for the overall management and success of the Louisiana Medicaid CCN implementation effort, including task completion, decision-making, issue escalation and resolution, and risk mitigation and contingency planning.

The organizational chart below outlines these leaders and the areas they represent:

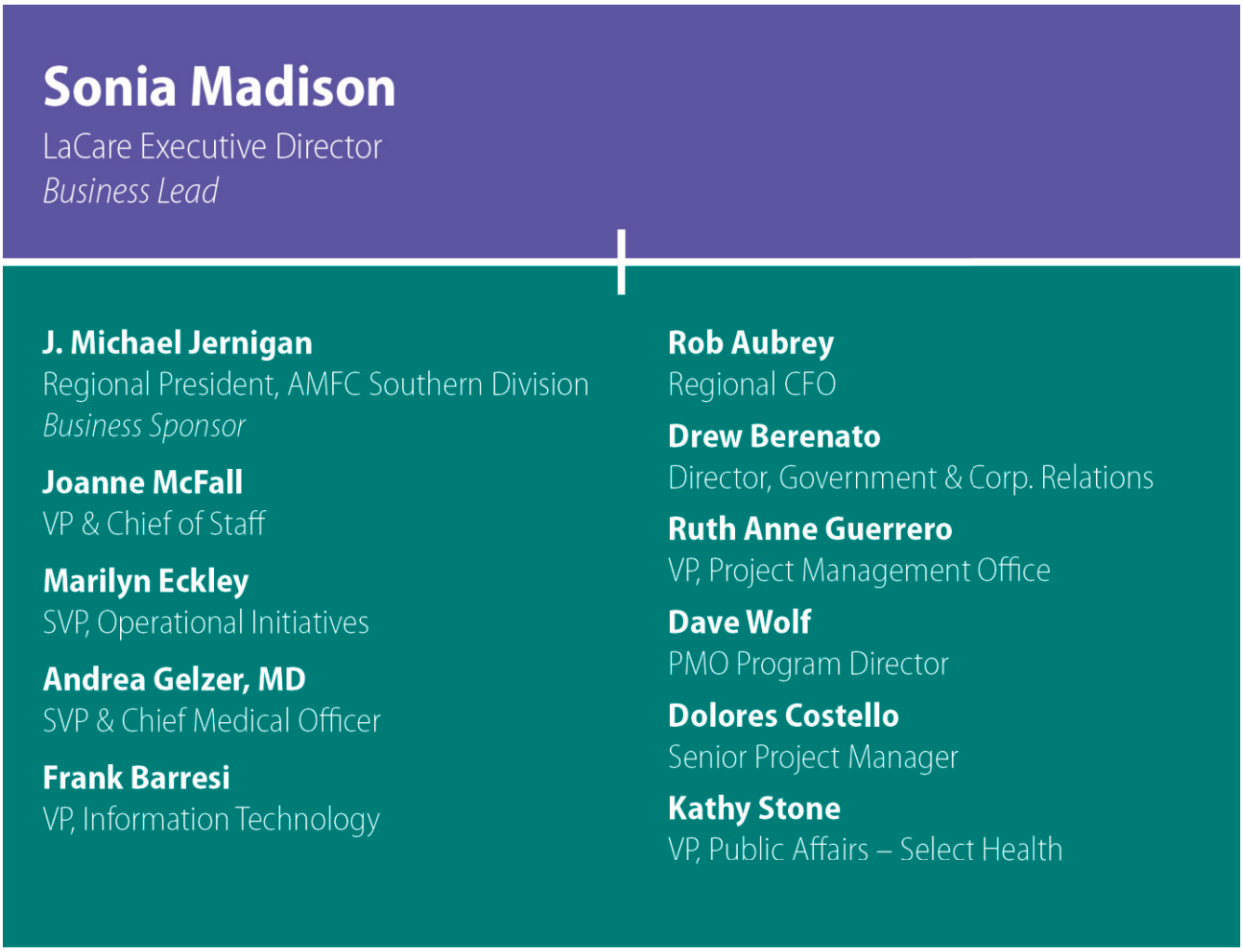


Figure 2: Governance Team

Implementation Team:

AmeriHealth Mercy Louisiana Implementation Team is a group of individuals especially skilled in implementing projects. The members of the implementation are members of AmeriHealth Mercy's Enterprise Portfolio Management Office (EPMO). This team will utilize methodologies that will enable us to prioritize activities and execute implementation projects with key personnel focused exclusively on serving the needs of the CCN Program.

The AMFC CCN implementation team will include the following resources:

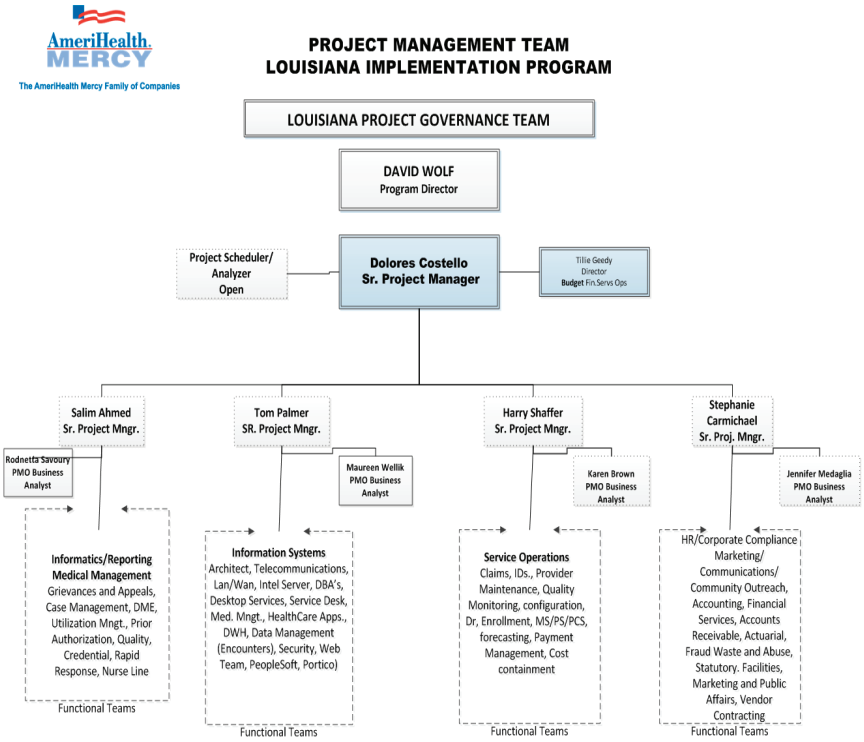


Figure 3: Project Management Team

A key aspect of the AmeriHealth Mercy EPMO structure is its ability to matrix resources from departments and functions throughout the organization into a precise project management organizational structure.

Itemization of Activities

The AMFC Project Implementation Team has established a detailed Work Plan and has committed significant resources to be prepared for the start date of the CCN Program. The Work Plan is included in C.4., but a brief description is included below. The end-to-end operational execution of our Louisiana Work Plan promotes ownership, accountability, and ensures that all activities are accurately identified and quickly implemented. Our Implementation Team has identified the CCN Program's "critical paths" and we are proactively managing the integrity of the project schedule. AMFC work shall, in all respects, conform to the timelines established under the RFP for deliverables.

Readiness Review

A key focus for the AMFC implementation and the readiness review/transition period is the cataloging, resourcing, and planning of activities required to assure a successful demonstration of our ability to comply with all RFP requirements. The readiness review is a key milestone in assuring a successful transition period for the state of Louisiana and its citizens.

Due to our experience, the activities in our readiness preparation have been collaboratively identified by the program management team in coordination with each functional workgroup and in accordance with the State requirements provided in Appendix JJ.

All activities are included in the AmeriHealth Mercy master implementation Work Plan which is included in Section C.4.

Contracts with Mandatory Health Care Providers

AmeriHealth Mercy has been diligently working to create a statewide network of providers through a combination of Letters of Intent and executed Provider Contracts. As of the submission of this response, AmeriHealth Mercy is proud to have nearly 7,000 providers that have signed a Letter of Intent or executed a Provider Contract. AmeriHealth Mercy has had as many as 10 provider network management staff working throughout the state meeting, educating and recruiting physicians, vendors, clinics and hospitals and implementing our provider network development plan. Vital areas of focus for network development include safety-net and rural providers, and large health systems to support the access requirements of the program. We will continue to expand the AmeriHealth Mercy network to ensure the best possible access for our future members. Key contracted providers are listed below:

- LSU Health System
- Franciscan Missionaries of Our Lady Health System
- Christus Health System
- Oschner Health System
- Tulane University Medical Group
- Office of Public Health
- Woman's Hospital

Person Hours

As a component of our comprehensive plan, we have included detailed information of the person hours required to complete each task described in that plan. The estimated number of hours that will be required to complete each task has also been submitted from each functional area, the total number of hours is estimated to be approximately 200,000 hours.

Interdependencies

All predecessor/successor relationships (interdependencies) are defined in the attached AmeriHealth Mercy implementation plan in Section C.4; and as with all activities, owners are assigned to each corresponding task. The AmeriHealth Mercy Project Implementation Team will serve as the primary organization to manage all interdependencies.

DHH Participation

The AmeriHealth Mercy Implementation Team has been reviewing and analyzing the RFP, Provider Manuals and other detailed information provided by DHH to fully understand the business rules associated with our contractual obligations. Getting a firm grasp of the business rules is, however, only the first step in this process. We know from previous experience that a frank and open dialogue between AmeriHealth Mercy and DHH will assure that our systems are configured to accurately accept enrollment information, process and pay claims, and report encounters according to the rules of the state agency.

In addition, agreed upon deliverables and timeframes will keep the project on target to meet readiness expectations and program requirements. While we understand (as provided in the RFP) that we cannot rely on DHH being responsible for any activities not specifically anticipated by the RFP, and are prepared to proceed with DHH doing only that which is required for a seamless implementation, AmeriHealth Mercy recommends that DHH:

- Assign a liaison / Project Manager to act as the single point of contact to escalate all issues and facilitate the approval of all required materials. Both DHH and AmeriHealth Mercy will agree upon a complete and comprehensive escalation process including deadlines for turnaround.
- Provide subject matter expertise (SME) in the areas listed below. These subject matter experts (SMEs) will be asked to fully participate in our implementation workgroups. Other SMEs may also be required to support the program implementation on an as-needed basis.
  - Hospital services,
  - Practitioner services,

  - Specialty services, including school-based clinics,
  - Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC),
  - Systems and connectivity,
  - Enrollment services,
  - Medical management and Member outreach.
- Provide key operational and tactical support for user acceptance testing. As requested, we will provide DHH with detailed explanations of any defects found as well as user sign-off on all approved test results.
- Attend scheduled project governance meetings which will be used to discuss implementation status and escalation of issues.
- Provide all materials, test files, system companion documents when required.
- Facilitate communications between the Enrollment Broker and AmeriHealth Mercy

The AmeriHealth Mercy Master Implementation Plan includes tasks that the AmeriHealth Mercy staff is required to complete but it also includes tasks that we will complete in partnership with DHH. This involves inter-dependent tasks which are described in the AmeriHealth Mercy-DHH Dependencies View.

C.3: Risk Management Plan

Describe your Risk Management Plan. At a minimum address the following contingency scenarios that could be encountered during implementation of the program:

- *Delays in building the appropriate Provider Network as stipulated in this RFP;*
- *Delays in building and/or configuring and testing the information systems within your organization's Span of Control required to implement the CCN program;*
- *Delays in hiring and training of the staff required to operate program functions;*
- *Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions;*
- *Delays in enrollment processing during the implementation of CCN; and*
- *Delays in the publication of marketing and related materials and/or the delivery of these materials to DHH and/or its agents.*

For each contingency scenario identified in the Proposal, at a minimum the Risk Management Plan must include the following:

- *Risk identification and mitigation strategies;*
- *Risk management implementation plans; and*
- *Proposed or recommended monitoring and tracking tools.*

The AmeriHealth Mercy Project Management Office has a well-defined, proven Risk Management Plan that will be used throughout the implementation process. The Risk Management Plan is customized for each individual project and outlines how we will structure and perform project risk management activities.

The principles supporting the Risk Management Plan include:

- A Risk Management Plan will be created and utilized for all projects.
- All project stakeholders are responsible for identifying and communicating risks to the EPMO Program Director.
- All risk information is to be documented using the Risk Log
- Risks will be proactively managed throughout all phases of the project.

Each functional team identified in the Project Management Plan meets weekly to review, analyze, and monitor existing risks and to identify and evaluate possible new risks. It is the responsibility of anyone

involved with the project team to identify risks. Risks are managed and monitored by the project team including the EPMO Program Director and project management leads. The purpose of this review is to identify the risks to be addressed with the Project Governance team. This allows us to continually identify and monitor risks throughout the entire project lifecycle.

Identifying and Tracking Risks

Based on our Project Management Methodology, we have developed a Risk Identification and Assessment form to formally identify, rank and monitor risks to the project. Once a risk is identified and submitted and assessed using the Risk Identification form, it is entered in the Risk Log. The Risk Log contains the result of the qualitative risk analysis, quantitative risk analysis, and risk response planning. The risk log details all identified risks, including description, category, cause, probability of occurring, impact(s) on objectives, proposed responses, owners and current status.

Both documents are components of the Project Management Plan and are used to identify and track the status of risks throughout the project lifecycle.

Risk Scenarios

The following are contingencies that AmeriHealth Mercy may encounter during the implementation of the program:

Table 2: Contingencies

Delays in Building Provider Network		
Risk Identification	**Risk Management Implementation Plan and Mitigation Strategies**	**Proposed or Recommended Monitoring Tool**
Member and provider complaints	▪ Identify non par providers who can service members ▪ Increase provider recruitment activities ▪ Assist with transportation arrangements to transport members to appointments ▪ Reach out to current participating providers for provider referrals	▪ Monitor member and provider complaints ▪ Review member utilization to identify where members are seeking service; identify gaps in the network ▪ We have developed a Risk Identification and Assessment form to formally identify, rank and monitor risks to the project. Once a risk is identified and submitted and assessed using the Risk Identification form, it is entered in the Risk Log, which details all identified risks, including description, category, cause, probability of occurring, impact(s) on objectives, proposed responses, owners and current status.
Delays in Building, Configuring and Testing Information Systems		
Risk Identification	**Risk Management Implementation Plan and Mitigation Strategies**	**Proposed or Recommended Monitoring Tool**

Delayed delivery of data	Information Solutions maintains a significant inventory of pre-defined test plans and scenarios for new business activation. In the event data is not available, testing will utilize the existing library of test scenarios to mitigate risk. Existing, scalable development and test environments will support parallel activities. Information Solutions currently maintains between 50 and 100 development, testing, QA, and pre-production environments. These environments can be reconfigured at any time to mitigate risks introduced by unforeseen scalability situations. Manual creation of test data to support the front loading of test activities.	Risk Log, as described above.
Delayed delivery of hardware	Risk mitigated by our continued capacity planning efforts to ensure robust infrastructure to support existing and potential growth opportunities. Information Solutions performs quarterly capacity analysis in concert with project demands and buffers for contingencies through a small pool of standby resources. By maintaining a small "just-in-time" inventory of hardware, exceptions to rapidly deploy hardware can be mitigated. Strategic partnerships with major vendors enable strong turnaround on acquisition of new hardware.	Risk Log, as described above.
Delayed delivery of applications	Scalability of existing MIS enables us to re-assign existing resources and systems to support the Louisiana business. Risk mitigation is also supported by strong strategic partnerships with key technology suppliers. We also contract with strategic partners for a temporary hosted MIS solution and staff augmentation for additional resources as needed.	Risk Log, as described above.
Delayed delivery of the connectivity to the local office	Centralization of the AmeriHealth Mercy service delivery model enables flexibly of routing key service delivery activities to other regional locations. Users of secure VPN capabilities over the Internet enable secure contingency plans for delayed delivery of connectivity.	Risk Log, as described above.
Delays in Hiring and Training Required Staff		
Risk Identification	**Risk Management Implementation Plan and Mitigation Strategies**	**Proposed or Recommended Monitoring Tool**

Hired and trained staff does not meet staffing requirements outlined in our staffing models.	Identify and contract with vendors to provide support as needed until the full complement of staff has been hired and trained (Contact Center overflow, Claims Processing, Enrollment keying and reconciliation, system configuration, Provider Maintenance, IT support). Use of staff from affiliate offices.	▪ Monitor key performance indicators ▪ Review standard management oversight reports ▪ Provider and Member complaints ▪ Risk Log, as described above
Work volumes exceeds capacity	Shift work to other regions to provider temporary overflow until staffing levels are stabilized (South Carolina, Pennsylvania and Indiana).	▪ Monitor key performance indicators ▪ Review standard management oversight reports ▪ Provider and Member complaints ▪ Risk Log, as described above
Recruitment activities and identification of qualified candidates are slower than targeted	Offer overtime for current staff to accommodate increased volume of work.	▪ Monitor key performance indicators ▪ Review standard management oversight reports ▪ Provider and Member complaints ▪ Risk Log, as described above.

Delays in the Construction and/or Acquisition or Office Space and the Delivery of Office Equipment		
Risk Identification	**Risk Management Implementation Plan and Mitigation Strategies**	**Proposed or Recommended Monitoring Tool**
No available office space	▪ Space options have been identified. The Facilities Project Team checks in regularly with the landlords to assess availability. ▪ Utilize staff in regional office in South Carolina to temporarily transfer roles and responsibilities. ▪ Identify alternative back-up space. ▪ Transfer roles and responsibilities to staff in Corporate Office in Philadelphia temporarily.	▪ Regular check in conference calls and site visits will be utilized to monitor progress. ▪ Risk Log, as described above.

Construction of facility falls behind schedule	▪ Construction team will operate under a construction schedule, which is managed by the construction Site Manager. The Site Manager will be in daily contact with the Facilities Project Team Lead to provide status on activities, any delays in activities and any potential areas at risk. ▪ Utilize staff in regional office in South Carolina to temporarily transfer roles and responsibilities. ▪ Identify alternative back-up space. ▪ Transfer roles and responsibilities to staff in Corporate Office in Philadelphia temporarily.	▪ Regular check in conference calls and site visits will be utilized to monitor progress. ▪ Risk Log, as described above.
Required furniture does not arrive on time	▪ Established vendors for the supply of office equipment will be utilized. The Facilities Team will be in regular contact with our supplier to check on delivery status. ▪ Utilize rented furniture if necessary	▪ Regular check in conference calls and site visits will be utilized to monitor progress. ▪ Risk Log, as described above.

Delays in Enrollment Processing During Implementation		
Risk Identification	**Risk Management Implementation Plan and Mitigation Strategies**	**Proposed or Recommended Monitoring Tool**
Failure in loading enrollment files from the state and Enrollment Broker	▪ Internal compliance checks. ▪ Member and Provider calls. ▪ Access state system for member eligibility verification. ▪ Contract with vendor to assist with the enrollment load and reconciliation process. ▪ Manually key member information. ▪ Identify member's claims that were denied in error and reprocess as needed.	▪ Monitor key performance indicators ▪ Review standard management oversight reports ▪ Provider and Member complaints.

Delays in the Publication and/or Delivery of Marketing and Related Materials		
Risk Identification and Mitigation Strategies	**Risk Management Implementation Plan**	**Proposed or Recommended Monitoring Tool**
Conflicting Workflow	Each communications project is entered into a web-based software program that guides incoming project requests and effectively pairs them with available resources. A designated Traffic Manager position facilitates the process and allows us to manage this critical workflow to assure critical deadlines and key activities are met.	▪ CurrentTrack® system is a web-based software program that is widely used in the marketing and advertising industry. The system helps us successfully manage projects, resources, and deliver consistent, quality results that support Louisiana's requirements. ▪ Risk Log, as described above

Employee Absence	Multiple cross-trained employees at the local, regional and national level with expertise in Louisiana-specific business rules, traffic management, graphic design and writing ensure that AmeriHealth Mercy materials will be completed on-time to allow for state approval submission and according to state specifications. A strong local presence throughout Louisiana will provide additional support staff for transporting and/or delivery of materials to the state, its agents, members or providers.	▪ CurrentTrack® system, as described above ▪ Risk Log, as described above
Systems Failure	Local, regional and corporate resources have access to shared data and information. If systems fail in one location, backup is provided in an alternative location. In addition, employees have secure access to systems and files from approved home locations.	▪ CurrentTrack® system, as described above ▪ Risk Log, as described above
Printing and/or distribution backlog	AmeriHealth Mercy is supported by a print management system and process that tracks key specifications and data fields throughout the lifecycle of each project. Our robust print and distribution network consists of national, local and company-owned print centers and distribution. Each piece of collateral and marketing material can be printed and fulfilled from different locations to mitigate various risks related to the print process. Our third-party print and fulfillment suppliers are reviewed on a regular basis to ensure compliance with our quality and service agreements.	▪ CurrentTrack® system, as described above ▪ Risk Log, as described above

C.4: Work Plan

C.4 Provide a copy of the Work Plan, generated in Microsoft Project or similar software product that includes the aforementioned implementation activities along with the timeframes, person-hours, and dependencies associated with these activities.

Enclosed please find the Work Plan, generated in Microsoft Project, which includes the aforementioned implementation activities along with the timeframes, person-hours and dependencies. Please note that the Work Plan has also been enclosed in a Dependency View to highlight the dependencies associated with the implementation.

Table 3: AmeriHealth Mercy Work Plan

ID	Task Name	Start	Finish	Estimated Work Effort
0	**Louisiana Implementation Schedule**	**Tue 1/11/11**	**Fri 2/1/13**	**182,615.95 hrs**
1	**Leadership Team**	**Mon 4/11/11**	**Tue 5/1/12**	**5,076 hrs**
2	**Leadership Team Activities**	**Mon 4/11/11**	**Mon 7/25/11**	**256 hrs**
3	Public Notice of RFP	Mon 4/11/11	Mon 4/11/11	8 hrs
4	Pre-Proposal Conference (Mandatory)	Tue 4/12/11	Mon 4/18/11	40 hrs
5	Deadline for Receipt of Written Questions (Initial timeline)	Fri 4/29/11	Fri 4/29/11	8 hrs
6	Response to Written Questions (revised timeline)	Mon 5/23/11	Mon 5/23/11	8 hrs
7	Deadline for Receipt of Proposals	Fri 6/24/11	Wed 6/29/11	32 hrs
8	Proposal Evaluation Period	Tue 6/28/11	Mon 7/25/11	160 hrs
9	**RFP Preparation Activities**	**Mon 4/11/11**	**Thu 6/30/11**	**1,152 hrs**
10	Arrange Meeting - video conference, regional and corporate SMEs	Mon 4/11/11	Mon 4/11/11	0 hrs
11	Send meeting requests to appropriate parties	Mon 4/11/11	Mon 4/11/11	8 hrs
12	Secure proposal preparation and writing contractors	Mon 4/11/11	Wed 4/13/11	24 hrs
13	Prepare Kick-off presentation and proposal management materials	Mon 4/11/11	Wed 4/13/11	24 hrs
14	Conduct Kick-off Meeting (Market Expansion)	Mon 4/11/11	Thu 4/14/11	32 hrs
15	Business Model Development	Mon 4/11/11	Thu 4/14/11	32 hrs
16	Technology identification and selection	Mon 4/11/11	Wed 4/13/11	24 hrs
17	Process Models	Mon 4/11/11	Wed 4/13/11	24 hrs
18	Key Personnel Identification	Mon 4/11/11	Wed 4/13/11	24 hrs
19	LPHI Agreement, Provider Network	Mon 4/11/11	Wed 4/13/11	24 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
20	Identification of Partnership Council and support letters	Mon 4/11/11	Wed 4/13/11	24 hrs
21	**Proposal Response Team**	**Mon 4/11/11**	**Fri 4/29/11**	**232 hrs**
22	Identify and assign SMEs	Mon 4/11/11	Mon 4/11/11	8 hrs
23	Secure writer	Mon 4/11/11	Mon 4/11/11	8 hrs
24	Secure preparation assistant	Mon 4/11/11	Tue 4/12/11	16 hrs
25	Assign writers	Mon 4/11/11	Fri 4/15/11	40 hrs
26	Create detailed assignment activity grid	Mon 4/11/11	Fri 4/29/11	120 hrs
27	Coordinate Share Point Access & Training	Mon 4/11/11	Fri 4/15/11	40 hrs
28	**Document Preparation**	**Tue 4/12/11**	**Thu 6/30/11**	**680 hrs**
29	**First Draft**	**Tue 4/12/11**	**Mon 6/6/11**	**376 hrs**
30	Review existing proposal materials	Tue 4/12/11	Thu 4/14/11	24 hrs
31	Create templates	Tue 4/12/11	Fri 4/15/11	32 hrs
32	Distribute templates to SMEs	Mon 4/18/11	Fri 4/22/11	40 hrs
33	Interview SMEs, respond to questions, address concerns	Mon 4/25/11	Fri 5/6/11	80 hrs
34	Review/Revise responses	Mon 5/9/11	Thu 5/12/11	32 hrs
35	Format response document	Fri 5/13/11	Mon 5/16/11	16 hrs
36	Create Executive Summary	Fri 5/13/11	Mon 5/16/11	16 hrs
37	Finalize 1st draft	Fri 5/13/11	Fri 5/13/11	8 hrs
38	Distribute for Team review (post to Share Point)	Mon 5/16/11	Fri 5/20/11	40 hrs
39	Revise where applicable	Mon 5/23/11	Mon 6/6/11	88 hrs
40	**Final Draft**	**Tue 6/7/11**	**Thu 6/16/11**	**64 hrs**
41	Create final draft document	Tue 6/7/11	Tue 6/7/11	8 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
42	Edit document and attachments where applicable	Wed 6/8/11	Wed 6/8/11	8 hrs
43	Distribute for review	Thu 6/9/11	Thu 6/9/11	8 hrs
44	Coordinate team review meeting	Fri 6/10/11	Mon 6/13/11	16 hrs
45	Incorporate changes	Tue 6/14/11	Tue 6/14/11	8 hrs
46	Copy editing (in sections)	Wed 6/15/11	Wed 6/15/11	8 hrs
47	Coordinate with attachments	Thu 6/16/11	Thu 6/16/11	8 hrs
48	**Document Production**	**Wed 6/8/11**	**Thu 6/30/11**	**240 hrs**
49	Create graphics	Wed 6/8/11	Wed 6/8/11	8 hrs
50	Design cover/spine artwork	Wed 6/8/11	Wed 6/8/11	8 hrs
51	Collate collateral materials/attachments	Fri 6/17/11	Fri 6/17/11	8 hrs
52	Order supplies	Wed 6/8/11	Thu 6/9/11	16 hrs
53	Submit for copying/electronic media	Fri 6/10/11	Thu 6/23/11	80 hrs
54	Build Binders	Tue 6/14/11	Sat 6/25/11	72 hrs
55	Coordinate distribution method/schedule	Fri 6/24/11	Wed 6/29/11	40 hrs
56	Deliver to State	Thu 6/30/11	Thu 6/30/11	8 hrs
57	**DHH On-site Demonstrations**	**Mon 7/25/11**	**Sun 1/1/12**	**168 hrs**
58	Contract Award Announced	Mon 7/25/11	Mon 7/25/11	8 hrs
59	Contract Negotiations Begin	Tue 7/26/11	Mon 8/8/11	160 hrs
60	Contract scheduled to begin	Sun 1/1/12	Sun 1/1/12	0 hrs
61	**Implementation Schedule**	**Thu 9/1/11**	**Tue 5/1/12**	**2,768 hrs**
62	**GSA A**	**Thu 9/1/11**	**Sun 1/1/12**	**928 hrs**
63	DHH Readiness Review - GSA "A"	Thu 9/1/11	Fri 10/14/11	512 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
64	GSA Network Adequacy Documentation Deadline	Tue 11/8/11	Tue 11/8/11	16 hrs
65	CCN Network & Control Submitted to CMS for approval	Mon 10/17/11	Tue 11/15/11	352 hrs
66	CCN Network Provider Directory and one page brochure to enrollment broker	Tue 11/8/11	Tue 11/8/11	16 hrs
67	Choice Letters Mailed to Enrollees - Enrollment begins	Tue 11/15/11	Tue 11/15/11	8 hrs
68	Deadline for Member Enrollment	Fri 12/23/11	Fri 12/23/11	8 hrs
69	GSA A Go-Live	Sun 1/1/12	Sun 1/1/12	16 hrs
70	**GSA "B"**	**Mon 9/19/11**	**Thu 3/1/12**	**912 hrs**
71	DHH Readiness Review - GSA "B"	Mon 9/19/11	Mon 10/31/11	512 hrs
72	GSA Network Adequacy Documentation Deadline	Fri 10/7/11	Fri 10/7/11	16 hrs
73	CCN Network & Control Submitted to CMS for approval	Fri 12/16/11	Thu 1/12/12	336 hrs
74	CCN Network Provider Directory and one-age brochure to enrollment broker	Fri 1/6/12	Fri 1/6/12	16 hrs
75	Choice Letters Mails to Enrollees - Enrollment begins	Mon 1/16/12	Mon 1/16/12	8 hrs
76	Deadline for Member Enrollment	Thu 2/23/12	Thu 2/23/12	8 hrs
77	GSA B Go-Live	Wed 2/29/12	Thu 3/1/12	16 hrs
78	**GSA "C"**	**Thu 9/1/11**	**Tue 5/1/12**	**928 hrs**
79	DHH Readiness Review - GSA "C"	Thu 9/1/11	Fri 10/14/11	512 hrs
80	GSA Network Adequacy Documentation Deadline	Thu 9/1/11	Thu 9/1/11	16 hrs
81	CCN Network & Control Submitted to CMS for approval	Fri 12/16/11	Thu 1/12/12	336 hrs
82	CCN Network Provider Directory and one-age brochure to enrollment broker	Fri 1/6/12	Fri 1/6/12	16 hrs
83	Choice Letters Mails to Enrollees - Enrollment begins	Thu 3/15/12	Thu 3/15/12	16 hrs
84	Deadline for Member Enrollment	Wed 4/25/12	Wed 4/25/12	16 hrs
85	GSA B Go-Live	Tue 5/1/12	Tue 5/1/12	16 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
86	**Readiness Review**	**Mon 7/25/11**	**Fri 12/9/11**	**232 hrs**
87	**LA RFP: C.2 - Implementation Work Plan**	**Thu 4/14/11**	**Mon 6/20/11**	**0 hrs**
88	Tasks associated with your establishment of a "project office" or similar organization by which you will manage the implementation of the CCN Program.	Thu 4/14/11	Mon 6/20/11	0 hrs
89	An itemization of activities that you will undertake during the period between the awarding of this procurement and the start date of the CCN Program.	Thu 4/14/11	Mon 6/20/11	0 hrs
90	All activities to prepare for and participate in the Readiness Review Process.	Thu 4/14/11	Mon 6/20/11	0 hrs
91	All activities necessary to obtain required contracts for mandatory health care providers as specified in this RFP.	Thu 4/14/11	Mon 6/20/11	0 hrs
92	An estimate of person-hours associated with each activity in the Work Plan	Thu 4/14/11	Mon 6/20/11	0 hrs
93	**LA RFP: Appendix JJ - Transition Period Requirements (Readiness Review)**	**Mon 7/25/11**	**Thu 9/1/11**	**232 hrs**
94	**Contract Start-Up and Planning**	**Mon 7/25/11**	**Thu 9/1/11**	**232 hrs**
95	Submit updated and detailed Transition/Implementation Plan to DHH	Mon 7/25/11	Thu 9/1/11	232 hrs
96	**Administration and Key CCN Personnel**	**Mon 6/20/11**	**Fri 9/30/11**	**0 hrs**
97	Create Readiness Checklist from Appendix JJ	Mon 6/20/11	Fri 6/24/11	0 hrs
98	Use Readiness Checklist to insure preparedness for Readiness Review	Mon 6/27/11	Thu 9/1/11	0 hrs
99	Perform Readiness Review	Thu 9/1/11	Fri 9/30/11	0 hrs
100	**Financial Readiness Review**	**Mon 7/25/11**	**Thu 9/1/11**	**0 hrs**
101	Create Readiness Checklist from Appendix JJ	Mon 6/20/11	Fri 6/24/11	0 hrs
102	Use Readiness Checklist to insure preparedness for Readiness Review	Mon 6/27/11	Thu 9/1/11	0 hrs
103	Perform Readiness Review	Thu 9/1/11	Fri 9/30/11	0 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
104	**Subcontractor Information**	**Mon 7/25/11**	**Thu 9/1/11**	**0 hrs**
105	Create Readiness Checklist from Appendix JJ	Mon 6/20/11	Fri 6/24/11	0 hrs
106	Use Readiness Checklist to insure preparedness for Readiness Review	Mon 6/27/11	Thu 9/1/11	0 hrs
107	Perform Readiness Review	Thu 9/1/11	Fri 9/30/11	0 hrs
108	**System Testing and Transfer of Data**	**Mon 7/25/11**	**Thu 9/1/11**	**0 hrs**
109	Create Readiness Checklist from Appendix JJ	Mon 6/20/11	Fri 6/24/11	0 hrs
110	Use Readiness Checklist to insure preparedness for Readiness Review	Mon 6/27/11	Thu 9/1/11	0 hrs
111	Perform Readiness Review	Thu 9/1/11	Fri 9/30/11	0 hrs
112	**System Readiness Review**	**Mon 7/25/11**	**Thu 9/1/11**	**0 hrs**
113	Create Readiness Checklist from Appendix JJ	Mon 6/20/11	Fri 6/24/11	0 hrs
114	Use Readiness Checklist to insure preparedness for Readiness Review	Mon 6/27/11	Thu 9/1/11	0 hrs
115	Perform Readiness Review	Thu 9/1/11	Fri 9/30/11	0 hrs
116	**Demonstration and Assessment of System Readiness**	**Mon 7/25/11**	**Thu 9/1/11**	**0 hrs**
117	Create Readiness Checklist from Appendix JJ	Mon 6/20/11	Fri 6/24/11	0 hrs
118	Use Readiness Checklist to insure preparedness for Readiness Review	Mon 6/27/11	Thu 9/1/11	0 hrs
119	Perform Readiness Review	Thu 9/1/11	Fri 9/30/11	0 hrs
120	**Operation Readiness**	**Mon 7/25/11**	**Thu 9/1/11**	**0 hrs**
121	Create Readiness Checklist from Appendix JJ	Mon 6/20/11	Fri 6/24/11	0 hrs
122	Use Readiness Checklist to insure preparedness for Readiness Review	Mon 6/27/11	Thu 9/1/11	0 hrs
123	Perform Readiness Review	Thu 9/1/11	Fri 9/30/11	0 hrs
124	**Assurance of System and Operation Readiness**	**Mon 7/25/11**	**Thu 9/1/11**	**0 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
125	Create Readiness Checklist from Appendix JJ	Mon 6/20/11	Fri 6/24/11	0 hrs
126	Use Readiness Checklist to insure preparedness for Readiness Review	Mon 6/27/11	Thu 9/1/11	0 hrs
127	Perform Readiness Review	Thu 9/1/11	Fri 9/30/11	0 hrs
128	**D/R and Business Continuity**	**Mon 7/25/11**	**Fri 12/9/11**	**500 hrs**
129	**Conduct a Business Impact Analysis**	**Mon 7/25/11**	**Fri 12/9/11**	**120 hrs**
130	Conduct Data Gathering Sessions.	Wed 8/10/11	Tue 8/30/11	60 hrs
131	Conduct Review sessions with the functional users impacted	Wed 8/10/11	Tue 8/30/11	60 hrs
132	**Develop Area Business Continuity Plans by**	**Wed 8/24/11**	**Tue 8/30/11**	**300 hrs**
133	Plan Development	Wed 8/24/11	Tue 8/30/11	0 hrs
134	Plan Review	Wed 8/24/11	Tue 8/30/11	100 hrs
135	Plan Validation	Wed 8/24/11	Tue 8/30/11	100 hrs
136	Validate and Test the Plans	Wed 8/24/11	Tue 8/30/11	100 hrs
137	Deliver Employee Awareness Training	Wed 8/17/11	Tue 8/30/11	40 hrs
138	Develop Local Office Emergency Evacuation Plan	Wed 8/17/11	Tue 8/30/11	40 hrs
139	**PM team**	**Tue 4/12/11**	**Mon 8/22/11**	**3,696 hrs**
140	**Project Implementation Activities - Pre-Initiation**	**Tue 4/12/11**	**Mon 5/23/11**	**624 hrs**
141	Form Project Committee	Tue 4/12/11	Thu 5/12/11	184 hrs
142	Contribute to RFP response	Tue 4/19/11	Fri 5/13/11	48 hrs
143	Develop High Level Project Plan	Mon 5/2/11	Mon 5/23/11	128 hrs
144	Prepare Proforma based on initial cost estimates	Tue 4/12/11	Mon 5/2/11	120 hrs
145	Run staffing model	Tue 5/3/11	Tue 5/10/11	48 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
146	Establish Project Implementation Budget	Tue 5/3/11	Tue 5/10/11	96 hrs
147	**Project Initiation**	**Tue 4/12/11**	**Tue 7/26/11**	**1,664 hrs**
148	Submit Work Request	Mon 5/2/11	Tue 5/10/11	56 hrs
149	Develop Project Charter/Scope	Mon 6/13/11	Wed 7/6/11	288 hrs
150	Complete Impact Assessment	Wed 6/1/11	Wed 6/29/11	176 hrs
151	Request Estimate - ROM	Mon 6/27/11	Tue 7/5/11	112 hrs
152	Complete Business Estimate - ROM	Wed 7/6/11	Tue 7/26/11	240 hrs
153	Identify Project Sponsor and Executive Oversight Committee	Mon 5/2/11	Mon 5/2/11	8 hrs
154	Identify Team Leads - Obtain Commitment from Management	Mon 5/2/11	Mon 5/9/11	48 hrs
155	Create Project Team Reporting Structure	Mon 5/2/11	Mon 5/2/11	8 hrs
156	Create Master Contact List	Fri 6/3/11	Fri 6/17/11	88 hrs
157	Review RFP Proposal to determine Deliverables	Tue 5/3/11	Mon 5/16/11	80 hrs
158	Draft Operations Project Overview document	Mon 5/16/11	Thu 6/16/11	192 hrs
159	Create secure folder on Network drive to house Plan documents	Tue 4/12/11	Wed 4/20/11	56 hrs
160	**Request High Level system architecture review**	**Thu 7/7/11**	**Wed 7/20/11**	**160 hrs**
161	Request High Level system security review	Thu 7/7/11	Wed 7/20/11	160 hrs
162	**Identify Functional Teams**	**Tue 5/3/11**	**Mon 5/16/11**	**152 hrs**
163	Identify Functional Teams	Tue 5/3/11	Wed 5/4/11	16 hrs
164	Define PM, Team Lead and Team Members Roles & Responsibilities	Fri 5/6/11	Mon 5/9/11	16 hrs
165	Finalize Team Structure & Team Assignments	Fri 5/6/11	Thu 5/12/11	40 hrs
166	Coordinate Project Kick off Meeting	Tue 5/10/11	Tue 5/10/11	8 hrs
167	Coordinate Workgroup Team meetings to begin detailed business requirements phase	Tue 5/10/11	Mon 5/16/11	72 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
168	**Planning**	**Thu 5/5/11**	**Thu 7/14/11**	**1,408 hrs**
169	Business Requirements (All functional areas)	Thu 5/5/11	Fri 6/24/11	296 hrs
170	Functional Requirements (All functional areas)	Thu 5/5/11	Wed 7/6/11	360 hrs
171	Traceability Matrix	Thu 7/7/11	Thu 7/14/11	48 hrs
172	Communication Plan	Thu 5/5/11	Wed 5/18/11	80 hrs
173	Determine High Level Project Schedule	Tue 5/17/11	Wed 5/18/11	16 hrs
174	Identify Project Risks/Constraints	Tue 5/17/11	Thu 7/7/11	608 hrs
175	**Develop File Layout Mock-ups**	**Thu 6/30/11**	**Mon 8/22/11**	**0 hrs**
176	834 Companion Guide	Thu 6/30/11	Thu 6/30/11	0 hrs
177	820 Companion Guide	Thu 6/30/11	Thu 6/30/11	0 hrs
178	837i Matkick Companion Guide	Thu 6/30/11	Thu 6/30/11	0 hrs
179	835 Matkick Companion Guide	Thu 6/30/11	Thu 6/30/11	0 hrs
180	Historical Claim File Format	Thu 6/30/11	Thu 6/30/11	0 hrs
181	Authorization File Format	Thu 6/30/11	Thu 6/30/11	0 hrs
182	834 Test File	Mon 8/22/11	Mon 8/22/11	0 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**
185	**Physician support**	**Tue 11/1/11**	**Tue 1/31/12**	**1,780 hrs**
186	**Staffing**	**Tue 11/1/11**	**Tue 1/31/12**	**1,252 hrs**
187	Hire day 1 staff	Tue 11/1/11	Fri 12/9/11	60 hrs
188	Orientation/Training - Day 1 staff	Thu 12/1/11	Fri 12/30/11	176 hrs
189	Management buddy	Thu 12/1/11	Fri 12/9/11	56 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
190	Repetitive Hiring/Training process	Thu 1/5/12	Tue 1/31/12	152 hrs
191	Train existing staff	Fri 12/9/11	Fri 12/30/11	128 hrs
192	Augment existing staff	Thu 1/5/12	Tue 1/31/12	152 hrs
193	**Care Coordination**	**Fri 7/1/11**	**Tue 1/31/12**	**12,172 hrs**
194	**Program Design**	**Fri 7/1/11**	**Mon 10/31/11**	**1,984 hrs**
195	Program Description	Fri 7/1/11	Thu 7/7/11	40 hrs
196	Homeless Outreach Plan (KY Only)	Fri 7/1/11	Mon 8/1/11	40 hrs
197	**Policies**	**Mon 8/1/11**	**Mon 10/31/11**	**1,208 hrs**
198	156.100 - Review Process for Case Management/Care Coordination Policies and Procedures	Mon 8/1/11	Fri 10/28/11	40 hrs
199	156.101 - Documentation and Confidentiality	Mon 8/1/11	Fri 10/28/11	40 hrs
200	156.102 - Orientation and Training of Case Management/Care CoordinationStaff	Mon 8/1/11	Fri 10/28/11	40 hrs
201	156.103 - Ethical Framework for CM/CC	Mon 8/1/11	Fri 10/28/11	40 hrs
202	156.201 - Case Management Standards of Practice	Mon 8/1/11	Fri 10/28/11	40 hrs
203	156.202 - Assignment of Members to the CM Program	Mon 8/1/11	Fri 10/28/11	40 hrs
204	156.209 - Case Management In-person and/or Home Visits	Mon 8/1/11	Fri 10/28/11	40 hrs
205	156.213 - Case Management Reassessment of Members who Refuse CM or Fail to Achieve Goals due to Non-adherence	Mon 8/1/11	Fri 10/28/11	40 hrs
206	156.214 - CM Closure	Mon 8/1/11	Fri 10/28/11	40 hrs
207	156.216 - CM Case Review	Mon 8/1/11	Fri 10/28/11	40 hrs
208	156.219 - Reporting Abuse, Neglect, or other Domestic Violence	Mon 8/1/11	Fri 10/28/11	40 hrs
209	156.303 - Case Management/Care Coordination WeeCare Maternity Program	Mon 8/1/11	Fri 10/28/11	40 hrs
210	156.400 - EPDST Services and Process	Mon 8/1/11	Fri 10/28/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
211	156.600 - Case Management/Care Coordination Process for the Special Care Unit	Mon 8/1/11	Fri 10/28/11	40 hrs
212	156.702 - Case Management Dispute Resolution	Mon 8/1/11	Fri 10/28/11	40 hrs
213	156.703 - Options Assessment and PDA Waiver	Mon 8/1/11	Fri 10/28/11	40 hrs
214	156.704 - CM Transportation Guidelines	Mon 8/1/11	Fri 10/28/11	40 hrs
215	**Case Rounds**	**Thu 12/1/11**	**Thu 12/15/11**	**176 hrs**
216	Develop annual case rounds calendar outlining educational topics and case manager assigned	Thu 12/1/11	Thu 12/15/11	88 hrs
217	**InterAgency Collaboration**	**Thu 12/1/11**	**Fri 12/30/11**	**256 hrs**
218	DCBS	Thu 12/1/11	Fri 12/30/11	40 hrs
219	DAIL	Thu 12/1/11	Fri 12/30/11	40 hrs
220	Program Lock-In	Tue 11/1/11	Wed 11/30/11	40 hrs
221	CCN Transfer Summary	Tue 11/1/11	Wed 11/30/11	40 hrs
222	Medication Therapy Management	Tue 8/2/11	Mon 10/31/11	120 hrs
223	**Transportation**	**Mon 8/1/11**	**Wed 8/31/11**	**224 hrs**
224	Develop transportation guidelines for medical/behavioral appointments	Mon 8/1/11	Wed 8/31/11	40 hrs
225	**Tools**	**Mon 8/1/11**	**Wed 11/30/11**	**4,720 hrs**
226	**Assessments**	**Mon 8/1/11**	**Wed 8/31/11**	**1,424 hrs**
227	Asthma Assessment & Education Tool	Mon 8/1/11	Wed 8/31/11	40 hrs
228	Diabetes Assessment & Education Tool	Mon 8/1/11	Wed 8/31/11	40 hrs
229	COPD Assessment & Education Tool	Mon 8/1/11	Wed 8/31/11	40 hrs
230	HTN Assessment & Education Tool	Mon 8/1/11	Wed 8/31/11	40 hrs
231	Heart Failure Assessment & Education Tool	Mon 8/1/11	Wed 8/31/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
232	Asthma Reassessment & Education Tool	Mon 8/1/11	Wed 8/31/11	40 hrs
233	Diabetes Reassessment & Education Tool	Mon 8/1/11	Wed 8/31/11	40 hrs
234	COPD Reassessment & Education Tool	Mon 8/1/11	Wed 8/31/11	40 hrs
235	Heart Failure Reassessment & Education Tool	Mon 8/1/11	Wed 8/31/11	40 hrs
236	CAT (Comprehensive Assessment Tool)	Mon 8/1/11	Wed 8/31/11	40 hrs
237	Case Management Letters	Mon 8/1/11	Wed 8/31/11	40 hrs
238	Care Coordination Disclosure and Information	Mon 8/1/11	Wed 8/31/11	40 hrs
239	EPDS (Edinburgh Perinatal Depression Scale)	Mon 8/1/11	Wed 8/31/11	40 hrs
240	EPSDT 3 yrs & under	Mon 8/1/11	Wed 8/31/11	40 hrs
241	EPSDT 3 yrs & older	Mon 8/1/11	Wed 8/31/11	40 hrs
242	HC HC tool	Mon 8/1/11	Wed 8/31/11	40 hrs
243	HIV Assessment and Reassessment Educational Tool	Mon 8/1/11	Wed 8/31/11	40 hrs
244	Lead Poisoning Assessment and Education Tool	Mon 8/1/11	Wed 8/31/11	40 hrs
245	MCAT	Mon 8/1/11	Wed 8/31/11	40 hrs
246	Mini-Survey WeeCare Level IID	Mon 8/1/11	Wed 8/31/11	40 hrs
247	Patient Activation Measure Survey	Mon 8/1/11	Wed 8/31/11	40 hrs
248	Peds CAT	Mon 8/1/11	Wed 8/31/11	40 hrs
249	Post discharge Follow Up Survey	Mon 8/1/11	Wed 8/31/11	40 hrs
250	Post Partum Survey (WeeCare)	Mon 8/1/11	Wed 8/31/11	40 hrs
251	Preventive Health/Care Gaps Survey	Mon 8/1/11	Wed 8/31/11	40 hrs
252	Referrals & Interventions	Mon 8/1/11	Wed 8/31/11	40 hrs
253	RROT CM Assessment & Referral Tool	Mon 8/1/11	Wed 8/31/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
254	Safety Survey	Mon 8/1/11	Wed 8/31/11	40 hrs
255	Sickle Cell Assessment & Reassessment Educational Tool	Mon 8/1/11	Wed 8/31/11	40 hrs
256	WeeCare CMT Survey Tool	Mon 8/1/11	Wed 8/31/11	40 hrs
257	SF 12 Survey	Mon 8/1/11	Wed 8/31/11	40 hrs
258	Care Plans	Thu 9/1/11	Fri 9/30/11	40 hrs
259	Educational materials	Thu 9/1/11	Fri 9/30/11	40 hrs
260	Provider materials	Thu 9/1/11	Fri 9/30/11	40 hrs
261	Workflows	Mon 8/1/11	Wed 8/31/11	40 hrs
262	**Letters**	**Thu 9/1/11**	**Fri 9/30/11**	**1,256 hrs**
263	Care Coordination Welcome Letter	Thu 9/1/11	Fri 9/30/11	40 hrs
264	Medicine Safety/Advance Directives Information	Thu 9/1/11	Fri 9/30/11	40 hrs
265	Consent Letter	Thu 9/1/11	Fri 9/30/11	40 hrs
266	Member's Rights	Thu 9/1/11	Fri 9/30/11	40 hrs
267	HIPAA	Thu 9/1/11	Fri 9/30/11	40 hrs
268	SF12**this is not an actual letter but a survey that is part of the engagement process	Thu 9/1/11	Fri 9/30/11	40 hrs
269	Provider Initiation Letter	Thu 9/1/11	Fri 9/30/11	40 hrs
270	Member Outreach Letter	Thu 9/1/11	Fri 9/30/11	40 hrs
271	Provider Unable to Reach Letter	Thu 9/1/11	Fri 9/30/11	40 hrs
272	Member Case Closure(Unable to Reach)	Thu 9/1/11	Fri 9/30/11	40 hrs
273	Provider Case Closure(Unable to Reach)	Thu 9/1/11	Fri 9/30/11	40 hrs
274	Member Case Closure(Ineligible)	Thu 9/1/11	Fri 9/30/11	40 hrs
275	Provider Case Closure(Ineligible)	Thu 9/1/11	Fri 9/30/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
276	Member Case Closure(Member Opts Out)	Thu 9/1/11	Fri 9/30/11	40 hrs
277	Provider Case Closure(Member Opts Out)	Thu 9/1/11	Fri 9/30/11	40 hrs
278	Prenatal Care Fact Sheet	Thu 9/1/11	Fri 9/30/11	40 hrs
279	Congratulations Card Wee Care	Thu 9/1/11	Fri 9/30/11	40 hrs
280	All About Wee Care	Thu 9/1/11	Fri 9/30/11	40 hrs
281	Wee Care Post Partum Fact Sheet	Thu 9/1/11	Fri 9/30/11	40 hrs
282	Perinatal Depression Booklet	Thu 9/1/11	Fri 9/30/11	40 hrs
283	Dental Screening Card for Prenatal Members	Thu 9/1/11	Fri 9/30/11	40 hrs
284	Having a Baby Booklet	Thu 9/1/11	Fri 9/30/11	40 hrs
285	Text4Baby Brochure	Thu 9/1/11	Fri 9/30/11	40 hrs
286	Post Partum Depression Booklet	Thu 9/1/11	Fri 9/30/11	40 hrs
287	Growth Chart Information	Thu 9/1/11	Fri 9/30/11	40 hrs
288	Healthy Eating	Thu 9/1/11	Fri 9/30/11	40 hrs
289	Dental Care When you are Pregnant	Thu 9/1/11	Fri 9/30/11	40 hrs
290	**Community Resources**	**Mon 8/1/11**	**Wed 11/30/11**	**824 hrs**
291	Develop a resource guide for case managers (State Specific)	Thu 11/10/11	Wed 11/30/11	120 hrs
292	**Audits**	**Fri 9/30/11**	**Mon 10/31/11**	**352 hrs**
293	Develop an internal audit tool to monitor compliance to policies and NCQA	Mon 10/3/11	Mon 10/31/11	176 hrs
294	**Application Configuration**	**Tue 11/1/11**	**Tue 12/20/11**	**1,224 hrs**
295	**configuration**	**Tue 11/15/11**	**Tue 12/20/11**	**720 hrs**
296	WorkQueues	Tue 11/15/11	Mon 12/5/11	120 hrs
297	Assessments	Tue 11/15/11	Mon 12/5/11	120 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
298	Care Plans	Tue 11/15/11	Mon 12/5/11	120 hrs
299	Letters	Thu 12/1/11	Thu 12/15/11	88 hrs
300	Fax server	Fri 12/9/11	Tue 12/20/11	64 hrs
301	Testing	Fri 12/9/11	Tue 12/20/11	64 hrs
302	On-line resource page	Thu 12/1/11	Thu 12/15/11	88 hrs
303	Audit Database	Tue 11/1/11	Thu 11/10/11	64 hrs
304	**Staffing**	**Tue 11/1/11**	**Tue 1/31/12**	**984 hrs**
305	Hire day 1 staff	Tue 11/1/11	Fri 12/9/11	60 hrs
306	Orientation program/plan	Tue 11/1/11	Mon 11/7/11	40 hrs
307	**Orientation/Training - Day 1 staff**	**Thu 12/1/11**	**Fri 12/30/11**	**216 hrs**
308	Four to Six week orientation program(overview of care coordination program/system training/overview of benefits/resources/emergency	Thu 12/1/11	Fri 12/30/11	40 hrs
309	Preceptor resources	Mon 11/21/11	Fri 12/30/11	80 hrs
310	Management buddy	Thu 12/1/11	Fri 12/9/11	20 hrs
311	Repetitive Hiring/Training process	Thu 1/5/12	Tue 1/31/12	40 hrs
312	**DHH approval**	**Thu 9/1/11**	**Mon 10/31/11**	**1,180 hrs**
313	Policies	Fri 9/2/11	Mon 10/31/11	404 hrs
314	Letters	Mon 10/3/11	Mon 10/31/11	216 hrs
315	Educational Materials	Mon 10/3/11	Mon 10/31/11	216 hrs
316	**Rapid Response**	**Wed 6/8/11**	**Tue 1/31/12**	**10,820 hrs**
317	**Program Design**	**Wed 6/8/11**	**Wed 11/30/11**	**2,084 hrs**
318	**Program Description**	**Fri 7/1/11**	**Mon 8/1/11**	**352 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
319	Determine after hour unit coverage plan	Fri 7/1/11	Mon 8/1/11	176 hrs
320	**Policies**	**Mon 8/1/11**	**Mon 10/31/11**	**780 hrs**
321	156.500 - Rapid Response and Outreach Team	Mon 8/1/11	Fri 10/28/11	120 hrs
322	156.501 - Health Form/Survey	Mon 8/1/11	Fri 10/28/11	12 hrs
323	156.505 - Care Coordination Case Management Technician Outreach Process	Mon 8/1/11	Fri 10/28/11	120 hrs
324	Orientation program/plan	Tue 11/1/11	Mon 11/7/11	40 hrs
325	New Member Assessment Process	Mon 10/3/11	Mon 10/31/11	40 hrs
326	**Tools**	**Mon 8/1/11**	**Fri 9/30/11**	**1,016 hrs**
327	Surveys	Mon 8/1/11	Wed 8/31/11	40 hrs
328	Special Project Workflows (Special Outreach Campaigns)	Mon 8/1/11	Wed 8/31/11	40 hrs
329	**Scripts**	**Thu 9/1/11**	**Fri 9/30/11**	**416 hrs**
330	Enrollment/New Member Support	Thu 9/1/11	Fri 9/30/11	40 hrs
331	Direct Call - Intake Process	Thu 9/1/11	Fri 9/30/11	40 hrs
332	CM Task Guidelines	Thu 9/1/11	Fri 9/30/11	40 hrs
333	Managing Abusive Callers	Thu 9/1/11	Fri 9/30/11	40 hrs
334	"Do Not Call" Documentation and Reporting	Thu 9/1/11	Fri 9/30/11	40 hrs
335	Care Gap Referral Process	Thu 9/1/11	Fri 9/30/11	40 hrs
336	Provider materials	Thu 9/1/11	Fri 9/30/11	40 hrs
337	Workflows	Thu 9/1/11	Fri 9/30/11	40 hrs
338	Letters	Thu 9/1/11	Fri 9/30/11	40 hrs
339	Audits	Thu 9/1/11	Fri 9/30/11	40 hrs
340	**Resource Library/Collection (State Specific)**	**Mon 8/1/11**	**Wed 11/30/11**	**1,504 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
341	Referral to Community Resources	Tue 8/2/11	Wed 11/30/11	160 hrs
342	Maternity Program Support Processes	Tue 8/2/11	Wed 11/30/11	160 hrs
343	Smoking Cessation Offerings	Tue 8/2/11	Wed 11/30/11	160 hrs
344	EPSDT Workflows	Tue 8/2/11	Wed 11/30/11	160 hrs
345	Transportation Support (includes referrals to State programs)	Tue 8/2/11	Wed 11/30/11	160 hrs
346	**Application Configuration**	**Mon 8/1/11**	**Tue 12/20/11**	**2,392 hrs**
347	**configuration**	**Mon 8/1/11**	**Tue 12/20/11**	**1,360 hrs**
348	WorkQueues	Tue 11/15/11	Mon 12/5/11	120 hrs
349	Surveys	Mon 8/1/11	Wed 8/31/11	184 hrs
350	Letters	Thu 12/1/11	Thu 12/15/11	88 hrs
351	Fax server	Fri 12/9/11	Tue 12/20/11	64 hrs
352	Phone queues	Thu 12/1/11	Thu 12/15/11	88 hrs
353	Testing	Fri 12/9/11	Tue 12/20/11	64 hrs
354	On-line resource page	Thu 12/1/11	Thu 12/15/11	88 hrs
355	Audit Database	Tue 11/1/11	Thu 11/10/11	64 hrs
356	**Staffing**	**Tue 11/1/11**	**Tue 1/31/12**	**1,012 hrs**
357	Hire day 1 staff	Tue 11/1/11	Fri 12/9/11	60 hrs
358	Orientation/Training - Day 1 staff	Thu 12/1/11	Fri 12/30/11	176 hrs
359	Preceptor resources	Mon 11/21/11	Fri 12/30/11	40 hrs
360	Management buddy	Thu 12/1/11	Fri 12/9/11	56 hrs
361	Repetitive Hiring/Training process	Thu 1/5/12	Tue 1/31/12	152 hrs
362	**DHH approval**	**Thu 9/1/11**	**Mon 10/31/11**	**1,452 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
363	Policies	Fri 9/2/11	Mon 10/31/11	404 hrs
364	Letters	Mon 10/3/11	Mon 10/31/11	352 hrs
365	Scripts	Fri 9/30/11	Fri 10/28/11	352 hrs
366	**Utilization Management**	**Sun 10/30/11**	**Sun 10/30/11**	**5,177 hrs**
367	**Program Design**	**Wed 6/8/11**	**Wed 11/30/11**	**1,747 hrs**
368	Program Description	Fri 7/1/11	Mon 8/1/11	176 hrs
369	**Policies**	**Mon 8/1/11**	**Wed 8/31/11**	**659 hrs**
370	153.001 - Glossary of Terms	Mon 8/1/11	Wed 8/31/11	25 hrs
371	153.002 - Concurrent Review	Mon 8/1/11	Wed 8/31/11	25 hrs
372	153.003 - Prior Auth Process	Mon 8/1/11	Wed 8/31/11	25 hrs
373	153.004 - Use of Consultants	Mon 8/1/11	Wed 8/31/11	25 hrs
374	153.007 - License Verification	Mon 8/1/11	Wed 8/31/11	25 hrs
375	153.008 - Utilization Management Criteria	Mon 8/1/11	Wed 8/31/11	25 hrs
376	153.010 - Decision Response Time	Mon 8/1/11	Wed 8/31/11	25 hrs
377	153.016 - Technology Assessment	Mon 8/1/11	Wed 8/31/11	25 hrs
378	153.017 - Denial Notice Content and Distribution	Mon 8/1/11	Wed 8/31/11	25 hrs
379	153.105 - Peer-toPeer Discussion	Mon 8/1/11	Wed 8/31/11	25 hrs
380	153.200 - Retrospective Review	Mon 8/1/11	Wed 8/31/11	25 hrs
381	153.401 - Direct Access to OB/GYN Providers	Mon 8/1/11	Wed 8/31/11	25 hrs
382	153.706 - Continuity of Care	Mon 8/1/11	Wed 8/31/11	25 hrs
383	153.708 - IRR Testing for Physicians & Nurses	Mon 8/1/11	Wed 8/31/11	25 hrs
384	153.709 - Orientation and Training of Utilization Management Staff	Mon 8/1/11	Wed 8/31/11	25 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
385	153.901 - UM Communication	Mon 8/1/11	Wed 8/31/11	25 hrs
386	153.902 - On-Site Concurrent Rev at Facilities	Mon 8/1/11	Wed 8/31/11	25 hrs
387	153.903 - Abbreviation List	Mon 8/1/11	Wed 8/31/11	25 hrs
388	153.904 - Prior Authorization of Non-Par Providers	Mon 8/1/11	Wed 8/31/11	25 hrs
389	Orientation program/plan	Thu 12/1/11	Wed 12/7/11	40 hrs
390	**Tools**	**Mon 8/1/11**	**Fri 12/30/11**	**1,112 hrs**
391	Coding access	Thu 12/1/11	Mon 12/5/11	6 hrs
392	Medical Necessity Criteria (InterQual)	Thu 12/1/11	Mon 12/5/11	6 hrs
393	Network payment info	Thu 12/1/11	Fri 12/30/11	40 hrs
394	Provider materials	Thu 9/1/11	Wed 9/7/11	40 hrs
395	Workflows	Mon 8/1/11	Fri 8/5/11	40 hrs
396	Letters	Thu 9/1/11	Wed 9/7/11	40 hrs
397	Denial Language templates	Mon 10/3/11	Wed 10/5/11	20 hrs
398	Audits	Tue 10/4/11	Mon 10/10/11	40 hrs
399	**Application Configuration**	**Tue 11/1/11**	**Tue 12/20/11**	**1,160 hrs**
400	**configuration**	**Tue 11/15/11**	**Tue 12/20/11**	**656 hrs**
401	WorkQueues	Tue 11/15/11	Mon 12/5/11	120 hrs
402	System triggers	Thu 12/1/11	Thu 12/15/11	88 hrs
403	Letters	Tue 11/1/11	Wed 11/30/11	176 hrs
404	Fax server	Fri 12/9/11	Tue 12/20/11	64 hrs
405	Testing	Fri 12/9/11	Tue 12/20/11	64 hrs
406	On-line resource page	Thu 12/1/11	Thu 12/15/11	88 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
407	Audit Database	Tue 11/1/11	Thu 11/10/11	64 hrs
408	**Staffing**	**Tue 11/1/11**	**Tue 1/31/12**	**714 hrs**
409	Hire day 1 staff	Tue 11/1/11	Mon 11/7/11	40 hrs
410	Orientation/Training - Day 1 staff	Thu 12/1/11	Fri 12/30/11	40 hrs
411	Preceptor resources	Mon 11/21/11	Fri 12/30/11	50 hrs
412	Management buddy	Thu 12/1/11	Fri 12/9/11	16 hrs
413	Repetitive Hiring/Training process	Thu 1/5/12	Tue 1/31/12	40 hrs
414	**DHH approval**	**Thu 9/1/11**	**Mon 10/31/11**	**444 hrs**
415	Policies	Fri 9/2/11	Tue 9/13/11	60 hrs
416	Letters	Mon 10/3/11	Fri 10/7/11	40 hrs
417	**Appeals**	**Fri 7/1/11**	**Tue 1/31/12**	**6,020 hrs**
418	**Program Design**	**Fri 7/1/11**	**Wed 11/30/11**	**992 hrs**
419	Program Description	Fri 7/1/11	Thu 7/7/11	40 hrs
420	Policies	Mon 8/1/11	Fri 8/5/11	40 hrs
421	Orientation program/plan	Tue 11/1/11	Mon 11/7/11	40 hrs
422	**Tools**	**Mon 8/1/11**	**Wed 11/30/11**	**904 hrs**
423	Data collection templates	Fri 9/30/11	Mon 10/31/11	40 hrs
424	Workflows	Mon 8/1/11	Wed 8/31/11	40 hrs
425	Letters	Thu 9/1/11	Fri 9/30/11	40 hrs
426	Community Resources	Tue 8/2/11	Wed 11/30/11	40 hrs
427	Audits	Mon 10/3/11	Mon 10/31/11	40 hrs
428	**Application Configuration**	**Tue 11/1/11**	**Tue 12/20/11**	**1,192 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
429	**configuration**	**Tue 11/15/11**	**Tue 12/20/11**	**688 hrs**
430	WorkQueues	Tue 11/15/11	Mon 12/5/11	120 hrs
431	Assessments	Tue 11/15/11	Mon 12/5/11	120 hrs
432	System triggers	Thu 12/1/11	Thu 12/15/11	88 hrs
433	Letters	Thu 12/1/11	Thu 12/15/11	88 hrs
434	Fax server	Fri 12/9/11	Tue 12/20/11	64 hrs
435	Testing	Fri 12/9/11	Tue 12/20/11	64 hrs
436	On-line resource page	Thu 12/1/11	Thu 12/15/11	88 hrs
437	Audit Database	Tue 11/1/11	Thu 11/10/11	64 hrs
438	**Staffing**	**Tue 11/1/11**	**Tue 1/31/12**	**744 hrs**
439	Hire day 1 staff	Tue 11/1/11	Fri 12/9/11	60 hrs
440	Orientation/Training - Day 1 staff	Thu 12/1/11	Fri 12/30/11	40 hrs
441	Preceptor resources	Mon 11/21/11	Fri 12/30/11	60 hrs
442	Management buddy	Thu 12/1/11	Fri 12/9/11	16 hrs
443	Repetitive Hiring/Training process	Thu 1/5/12	Tue 1/31/12	40 hrs
444	**DHH approval**	**Thu 9/1/11**	**Mon 10/31/11**	**964 hrs**
445	Policies	Fri 9/2/11	Mon 10/31/11	404 hrs
446	Letters	Mon 10/3/11	Mon 10/31/11	216 hrs
447	**Quality Management**	**Wed 6/8/11**	Fri 2/1/13	**15,364 hrs**
448	**Program Design**	**Wed 6/8/11**	**Wed 11/30/11**	**1,704 hrs**
449	Program Description	Fri 7/1/11	Thu 7/7/11	40 hrs
450	Work plan	Fri 7/1/11	Mon 8/1/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
451	**Policies**	**Mon 8/1/11**	**Mon 10/31/11**	**724 hrs**
452	154.100 - Oversight of Delegated Activities	Mon 8/1/11	Wed 8/31/11	28 hrs
453	154.101 - Medical Record Review	Mon 8/1/11	Wed 8/31/11	28 hrs
454	154.105 - Physicians Sanction & Adverse Reporting	Mon 8/1/11	Wed 8/31/11	28 hrs
455	154.200 - Clinical Practice Guidelines	Mon 8/1/11	Wed 8/31/11	28 hrs
456	154.300 - Review of Potential Quality of Care Cases	Mon 8/1/11	Wed 8/31/11	28 hrs
457	154.303 - Monitoring Over & Under Utilization	Mon 8/1/11	Wed 8/31/11	28 hrs
458	154.403 - Withdrawal of Delegated Activities	Mon 8/1/11	Wed 8/31/11	28 hrs
459	Orientation program/plan	Tue 11/1/11	Fri 11/4/11	28 hrs
460	**Quality Committee Structure**	**Thu 9/1/11**	**Wed 2/15/12**	**1,100 hrs**
461	Committee Charters	Thu 9/1/11	Fri 9/30/11	40 hrs
462	Committee Membership	Mon 10/3/11	Wed 11/30/11	60 hrs
463	Committee Initial Meetings	Mon 1/16/12	Wed 2/15/12	40 hrs
464	**NCQA Accreditation (PH)**	**Thu 3/1/12**	**Fri 6/29/12**	**936 hrs**
465	Gap Analysis	Thu 3/1/12	Thu 5/31/12	120 hrs
466	New Plan Application	Fri 6/1/12	Fri 6/29/12	120 hrs
467	**Satisfaction Surveys**	**Wed 6/8/11**	Fri 2/1/13	**1,968 hrs**
468	CAHPS	Sun 6/10/12	Fri 2/1/13	300 hrs
469	Provider Satisfaction	Sun 6/10/12	Fri 2/1/13	300 hrs
470	**Medical Record Review Guidelines**	**Thu 9/1/11**	**Fri 9/30/11**	**216 hrs**
471	Medical Record Standards	Thu 9/1/11	Fri 9/30/11	40 hrs
472	Clinical Practice Guidelines	Mon 10/3/11	Mon 10/31/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
473	**Quality Improvement Activities**	**Wed 2/1/12**	**Fri 6/1/12**	**944 hrs**
474	Dental	Wed 2/1/12	Fri 6/1/12	120 hrs
475	Pre-term Birth	Wed 2/1/12	Fri 6/1/12	120 hrs
476	**Tools**	**Mon 8/1/11**	**Mon 10/31/11**	**688 hrs**
477	Workflows	Mon 8/1/11	Wed 8/31/11	40 hrs
478	Letters	Thu 9/1/11	Fri 9/30/11	40 hrs
479	Delegation Oversight forms	Mon 8/1/11	Wed 8/31/11	40 hrs
480	Audits	Mon 10/3/11	Mon 10/31/11	40 hrs
481	**Application Configuration**	**Wed 6/8/11**	**Tue 12/20/11**	**2,728 hrs**
482	**configuration**	**Wed 6/8/11**	**Thu 12/15/11**	**1,392 hrs**
483	WorkQueues	Tue 11/15/11	Mon 12/5/11	120 hrs
484	Letters	Thu 12/1/11	Thu 12/15/11	88 hrs
485	Fax server	Thu 12/1/11	Thu 12/15/11	88 hrs
486	Testing	Fri 12/9/11	Tue 12/20/11	64 hrs
487	On-line resource page	Thu 12/1/11	Thu 12/15/11	88 hrs
488	Audit Database	Tue 11/1/11	Thu 11/10/11	64 hrs
489	**Staffing**	**Tue 11/1/11**	**Tue 1/31/12**	**1,012 hrs**
490	Hire day 1 staff	Tue 11/1/11	Fri 12/9/11	60 hrs
491	Orientation/Training - Day 1 staff	Thu 12/1/11	Fri 12/30/11	176 hrs
492	Preceptor resources	Mon 11/21/11	Fri 12/30/11	40 hrs
493	Management buddy	Thu 12/1/11	Fri 12/9/11	56 hrs
494	Repetitive Hiring/Training process	Thu 1/5/12	Tue 1/31/12	152 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
495	**DHH approval**	**Thu 9/1/11**	**Mon 10/31/11**	**1,100 hrs**
496	Policies	Fri 9/2/11	Mon 10/31/11	404 hrs
497	Letters	Mon 10/3/11	Mon 10/31/11	352 hrs
498	**PreDelegation**	**Thu 9/1/11**	**Mon 10/31/11**	**704 hrs**
499	Assessment	Thu 9/1/11	Fri 9/30/11	176 hrs
500	Action Plan	Fri 9/30/11	Fri 10/14/11	88 hrs
501	Decision	Sat 10/15/11	Mon 10/31/11	96 hrs
502	**Credentialing**	**Wed 6/1/11**	**Tue 1/31/12**	**9,042 hrs**
503	**Program Design**	**Tue 11/1/11**	**Wed 11/30/11**	**778 hrs**
504	**Policies**	**Mon 8/1/11**	**Wed 8/31/11**	**424 hrs**
505	210.100 - Credentialing & Recredentialing	Mon 8/1/11	Wed 8/31/11	40 hrs
506	210.102 - Practitioners Requesting Dual Status	Mon 8/1/11	Wed 8/31/11	40 hrs
507	210.103 - Hospital & Ancillary Cred/Recred	Mon 8/1/11	Wed 8/31/11	40 hrs
508	210.104 - Hosp. & Ancillary Provider Site Visits	Mon 8/1/11	Wed 8/31/11	40 hrs
509	210.203 - Medicare/Medicaid Sanctions and Medicheck Bulletins	Mon 8/1/11	Wed 8/31/11	40 hrs
510	210.400 - Confidentiality of Cred. Information	Mon 8/1/11	Wed 8/31/11	40 hrs
511	Orientation program/plan	Tue 11/1/11	Thu 12/1/11	178 hrs
512	**Tools**	**Mon 8/1/11**	**Mon 10/31/11**	**1,240 hrs**
513	Provider materials	Thu 9/1/11	Fri 9/30/11	176 hrs
514	Workflows	Mon 8/1/11	Wed 8/31/11	184 hrs
515	Letters	Thu 9/1/11	Fri 9/30/11	176 hrs
516	Audits	Mon 10/3/11	Mon 10/31/11	176 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
517	**Application Configuration**	**Wed 6/1/11**	**Tue 12/20/11**	**3,160 hrs**
518	**configuration**	**Wed 6/1/11**	**Thu 12/15/11**	**1,608 hrs**
519	WorkQueues	Tue 11/15/11	Mon 12/5/11	120 hrs
520	Letters	Thu 12/1/11	Thu 12/15/11	88 hrs
521	Fax server	Thu 12/1/11	Thu 12/15/11	88 hrs
522	CAHQ/NPDB integration	Wed 6/1/11	Thu 6/30/11	176 hrs
523	Primary verification sources	Wed 6/1/11	Thu 6/30/11	176 hrs
524	Testing	Fri 12/9/11	Tue 12/20/11	64 hrs
525	On-line resource page	Thu 12/1/11	Thu 12/15/11	88 hrs
526	Audit Database	Tue 11/1/11	Thu 11/10/11	64 hrs
527	**Staffing**	**Tue 11/1/11**	**Tue 1/31/12**	**1,012 hrs**
528	Hire day 1 staff	Tue 11/1/11	Fri 12/9/11	60 hrs
529	Orientation/Training - Day 1 staff	Thu 12/1/11	Fri 12/30/11	176 hrs
530	Preceptor resources	Mon 11/21/11	Fri 12/30/11	40 hrs
531	Management buddy	Thu 12/1/11	Fri 12/9/11	56 hrs
532	Repetitive Hiring/Training process	Thu 1/5/12	Tue 1/31/12	152 hrs
533	**DHH approval**	**Thu 9/1/11**	**Mon 10/31/11**	**1,452 hrs**
534	Policies	Fri 9/2/11	Mon 10/31/11	404 hrs
535	Letters	Mon 10/3/11	Mon 10/31/11	352 hrs
536	**Nurse Line Integration**	**Fri 7/1/11**	**Wed 12/28/11**	**8,044 hrs**
537	**Planning**	**Fri 7/1/11**	**Wed 8/31/11**	**1,064 hrs**
538	Initial implementation teleconference (SironaHealth & client)	Fri 7/1/11	Fri 7/15/11	88 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
539	Identify implementation teams & contact information	Fri 7/1/11	Fri 7/15/11	88 hrs
540	Establish teleconference schedule	Fri 7/1/11	Fri 7/15/11	88 hrs
541	Establish start date	Mon 7/11/11	Mon 8/1/11	128 hrs
542	Prepare implementation schedule	Mon 7/11/11	Mon 8/1/11	128 hrs
543	Review implementation schedule	Mon 8/1/11	Mon 8/15/11	88 hrs
544	Finalize and approve implementation schedule	Mon 8/15/11	Wed 8/31/11	104 hrs
545	**Program Design**	**Mon 8/1/11**	**Wed 12/28/11**	**2,912 hrs**
546	Complete implementation information request forms	Mon 8/1/11	Mon 8/15/11	88 hrs
547	QA of completed information requests (Sirona)	Mon 8/15/11	Wed 8/31/11	104 hrs
548	Review and document call/work flow	Thu 9/1/11	Thu 9/15/11	88 hrs
549	**Rule Sets**	**Mon 8/15/11**	**Wed 11/30/11**	**1,432 hrs**
550	Review and document transaction rule sets	Thu 9/1/11	Thu 9/15/11	88 hrs
551	Build transaction rule sets	Thu 9/15/11	Fri 9/30/11	96 hrs
552	Clinical review of rule sets	Fri 9/30/11	Fri 10/14/11	88 hrs
553	Review and document outbound communication requirements	Mon 8/15/11	Thu 9/15/11	192 hrs
554	Build outbound communications rule sets	Tue 10/4/11	Mon 10/31/11	168 hrs
555	Review: work flow, transaction and outbound communications rules sets	Tue 11/1/11	Wed 11/30/11	176 hrs
556	**Account Set Up**	**Thu 12/1/11**	**Wed 12/28/11**	**336 hrs**
557	Internal QA of account set up	Thu 12/1/11	Mon 12/5/11	24 hrs
558	Final client review of account set up	Tue 12/6/11	Thu 12/15/11	64 hrs
559	Final account revisions	Thu 12/15/11	Tue 12/20/11	32 hrs
560	Test outbound communications	Tue 12/20/11	Wed 12/28/11	56 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
561	**Reporting**	**Mon 8/1/11**	**Mon 10/31/11**	**976 hrs**
562	Forward sample reports to client for review	Mon 8/1/11	Fri 8/5/11	40 hrs
563	Client report review	Fri 8/5/11	Mon 8/15/11	56 hrs
564	Development of custom reports as required	Thu 9/1/11	Fri 9/30/11	176 hrs
565	Client approval of final report design and report distribution	Mon 10/3/11	Mon 10/31/11	176 hrs
566	**Clinical Review**	**Thu 9/1/11**	**Mon 10/31/11**	**535 hrs**
567	Provide clinical content for review	Thu 9/1/11	Thu 9/15/11	25 hrs
568	Clinical sign content review and sign off	Mon 9/19/11	Mon 10/31/11	50 hrs
569	Provide sample triage encounter document	Thu 9/1/11	Mon 9/5/11	8 hrs
570	Triage encounter document sign off	Mon 9/19/11	Mon 10/31/11	50 hrs
571	Provide sample triage encounter document	Thu 9/1/11	Mon 9/5/11	8 hrs
572	Triage encounter document sign off	Mon 9/19/11	Mon 10/31/11	50 hrs
573	**Configuration**	**Thu 9/1/11**	**Thu 12/15/11**	**697 hrs**
574	Identify language(s) required and IVR requirements	Thu 9/1/11	Thu 9/15/11	25 hrs
575	Build call routing within SironaHealth phone switch	Mon 10/3/11	Mon 10/31/11	40 hrs
576	Test inbound calls and call routing	Thu 12/1/11	Mon 12/5/11	8 hrs
577	Client Test and Approve Front-End Greeting	Mon 12/5/11	Thu 12/15/11	16 hrs
578	**Technical Requirements**	**Thu 9/1/11**	**Wed 12/21/11**	**828 hrs**
579	Identify membership file data requirements & formats	Thu 9/1/11	Fri 9/30/11	40 hrs
580	Identify membership file transmission requirements	Thu 9/1/11	Fri 9/30/11	40 hrs
581	Build membership file transmission	Mon 10/3/11	Mon 10/31/11	40 hrs
582	Test membership file transmission	Tue 11/1/11	Tue 11/15/11	20 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
583	Revise membership transmission and load (as required)	Thu 12/1/11	Fri 12/9/11	15 hrs
584	Design and test monthly membership load process	Tue 11/15/11	Wed 11/30/11	25 hrs
585	Final Membership load	Tue 12/20/11	Wed 12/21/11	8 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**
589	Planning	Fri 6/17/11	Thu 6/30/11	80 hrs
590	Design	Fri 6/24/11	Thu 6/30/11	40 hrs
591	Development	Fri 7/1/11	Thu 7/14/11	80 hrs
592	Testing	Wed 7/20/11	Fri 7/22/11	40 hrs
593	Deployment	Thu 12/15/11	Thu 12/15/11	8 hrs
594	Stabilization	Thu 12/15/11	Mon 12/19/11	24 hrs
595	**Member Extract**	**Thu 6/16/11**	**Thu 12/15/11**	**142 hrs**
596	Planning	Thu 6/16/11	Mon 6/20/11	24 hrs
597	Design	Tue 6/21/11	Thu 6/23/11	24 hrs
598	Development	Fri 6/24/11	Thu 6/30/11	40 hrs
599	Testing	Mon 7/4/11	Fri 7/8/11	40 hrs
600	Deployment	Thu 12/15/11	Thu 12/15/11	6 hrs
601	Stabilization	Thu 12/15/11	Thu 12/15/11	8 hrs
602	**Provider Extract**	**Thu 6/16/11**	**Thu 12/15/11**	**142 hrs**
603	Planning	Thu 6/16/11	Mon 6/20/11	24 hrs
604	Design	Tue 6/21/11	Thu 6/23/11	24 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
605	Development	Fri 6/24/11	Thu 6/30/11	40 hrs
606	Testing	Mon 7/4/11	Fri 7/8/11	40 hrs
607	Deployment	Thu 12/15/11	Thu 12/15/11	6 hrs
608	Stabilization	Thu 12/15/11	Thu 12/15/11	8 hrs
609	**UM Load**	**Fri 6/17/11**	**Fri 12/16/11**	**268 hrs**
610	Planning	Fri 6/17/11	Fri 6/24/11	48 hrs
611	Design	Wed 6/29/11	Wed 7/6/11	48 hrs
612	Development	Thu 7/7/11	Wed 7/20/11	80 hrs
613	Testing	Thu 7/21/11	Wed 8/3/11	80 hrs
614	Deployment	Thu 12/15/11	Thu 12/15/11	6 hrs
615	Stabilization	Fri 12/16/11	Fri 12/16/11	6 hrs
616	**Clinical Criteria - McKesson**	**Fri 6/17/11**	**Fri 6/17/11**	**4 hrs**
617	Adjust Contract for new LoB	Fri 6/17/11	Fri 6/17/11	4 hrs
618	**Streamline Application**	**Thu 6/16/11**	**Thu 6/30/11**	**28 hrs**
619	Vendor Adjust ini to reflect new LoB	Thu 6/16/11	Thu 6/16/11	4 hrs
620	Testing	Fri 6/17/11	Fri 6/17/11	8 hrs
621	Deployment	Wed 6/29/11	Wed 6/29/11	8 hrs
622	Stabilization	Thu 6/30/11	Thu 6/30/11	8 hrs
623	**Visual Cactus Application**	**Wed 6/15/11**	**Thu 12/15/11**	**292 hrs**
624	**Addition of Entity**	**Wed 6/15/11**	**Fri 7/15/11**	**84 hrs**
625	Planning	Wed 6/15/11	Thu 6/16/11	16 hrs
626	Design	Fri 6/17/11	Fri 6/24/11	48 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
627	Development	Fri 7/1/11	Fri 7/1/11	8 hrs
628	Testing	Fri 7/8/11	Fri 7/8/11	4 hrs
629	Deployment	Fri 7/15/11	Fri 7/15/11	4 hrs
630	Stabilization	Fri 7/15/11	Fri 7/15/11	4 hrs
631	**LEMM Module**	**Wed 6/15/11**	**Thu 12/15/11**	**136 hrs**
632	Planning	Thu 6/16/11	Wed 6/22/11	40 hrs
633	Design	Wed 6/15/11	Wed 6/22/11	48 hrs
634	Development	Thu 6/30/11	Thu 6/30/11	8 hrs
635	Testing	Wed 7/6/11	Fri 7/8/11	24 hrs
636	Deployment	Thu 12/15/11	Thu 12/15/11	8 hrs
637	Stabilization	Thu 12/15/11	Thu 12/15/11	8 hrs
638	**Client Letter Application**	**Wed 6/22/11**	**Mon 8/1/11**	**72 hrs**
639	Identification of Templates	Wed 6/22/11	Wed 6/22/11	4 hrs
640	Identification of Source Data	Tue 6/28/11	Wed 6/29/11	16 hrs
641	Entry of Templates	Thu 6/30/11	Fri 7/1/11	16 hrs
642	Add CL Web to New Users Citrix Profile	Fri 7/15/11	Fri 7/15/11	4 hrs
643	Validate Templates	Thu 7/21/11	Fri 7/22/11	16 hrs
644	Deployment	Fri 7/29/11	Fri 7/29/11	8 hrs
645	Stabilization and close	Mon 8/1/11	Mon 8/1/11	8 hrs
646	**REPORTING**	**Wed 6/1/11**	**Fri 3/30/12**	**2,439 hrs**
647	**Ops Reporting/Informatics**	**Wed 6/15/11**	**Fri 8/26/11**	**200 hrs**
648	Review reporting requirements.	Wed 6/15/11	Fri 7/15/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
649	Determine which reports currently exist or exist in some version.	Wed 6/22/11	Fri 7/22/11	40 hrs
650	Determine which reports need to be created.	Mon 6/27/11	Fri 7/22/11	40 hrs
651	Determine which systems & data sources will be needed to produce the reports.	Fri 7/1/11	Fri 7/22/11	30 hrs
652	Testing of report production & validation of reports & data.	Mon 7/25/11	Fri 8/26/11	50 hrs
653	**Statutory Reporting**	**Mon 8/1/11**	**Thu 1/19/12**	**1,316 hrs**
654	Receive Reporting Requirements from DHH	Mon 8/1/11	Mon 8/1/11	16 hrs
655	**Identify reporting requirements**	**Tue 8/2/11**	**Mon 8/8/11**	**80 hrs**
656	Identify frequency of reports and due dates	Tue 8/2/11	Mon 8/8/11	20 hrs
657	Identify responsible area for reporting requirements	Tue 8/2/11	Mon 8/8/11	20 hrs
658	**Review Statutory Reports**	**Tue 8/9/11**	**Mon 9/19/11**	**420 hrs**
659	Identify/Resolve any issues pertaining to obtaining/reporting data	Tue 8/9/11	Mon 9/19/11	60 hrs
660	Identify/Resolve any access issues to systems containing data	Tue 8/9/11	Mon 9/19/11	60 hrs
661	Identify if IS resources are required for report development	Tue 8/9/11	Mon 9/19/11	60 hrs
662	**Report Development**	**Tue 9/20/11**	**Thu 1/19/12**	**800 hrs**
663	Develop specifications for report	Tue 9/20/11	Thu 1/19/12	20 hrs
664	Develop report	Tue 9/20/11	Thu 1/19/12	20 hrs
665	Analyze results	Tue 9/20/11	Thu 1/19/12	20 hrs
666	Receive approval/signoff from business area if applicable	Tue 9/20/11	Thu 1/19/12	20 hrs
667	**Actuarial Reporting**	**Wed 6/1/11**	**Fri 3/30/12**	**923 hrs**
668	Preliminary Financial Forecasting	Wed 6/1/11	Tue 8/30/11	60 hrs
669	Review State Reporting Requirements	Mon 8/8/11	Fri 8/12/11	15 hrs
670	Develop reports and processes	Tue 10/4/11	Fri 12/30/11	60 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
671	Review and test reporting	Sun 1/1/12	Fri 1/27/12	40 hrs
672	**Develop internal reports and processes:**	**Thu 12/1/11**	**Wed 2/29/12**	**708 hrs**
673	Lag Schedules/Reserves	Fri 12/2/11	Wed 2/29/12	60 hrs
674	Revenue Reports	Fri 12/2/11	Wed 2/29/12	60 hrs
675	Medical Cost Trending	Fri 12/2/11	Wed 2/29/12	60 hrs
676	Review and test reporting	Wed 2/29/12	Fri 3/30/12	40 hrs
677	**PROVIDER NETWORK MANAGEMENT**	**Mon 2/7/11**	**Thu 8/9/12**	**13,814 hrs**
678	**Identify and establish resources needed**	**Wed 2/9/11**	**Fri 7/15/11**	**2,368 hrs**
679	Establish and set up toll-free # and email address for AmeriHealth Mercy Provider Network	Wed 2/9/11	Wed 2/23/11	88 hrs
680	Hire network development lead and core expansion team.	Thu 2/10/11	Tue 3/8/11	152 hrs
681	Identify consulting-perm resources based in LA for short/long term needs.	Tue 3/1/11	Fri 4/1/11	192 hrs
682	Identify staffing needs post Award	Thu 6/16/11	Fri 7/15/11	184 hrs
683	**Train staff in accordance with DHH and Operational Requirements**	**Tue 3/1/11**	**Mon 5/2/11**	**1,752 hrs**
684	**Network Development**	**Mon 2/7/11**	**Fri 4/22/11**	**1,032 hrs**
685	Develop and approve Network Development Strategy Plan Summary	Mon 2/7/11	Wed 2/23/11	104 hrs
686	Create and distribute provider recruitment packet materials to providers	Wed 2/9/11	Wed 4/6/11	60 hrs
687	Develop provider agreement templates in accordance with regulatory (DHH, CMS and DOI), contractual and operational	Wed 2/9/11	Wed 3/23/11	308 hrs
688	Develop additional materials for AmeriHealth Mercy Provider Recruitment Packets	Wed 2/9/11	Wed 4/6/11	60 hrs
689	Determine credentialing options (i.e. CAQH, LA State App, company app)	Wed 2/16/11	Wed 2/23/11	88 hrs
690	Submit FINAL pieces for Provider Recruitment Packet to DHH for approval	Tue 2/22/11	Fri 4/22/11	412 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
691	**Create provider mailing lists**	**Wed 2/16/11**	**Fri 7/1/11**	**1,280 hrs**
692	Obtain and format DHH Provider Data to create statewide provider mailing list	Tue 3/1/11	Wed 3/23/11	272 hrs
693	Ensure providers selected include all DHH required services	Tue 3/1/11	Wed 3/23/11	272 hrs
694	Compile and compare provider datasets from key providers (we are working with directly) in order to make best efforts to exclude providers from unnecessary mailings	Wed 2/16/11	Wed 3/23/11	60 hrs
695	Identify providers in updated DHH file that were not in original mailing	Tue 4/12/11	Fri 6/17/11	452 hrs
696	Partner with medical associations and key advocates to identify and partner with key providers	Wed 2/23/11	Wed 3/2/11	48 hrs
697	Host and present at LMA/NOLA Dinner Meeting	Thu 2/24/11	Thu 2/24/11	8 hrs
698	Present in collaborative meeting with Louisiana American Academy of Pediatrics (LAAAP), Louisiana Academy of Family Physicians (LAFP), MedicineLouisiana,	Wed 4/20/11	Wed 4/20/11	8 hrs
699	Participate and sponsor March of Dimes event in Baton Rouge and New Orleans	Sat 4/30/11	Sat 4/30/11	0 hrs
700	Present and sponsor Louisiana Rural Hospital Coalition meeting	Mon 5/9/11	Tue 5/10/11	16 hrs
701	Sponsor and attend LMA Spring Meeting - Shreveport	Thu 6/2/11	Fri 6/3/11	16 hrs
702	Sponsor LA Quality Health Forum Meeting - Baton Rouge	Thu 6/9/11	Thu 6/9/11	8 hrs
703	Contract with Providers with completed Letters of Intent or Provider Agreements for RFP Submission	Tue 3/15/11	Wed 6/15/11	60 hrs
704	Identify and ensure outreach to STPs	Mon 5/23/11	Fri 7/1/11	60 hrs
705	**Identify and report provider data**	**Wed 2/16/11**	**Wed 6/15/11**	**400 hrs**
706	Identify provider data capture needs to satisfy regulatory, legal and operational needs	Wed 2/16/11	Fri 3/18/11	184 hrs
707	Create tracking mechanism for provider recruitment efforts, directory and reporting requirements.	Mon 2/28/11	Wed 4/6/11	60 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
708	Create Network Activity Report for Network Workgroup weekly reporting	Wed 3/30/11	Wed 4/6/11	48 hrs
709	Create Network Summary Report for Regional reporting	Wed 3/30/11	Wed 4/6/11	48 hrs
710	Create Network Provider Listing for RFP submission	Mon 4/11/11	Wed 6/15/11	60 hrs
711	**Ensure network adequacy**	**Mon 4/11/11**	**Fri 6/17/11**	**84 hrs**
712	Create GeoAccess maps for RFP Submission	Mon 4/11/11	Wed 6/15/11	60 hrs
713	Identify network gaps for additional contracting needs.	Wed 6/15/11	Fri 6/17/11	24 hrs
714	**Create provider directories**	**Wed 2/16/11**	**Tue 7/26/11**	**304 hrs**
715	Create Provider Directory template based on DHH and business requirements	Mon 5/23/11	Fri 7/1/11	280 hrs
716	Determine Physician Incentive Plans and/or Pay-for-Performance Plans	Wed 2/16/11	Wed 2/16/11	8 hrs
717	Support Medical Management efforts to create and implement Provider Council	Tue 7/26/11	Tue 7/26/11	8 hrs
718	Present plan ideas to council for collaborative meeting	Tue 7/26/11	Tue 7/26/11	8 hrs
719	**Outreach to Statewide Providers**	**Wed 2/16/11**	**Fri 6/17/11**	**716 hrs**
720	Partner with Regional Ancillary team to identify provider types handled on statewide level.	Wed 2/16/11	Wed 4/6/11	40 hrs
721	Partner with DHH Office of Public Health and establish LOI to enter into MOU with Public Health Departments.	Wed 3/23/11	Thu 6/9/11	516 hrs
722	Contact FQHCs to establish contracts where possible.	Mon 2/21/11	Fri 6/17/11	80 hrs
723	Confirm School Based contract requirements.	Wed 2/16/11	Wed 5/25/11	80 hrs
724	**Prepare for Readiness Review**	**Mon 4/4/11**	**Thu 9/1/11**	**3,920 hrs**
725	Document process flow for contract and credentialing requirements.	Mon 4/4/11	Fri 7/1/11	80 hrs
726	Develop Network Policies and Procedures in accordance with DHH and regulatory requirements	Mon 4/4/11	Fri 8/19/11	880 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
727	Access & Availability Standards	Mon 4/4/11	Fri 8/19/11	80 hrs
728	Provider Orientation	Mon 4/4/11	Fri 8/19/11	80 hrs
729	Provider Site Visits	Mon 4/4/11	Fri 8/19/11	80 hrs
730	Department Training	Mon 4/4/11	Fri 8/19/11	80 hrs
731	Department Functions	Mon 4/4/11	Fri 8/19/11	80 hrs
732	Provider Communication Process	Mon 4/4/11	Fri 8/19/11	80 hrs
733	Non - standard Contract Approval Process	Mon 4/4/11	Fri 8/19/11	80 hrs
734	Geo - Access	Mon 4/4/11	Fri 8/19/11	80 hrs
735	Cultural Needs and Preferences	Mon 4/4/11	Fri 8/19/11	80 hrs
736	Provider Application and Contracting Process	Mon 4/4/11	Fri 8/19/11	80 hrs
737	Provider Grievances	Mon 4/4/11	Fri 8/19/11	80 hrs
738	Investigation of potential quality issues	Mon 4/4/11	Fri 8/19/11	80 hrs
739	Network Development Policy	Mon 4/4/11	Fri 8/19/11	80 hrs
740	Provider Termination	Mon 4/4/11	Fri 8/19/11	80 hrs
741	Develop a DRAFT Provider Manual for DHH review and approval	Mon 4/11/11	Mon 8/1/11	728 hrs
742	Submit template provider directory to DHH	Mon 7/25/11	Tue 8/23/11	352 hrs
743	Submit Network Development Strategy Plan to DHH	Mon 8/15/11	Thu 9/1/11	224 hrs
744	Submit DRAFT Provider Manual for DHH review	Mon 8/15/11	Thu 9/1/11	224 hrs
745	Submit a copy of the Provider Training Manual training schedule to DHH for approval.	Mon 7/25/11	Thu 9/1/11	40 hrs
746	Create Provider Training Manual training schedule to DHH for approval.	Mon 7/25/11	Thu 9/1/11	272 hrs
747	**Prepare for Readiness Review-GSA A**	**Wed 3/30/11**	**Mon 1/30/12**	**1,688 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
748	Ensure network capacity and availability meet DHH standards	Wed 7/13/11	Fri 10/7/11	1,000 hrs
749	Create Network Provider and Subcontractor Registry listing of all contracted and credentialed Providers	Fri 9/23/11	Fri 10/7/11	88 hrs
750	Submit to DHH, a Network Provider and Subcontractor Registry listing of all contracted and credentialed Providers	Fri 9/23/11	Fri 10/7/11	176 hrs
751	Send provider data file to IT to create provider directory	Mon 10/10/11	Fri 10/28/11	128 hrs
752	Provide sufficient copies of final Provider Directory to the DHH's Enrollment Broker in sufficient time to meet the enrollment schedule.-GSA A	Tue 11/8/11	Tue 11/8/11	16 hrs
753	Send PCP Linkage File to IT to support reporting	Mon 11/7/11	Mon 11/7/11	8 hrs
754	Send PCP Linkage File to DHH-EB GSA A	Tue 11/8/11	Tue 11/8/11	16 hrs
755	**Provide training to all contracted providers**	**Thu 11/17/11**	**Fri 12/30/11**	**256 hrs**
756	Provide training to all providers and their staff regarding the requirements of the Contract, including limitations on provider marketing, and identification of special	Thu 11/17/11	Fri 12/30/11	256 hrs
757	**Prepare for Readiness Review-GSA B**	**Wed 6/15/11**	**Fri 3/30/12**	**1,202 hrs**
758	Ensure network capacity and availability meet DHH standards	Wed 8/31/11	Mon 11/7/11	500 hrs
759	Submit to DHH, a Network Provider and Subcontractor Registry listing of all contracted and credentialed Providers	Mon 11/7/11	Mon 11/7/11	16 hrs
760	Send provider data file to IT to create provider directory	Mon 12/5/11	Mon 12/5/11	8 hrs
761	Provide sufficient copies of final Provider Directory to the DHH's Enrollment Broker in sufficient time to meet the enrollment schedule.-GSA B	Tue 12/6/11	Fri 1/6/12	250 hrs
762	Send PCP Linkage File to IT to support reporting	Tue 12/6/11	Fri 12/16/11	72 hrs
763	Send PCP Linkage File to DHH-EB GSA B	Mon 12/19/11	Fri 1/6/12	256 hrs
764	**Provide training to all contracted providers**	**Mon 1/16/12**	**Fri 3/30/12**	**100 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
765	Provide training to all providers and their staff regarding the requirements of the Contract, including limitations on provider marketing, and identification of special	Mon 1/16/12	Fri 3/30/12	100 hrs
766	**Prepare for Readiness Review-GSA C**	**Wed 6/15/11**	**Fri 3/30/12**	**1,852 hrs**
767	Ensure network capacity and availability meet DHH standards	Wed 6/15/11	Mon 1/9/12	1,368 hrs
768	Submit to DHH, a Network Provider and Subcontractor Registry listing of all contracted and credentialed Providers	Mon 1/9/12	Mon 1/9/12	16 hrs
769	Send provider data file to IT to create provider directory	Mon 1/23/12	Thu 2/23/12	192 hrs
770	Provide sufficient copies of final Provider Directory to the DHH's Enrollment Broker in sufficient time to meet the enrollment schedule. - GSA C	Fri 2/24/12	Fri 3/9/12	176 hrs
771	**Provide training to all contracted providers**	**Mon 1/16/12**	**Fri 3/30/12**	**100 hrs**
772	Provide training to all providers and their staff regarding the requirements of the Contract, including limitations on provider marketing, and identification of special	Mon 1/16/12	Fri 3/30/12	100 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**
777	Obtain Vendor Layout	Thu 7/28/11	Mon 8/8/11	64 hrs
778	Obtain Vendor Data Source File(s)	Tue 8/9/11	Thu 8/18/11	64 hrs
779	Determine Feed Type	Fri 8/19/11	Wed 8/24/11	32 hrs
780	**Gap Analyses**	**Mon 8/1/11**	**Sat 10/15/11**	**448 hrs**
781	Perform Business Focus Gap Analysis (Profile)	Mon 8/1/11	Thu 9/1/11	192 hrs
782	Perform IS/IT Focus Gap Analysis	Fri 9/2/11	Fri 9/23/11	128 hrs
783	Build E2E Mapping Document	Mon 9/26/11	Sat 10/15/11	128 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
784	**Business Rules**	**Mon 10/17/11**	**Wed 10/26/11**	**64 hrs**
785	Determine new business rules, if any	Mon 10/17/11	Thu 10/20/11	32 hrs
786	Map new business rules in Data Intake (D)I	Fri 10/21/11	Wed 10/26/11	32 hrs
787	**Architecture Review**	**Thu 10/27/11**	**Mon 11/7/11**	**64 hrs**
788	Perform DISS Architecture Review	Thu 10/27/11	Tue 11/1/11	32 hrs
789	Perform MDWH Architecture Review	Wed 11/2/11	Mon 11/7/11	32 hrs
790	**Identify Impacted Objects**	**Tue 11/8/11**	**Thu 11/17/11**	**64 hrs**
791	Determine the DISS Objects to be modified for Implementation	Tue 11/8/11	Fri 11/11/11	32 hrs
792	Determine Objects that to be modified	Mon 11/14/11	Thu 11/17/11	32 hrs
793	**Documentation Requirements**	**Fri 8/12/11**	**Thu 1/5/12**	**990 hrs**
794	Review Business Requirements	Fri 11/18/11	Wed 11/23/11	32 hrs
795	Develop Combined DISS & DWH Functional Requirements (FR)	Thu 11/24/11	Tue 12/27/11	192 hrs
796	Review FR with DI Team	Wed 12/28/11	Sun 1/1/12	32 hrs
797	Revise FR	Wed 8/31/11	Mon 9/5/11	32 hrs
798	Distribute and obtain Business Stakeholders Signoff	Tue 9/6/11	Fri 10/28/11	30 hrs
799	**Revise DI & Data Warehouse (DWH) Systems**	**Fri 8/12/11**	**Thu 1/5/12**	**672 hrs**
800	Revise DI & DWH Systems	Fri 8/12/11	Fri 8/12/11	0 hrs
801	Revise DI & DWH Systems	Fri 8/26/11	Fri 8/26/11	0 hrs
802	Revise IBM WTX code	Fri 10/21/11	Fri 11/11/11	128 hrs
803	Revise Operational Console code	Mon 11/14/11	Thu 1/5/12	320 hrs
804	Revise DataStage Code	Tue 8/23/11	Thu 9/1/11	64 hrs
805	Revise Unix code / Scripts	Fri 9/2/11	Wed 9/7/11	32 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
806	Revise Business Objects Web-I	Wed 8/24/11	Mon 8/29/11	32 hrs
807	Revise Operational Guidance	Thu 8/25/11	Tue 8/30/11	32 hrs
808	Revise MDWH Load Ready DataStage code	Fri 8/26/11	Tue 9/6/11	64 hrs
809	**Unit & System Integration Testing (SIT)**	**Fri 8/12/11**	**Thu 9/29/11**	**1,349 hrs**
810	**Unit Test**	**Fri 8/12/11**	**Thu 9/22/11**	**705 hrs**
811	Execute Vendor file using each modified object	Fri 8/12/11	Thu 9/22/11	235 hrs
812	Revise object code	Fri 8/12/11	Thu 9/22/11	235 hrs
813	Validate results	Fri 8/12/11	Thu 9/22/11	235 hrs
814	**SIT**	**Mon 8/29/11**	**Thu 9/29/11**	**576 hrs**
815	Execute Vendor file via Revised DISS (pickup, accept, validate, generate LR's)	Mon 8/29/11	Thu 9/29/11	192 hrs
816	Revise code	Mon 8/29/11	Thu 9/29/11	192 hrs
817	Validate results	Mon 8/29/11	Thu 9/29/11	192 hrs
818	**DWH Testing**	**Wed 8/31/11**	**Fri 9/9/11**	**68 hrs**
819	Submit DISS generated LR files to DWH Group	Wed 8/31/11	Wed 8/31/11	4 hrs
820	Validate results	Wed 8/31/11	Fri 9/9/11	64 hrs
821	**Quality Assurance**	**Thu 9/1/11**	**Wed 2/1/12**	**896 hrs**
822	Migrate DISS and DWH code Objects to Testing environments	Thu 9/1/11	Mon 9/12/11	64 hrs
823	Perform User Acceptance Testing	Tue 9/13/11	Fri 12/30/11	640 hrs
824	Validate results	Sun 1/1/12	Fri 1/20/12	128 hrs
825	Log Test Results in Mercury QC	Mon 1/23/12	Wed 2/1/12	64 hrs
826	**Production Migration**	**Tue 9/27/11**	**Thu 10/6/11**	**128 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
827	Obtain Change Management Board Approval	Tue 9/27/11	Thu 10/6/11	64 hrs
828	Migrate DISS and DWH code Objects to Production environments	Thu 9/29/11	Tue 10/4/11	32 hrs
829	GO LIVE	Thu 9/29/11	Tue 10/4/11	32 hrs
830	**Historical Loads**	**Fri 9/30/11**	**Tue 1/17/12**	**640 hrs**
831	Process vendor Historical Load Set1	Fri 9/30/11	Tue 10/11/11	64 hrs
832	Business Validates Set 1	Wed 10/12/11	Tue 11/1/11	128 hrs
833	IS Team loads remaining Historical Load Sets	Wed 11/2/11	Tue 12/27/11	320 hrs
834	Notify Business Vendor data is available in the MDWH, DISS & BO	Wed 12/28/11	Thu 1/5/12	64 hrs
835	Project END --- DISS & MDWH Ready for Incremental files	Fri 1/6/12	Tue 1/17/12	64 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**
839	Enrollment	Mon 5/16/11	Mon 8/15/11	526 hrs
840	Provider Network Management	Mon 5/16/11	Mon 8/15/11	526 hrs
841	Claims Processing	Mon 5/16/11	Wed 7/27/11	421 hrs
842	Customer Service	Mon 5/16/11	Thu 6/2/11	105 hrs
843	Finance	Mon 5/16/11	Wed 7/27/11	421 hrs
844	Utilization Management	Tue 6/28/11	Fri 7/15/11	105 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**	**5,949 hrs**
847	**Enrollment**	**Mon 7/11/11**	**Fri 7/29/11**	**1,120 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
848	Enrollment file processing(Broker/Fiscal Intermediary)	Mon 6/13/11	Wed 6/29/11	112 hrs
849	PCP assignments	Mon 6/13/11	Wed 6/29/11	112 hrs
850	PCP Auto assignment	Mon 6/13/11	Wed 6/29/11	112 hrs
851	Inbound TPL	Mon 6/13/11	Wed 6/29/11	112 hrs
852	Outbound TPL	Mon 6/13/11	Wed 6/29/11	112 hrs
853	Maintenance of TPL information	Mon 6/13/11	Wed 6/29/11	112 hrs
854	Capitation processing (PCP, global subcontractor)	Mon 6/13/11	Wed 6/29/11	112 hrs
855	Real Time Eligibility	Mon 6/13/11	Wed 6/29/11	112 hrs
856	Outbound Eligibility	Mon 6/13/11	Wed 6/29/11	112 hrs
857	Member ID cards	Mon 6/13/11	Wed 6/29/11	112 hrs
858	**Provider Network Management**	**Mon 7/11/11**	**Mon 9/12/11**	**2,046 hrs**
859	Provider file processing	Mon 6/13/11	Tue 6/28/11	101 hrs
860	Provider recruiting	Mon 7/11/11	Mon 9/12/11	360 hrs
861	Network Adequacy	Mon 7/11/11	Mon 9/12/11	360 hrs
862	Provider file maintenance	Mon 7/11/11	Mon 9/12/11	360 hrs
863	Pay For Performance	Mon 6/13/11	Tue 6/28/11	101 hrs
864	Provider directory	Mon 6/13/11	Tue 6/28/11	101 hrs
865	Panel roster	Mon 6/13/11	Tue 6/28/11	101 hrs
866	Capitation roster	Mon 6/13/11	Tue 6/28/11	101 hrs
867	Outbound Provider Extracts	Mon 7/11/11	Thu 7/28/11	101 hrs
868	Claim remittance advice	Mon 7/11/11	Mon 9/12/11	360 hrs
869	**Claims Processing**	**Mon 7/11/11**	**Mon 9/12/11**	**1,570 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
870	Paper Claims intake	Mon 6/13/11	Wed 6/29/11	110 hrs
871	Medicare Crossover	Mon 7/11/11	Mon 9/12/11	360 hrs
872	Clinical Editing	Mon 6/13/11	Wed 6/29/11	110 hrs
873	Claims adjudication	Mon 6/13/11	Wed 6/29/11	110 hrs
874	COB processing	Mon 6/13/11	Wed 6/29/11	110 hrs
875	Electronic COB Processing from EDI Claims	Mon 6/13/11	Wed 6/29/11	110 hrs
876	Cost Containment	Mon 6/13/11	Wed 6/29/11	110 hrs
877	EPSDT claims processing	Mon 6/13/11	Wed 6/29/11	110 hrs
878	Claims auditing	Mon 6/13/11	Wed 6/29/11	110 hrs
879	Subrogation	Mon 6/13/11	Wed 6/29/11	110 hrs
880	DRG Grouper	Mon 6/13/11	Wed 6/29/11	110 hrs
881	Matkick	Mon 6/13/11	Wed 6/29/11	110 hrs
882	**Customer Service**	**Mon 7/11/11**	**Fri 7/22/11**	**201 hrs**
883	Member Call Center	Mon 6/13/11	Thu 6/23/11	67 hrs
884	Provider Call Center	Mon 6/13/11	Thu 6/23/11	67 hrs
885	Provider Claim Services	Mon 6/13/11	Thu 6/23/11	67 hrs
886	**Finance**	**Mon 7/11/11**	**Wed 8/3/11**	**810 hrs**
887	Capitation processing (PCP, global subcontractor)	Mon 7/11/11	Wed 8/3/11	135 hrs
888	1099 processing	Mon 6/13/11	Mon 7/4/11	135 hrs
889	Member Premium Billing	Mon 6/13/11	Mon 7/4/11	135 hrs
890	Produce claims checks	Mon 6/13/11	Mon 7/4/11	135 hrs
891	EFT	Mon 6/13/11	Mon 7/4/11	135 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
892	ERA	Mon 6/13/11	Mon 7/4/11	135 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**	**1,200 hrs**
895	Enrollment	Mon 10/17/11	Fri 11/25/11	240 hrs
896	Provider Network Management	Mon 10/17/11	Fri 11/25/11	240 hrs
897	Claims Processing	Mon 10/17/11	Fri 11/25/11	240 hrs
898	Customer Service	Mon 10/17/11	Fri 11/25/11	240 hrs
899	Finance	Mon 10/17/11	Fri 11/25/11	240 hrs
900	Deploy to QA/UAT	Mon 11/28/11	Tue 11/29/11	16 hrs
901	QA/UAT Testing Support	Wed 11/30/11	Mon 1/9/12	480 hrs
902	Go Live Preparation & Readiness Resolution	Tue 1/10/12	Mon 1/30/12	240 hrs
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**
906	Create LA DWH Schema from Standard Model	Fri 7/1/11	Mon 7/4/11	16 hrs
907	Copy Standard Model DWH Tables to LA Schema	Mon 7/4/11	Wed 7/6/11	16 hrs
908	Incorporate LA Requirements into LA Schema	Wed 7/6/11	Fri 7/8/11	16 hrs
909	Create Standard model Data Stage components to LA DS Groupings	Mon 7/11/11	Mon 7/11/11	8 hrs
910	Copy Standard Model Data Stage components to LA DS Groupings	Tue 7/12/11	Wed 7/13/11	16 hrs
911	Incorporate LA Requirements into LA DS components	Thu 7/14/11	Fri 7/15/11	16 hrs
912	Create Standard Job Groupings from STD Model	Mon 7/18/11	Mon 7/18/11	8 hrs
913	Unit Test Jobs to meet requirements	Tue 7/19/11	Thu 7/21/11	24 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
914	Make needed changes	Fri 7/22/11	Thu 7/28/11	40 hrs
915	Prepare Job Documentation	Tue 7/19/11	Thu 7/21/11	24 hrs
916	Prepare Documentation for LA Migration to UAT via TRC	Fri 7/22/11	Fri 7/22/11	8 hrs
917	Migrate to UAT	Fri 7/29/11	Fri 7/29/11	8 hrs
918	**User Acceptance Testing (UAT)**	**Mon 8/1/11**	**Tue 9/20/11**	**176 hrs**
919	UAT Test by Job Groupings	Mon 8/1/11	Wed 8/3/11	24 hrs
920	Make required changes	Fri 8/5/11	Fri 8/5/11	16 hrs
921	Restart UAT from beginning if changes made	Tue 8/9/11	Tue 8/9/11	0 hrs
922	Seek UAT Approval	Wed 8/17/11	Thu 8/18/11	24 hrs
923	DWH UAT Env Ready for testing (Facets Dependency)	Mon 9/5/11	Mon 9/5/11	0 hrs
924	Get Feedback from other Groups Testing	Mon 9/5/11	Mon 9/12/11	40 hrs
925	Make required changes	Mon 9/12/11	Wed 9/14/11	24 hrs
926	Prep for move to PROD via CMB	Wed 9/14/11	Thu 9/15/11	24 hrs
927	Obtain CMB Approval	Thu 9/15/11	Mon 9/19/11	16 hrs
928	Move LA Processing Package to PROD	Mon 9/19/11	Tue 9/20/11	8 hrs
929	**Start Readiness Cycle**	**Fri 9/2/11**	**Fri 12/30/11**	**1,168 hrs**
930	Run Readiness Cycles as needed	Fri 9/2/11	Mon 10/31/11	344 hrs
931	Support Readiness Cycles	Mon 10/3/11	Mon 10/31/11	344 hrs
932	Make Changes to be Ready for PROD Deployment	Mon 9/12/11	Thu 10/20/11	240 hrs
933	Convert Post Adjudicated Claims and Subcons & Load DWH	Mon 12/12/11	Fri 12/30/11	240 hrs
934	**Ready for Go Live**	**Tue 11/1/11**	**Mon 12/12/11**	**352 hrs**
935	Support Start-up Processing as required	Tue 11/1/11	Mon 12/12/11	352 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
936	**Go Live**	**Sun 1/1/12**	**Thu 2/9/12**	**240 hrs**
937	Support PROD Cycles as required	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**
943	837P	Thu 6/16/11	Tue 6/28/11	80 hrs
944	837I	Wed 6/29/11	Tue 7/12/11	80 hrs
945	835	Thu 6/16/11	Tue 6/28/11	80 hrs
946	834	Wed 6/29/11	Tue 7/12/11	80 hrs
947	820	Wed 7/13/11	Tue 7/26/11	80 hrs
948	EDI FAQS	Wed 7/13/11	Tue 7/26/11	80 hrs
949	Health Plan web page EDI Update	Wed 7/27/11	Tue 8/9/11	80 hrs
950	837I Matkick	Thu 6/30/11	Wed 7/6/11	40 hrs
951	835 Matkick	Tue 2/8/11	Mon 2/14/11	40 hrs
952	**Development (EDI maps)**	**Tue 2/15/11**	**Tue 8/16/11**	**500 hrs**
953	EDI mapping 837 professional	Wed 6/29/11	Tue 7/12/11	80 hrs
954	EDI mapping 837 institutional	Wed 7/13/11	Tue 7/26/11	80 hrs
955	EDI mapping 835	Wed 6/29/11	Tue 7/12/11	80 hrs
956	EDI mapping 834	Wed 7/13/11	Tue 7/26/11	80 hrs
957	EDI mapping 820	Wed 7/27/11	Fri 8/5/11	60 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
958	EDI mapping 837I Matkick	Thu 7/7/11	Mon 7/18/11	60 hrs
959	EDI mapping 835 Matkick	Tue 2/15/11	Thu 2/24/11	60 hrs
960	**Development (Sybase/NET)**	**Wed 6/29/11**	**Fri 9/2/11**	**608 hrs**
961	Set up file intake process (ftp, archiving, etc)	Wed 6/29/11	Tue 7/12/11	80 hrs
962	Build Tidal jobs (automation)	Wed 6/29/11	Tue 7/12/11	80 hrs
963	Pre-edi load	Wed 6/29/11	Fri 7/8/11	60 hrs
964	EDI load	Wed 6/29/11	Wed 6/29/11	8 hrs
965	Post edi load	Wed 6/29/11	Fri 7/8/11	60 hrs
966	Member crosswalk	Mon 7/11/11	Fri 7/15/11	40 hrs
967	Provider crosswalk	Mon 7/18/11	Fri 7/29/11	80 hrs
968	Acknowledgment Process	Mon 8/1/11	Fri 8/12/11	80 hrs
969	ED reconciliation reports	Mon 8/15/11	Wed 8/24/11	60 hrs
970	NPI mismatch reports	Fri 9/2/11	Fri 9/2/11	60 hrs
971	**QA / UAT Testing**	**Mon 9/5/11**	**Fri 11/4/11**	**362 hrs**
972	Deploy testing support	Mon 9/5/11	Mon 9/5/11	2 hrs
973	QA/UAT testing support	Mon 9/5/11	Wed 9/14/11	120 hrs
974	UAT Testing	Mon 10/17/11	Fri 11/4/11	240 hrs
975	**Production Deployment**	**Mon 11/7/11**	**Mon 11/7/11**	**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	1 hr
978	Deploy to production	Mon 11/7/11	Mon 11/7/11	4 hrs
979	**FACETS CONFIGURATION**	**Mon 6/20/11**	**Wed 3/7/12**	**8,035 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
980	**Data Gathering Requirements dependencies**	**Mon 6/20/11**	**Mon 8/1/11**	**33 hrs**
981	Provider files (PCP, Specialists, Facilities,)	Mon 8/1/11	Mon 8/1/11	3 hrs
982	Membership files/Classification/Demographic	Mon 6/20/11	Mon 6/20/11	3 hrs
983	Membership files/Classification/Demographic	Mon 6/20/11	Mon 6/20/11	3 hrs
984	Define Plan Benefits including limitations & copay's, Carve outs and service exclusions	Mon 8/1/11	Mon 8/1/11	3 hrs
985	Review Inbound Data element edit requirements (ACS/EDI)	Mon 6/20/11	Mon 6/20/11	3 hrs
986	State Provider Specialty Types/Provider Types	Mon 6/20/11	Mon 6/20/11	3 hrs
987	Auth/Referral requirements/UM Service Groups	Mon 6/20/11	Mon 6/20/11	3 hrs
988	Provider Contracts/Agreements	Mon 6/20/11	Mon 6/20/11	3 hrs
989	State Fee Schedule	Mon 6/20/11	Mon 6/20/11	3 hrs
990	Financial Reporting Structure	Mon 6/20/11	Mon 6/20/11	3 hrs
991	Define Security Requirements/Profiles	Mon 6/20/11	Mon 6/20/11	3 hrs
992	**Technical Requirements**	**Mon 6/27/11**	**Mon 7/11/11**	**32 hrs**
993	Obtain access to new 4.61 'DEV' environment	Mon 6/27/11	Mon 6/27/11	8 hrs
994	Validate Facets system functionality	Mon 6/27/11	Mon 6/27/11	8 hrs
995	Validate Citrix service setup and access	Tue 6/28/11	Tue 6/28/11	8 hrs
996	Installation of Network pricing	Mon 7/11/11	Mon 7/11/11	8 hrs
997	**Finance**	**Fri 7/1/11**	**Mon 10/3/11**	**856 hrs**
998	Set up Bank Account	Tue 8/2/11	Mon 8/8/11	40 hrs
999	G/L Accounting Mapping	Tue 8/2/11	Mon 8/8/11	40 hrs
1000	Payer	Tue 8/2/11	Mon 8/8/11	40 hrs
1001	Accounting Period	Tue 8/2/11	Mon 8/8/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1002	Accounting Description	Tue 8/2/11	Mon 8/8/11	40 hrs
1003	LOB	Tue 8/2/11	Mon 8/8/11	40 hrs
1004	Bank Data	Tue 8/2/11	Mon 8/8/11	40 hrs
1005	PCP Capitation	Tue 8/2/11	Thu 9/1/11	184 hrs
1006	Subcon Capitation	Tue 8/2/11	Fri 9/2/11	192 hrs
1007	General Ledger	Tue 8/2/11	Mon 10/3/11	40 hrs
1008	Billing Group (Non applicable)	Tue 8/2/11	Mon 10/3/11	40 hrs
1009	Premium Rate Table	Tue 8/2/11	Mon 10/3/11	40 hrs
1010	Billing Component	Tue 8/2/11	Mon 10/3/11	40 hrs
1011	Billing Entity	Tue 8/2/11	Mon 10/3/11	40 hrs
1012	**Facets Configuration Requirements/SA**	**Tue 8/2/11**	**Wed 8/3/11**	**80 hrs**
1013	Auto Numbering	Tue 8/2/11	Wed 8/3/11	16 hrs
1014	Member (if applicable)	Tue 8/2/11	Wed 8/3/11	16 hrs
1015	Provider	Tue 8/2/11	Wed 8/3/11	16 hrs
1016	Claims	Tue 8/2/11	Wed 8/3/11	16 hrs
1017	Authorizations (if applicable)	Tue 8/2/11	Wed 8/3/11	16 hrs
1018	**Providers**	**Tue 8/2/11**	**Fri 10/21/11**	**304 hrs**
1019	Network	Tue 8/2/11	Tue 8/2/11	8 hrs
1020	Network Set	Tue 8/2/11	Tue 8/2/11	8 hrs
1021	Covering Provider Set Prefix	Tue 8/2/11	Tue 8/2/11	8 hrs
1022	Load provider records	Tue 8/2/11	Fri 10/21/11	40 hrs
1023	Attach agreements	Tue 8/2/11	Fri 10/21/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1024	Capitation Load to Providers	Tue 8/2/11	Fri 10/21/11	40 hrs
1025	Common Prac	Tue 8/2/11	Fri 10/21/11	40 hrs
1026	Group	Tue 8/2/11	Fri 10/21/11	40 hrs
1027	Facility	Tue 8/2/11	Fri 10/21/11	40 hrs
1028	Practitioners	Tue 8/2/11	Fri 10/21/11	40 hrs
1029	**User Defined Codes**	**Tue 8/2/11**	**Fri 10/21/11**	**1,416 hrs**
1030	Provider Specialties	Tue 8/2/11	Fri 8/26/11	152 hrs
1031	Provider Types	Tue 8/2/11	Fri 8/26/11	152 hrs
1032	Providers/Networks	Tue 8/2/11	Fri 10/21/11	40 hrs
1033	Agreement Types	Tue 8/2/11	Fri 10/21/11	40 hrs
1034	Room Types	Tue 8/2/11	Fri 8/26/11	152 hrs
1035	Service Setting	Tue 8/2/11	Fri 8/26/11	152 hrs
1036	Termination Reasons	Tue 8/2/11	Fri 10/21/11	40 hrs
1037	Claims Status Reasons	Tue 8/2/11	Fri 10/21/11	40 hrs
1038	Member Benefit/Plan codes	Tue 8/2/11	Fri 8/26/11	152 hrs
1039	User Warning Messages	Tue 8/2/11	Fri 10/21/11	40 hrs
1040	Capitation	Tue 8/2/11	Fri 8/26/11	152 hrs
1041	Subscriber Member Defined Codes	Tue 8/2/11	Fri 8/26/11	152 hrs
1042	Language	Tue 8/2/11	Fri 8/26/11	152 hrs
1043	**Membership**	**Tue 8/2/11**	**Sat 10/15/11**	**240 hrs**
1044	Group set up	Tue 8/2/11	Sat 10/15/11	40 hrs
1045	Class/Plan set up	Tue 8/2/11	Sat 10/15/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1046	Plan Descriptions	Tue 8/2/11	Sat 10/15/11	40 hrs
1047	COB Carriers	Tue 8/2/11	Sat 10/15/11	40 hrs
1048	Load Membership files	Tue 8/2/11	Sat 10/15/11	40 hrs
1049	Membership Structure	Tue 8/2/11	Sat 10/15/11	40 hrs
1050	**Benefits**	**Tue 8/2/11**	**Mon 9/26/11**	**1,384 hrs**
1051	Plan Descriptions	Tue 8/2/11	Mon 9/26/11	40 hrs
1052	Accumulator Description	Tue 8/2/11	Mon 9/26/11	40 hrs
1053	Diagnosis Codes	Tue 8/2/11	Mon 9/26/11	40 hrs
1054	Clinical Editing Admin Rules	Tue 8/2/11	Mon 9/26/11	40 hrs
1055	Clinical Edit Default Exceptions	Tue 8/2/11	Wed 8/3/11	16 hrs
1056	Clinical Editing Criteria	Tue 8/2/11	Mon 9/26/11	40 hrs
1057	Limit Rules	Tue 8/2/11	Mon 9/26/11	40 hrs
1058	Medical Utilization Edits	Tue 8/2/11	Mon 9/26/11	40 hrs
1059	Diagnosis Edit Criteria	Tue 8/2/11	Mon 9/26/11	40 hrs
1060	Same Day Follow Up procedures	Tue 8/2/11	Mon 9/26/11	40 hrs
1061	Clinical Organ Disease Panel	Tue 8/2/11	Mon 9/26/11	40 hrs
1062	Service Related Parameters	Tue 8/2/11	Mon 9/26/11	40 hrs
1063	Service Rule Definitions	Tue 8/2/11	Mon 9/26/11	40 hrs
1064	Service Definition	Tue 8/2/11	Mon 9/26/11	40 hrs
1065	Explanation Codes	Tue 8/2/11	Mon 9/26/11	40 hrs
1066	Warning Messages	Tue 8/2/11	Mon 9/26/11	40 hrs
1067	Procedure Codes-Modifiers	Tue 8/2/11	Mon 9/26/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1068	Product Category	Tue 8/2/11	Mon 9/26/11	40 hrs
1069	Component Descriptions	Tue 8/2/11	Mon 9/26/11	40 hrs
1070	Service ID descriptions	Tue 8/2/11	Mon 9/26/11	40 hrs
1071	Service/Procedure Conversion	Tue 8/2/11	Mon 9/26/11	40 hrs
1072	Service/Revenue Conversion	Tue 8/2/11	Mon 9/26/11	40 hrs
1073	Product Shell	Tue 8/2/11	Mon 9/26/11	40 hrs
1074	Group Administration Rules/Stop Ages/Waiting Periods	Tue 8/2/11	Mon 9/26/11	40 hrs
1075	Service Conversion description	Tue 8/2/11	Mon 9/26/11	40 hrs
1076	Supplemental Procedure Conversion	Tue 8/2/11	Mon 9/26/11	40 hrs
1077	Supplemental Revenue Conversion	Tue 8/2/11	Mon 9/26/11	40 hrs
1078	Administrative Rules	Tue 8/2/11	Mon 9/26/11	40 hrs
1079	Administrative Information	Tue 8/2/11	Mon 9/26/11	40 hrs
1080	COB Rules	Tue 8/2/11	Mon 9/26/11	40 hrs
1081	Co-pay (if applicable)	Tue 8/2/11	Mon 9/26/11	40 hrs
1082	Claim to UM Match Parameters	Tue 8/2/11	Mon 9/26/11	40 hrs
1083	Service Payment	Tue 8/2/11	Mon 9/26/11	40 hrs
1084	Benefit Summary	Tue 8/2/11	Mon 9/26/11	40 hrs
1085	Conversion Factor	Tue 8/2/11	Tue 8/2/11	8 hrs
1086	Unit Value Price Def	Tue 8/2/11	Mon 9/26/11	40 hrs
1087	**Agreements**	**Tue 8/2/11**	**Fri 10/21/11**	**440 hrs**
1088	R & C Schedule	Tue 8/2/11	Fri 10/21/11	40 hrs
1089	DRG Rules	Tue 8/2/11	Fri 10/21/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1090	DRG Profile	Tue 8/2/11	Fri 10/21/11	40 hrs
1091	Exclusions	Tue 8/2/11	Fri 10/21/11	40 hrs
1092	Fee Schedule Profile	Tue 8/2/11	Fri 10/21/11	40 hrs
1093	Stop loss	Tue 8/2/11	Fri 10/21/11	40 hrs
1094	ASC Multiple Procedures	Tue 8/2/11	Fri 10/21/11	40 hrs
1095	Auto Room Type	Tue 8/2/11	Fri 10/21/11	40 hrs
1096	Room Type Profile	Tue 8/2/11	Fri 10/21/11	40 hrs
1097	Procedure	Tue 8/2/11	Fri 10/21/11	40 hrs
1098	Service Pricing	Tue 8/2/11	Fri 10/21/11	40 hrs
1099	**Claims Processing**	**Tue 8/2/11**	**Fri 8/12/11**	**520 hrs**
1100	Processing Control Area	Tue 8/2/11	Fri 8/12/11	72 hrs
1101	Clinical Editing	Tue 8/2/11	Fri 8/12/11	72 hrs
1102	Warning messages	Tue 8/2/11	Fri 8/12/11	72 hrs
1103	Interest Calculation	Tue 8/2/11	Fri 8/12/11	72 hrs
1104	Modifier Hierarchy	Tue 8/2/11	Fri 8/12/11	72 hrs
1105	Duplicate Claim Rules	Tue 8/2/11	Wed 8/3/11	16 hrs
1106	System Codes	Tue 8/2/11	Fri 8/12/11	72 hrs
1107	Warning Messages	Tue 8/2/11	Fri 8/12/11	72 hrs
1108	**Utilization Management**	**Tue 8/2/11**	**Wed 8/10/11**	**224 hrs**
1109	UM Service Groups	Tue 8/2/11	Wed 8/10/11	56 hrs
1110	Duplicate UM Rules	Tue 8/2/11	Wed 8/10/11	56 hrs
1111	Confinement Service Set up	Tue 8/2/11	Wed 8/10/11	56 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1112	User Warning Messages	Tue 8/2/11	Wed 8/10/11	56 hrs
1113	**Testing**	**Mon 10/24/11**	**Fri 12/2/11**	**1,912 hrs**
1114	Membership Load	Mon 10/24/11	Thu 12/1/11	232 hrs
1115	Provider Load	Mon 10/24/11	Fri 12/2/11	240 hrs
1116	Auth/Referral requirements	Mon 10/24/11	Fri 12/2/11	240 hrs
1117	Claims Adjudication	Mon 10/24/11	Fri 12/2/11	240 hrs
1118	Reimbursement including G/L interface	Mon 10/24/11	Fri 12/2/11	240 hrs
1119	Capitation	Mon 10/24/11	Fri 12/2/11	240 hrs
1120	Capitation Panel Rosters	Mon 10/24/11	Fri 12/2/11	240 hrs
1121	Facilitate IS testing requirements	Mon 10/24/11	Fri 12/2/11	240 hrs
1122	**Training**	**Mon 11/28/11**	**Wed 11/30/11**	**48 hrs**
1123	Schedule training sessions for Configuration staff	Mon 12/5/11	Wed 12/7/11	24 hrs
1124	Develop training materials	Mon 12/5/11	Wed 12/7/11	24 hrs
1125	**Production Readiness**	**Mon 12/5/11**	**Tue 12/20/11**	**96 hrs**
1126	Participate in Deployment functions	Mon 12/5/11	Mon 12/12/11	48 hrs
1127	Validate configuration system functionality	Tue 12/13/11	Tue 12/20/11	48 hrs
1128	**Stabilization Process**	**Wed 12/21/11**	**Wed 3/7/12**	**450 hrs**
1129	Begin daily Facets Operations processes (Work requests (Tracer) process)	Wed 12/21/11	Wed 1/4/12	90 hrs
1130	Test	Wed 1/4/12	Thu 1/19/12	90 hrs
1131	Perform audit functions	Thu 1/19/12	Fri 2/3/12	90 hrs
1132	Document changes	Fri 2/3/12	Mon 2/20/12	90 hrs
1133	Deploy Changes	Tue 2/21/12	Wed 3/7/12	90 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
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
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**
1138	Develop Functional Specs per State Companion Guide	Wed 6/1/11	Tue 6/14/11	80 hrs
1139	Config Build Process	Wed 6/15/11	Mon 6/27/11	80 hrs
1140	Config Initial Submit Process	Wed 6/29/11	Tue 7/12/11	80 hrs
1141	Config Multiple builds	Wed 7/13/11	Tue 7/26/11	80 hrs
1142	**Selection criteria**	**Wed 6/15/11**	**Tue 6/21/11**	**40 hrs**
1143	Create scripts to select claims for Louisiana from DWH	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**
1145	a- Submit file as initial encounters	Wed 6/15/11	Tue 6/21/11	40 hrs
1146	b- Resubmission processing of rejected claims	Wed 6/15/11	Mon 6/27/11	80 hrs
1147	**Config void & adjustment processes**	**Wed 6/15/11**	**Mon 6/27/11**	**160 hrs**
1148	Config auto void process	Wed 6/15/11	Mon 6/27/11	80 hrs
1149	Config manual void process	Wed 6/15/11	Mon 6/27/11	80 hrs
1150	**Pre-submission process**	**Wed 6/15/11**	**Tue 6/21/11**	**80 hrs**
1151	Identify validation rules	Wed 6/15/11	Tue 6/21/11	40 hrs
1152	Config process to validate provider and member data	Wed 6/15/11	Tue 6/21/11	40 hrs
1153	**Pre-readiness testing**	**Mon 9/5/11**	**Mon 9/26/11**	**420 hrs**
1154	Roll up claims	Wed 6/15/11	Fri 6/24/11	60 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1155	837 Professional	Wed 6/15/11	Mon 7/4/11	120 hrs
1156	837 Institutional	Thu 6/16/11	Tue 7/5/11	120 hrs
1157	Subcon Data (incorporated into our internal build based on DWH input data)	Wed 6/15/11	Mon 7/4/11	120 hrs
1158	**Create file tracking & monthly control file**	**Wed 6/15/11**	**Tue 8/9/11**	**240 hrs**
1159	Update file tracking tables	Wed 6/15/11	Mon 6/27/11	80 hrs
1160	Config monthly control file containing data required by Louisiana	Wed 6/15/11	Mon 6/27/11	80 hrs
1161	Config automated process to create monthly control file	Wed 7/27/11	Tue 8/9/11	80 hrs
1162	Readiness Test	Mon 9/26/11	Fri 10/28/11	200 hrs
1163	**Phase 2 - Corrections & Production Prep**	**Fri 10/28/11**	**Fri 11/25/11**	**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**
1166	Update audit table for reconciliation	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**
1168	Config to receive and process acknowledge (997) file	Thu 9/15/11	Mon 9/19/11	24 hrs
1169	Config to receive and process pre-edit files (TA1)	Thu 9/15/11	Mon 9/19/11	24 hrs
1170	Config to receive and process response file (835) file	Thu 9/15/11	Mon 9/19/11	24 hrs
1171	Process State reports	Thu 9/15/11	Mon 9/19/11	24 hrs
1172	Config split the internal and subcon files	Thu 9/15/11	Mon 9/19/11	24 hrs
1173	Config send subcon response files to subcons	Thu 9/15/11	Mon 9/19/11	24 hrs
1174	Config to process rebound and report files to ensure efficient Post-Submission corrections (835)	Thu 9/15/11	Wed 10/12/11	160 hrs
1175	**Reconciliation process for encounters**	**Fri 10/28/11**	**Fri 11/25/11**	**480 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
1176	Reconciliation of reported encounters to processed claims	Thu 9/15/11	Wed 10/12/11	160 hrs
1177	Configure reconciliation process for all claims processed and submitted to achieve near 100% acceptance rate	Thu 9/15/11	Wed 9/21/11	40 hrs
1178	Track all claims submitted denoting the rejections and reporting to the state why these claims were rejected to achieve the 100% acceptance rate	Thu 9/15/11	Wed 9/21/11	40 hrs
1179	**Second Reconciliation**	**Fri 10/28/11**	**Fri 11/11/11**	**120 hrs**
1180	Reconcile all submitted against all accepted	Fri 10/28/11	Fri 11/11/11	80 hrs
1181	Reconcile with 100% of reported claims and accept/reject status	Fri 10/28/11	Fri 11/4/11	40 hrs
1182	**Encounters tracking**	**Fri 10/28/11**	**Fri 11/11/11**	**120 hrs**
1183	Designate all claims either accepted or rejected in Audit	Fri 10/28/11	Fri 11/11/11	80 hrs
1184	Must log and report all claims that are "non-reparable"	Fri 10/28/11	Fri 11/4/11	40 hrs
1185	**Phase 3 - Final QA**	**Fri 11/25/11**	**Fri 12/2/11**	**120 hrs**
1186	Finalize HIPPA certification	Fri 11/25/11	Fri 12/2/11	40 hrs
1187	Systems Integration & Final QA with DHH	Fri 11/25/11	Fri 12/2/11	80 hrs
1188	**Phase 4 - Deployment & Stabilization**	**Thu 1/12/12**	**Mon 3/19/12**	**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**
1191	Prep and Submit First Production Encounters Files to DHH	Tue 1/31/12	Mon 2/13/12	160 hrs
1192	Post DHH response files; identify problematic claims and claims that have been coded as rejections for certain reasons	Tue 2/14/12	Mon 2/27/12	160 hrs
1193	Coordinate with plan personnel to review rejected encounters and decipher which high volume providers need to be addressed either by education or some	Tue 2/28/12	Mon 3/12/12	80 hrs
1194	Finalize automation of archive files	Tue 3/13/12	Thu 3/15/12	20 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1195	Finalize automation of routine production schedule	Thu 3/15/12	Mon 3/19/12	20 hrs
1196	**Corporate Infrastructure / Hardware**	**Tue 2/8/11**	**Fri 10/7/11**	**3,112 hrs**
1197	**Telecomm**	**Fri 7/15/11**	**Fri 10/7/11**	**2,168 hrs**
1198	Call Management System (CMS)	Fri 7/15/11	Thu 9/15/11	360 hrs
1199	Interactive Voice Response - IVR	Fri 7/15/11	Thu 10/6/11	480 hrs
1200	Call Center Design and Programming	Fri 7/15/11	Thu 9/15/11	360 hrs
1201	Configure Call Logger (if applicable)	Fri 7/15/11	Thu 10/6/11	480 hrs
1202	Configure Witness	Fri 7/15/11	Fri 10/7/11	488 hrs
1203	**Database**	**Tue 2/8/11**	**Mon 4/4/11**	**584 hrs**
1204	Plan	Tue 2/8/11	Mon 2/21/11	80 hrs
1205	**Build**	**Tue 2/22/11**	**Fri 3/4/11**	**184 hrs**
1206	**UNIX**	**Tue 2/22/11**	**Wed 3/2/11**	**112 hrs**
1207	Resource Review	Tue 2/22/11	Fri 2/25/11	32 hrs
1208	Resource allocation	Mon 2/28/11	Wed 3/2/11	24 hrs
1209	Storage Provisioning	Tue 2/22/11	Thu 2/24/11	24 hrs
1210	Expand Database	Fri 2/25/11	Tue 3/1/11	24 hrs
1211	Adjust Database Dump environments	Wed 3/2/11	Fri 3/4/11	24 hrs
1212	Database Configuration	Tue 2/8/11	Mon 2/14/11	40 hrs
1213	Refresh Data Support	Tue 2/15/11	Mon 4/4/11	280 hrs
1214	**Intel Servers**	**Tue 2/8/11**	**Mon 3/21/11**	**360 hrs**
1215	Get Citrix Applications Requirements	Tue 2/8/11	Mon 2/14/11	40 hrs
1216	Review Citrix Licensing and Possibly Purchase Additional Licenses	Tue 2/15/11	Mon 2/21/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1217	Setup Citrix Requirements	Tue 2/22/11	Mon 2/28/11	40 hrs
1218	Add new Citrix Servers depending on load	Tue 2/8/11	Mon 3/21/11	240 hrs
1219	**LA Care Implementation Test Schedule**	**Mon 8/1/11**	**Fri 8/5/11**	**88 hrs**
1220	LA Care Contract/State Guidelines	Mon 8/1/11	Mon 8/1/11	8 hrs
1221	Provider File	Mon 8/1/11	Mon 8/1/11	8 hrs
1222	PeopleSoft GL Configuration	Tue 8/2/11	Tue 8/2/11	8 hrs
1223	**Facets Configuration**	**Mon 8/1/11**	**Thu 8/4/11**	**56 hrs**
1224	LOB (GRGR_CK)	Mon 8/1/11	Mon 8/1/11	8 hrs
1225	Auto numbering	Mon 8/1/11	Mon 8/1/11	8 hrs
1226	Plan/Product	Tue 8/2/11	Tue 8/2/11	8 hrs
1227	Clinical Edits	Wed 8/3/11	Wed 8/3/11	8 hrs
1228	UM Service Group (SEGR)	Wed 8/3/11	Wed 8/3/11	8 hrs
1229	PCA/Pend Reason Codes	Thu 8/4/11	Thu 8/4/11	8 hrs
1230	Bank Information	Tue 8/2/11	Tue 8/2/11	8 hrs
1231	**iHealth Web App**	**Fri 8/5/11**	**Fri 8/5/11**	**8 hrs**
1232	Business Rules Setup	Fri 8/5/11	Fri 8/5/11	8 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**
1235	Complete Network design (based on number of agents)	Tue 7/5/11	Tue 7/5/11	8 hrs
1236	Obtain quotes for circuits	Mon 7/4/11	Thu 7/7/11	32 hrs
1237	Submit circuit orders for contract approval	Fri 7/8/11	Fri 7/22/11	88 hrs
1238	Order Circuits and wait for completion	Mon 7/25/11	Fri 9/30/11	400 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1239	Order Hardware	Tue 7/5/11	Fri 9/30/11	512 hrs
1240	Install, test, and implement	Mon 10/3/11	Fri 10/14/11	80 hrs
1241	**TELECOM**	**Tue 2/8/11**	**Fri 12/16/11**	**3,784 hrs**
1242	**Coordinate Telecom and Connectivity Requirements**	**Tue 2/8/11**	**Fri 12/16/11**	**3,784 hrs**
1243	Installation of ESS/LSP and Local Avaya CM Gateway	Mon 10/17/11	Fri 12/16/11	360 hrs
1244	Obtain '800' telephone numbers for Member lines	Fri 7/15/11	Wed 7/20/11	32 hrs
1245	24/7 Nurse Help Line	Fri 7/15/11	Wed 7/20/11	32 hrs
1246	Telephony Programming	Fri 7/15/11	Thu 9/15/11	360 hrs
1247	TDD/TTY	Fri 7/15/11	Wed 7/20/11	32 hrs
1248	Coordinate installation (VPN or T1 lines)	Tue 7/26/11	Mon 10/17/11	488 hrs
1249	**INTEL SERVER**	**Tue 2/8/11**	**Tue 12/6/11**	**792 hrs**
1250	**Install and configure local servers (AD, Print and SCCM)**	**Sat 10/15/11**	**Fri 11/25/11**	**552 hrs**
1251	Install Windows 2008 on WAAS Blade	Sat 10/15/11	Mon 10/17/11	16 hrs
1252	Configure Active Directory Services	Wed 10/19/11	Thu 10/20/11	16 hrs
1253	Configure DHCP Scope	Fri 10/21/11	Mon 10/24/11	16 hrs
1254	Get Make/Model of Printers / Windows 2008 Compliant Drivers	Tue 10/25/11	Tue 10/25/11	8 hrs
1255	Configure Print Services	Wed 10/26/11	Thu 10/27/11	16 hrs
1256	Purchase 1 Server for SCCM Distribution Point	Mon 10/17/11	Fri 11/25/11	240 hrs
1257	Purchase KVM (USB Compliant)	Mon 10/17/11	Fri 11/25/11	240 hrs
1258	Install and configure local SCCM Distribution Server	Mon 11/28/11	Tue 12/6/11	56 hrs
1259	**Setup New Associate Accounts**	**Tue 2/8/11**	**Thu 3/3/11**	**184 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
1260	Coordinate Storage and Allocate for Email, File and Profiles	Tue 2/8/11	Mon 2/14/11	40 hrs
1261	Account Provisioning: Active Directory	Tue 2/15/11	Mon 2/21/11	40 hrs
1262	Account Provisioning: Email	Tue 2/22/11	Mon 2/28/11	40 hrs
1263	Setup new department folders / share and cluster resource	Tue 2/22/11	Thu 2/24/11	24 hrs
1264	Setup base permissions	Fri 2/25/11	Thu 3/3/11	40 hrs
1265	**DESKTOP**	**Tue 2/8/11**	**Thu 5/19/11**	**736 hrs**
1266	Interview on-site technical resources	Tue 2/8/11	Fri 2/25/11	112 hrs
1267	Get Hardware Requirements	Tue 2/8/11	Mon 2/14/11	40 hrs
1268	Purchase Desktop / Laptop Hardware	Tue 2/8/11	Mon 3/21/11	240 hrs
1269	Get Software Requirements	Tue 3/22/11	Mon 3/28/11	40 hrs
1270	Purchase Licensing	Tue 3/29/11	Mon 4/11/11	80 hrs
1271	Build Desktops (Based on 50 users)	Tue 4/12/11	Mon 4/25/11	80 hrs
1272	Install Software	Tue 4/26/11	Mon 5/9/11	80 hrs
1273	Shipping	Tue 5/10/11	Thu 5/12/11	24 hrs
1274	Fly two resources to site	Fri 5/13/11	Fri 5/13/11	8 hrs
1275	Installation	Mon 5/16/11	Thu 5/19/11	32 hrs
1276	**Service Desk**	**Tue 2/8/11**	**Thu 12/15/11**	**952 hrs**
1277	Update Processes and Scripts	Mon 11/28/11	Thu 12/15/11	112 hrs
1278	Implement new Service Desk tool with Self Service	Tue 2/8/11	Mon 6/13/11	720 hrs
1279	Train users on new tool	Tue 2/8/11	Fri 2/25/11	112 hrs
1280	Load Data into new tool	Tue 2/8/11	Tue 2/8/11	8 hrs
1281	**Workflow**	**Tue 6/14/11**	**Fri 12/23/11**	**1,472 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
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	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
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**
1302	Adjust Contract for new LOB	Fri 6/17/11	Fri 6/17/11	8 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1303	Planning	Sun 6/26/11	Thu 6/30/11	40 hrs
1304	Design	Fri 7/1/11	Thu 7/7/11	40 hrs
1305	Vendor Implementation	Fri 7/1/11	Thu 9/22/11	60 hrs
1306	Development	Mon 9/5/11	Mon 9/19/11	80 hrs
1307	Testing	Mon 9/19/11	Thu 9/22/11	40 hrs
1308	Deployment	Fri 9/23/11	Tue 9/27/11	20 hrs
1309	Stabilization	Tue 9/27/11	Thu 9/29/11	20 hrs
1310	**Member Portal**	**Fri 6/17/11**	**Tue 9/27/11**	**188 hrs**
1311	Planning	Fri 6/17/11	Tue 6/21/11	20 hrs
1312	Design	Tue 6/21/11	Thu 6/23/11	20 hrs
1313	Development	Mon 9/5/11	Mon 9/19/11	80 hrs
1314	Testing	Mon 9/19/11	Thu 9/22/11	40 hrs
1315	Deployment	Thu 9/22/11	Mon 9/26/11	20 hrs
1316	Stabilization	Mon 9/26/11	Tue 9/27/11	8 hrs
1317	**Online Provider Directory**	**Fri 6/17/11**	**Fri 7/29/11**	**198 hrs**
1318	Planning	Fri 6/17/11	Tue 6/21/11	20 hrs
1319	Design	Tue 6/21/11	Thu 6/23/11	20 hrs
1320	Development	Fri 6/24/11	Fri 7/8/11	90 hrs
1321	Testing	Fri 7/8/11	Tue 7/12/11	40 hrs
1322	Deployment	Wed 7/13/11	Fri 7/15/11	20 hrs
1323	Stabilization	Fri 7/29/11	Fri 7/29/11	8 hrs
1324	**IVR**	**Thu 6/16/11**	**Thu 9/22/11**	**201 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
1325	Planning	Thu 6/16/11	Fri 6/24/11	50 hrs
1326	Design	Fri 7/1/11	Wed 7/6/11	25 hrs
1327	Development	Mon 9/5/11	Thu 9/15/11	60 hrs
1328	Testing	Thu 9/15/11	Mon 9/19/11	40 hrs
1329	Deployment	Mon 9/19/11	Thu 9/22/11	20 hrs
1330	Stabilization	Thu 9/22/11	Thu 9/22/11	6 hrs
1331	**Clearinghouses (HDX, Emdeon)**	**Fri 6/17/11**	**Thu 9/29/11**	**284 hrs**
1332	Adjust Contract(s) for new LOB	Mon 6/20/11	Tue 6/28/11	64 hrs
1333	Planning	Tue 6/28/11	Thu 6/30/11	20 hrs
1334	Design	Fri 7/1/11	Thu 7/7/11	40 hrs
1335	Vendor Implementation	Fri 7/8/11	Thu 9/29/11	60 hrs
1336	Development	Fri 7/8/11	Wed 7/13/11	30 hrs
1337	Testing	Wed 7/20/11	Fri 7/22/11	40 hrs
1338	Deployment	Mon 7/25/11	Wed 7/27/11	20 hrs
1339	Stabilization	Fri 7/29/11	Mon 8/1/11	10 hrs
1340	**Voice Network Services**	**Thu 6/30/11**	**Wed 12/28/11**	**18,728 hrs**
1341	**Cabling**	**Wed 11/2/11**	**Tue 11/15/11**	**96 hrs**
1342	Order Cabling	Mon 11/14/11	Tue 11/15/11	16 hrs
1343	Installation of cabling	Wed 11/2/11	Tue 11/15/11	80 hrs
1344	**Installation of Avaya Survivable Gateway**	**Thu 9/1/11**	**Fri 11/25/11**	**408 hrs**
1345	Order Equipment	Tue 10/11/11	Fri 10/28/11	120 hrs
1346	Installation of Equipment	Mon 11/7/11	Fri 11/25/11	120 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1347	Test Phone system	Fri 10/28/11	Fri 11/4/11	48 hrs
1348	Install Telephones	Thu 9/1/11	Fri 10/28/11	120 hrs
1349	**VoiceMail Implementation**	**Tue 11/1/11**	**Tue 11/15/11**	**176 hrs**
1350	Add Subscribers to Modular Messaging	Tue 11/1/11	Tue 11/15/11	88 hrs
1351	Confirm Routing & Coverage Path	Tue 11/1/11	Tue 11/15/11	88 hrs
1352	**Voice Circuits**	**Mon 11/28/11**	**Mon 12/26/11**	**480 hrs**
1353	Determine phone line capacity needs	Mon 11/28/11	Tue 12/6/11	56 hrs
1354	Order telephone lines	Mon 11/28/11	Tue 11/29/11	16 hrs
1355	Order DID numbers	Mon 11/28/11	Tue 11/29/11	16 hrs
1356	Receive DID numbers	Wed 12/7/11	Wed 12/7/11	8 hrs
1357	Installation	Mon 11/28/11	Mon 12/26/11	168 hrs
1358	Test telephone lines	Mon 11/28/11	Mon 12/5/11	48 hrs
1359	Assign telephone numbers for associates	Mon 11/28/11	Tue 12/6/11	56 hrs
1360	Assign Main #	Mon 11/28/11	Tue 12/6/11	56 hrs
1361	Assign fax numbers	Mon 11/28/11	Tue 12/6/11	56 hrs
1362	**Call Center Build**	**Mon 8/1/11**	**Tue 11/15/11**	**11,064 hrs**
1363	Determine # of 800#'s required	Mon 8/1/11	Mon 8/15/11	88 hrs
1364	**Member / Provider Services**	**Mon 8/1/11**	**Tue 11/15/11**	**3,232 hrs**
1365	Create Call flow diagram	Mon 8/1/11	Tue 8/30/11	176 hrs
1366	Determine call flow needs	Mon 8/1/11	Tue 8/30/11	176 hrs
1367	Obtain Approval of call flow	Tue 8/30/11	Tue 8/30/11	8 hrs
1368	Determine announcement #'s	Mon 8/1/11	Tue 8/30/11	176 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1369	DigitalBase Recorded Announcements	Tue 8/30/11	Fri 9/2/11	32 hrs
1370	Determine Hunt group #'s	Mon 8/1/11	Tue 8/30/11	176 hrs
1371	Determine VDN's	Mon 8/1/11	Tue 8/30/11	176 hrs
1372	Program 800# call-flow	Mon 8/1/11	Tue 8/30/11	176 hrs
1373	Update Centrevu	Mon 8/1/11	Tue 8/30/11	176 hrs
1374	Test 800# programming	Mon 8/1/11	Tue 8/30/11	176 hrs
1375	Call center go-live	Tue 11/15/11	Tue 11/15/11	8 hrs
1376	Purchase required AWFO Licenses	Mon 8/1/11	Tue 8/30/11	176 hrs
1377	Add Extensions to Quality Monitoring	Tue 10/4/11	Fri 10/28/11	160 hrs
1378	Create Agent Group in Quality Monitoring	Tue 10/4/11	Fri 10/28/11	160 hrs
1379	Create Business Rule in Quality Monitoring	Tue 10/4/11	Fri 10/28/11	160 hrs
1380	Create contact folders in Quality Monitoring	Tue 10/4/11	Fri 10/28/11	160 hrs
1381	Create Users and hierarchy in Quality Monitoring	Tue 10/4/11	Fri 10/28/11	160 hrs
1382	Create users in Right Fax	Tue 10/4/11	Fri 10/28/11	160 hrs
1383	Create fax mail boxes in Right Fax	Tue 10/4/11	Fri 10/28/11	160 hrs
1384	Procure Symon licenses	Tue 10/4/11	Fri 10/28/11	160 hrs
1385	Create Symon display	Tue 10/4/11	Fri 10/28/11	160 hrs
1386	Create link for WFM	Tue 10/4/11	Fri 10/28/11	160 hrs
1387	**EDI**	**Mon 8/1/11**	**Tue 8/30/11**	**3,696 hrs**
1388	Create Call flow diagram	Mon 8/1/11	Tue 8/30/11	176 hrs
1389	Determine call flow needs	Mon 8/1/11	Tue 8/30/11	176 hrs
1390	Obtain Approval of call flow	Mon 8/1/11	Tue 8/30/11	176 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1391	Determine announcement #'s	Mon 8/1/11	Tue 8/30/11	176 hrs
1392	DigitalBase Recorded Announcements	Mon 8/1/11	Tue 8/30/11	176 hrs
1393	Determine Hunt group #'s	Mon 8/1/11	Tue 8/30/11	176 hrs
1394	Determine VDN's	Mon 8/1/11	Tue 8/30/11	176 hrs
1395	Program 800# call-flow	Mon 8/1/11	Tue 8/30/11	176 hrs
1396	Update CMS	Mon 8/1/11	Tue 8/30/11	176 hrs
1397	Test 800# programming	Mon 8/1/11	Tue 8/30/11	176 hrs
1398	Call center go-live	Mon 8/1/11	Tue 8/30/11	176 hrs
1399	Add Extensions to Quality Monitoring	Mon 8/1/11	Tue 8/30/11	176 hrs
1400	Create Agent Group in Quality Monitoring	Mon 8/1/11	Tue 8/30/11	176 hrs
1401	Create Business Rule in Quality Monitoring	Mon 8/1/11	Tue 8/30/11	176 hrs
1402	Create contact folders in Quality Monitoring	Mon 8/1/11	Tue 8/30/11	176 hrs
1403	Create Users and hierarchy in Quality Monitoring	Mon 8/1/11	Tue 8/30/11	176 hrs
1404	Create users in Right Fax	Mon 8/1/11	Tue 8/30/11	176 hrs
1405	Create fax mail boxes in Right Fax	Mon 8/1/11	Tue 8/30/11	176 hrs
1406	Procure Symon licenses	Mon 8/1/11	Tue 8/30/11	176 hrs
1407	Create Symon display	Mon 8/1/11	Tue 8/30/11	176 hrs
1408	Create link for WFM	Mon 8/1/11	Tue 8/30/11	176 hrs
1409	**Medical Management**	**Mon 8/1/11**	**Wed 8/31/11**	**4,048 hrs**
1410	Create Call flow diagram	Mon 8/1/11	Wed 8/31/11	184 hrs
1411	Determine call flow needs	Mon 8/1/11	Wed 8/31/11	184 hrs
1412	Obtain Approval of call flow	Mon 8/1/11	Wed 8/31/11	184 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1413	Determine announcement #'s	Mon 8/1/11	Wed 8/31/11	184 hrs
1414	DigitalBase Recorded Announcements	Mon 8/1/11	Wed 8/31/11	184 hrs
1415	Determine Hunt group #'s	Mon 8/1/11	Wed 8/31/11	184 hrs
1416	Determine VDN's	Mon 8/1/11	Wed 8/31/11	184 hrs
1417	Program 800# call-flow	Mon 8/1/11	Wed 8/31/11	184 hrs
1418	Update Centrevu	Mon 8/1/11	Wed 8/31/11	184 hrs
1419	Test 800# programming	Mon 8/1/11	Wed 8/31/11	184 hrs
1420	Call center go-live	Mon 8/1/11	Wed 8/31/11	184 hrs
1421	Add Extensions to Quality Monitoring	Mon 8/1/11	Wed 8/31/11	184 hrs
1422	Create Agent Group in Quality Monitoring	Mon 8/1/11	Wed 8/31/11	184 hrs
1423	Create Business Rule in Quality Monitoring	Mon 8/1/11	Wed 8/31/11	184 hrs
1424	Create contact folders in Quality Monitoring	Mon 8/1/11	Wed 8/31/11	184 hrs
1425	Create Users and hierarchy in Quality Monitoring	Mon 8/1/11	Wed 8/31/11	184 hrs
1426	Create users in Right Fax	Mon 8/1/11	Wed 8/31/11	184 hrs
1427	Create fax mail boxes in Right Fax	Mon 8/1/11	Wed 8/31/11	184 hrs
1428	Procure Symon licenses	Mon 8/1/11	Wed 8/31/11	184 hrs
1429	Create Symon display	Mon 8/1/11	Wed 8/31/11	184 hrs
1430	Create link for WFM	Mon 8/1/11	Wed 8/31/11	184 hrs
1431	**Language Services Associates**	**Mon 8/1/11**	**Tue 8/30/11**	**704 hrs**
1432	Determine Amount of Accounts Needed	Mon 8/1/11	Tue 8/30/11	176 hrs
1433	Request New Account	Mon 8/1/11	Tue 8/30/11	176 hrs
1434	Order Language Line Materials	Mon 8/1/11	Tue 8/30/11	176 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1435	Dual Handset Phone?	Mon 8/1/11	Tue 8/30/11	176 hrs
1436	**eCas**	**Mon 11/28/11**	**Fri 12/9/11**	**80 hrs**
1437	Populate eCAS Database	Mon 11/28/11	Fri 12/9/11	80 hrs
1438	**Office set-up**	**Mon 11/28/11**	**Wed 12/28/11**	**1,064 hrs**
1439	Determine Coverage Paths	Mon 11/28/11	Tue 12/27/11	176 hrs
1440	Determine button for telephone	Mon 11/28/11	Tue 12/27/11	176 hrs
1441	Create phone labels	Mon 11/28/11	Tue 12/27/11	176 hrs
1442	Program Coverage Paths	Mon 11/28/11	Tue 12/27/11	176 hrs
1443	Program telephone stations	Mon 11/28/11	Tue 12/27/11	176 hrs
1444	Program Agents	Mon 11/28/11	Tue 12/27/11	176 hrs
1445	Office go-live	Wed 12/28/11	Wed 12/28/11	8 hrs
1446	**IP Phones**	**Tue 10/4/11**	**Tue 11/1/11**	**1,232 hrs**
1447	Develop Option String Settings	Tue 10/4/11	Tue 11/1/11	176 hrs
1448	Provide Settings to LAN/WAN	Tue 10/4/11	Tue 11/1/11	176 hrs
1449	LAN/WAN provides Intel with Final Option String	Tue 10/4/11	Tue 11/1/11	176 hrs
1450	Intel loads Option String onto Determined Server	Tue 10/4/11	Tue 11/1/11	176 hrs
1451	DHCP Scope	Tue 10/4/11	Tue 11/1/11	176 hrs
1452	Populate CM IP-Network-Map	Tue 10/4/11	Tue 11/1/11	176 hrs
1453	Network Region	Tue 10/4/11	Tue 11/1/11	176 hrs
1454	Boot phone--verify DHCP	Wed 11/2/11	Thu 12/1/11	176 hrs
1455	Boot phone--verify Option 242	Wed 11/2/11	Thu 12/1/11	176 hrs
1456	Log-in extension	Tue 10/4/11	Tue 11/1/11	176 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
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**
1461	IP Phone User Guides	Tue 11/1/11	Fri 11/11/11	72 hrs
1462	Tip Sheet?	Tue 11/1/11	Fri 11/11/11	72 hrs
1463	Provide Quick Reference Guides	Tue 11/1/11	Fri 11/11/11	72 hrs
1464	VoiceMail Setup Instructions	Tue 11/1/11	Fri 11/11/11	72 hrs
1465	Modular Messaging Guides	Tue 11/1/11	Fri 11/11/11	72 hrs
1466	**IVR**	**Mon 7/25/11**	**Thu 9/1/11**	**424 hrs**
1467	**Determine Business Requirements**	**Sat 7/30/11**	**Sat 7/30/11**	**192 hrs**
1468	Speech Recognition or DTMF or Both?	Mon 7/25/11	Tue 7/26/11	16 hrs
1469	Authentication	Mon 7/25/11	Tue 7/26/11	16 hrs
1470	Eligibility	Mon 7/25/11	Tue 7/26/11	16 hrs
1471	Replacement ID Card Requests	Mon 7/25/11	Tue 7/26/11	16 hrs
1472	**Literature Requests**	**Mon 8/1/11**	**Tue 8/16/11**	**112 hrs**
1473	Provider Directory	Mon 8/1/11	Tue 8/16/11	96 hrs
1474	Member Handbook	Mon 8/1/11	Tue 8/2/11	16 hrs
1475	Claims Status	Mon 7/25/11	Tue 7/26/11	16 hrs
1476	Create Statement of Work	Mon 7/25/11	Mon 7/25/11	8 hrs
1477	Send to Vendors for Quote	Tue 7/26/11	Tue 7/26/11	8 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1478	Secure Vendor	Wed 7/27/11	Wed 7/27/11	8 hrs
1479	**Create VUI (Voice User Interface)**	**Fri 7/29/11**	**Fri 7/29/11**	**8 hrs**
1480	Business Approval	Fri 7/29/11	Fri 7/29/11	8 hrs
1481	**Create DID (Data Interface Design) Document**	**Fri 7/29/11**	**Fri 7/29/11**	**8 hrs**
1482	Business Approval	Fri 7/29/11	Fri 7/29/11	8 hrs
1483	**Program Interface**	**Thu 8/4/11**	**Mon 8/15/11**	**72 hrs**
1484	VUI	Thu 8/4/11	Thu 8/4/11	8 hrs
1485	Data (Real-Time/MQ) Interface	Thu 8/4/11	Mon 8/15/11	64 hrs
1486	Application install in DEV/QA	Wed 8/17/11	Wed 8/17/11	8 hrs
1487	**SIT Testing**	**Wed 8/17/11**	**Fri 8/19/11**	**24 hrs**
1488	Testing Completed	Wed 8/17/11	Fri 8/19/11	24 hrs
1489	**UAT Testing**	**Fri 8/12/11**	**Thu 8/25/11**	**80 hrs**
1490	UAT Testing completed	Fri 8/12/11	Thu 8/25/11	80 hrs
1491	Go Live Scheduled	Thu 9/1/11	Thu 9/1/11	8 hrs
1492	**Avaya Contact Recorder / Call Logger Build**	**Thu 6/30/11**	**Mon 11/14/11**	**1,056 hrs**
1493	Purchase required licenses	Thu 6/30/11	Sat 7/30/11	176 hrs
1494	Determine storage requirements	Thu 6/30/11	Sat 7/30/11	176 hrs
1495	create IP ports for ACR	Mon 10/31/11	Mon 11/14/11	88 hrs
1496	add agents to ACR	Mon 10/31/11	Mon 11/14/11	88 hrs
1497	add group extensions to ACR	Mon 10/31/11	Mon 11/14/11	88 hrs
1498	build e-ware groups	Mon 10/31/11	Mon 11/14/11	88 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1499	build e-ware end users	Mon 10/31/11	Mon 11/14/11	88 hrs
1500	build e-ware queries	Mon 10/31/11	Mon 11/14/11	88 hrs
1501	test	Mon 10/31/11	Mon 11/14/11	88 hrs
1502	build archive campaigns	Mon 10/31/11	Mon 11/14/11	88 hrs
1503	**Video Conferencing**	**Tue 11/1/11**	**Tue 11/15/11**	**528 hrs**
1504	assess Avaya 1X for desktop video	Tue 11/1/11	Tue 11/15/11	88 hrs
1505	assess site endpoints	Tue 11/1/11	Tue 11/15/11	88 hrs
1506	quote and order endpoints	Tue 11/1/11	Tue 11/15/11	88 hrs
1507	install endpoints	Tue 11/1/11	Tue 11/15/11	88 hrs
1508	register endpoints	Tue 11/1/11	Tue 11/15/11	88 hrs
1509	perform testing	Tue 11/1/11	Tue 11/15/11	88 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**
1512	QA Environment Ready	Thu 9/1/11	Thu 9/1/11	4 hrs
1513	Mock up Data	Thu 9/1/11	Wed 9/7/11	32 hrs
1514	**Change Management and QA Migration (estimate 10 Tickets)**	**Thu 9/1/11**	**Fri 9/2/11**	**16 hrs**
1515	Team Track - Code migration and QA Object and Doc review	Thu 9/1/11	Thu 9/1/11	8 hrs
1516	Team track - Operation guidance review and building Tidal Jobs	Fri 9/2/11	Fri 9/2/11	8 hrs
1517	**Execute QA Test**	**Wed 9/7/11**	**Tue 9/20/11**	**102.4 hrs**
1518	**Core Load processes**	**Wed 9/7/11**	**Mon 9/19/11**	**73.6 hrs**
1519	XPF Load	Wed 9/7/11	Wed 9/7/11	2.4 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1520	**NPI Crosswalk**	**Wed 9/7/11**	**Mon 9/19/11**	**71.2 hrs**
1521	010_UNIX_PROD1025_npifacetstocrosswalkload	Wed 9/7/11	Thu 9/8/11	2.4 hrs
1522	020_UNIX_PROD1025_npicrosswalk	Thu 9/8/11	Thu 9/8/11	1.6 hrs
1523	030_UNIX_PROD1025_npicrosswlktofacetsload.ksh	Thu 9/8/11	Thu 9/8/11	1.6 hrs
1524	040_UNIX_PROD1025_npicrosswalkloginlockreset.ksh	Thu 9/8/11	Thu 9/8/11	1.6 hrs
1525	NPI Web Application	Wed 9/7/11	Mon 9/19/11	64 hrs
1526	**Provider Automation Inspection**	**Mon 9/19/11**	**Tue 9/20/11**	**8 hrs**
1527	Availability	Mon 9/19/11	Tue 9/20/11	4 hrs
1528	Testing	Mon 9/19/11	Tue 9/20/11	4 hrs
1529	**Extracts**	**Thu 9/8/11**	**Fri 9/9/11**	**4.8 hrs**
1530	Jiva	Thu 9/8/11	Thu 9/8/11	1.6 hrs
1531	DWH	Thu 9/8/11	Fri 9/9/11	1.6 hrs
1532	ACS/MACESS	Fri 9/9/11	Fri 9/9/11	1.6 hrs
1533	QA Validation - 20% failure threshold- 80% loaded	Fri 9/9/11	Tue 9/13/11	16 hrs
1534	**Defect Resolution**	**Tue 9/13/11**	**Thu 9/15/11**	**25 hrs**
1535	Root cause Analysis	Tue 9/13/11	Wed 9/14/11	8 hrs
1536	Remediate and unit test	Wed 9/14/11	Thu 9/15/11	6 hrs
1537	Re- package	Thu 9/15/11	Thu 9/15/11	4 hrs
1538	**Change Management and QA Migration**	**Thu 9/15/11**	**Thu 9/15/11**	**7 hrs**
1539	Team Track - Code migration and QA Object and Doc review	Thu 9/15/11	Thu 9/15/11	4 hrs
1540	Team track - Operation guidance review and building Tidal Jobs	Thu 9/15/11	Thu 9/15/11	2 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1541	Defect Mgt tracking	Thu 9/15/11	Thu 9/15/11	1 hr
1542	Re-Execute Core Load processes	Thu 9/15/11	Fri 9/16/11	2 hrs
1543	Re-Validation - Go back to Defect Resolution activities until all defects resolved	Fri 9/16/11	Fri 9/16/11	2 hrs
1544	**Batch 1a - Provider test with Supplied Data - On Request**	**Thu 9/22/11**	**Wed 9/28/11**	**39.8 hrs**
1545	Receive Supplied data and validate format	Thu 9/22/11	Thu 9/22/11	4 hrs
1546	**Change Management and QA Migration**	**Thu 9/22/11**	**Wed 9/28/11**	**35.8 hrs**
1547	Team Track - Code migration and QA Object and Doc review	Thu 9/22/11	Thu 9/22/11	0 hrs
1548	Team track - Operation guidance review and building Tidal Jobs	Fri 9/23/11	Fri 9/23/11	0 hrs
1549	**Execute QA Test**	**Mon 9/26/11**	**Wed 9/28/11**	**35.8 hrs**
1550	**Core Load processes**	**Mon 9/26/11**	**Mon 9/26/11**	**12.8 hrs**
1551	XPF Load	Mon 9/26/11	Mon 9/26/11	3.2 hrs
1552	**NPI Crosswalk**	**Mon 9/26/11**	**Mon 9/26/11**	**9.6 hrs**
1553	010_UNIX_PROD1025_npifacetstocrosswalkload	Mon 9/26/11	Mon 9/26/11	2.4 hrs
1554	020_UNIX_PROD1025_npicrosswalk	Mon 9/26/11	Mon 9/26/11	2.4 hrs
1555	030_UNIX_PROD1025_npicrosswlktofacetsload.ksh	Mon 9/26/11	Mon 9/26/11	2.4 hrs
1556	040_UNIX_PROD1025_npicrosswalkloginlockreset.ksh	Mon 9/26/11	Mon 9/26/11	2.4 hrs
1557	NPI Xwalk Web Application	Mon 9/26/11	Mon 9/26/11	0 hrs
1558	**Extracts**	**Mon 9/26/11**	**Mon 9/26/11**	**0 hrs**
1559	Jiva	Mon 9/26/11	Mon 9/26/11	0 hrs
1560	DWH	Mon 9/26/11	Mon 9/26/11	0 hrs
1561	ACS/MACCESS	Mon 9/26/11	Mon 9/26/11	0 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1562	QA Validation - 20% failure threshold- 80% loaded	Tue 9/27/11	Tue 9/27/11	0 hrs
1563	**Defect Resolution**	**Tue 9/27/11**	**Tue 9/27/11**	**12 hrs**
1564	Root cause Analysis	Tue 9/27/11	Tue 9/27/11	4 hrs
1565	Remediate and Unit test	Tue 9/27/11	Tue 9/27/11	6 hrs
1566	Re- package	Tue 9/27/11	Tue 9/27/11	2 hrs
1567	**Change Management and QA Migration**	**Wed 9/28/11**	**Wed 9/28/11**	**7 hrs**
1568	Team Track - Code migration and QA Object and Doc review	Wed 9/28/11	Wed 9/28/11	4 hrs
1569	Team track - Operation guidance review and building Tidal Jobs	Wed 9/28/11	Wed 9/28/11	2 hrs
1570	Defect Mgt tracking	Wed 9/28/11	Wed 9/28/11	1 hr
1571	Re-Execute Core Load processes	Wed 9/28/11	Wed 9/28/11	2 hrs
1572	Validation - Go back to Defect Resolution activities until all defects resolved	Wed 9/28/11	Wed 9/28/11	2 hrs
1573	**Batch 2 - Member Load - Mocked up data**	**Fri 9/2/11**	**Tue 9/27/11**	**67 hrs**
1574	Mock up data	Fri 9/2/11	Fri 9/2/11	4 hrs
1575	**Exec E&E LOAD**	**Mon 9/19/11**	**Tue 9/27/11**	**63 hrs**
1576	**Exec Core Membership load process**	**Mon 9/19/11**	**Mon 9/19/11**	**11.2 hrs**
1577	Proprietary Inbound Enrollment Process (834 being developed as a contingency)	Mon 9/19/11	Mon 9/19/11	1.6 hrs
1578	MMS Load	Mon 9/19/11	Mon 9/19/11	1.6 hrs
1579	Member Elig	Mon 9/19/11	Mon 9/19/11	1.6 hrs
1580	Term By Absence	Mon 9/19/11	Mon 9/19/11	1.6 hrs
1581	PCP Assignment	Mon 9/19/11	Mon 9/19/11	1.6 hrs
1582	ID Cards	Mon 9/19/11	Mon 9/19/11	1.6 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1583	Member Labels	Mon 9/19/11	Mon 9/19/11	1.6 hrs
1584	**Streamline Inspection**	**Tue 9/20/11**	**Tue 9/20/11**	**8 hrs**
1585	Availability	Tue 9/20/11	Tue 9/20/11	4 hrs
1586	Testing	Tue 9/20/11	Tue 9/20/11	4 hrs
1587	**Extracts**	**Tue 9/20/11**	**Tue 9/20/11**	**4.8 hrs**
1588	Jiva	Tue 9/20/11	Tue 9/20/11	1.6 hrs
1589	DWH	Tue 9/20/11	Tue 9/20/11	1.6 hrs
1590	ACS/MACCESS	Tue 9/20/11	Tue 9/20/11	1.6 hrs
1591	QA Validation - Threshold of 5% failures	Tue 9/20/11	Thu 9/22/11	16 hrs
1592	**Defect Resolution**	**Thu 9/22/11**	**Tue 9/27/11**	**23 hrs**
1593	Root cause analysis	Thu 9/22/11	Thu 9/22/11	4 hrs
1594	Remediation and unit testing	Fri 9/23/11	Fri 9/23/11	6 hrs
1595	re-package	Fri 9/23/11	Fri 9/23/11	2 hrs
1596	**Change Management and QA Migration**	**Mon 9/26/11**	**Mon 9/26/11**	**7 hrs**
1597	Team Track - Code migration and QA Object and Doc review	Mon 9/26/11	Mon 9/26/11	4 hrs
1598	Team track - Operation guidance review and building Tidal Jobs	Mon 9/26/11	Mon 9/26/11	2 hrs
1599	Defect Mgt tracking	Mon 9/26/11	Mon 9/26/11	1 hr
1600	Re- exec E&E core load process	Mon 9/26/11	Mon 9/26/11	2 hrs
1601	Re-Validation - Go back to Defect Resolution activities until all defects resolved	Tue 9/27/11	Tue 9/27/11	2 hrs
1602	**Batch 2a - Member Load - Supplied data - on request**	**Tue 9/20/11**	**Mon 10/3/11**	**44 hrs**
1603	Receive File	Mon 9/26/11	Mon 9/26/11	4 hrs
1604	**Change Management and QA Migration**	**Mon 9/26/11**	**Mon 9/26/11**	**0 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
1605	Team Track - Code migration and QA Object and Doc review	Mon 9/26/11	Mon 9/26/11	0 hrs
1606	Team track - Operation guidance review and building Tidal Jobs	Mon 9/26/11	Mon 9/26/11	0 hrs
1607	**Exec E&E LOAD**	**Tue 9/27/11**	**Thu 9/29/11**	**16 hrs**
1608	**Exec Core Membership load process**	**Tue 9/27/11**	**Thu 9/29/11**	**16 hrs**
1609	Proprietary Inbound Enrollment Process (834 being developed as a contingency)	Tue 9/27/11	Tue 9/27/11	1.6 hrs
1610	MMS Load	Tue 9/27/11	Tue 9/27/11	1.6 hrs
1611	Member Elig	Tue 9/27/11	Tue 9/27/11	1.6 hrs
1612	Term By Absence	Tue 9/27/11	Tue 9/27/11	1.6 hrs
1613	PCP Assignment	Tue 9/27/11	Tue 9/27/11	1.6 hrs
1614	ID Cards	Tue 9/27/11	Tue 9/27/11	1.6 hrs
1615	Member Labels	Tue 9/27/11	Tue 9/27/11	1.6 hrs
1616	**Extracts**	**Thu 9/29/11**	**Thu 9/29/11**	**4.8 hrs**
1617	Jiva	Thu 9/29/11	Thu 9/29/11	1.6 hrs
1618	DWH	Thu 9/29/11	Thu 9/29/11	1.6 hrs
1619	ACS/MACCESS	Thu 9/29/11	Thu 9/29/11	1.6 hrs
1620	Exec Validation - Threshold of 5% failures	Thu 9/29/11	Thu 9/29/11	0 hrs
1621	**Defect Resolution**	**Thu 9/29/11**	**Mon 10/3/11**	**23 hrs**
1622	Root cause analysis	Thu 9/29/11	Thu 9/29/11	4 hrs
1623	Remediate and Unit test	Thu 9/29/11	Fri 9/30/11	6 hrs
1624	re-package	Fri 9/30/11	Fri 9/30/11	2 hrs
1625	**Change Management and QA Migration**	**Fri 9/30/11**	**Mon 10/3/11**	**7 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
1626	Team Track - Code migration and QA Object and Doc review	Fri 9/30/11	Fri 9/30/11	4 hrs
1627	Team track - Operation guidance review and building Tidal Jobs	Mon 10/3/11	Mon 10/3/11	2 hrs
1628	Defect Mgt tracking	Fri 9/30/11	Fri 9/30/11	1 hr
1629	Re- exec E&E load process	Mon 10/3/11	Mon 10/3/11	2 hrs
1630	re-Validation	Mon 10/3/11	Mon 10/3/11	2 hrs
1631	Send Member and Provider Files to ACS	Tue 9/20/11	Tue 9/20/11	1 hr
1632	**Batch 3 -UMI Load Process- Mocked up data**	**Thu 9/1/11**	**Tue 9/27/11**	**63 hrs**
1633	Mock up data	Thu 9/1/11	Thu 9/1/11	4 hrs
1634	**Change Management and QA Migration**	**Thu 9/1/11**	**Fri 9/2/11**	**12 hrs**
1635	Team Track - Code migration and QA Object and Doc review	Thu 9/1/11	Thu 9/1/11	4 hrs
1636	Team track - Operation guidance review and building Tidal Jobs	Thu 9/1/11	Fri 9/2/11	8 hrs
1637	**JIVA**	**Fri 9/2/11**	**Tue 9/27/11**	**47 hrs**
1638	**Exec UMI Load**	**Tue 9/27/11**	**Tue 9/27/11**	**8 hrs**
1639	**UMI Load Process**	**Tue 9/27/11**	**Tue 9/27/11**	**8 hrs**
1640	VB Application	Tue 9/27/11	Tue 9/27/11	1.6 hrs
1641	Void Process	Tue 9/27/11	Tue 9/27/11	1.6 hrs
1642	CP_UMILOAD_PROCESS	Tue 9/27/11	Tue 9/27/11	1.6 hrs
1643	UMI_intUMIRestor	Tue 9/27/11	Tue 9/27/11	1.6 hrs
1644	CP_UMI_UMIRESUBrename	Tue 9/27/11	Tue 9/27/11	1.6 hrs
1645	QA Validation	Fri 9/2/11	Tue 9/6/11	16 hrs
1646	**Defect Resolution**	**Tue 9/6/11**	**Fri 9/9/11**	**23 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
1647	Root cause analysis	Tue 9/6/11	Tue 9/6/11	4 hrs
1648	Remediation and unit testing	Wed 9/7/11	Wed 9/7/11	6 hrs
1649	re-package	Wed 9/7/11	Wed 9/7/11	2 hrs
1650	**Change Management and QA Migration**	**Thu 9/8/11**	**Thu 9/8/11**	**7 hrs**
1651	Team Track - Code migration and QA Object and Doc review	Thu 9/8/11	Thu 9/8/11	4 hrs
1652	Team track - Operation guidance review and building Tidal Jobs	Thu 9/8/11	Thu 9/8/11	2 hrs
1653	Defect Mgt tracking	Thu 9/8/11	Thu 9/8/11	1 hr
1654	Re- execute	Thu 9/8/11	Thu 9/8/11	2 hrs
1655	Re-Validation	Fri 9/9/11	Fri 9/9/11	2 hrs
1656	**Batch 4 -Medical Management**	**Tue 9/27/11**	**Fri 9/30/11**	**74 hrs**
1657	**JIVA**	**Tue 9/27/11**	**Thu 9/29/11**	**35 hrs**
1658	**Change Management and QA Migration**	**Tue 9/27/11**	**Wed 9/28/11**	**12 hrs**
1659	Team Track - Code migration and QA Object and Doc review	Tue 9/27/11	Tue 9/27/11	4 hrs
1660	Team track - Operation guidance review and building Tidal Jobs	Tue 9/27/11	Wed 9/28/11	8 hrs
1661	**QA Validation**	**Tue 9/27/11**	**Thu 9/29/11**	**23 hrs**
1662	**Defect Resolution**	**Tue 9/27/11**	**Thu 9/29/11**	**23 hrs**
1663	Root cause analysis	Tue 9/27/11	Tue 9/27/11	4 hrs
1664	Remediation and unit testing	Tue 9/27/11	Wed 9/28/11	6 hrs
1665	re-package	Wed 9/28/11	Wed 9/28/11	2 hrs
1666	**Change Management and QA Migration**	**Wed 9/28/11**	**Thu 9/29/11**	**7 hrs**
1667	Team Track - Code migration and QA Object and Doc review	Wed 9/28/11	Thu 9/29/11	4 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1668	Team track - Operation guidance review and building Tidal Jobs	Thu 9/29/11	Thu 9/29/11	2 hrs
1669	Defect Mgt tracking	Wed 9/28/11	Wed 9/28/11	1 hr
1670	Re-Execution	Thu 9/29/11	Thu 9/29/11	2 hrs
1671	Re-Validation	Thu 9/29/11	Thu 9/29/11	2 hrs
1672	**Client Letter**	**Tue 9/27/11**	**Fri 9/30/11**	**39 hrs**
1673	**Change Management and QA Migration**	**Tue 9/27/11**	**Wed 9/28/11**	**12 hrs**
1674	Team Track - Code migration and QA Object and Doc review	Tue 9/27/11	Tue 9/27/11	4 hrs
1675	Team track - Operation guidance review and building Tidal Jobs	Tue 9/27/11	Wed 9/28/11	8 hrs
1676	**QA Validation - Threshold of 5% failures**	**Tue 9/27/11**	**Fri 9/30/11**	**27 hrs**
1677	**Defect Resolution**	**Tue 9/27/11**	**Wed 9/28/11**	**12 hrs**
1678	Root cause analysis	Tue 9/27/11	Tue 9/27/11	4 hrs
1679	Remediation and unit testing	Tue 9/27/11	Wed 9/28/11	6 hrs
1680	re-package	Wed 9/28/11	Wed 9/28/11	2 hrs
1681	**Change Management and QA Migration**	**Wed 9/28/11**	**Fri 9/30/11**	**15 hrs**
1682	Team Track - Code migration and QA Object and Doc review	Wed 9/28/11	Thu 9/29/11	4 hrs
1683	Team track - Operation guidance review and building Tidal Jobs	Thu 9/29/11	Thu 9/29/11	2 hrs
1684	Defect Mgt tracking	Wed 9/28/11	Wed 9/28/11	1 hr
1685	Re-Execution	Thu 9/29/11	Thu 9/29/11	4 hrs
1686	Re-Validation	Fri 9/30/11	Fri 9/30/11	4 hrs
1687	**Batch 5 - Claims Load process - Mocked up paper claims only**	**Thu 9/1/11**	**Wed 9/28/11**	**87.2 hrs**
1688	Mock up ACS Claims	Thu 9/1/11	Thu 9/1/11	1 hr

ID	Task Name	Start	Finish	Estimated Work Effort
1689	**Change Management and QA Migration**	**Thu 9/1/11**	**Fri 9/2/11**	**12 hrs**
1690	Team Track - Code migration and QA Object and Doc review	Thu 9/1/11	Thu 9/1/11	4 hrs
1691	Team track - Operation guidance review and building Tidal Jobs	Thu 9/1/11	Fri 9/2/11	8 hrs
1692	**Exec QA Claims LOAD _paper claims only**	**Tue 9/20/11**	**Wed 9/28/11**	**74.2 hrs**
1693	**Execute Paper Claims Load processes**	**Tue 9/20/11**	**Wed 9/28/11**	**74.2 hrs**
1694	**Exec core engine batch cycle**	**Tue 9/20/11**	**Fri 9/23/11**	**45.4 hrs**
1695	**ACS CLAIMS LOAD**	**Tue 9/20/11**	**Fri 9/23/11**	**45.4 hrs**
1696	005_VB_PROD100_CLM_XCTRANSLATOR	Tue 9/20/11	Tue 9/20/11	1.6 hrs
1697	020_W2K_PRDIND_MAC_XCLOAD_2ND	Tue 9/20/11	Tue 9/20/11	1.6 hrs
1698	025_UX_PRDIND_MAC_post_xcload_2nd	Tue 9/20/11	Tue 9/20/11	1.6 hrs
1699	030_UX_PRDIND_ACSNPICOL	Tue 9/20/11	Tue 9/20/11	1.6 hrs
1700	028_VB_PRDIND_EDI_DRGGROUPER	Tue 9/20/11	Tue 9/20/11	1.6 hrs
1701	044_UX_PRDIND_ndc_resync	Tue 9/20/11	Tue 9/20/11	1.6 hrs
1702	045_UX_PRDIND_MAC_pre_autoadj	Tue 9/20/11	Tue 9/20/11	1.6 hrs
1703	046_UX_PRD_INDIANA_BILL_TYPE_UPD	Tue 9/20/11	Tue 9/20/11	1.6 hrs
1704	047_SP_PRD_INDIANA_DIAG_UPD	Tue 9/20/11	Tue 9/20/11	1.6 hrs
1705	050_W2K_PRDIND_MAC_AUTOADJ_2ND	Tue 9/20/11	Tue 9/20/11	1.6 hrs
1706	090_UX_PRDIND_MAC_post_autoadj	Tue 9/20/11	Tue 9/20/11	1.6 hrs
1707	ACS Acknowledgements	Tue 9/20/11	Tue 9/20/11	0.8 hrs
1708	**QA validation and Defect Resolution**	**Tue 9/20/11**	**Thu 9/22/11**	**21 hrs**
1709	QA Validation	Tue 9/20/11	Tue 9/20/11	2 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1710	**Defect Resolution**	**Tue 9/20/11**	**Thu 9/22/11**	**19 hrs**
1711	Root cause analysis	Tue 9/20/11	Tue 9/20/11	4 hrs
1712	Remediation and Unit testing	Tue 9/20/11	Wed 9/21/11	6 hrs
1713	re-package	Wed 9/21/11	Wed 9/21/11	2 hrs
1714	**Change Management and QA Migration**	**Wed 9/21/11**	**Thu 9/22/11**	**7 hrs**
1715	Team Track - Code migration and QA Object and Doc review	Wed 9/21/11	Thu 9/22/11	2 hrs
1716	Team track - Operation guidance review and building Tidal Jobs	Thu 9/22/11	Thu 9/22/11	4 hrs
1717	Defect Mgt tracking	Thu 9/22/11	Thu 9/22/11	1 hr
1718	Re- exec process	Thu 9/22/11	Thu 9/22/11	2 hrs
1719	re-Validation	Thu 9/22/11	Fri 9/23/11	4 hrs
1720	**FINANCE**	**Fri 9/23/11**	**Wed 9/28/11**	**28.8 hrs**
1721	ABF Process (without 835 process mapping execution)	Fri 9/23/11	Fri 9/23/11	0.8 hrs
1722	Claim Check Process	Fri 9/23/11	Fri 9/23/11	0.8 hrs
1723	Claims Batch Verify Process	Fri 9/23/11	Fri 9/23/11	0.8 hrs
1724	Claim Recon Process	Fri 9/23/11	Fri 9/23/11	0.8 hrs
1725	EFT Enroll Process	Fri 9/23/11	Fri 9/23/11	0.8 hrs
1726	Claims GL Process	Fri 9/23/11	Fri 9/23/11	0.8 hrs
1727	**QA validation and Defect Resolution**	**Fri 9/23/11**	**Wed 9/28/11**	**20 hrs**
1728	QA validation	Fri 9/23/11	Fri 9/23/11	1 hr
1729	**Defect Resolution**	**Fri 9/23/11**	**Tue 9/27/11**	**12 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
1730	Root cause analysis	Fri 9/23/11	Mon 9/26/11	4 hrs
1731	Remediation and Unit testing	Mon 9/26/11	Mon 9/26/11	6 hrs
1732	re-package	Mon 9/26/11	Tue 9/27/11	2 hrs
1733	**Change Management and QA Migration**	**Tue 9/27/11**	**Wed 9/28/11**	**7 hrs**
1734	Team Track - Code migration and QA Object and Doc review	Tue 9/27/11	Tue 9/27/11	4 hrs
1735	Team track - Operation guidance review and building Tidal Jobs	Tue 9/27/11	Tue 9/27/11	2 hrs
1736	Defect Mgt tracking	Tue 9/27/11	Wed 9/28/11	1 hr
1737	Re- exec process	Wed 9/28/11	Wed 9/28/11	2 hrs
1738	re-Validation	Wed 9/28/11	Wed 9/28/11	2 hrs
1739	**End Test Cycle 1**	**Fri 9/30/11**	**Fri 9/30/11**	**2 hrs**
1740	End Cycle 1 QA sign off	Fri 9/30/11	Fri 9/30/11	2 hrs
1741	Turn Over to UAT	Fri 9/30/11	Fri 9/30/11	0 hrs
1742	**Test Cycle 2 - Basic processing engine with EDI, Paper claims and extracts**	**Mon 10/3/11**	**Wed 11/16/11**	**1,061.8 hrs**
1743	**Batch 1 - Provider Test 2 - Mocked data**	**Mon 10/3/11**	**Sat 10/15/11**	**92.2 hrs**
1744	**Change Management and QA Migration**	**Mon 10/3/11**	**Wed 10/5/11**	**16 hrs**
1745	Team Track - Code migration and QA Object and Doc review	Mon 10/3/11	Tue 10/4/11	8 hrs
1746	Team track - Operation guidance review and building Tidal Jobs	Tue 10/4/11	Wed 10/5/11	8 hrs
1747	Mock up Data	Mon 10/3/11	Wed 10/5/11	16 hrs
1748	**Execute QA Test**	**Wed 10/5/11**	**Mon 10/10/11**	**22.2 hrs**
1749	**Core Load processes**	**Wed 10/5/11**	**Fri 10/7/11**	**12.2 hrs**
1750	XPF Load	Wed 10/5/11	Wed 10/5/11	0 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1751	**NPI Crosswalk**	**Wed 10/5/11**	**Thu 10/6/11**	**7.4 hrs**
1752	010_UNIX_PROD1025_npifacetstocrosswalkload	Wed 10/5/11	Wed 10/5/11	1.6 hrs
1753	020_UNIX_PROD1025_npicrosswalk	Wed 10/5/11	Thu 10/6/11	1.6 hrs
1754	030_UNIX_PROD1025_npicrosswlktofacetsload.ksh	Thu 10/6/11	Thu 10/6/11	1.6 hrs
1755	040_UNIX_PROD1025_npicrosswalkloginlockreset.ksh	Thu 10/6/11	Thu 10/6/11	1.6 hrs
1756	NPI Web Application	Thu 10/6/11	Thu 10/6/11	1 hr
1757	Panel Rosters	Thu 10/6/11	Thu 10/6/11	1.6 hrs
1758	Panel Count	Thu 10/6/11	Fri 10/7/11	1.6 hrs
1759	Navimedix Provider Extract	Fri 10/7/11	Fri 10/7/11	1.6 hrs
1760	**Extracts**	**Fri 10/7/11**	**Mon 10/10/11**	**8 hrs**
1761	Jiva	Fri 10/7/11	Fri 10/7/11	1.6 hrs
1762	DWH	Fri 10/7/11	Fri 10/7/11	1.6 hrs
1763	ACS/MACCESS	Fri 10/7/11	Fri 10/7/11	1.6 hrs
1764	Provider Directory	Fri 10/7/11	Mon 10/10/11	1.6 hrs
1765	Global Provider Directory	Mon 10/10/11	Mon 10/10/11	1.6 hrs
1766	QA Validation - 20% failure threshold- 80% loaded	Mon 10/10/11	Mon 10/10/11	2 hrs
1767	**Defect Resolution**	**Mon 10/10/11**	**Fri 10/14/11**	**34 hrs**
1768	Root cause Analysis	Mon 10/10/11	Tue 10/11/11	4 hrs
1769	Remediate and unit test	Tue 10/11/11	Tue 10/11/11	6 hrs
1770	Re- package	Tue 10/11/11	Thu 10/13/11	16 hrs
1771	**Change Management and QA Migration**	**Thu 10/13/11**	**Fri 10/14/11**	**8 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
1772	Team Track - Code migration and QA Object and Doc review	Thu 10/13/11	Fri 10/14/11	4 hrs
1773	Team track - Operation guidance review and building Tidal Jobs	Fri 10/14/11	Fri 10/14/11	2 hrs
1774	Defect Mgt tracking	Fri 10/14/11	Fri 10/14/11	2 hrs
1775	Re-Execute Core Load processes	Fri 10/14/11	Fri 10/14/11	2 hrs
1776	Re-Validation	Fri 10/14/11	Sat 10/15/11	2 hrs
1777	**Batch 2 - Member Load - Mocked up data**	**Mon 10/3/11**	**Thu 10/13/11**	**46 hrs**
1778	Mock up data	Mon 10/3/11	Tue 10/4/11	4 hrs
1779	**Exec E&E LOAD**	**Mon 10/3/11**	**Mon 10/10/11**	**19 hrs**
1780	**Exec Core Membership load process**	**Mon 10/10/11**	**Mon 10/10/11**	**16 hrs**
1781	Proprietary Inbound Enrollment Process (834 being developed as a contingency)	Mon 10/10/11	Mon 10/10/11	1.6 hrs
1782	MMS Load	Mon 10/10/11	Mon 10/10/11	1.6 hrs
1783	Member Elig	Mon 10/10/11	Mon 10/10/11	1.6 hrs
1784	Term By Absence	Mon 10/10/11	Mon 10/10/11	1.6 hrs
1785	PCP Assignment	Mon 10/10/11	Mon 10/10/11	1.6 hrs
1786	ID Cards	Mon 10/10/11	Mon 10/10/11	1.6 hrs
1787	Member Labels	Mon 10/10/11	Mon 10/10/11	1.6 hrs
1788	**Extracts**	**Mon 10/10/11**	**Mon 10/10/11**	**4.8 hrs**
1789	Jiva	Mon 10/10/11	Mon 10/10/11	1.6 hrs
1790	DWH	Mon 10/10/11	Mon 10/10/11	1.6 hrs
1791	ACS/MACCESS	Mon 10/10/11	Mon 10/10/11	1.6 hrs
1792	**SUBCON**	**Mon 10/10/11**	**Mon 10/10/11**	**0 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
1793	Family Planning	Mon 10/10/11	Mon 10/10/11	0 hrs
1794	Transportation	Mon 10/10/11	Mon 10/10/11	0 hrs
1795	QA Validation - Threshold of 5% failures	Mon 10/3/11	Mon 10/3/11	2 hrs
1796	Send Member and Provider Files to ACS	Mon 10/10/11	Mon 10/10/11	1 hr
1797	**Defect Resolution**	**Mon 10/10/11**	**Thu 10/13/11**	**23 hrs**
1798	Root cause analysis	Mon 10/10/11	Tue 10/11/11	4 hrs
1799	Remediation and unit testing	Tue 10/11/11	Wed 10/12/11	6 hrs
1800	re-package	Wed 10/12/11	Wed 10/12/11	2 hrs
1801	**Change Management and QA Migration**	**Wed 10/12/11**	**Thu 10/13/11**	**7 hrs**
1802	Team Track - Code migration and QA Object and Doc review	Wed 10/12/11	Wed 10/12/11	4 hrs
1803	Team track - Operation guidance review and building Tidal Jobs	Wed 10/12/11	Thu 10/13/11	2 hrs
1804	Defect Mgt tracking	Wed 10/12/11	Wed 10/12/11	1 hr
1805	Re- exec E&E core load process	Thu 10/13/11	Thu 10/13/11	2 hrs
1806	Re-Validation	Thu 10/13/11	Thu 10/13/11	2 hrs
1807	**Batch 3 -UMI Load Process- Mocked up data**	**Mon 10/3/11**	**Tue 10/11/11**	**63 hrs**
1808	Mock up data	Mon 10/3/11	Tue 10/4/11	4 hrs
1809	**Change Management and QA Migration**	**Mon 10/3/11**	**Wed 10/5/11**	**12 hrs**
1810	Team Track - Code migration and QA Object and Doc review	Mon 10/3/11	Tue 10/4/11	4 hrs
1811	Team track - Operation guidance review and building Tidal Jobs	Tue 10/4/11	Wed 10/5/11	8 hrs
1812	**Care Planner Web**	**Wed 10/5/11**	**Tue 10/11/11**	**47 hrs**
1813	**Exec UMI Load**	**Wed 10/5/11**	**Wed 10/5/11**	**8 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
1814	**UMI Load Process**	**Wed 10/5/11**	**Wed 10/5/11**	**8 hrs**
1815	VB Application	Wed 10/5/11	Wed 10/5/11	1.6 hrs
1816	Void Process	Wed 10/5/11	Wed 10/5/11	1.6 hrs
1817	CP_UMILOAD_PROCESS	Wed 10/5/11	Wed 10/5/11	1.6 hrs
1818	UMI_intUMIRestor	Wed 10/5/11	Wed 10/5/11	1.6 hrs
1819	CP_UMI_UMIRESUBrename	Wed 10/5/11	Wed 10/5/11	1.6 hrs
1820	QA Validation	Wed 10/5/11	Fri 10/7/11	16 hrs
1821	**Defect Resolution**	**Fri 10/7/11**	**Tue 10/11/11**	**23 hrs**
1822	Root cause analysis	Fri 10/7/11	Fri 10/7/11	4 hrs
1823	Remediation and unit testing	Fri 10/7/11	Mon 10/10/11	6 hrs
1824	re-package	Mon 10/10/11	Mon 10/10/11	2 hrs
1825	**Change Management and QA Migration**	**Mon 10/10/11**	**Tue 10/11/11**	**7 hrs**
1826	Team Track - Code migration and QA Object and Doc review	Mon 10/10/11	Tue 10/11/11	4 hrs
1827	Team track - Operation guidance review and building Tidal Jobs	Tue 10/11/11	Tue 10/11/11	2 hrs
1828	Defect Mgt tracking	Mon 10/10/11	Mon 10/10/11	1 hr
1829	Re- execute	Tue 10/11/11	Tue 10/11/11	2 hrs
1830	Re-Validation	Tue 10/11/11	Tue 10/11/11	2 hrs
1831	**Batch 4 -Medical Management**	**Mon 10/3/11**	**Thu 10/6/11**	**74 hrs**
1832	**JIVA**	**Mon 10/3/11**	**Thu 10/6/11**	**35 hrs**
1833	**Change Management and QA Migration**	**Mon 10/3/11**	**Wed 10/5/11**	**12 hrs**
1834	Team Track - Code migration and QA Object and Doc review	Mon 10/3/11	Tue 10/4/11	4 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1835	Team track - Operation guidance review and building Tidal Jobs	Tue 10/4/11	Wed 10/5/11	8 hrs
1836	**QA Validation - Threshold ?**	**Mon 10/3/11**	**Thu 10/6/11**	**23 hrs**
1837	**Defect Resolution**	**Mon 10/3/11**	**Thu 10/6/11**	**23 hrs**
1838	Root cause analysis	Mon 10/3/11	Tue 10/4/11	4 hrs
1839	Remediation and unit testing	Tue 10/4/11	Tue 10/4/11	6 hrs
1840	re-package	Wed 10/5/11	Wed 10/5/11	2 hrs
1841	**Change Management and QA Migration**	**Wed 10/5/11**	**Wed 10/5/11**	**7 hrs**
1842	Team Track - Code migration and QA Object and Doc review	Wed 10/5/11	Wed 10/5/11	4 hrs
1843	Team track - Operation guidance review and building Tidal Jobs	Wed 10/5/11	Wed 10/5/11	2 hrs
1844	Defect Mgt tracking	Wed 10/5/11	Wed 10/5/11	1 hr
1845	Re-Execution	Thu 10/6/11	Thu 10/6/11	2 hrs
1846	Re-Validation	Thu 10/6/11	Thu 10/6/11	2 hrs
1847	**Client Letter**	**Mon 10/3/11**	**Thu 10/6/11**	**39 hrs**
1848	**Change Management and QA Migration**	**Mon 10/3/11**	**Wed 10/5/11**	**12 hrs**
1849	Team Track - Code migration and QA Object and Doc review	Mon 10/3/11	Tue 10/4/11	4 hrs
1850	Team track - Operation guidance review and building Tidal Jobs	Tue 10/4/11	Wed 10/5/11	8 hrs
1851	**QA Validation - Threshold of 5% failures**	**Mon 10/3/11**	**Thu 10/6/11**	**27 hrs**
1852	**Defect Resolution**	**Mon 10/3/11**	**Wed 10/5/11**	**12 hrs**
1853	Root cause analysis	Mon 10/3/11	Tue 10/4/11	4 hrs
1854	Remediation and unit testing	Tue 10/4/11	Tue 10/4/11	6 hrs
1855	re-package	Wed 10/5/11	Wed 10/5/11	2 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1856	**Change Management and QA Migration**	**Wed 10/5/11**	**Thu 10/6/11**	**15 hrs**
1857	Team Track - Code migration and QA Object and Doc review	Wed 10/5/11	Wed 10/5/11	4 hrs
1858	Team track - Operation guidance review and building Tidal Jobs	Wed 10/5/11	Wed 10/5/11	2 hrs
1859	Defect Mgt tracking	Wed 10/5/11	Wed 10/5/11	1 hr
1860	Re-Execution	Thu 10/6/11	Thu 10/6/11	4 hrs
1861	Re-Validation	Thu 10/6/11	Thu 10/6/11	4 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**
1863	Mock up Data	Mon 10/3/11	Mon 10/3/11	1 hr
1864	**Exec QA Claims LOAD _paper claims and EDI Claims**	**Mon 10/3/11**	**Mon 10/31/11**	**328 hrs**
1865	**837**	**Wed 10/5/11**	**Tue 10/11/11**	**36.4 hrs**
1866	EDI Claims Map HIPAA Gateway	Wed 10/5/11	Thu 10/6/11	2.4 hrs
1867	005_UX_PRDIND_EDI_pre_ediload4010	Wed 10/5/11	Wed 10/5/11	1.6 hrs
1868	010_W2000_PRDIND_EDILOAD4010	Wed 10/5/11	Wed 10/5/11	1.6 hrs
1869	015_UX_PRDIND_EDI_post_ediload4010	Wed 10/5/11	Wed 10/5/11	1.6 hrs
1870	020_VB_PRDIND_EDI_DRGGROUPER	Wed 10/5/11	Wed 10/5/11	1.6 hrs
1871	025_UX_PRDIND_KWD_DELETE	Wed 10/5/11	Wed 10/5/11	1.6 hrs
1872	**QA Validation and Defect Resolution**	**Wed 10/5/11**	**Tue 10/11/11**	**26 hrs**
1873	QA validation	Wed 10/5/11	Thu 10/6/11	2 hrs
1874	**Defect Resolution**	**Thu 10/6/11**	**Fri 10/7/11**	**12 hrs**
1875	Root cause analysis	Thu 10/6/11	Thu 10/6/11	4 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1876	Remediation and Unit testing	Thu 10/6/11	Fri 10/7/11	6 hrs
1877	re-package	Fri 10/7/11	Fri 10/7/11	2 hrs
1878	**Change Management and QA Migration**	**Fri 10/7/11**	**Mon 10/10/11**	**7 hrs**
1879	Team Track - Code migration and QA Object and Doc review	Fri 10/7/11	Mon 10/10/11	4 hrs
1880	Team track - Operation guidance review and building Tidal Jobs	Mon 10/10/11	Mon 10/10/11	2 hrs
1881	Defect Mgt tracking	Mon 10/10/11	Mon 10/10/11	1 hr
1882	Re- exec process	Mon 10/10/11	Tue 10/11/11	4 hrs
1883	re-Validation	Tue 10/11/11	Tue 10/11/11	1 hr
1884	Send Paper to ACS - Work With Dawn D to mock up paper claims	Mon 10/3/11	Mon 10/3/11	1 hr
1885	Receive Claims From ACS	Mon 10/3/11	Mon 10/3/11	1 hr
1886	**ACS CLAIMS LOAD**	**Tue 10/4/11**	**Thu 10/13/11**	**131.8 hrs**
1887	005_VB_PROD100_CLM_XCTRANSLATOR	Tue 10/4/11	Tue 10/4/11	1.6 hrs
1888	020_W2K_PRDIND_MAC_XCLOAD_2ND	Tue 10/4/11	Tue 10/4/11	1.6 hrs
1889	025_UX_PRDIND_MAC_post_xcload_2nd	Tue 10/4/11	Tue 10/4/11	1.6 hrs
1890	030_UX_PRDIND_ACSNPICOL	Tue 10/4/11	Tue 10/4/11	1.6 hrs
1891	028_VB_PRDIND_EDI_DRGGROUPER	Tue 10/4/11	Tue 10/4/11	1.6 hrs
1892	044_UX_PRDIND_ndc_resync	Tue 10/4/11	Tue 10/4/11	1.6 hrs
1893	**QA validation and Defect Resolution**	**Tue 10/4/11**	**Fri 10/7/11**	**23 hrs**
1894	QA validation	Tue 10/4/11	Tue 10/4/11	4 hrs
1895	**Defect Resolution**	**Tue 10/4/11**	**Thu 10/6/11**	**12 hrs**
1896	Root cause analysis	Tue 10/4/11	Wed 10/5/11	4 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1897	Remediation and Unit testing	Wed 10/5/11	Wed 10/5/11	6 hrs
1898	re-package	Wed 10/5/11	Thu 10/6/11	2 hrs
1899	**Change Management and QA Migration**	**Thu 10/6/11**	**Fri 10/7/11**	**7 hrs**
1900	Team Track - Code migration and QA Object and Doc review	Thu 10/6/11	Thu 10/6/11	4 hrs
1901	Team track - Operation guidance review and building Tidal Jobs	Thu 10/6/11	Thu 10/6/11	2 hrs
1902	Defect Mgt tracking	Thu 10/6/11	Fri 10/7/11	1 hr
1903	Re- exec process	Thu 10/6/11	Fri 10/7/11	4 hrs
1904	re-Validation	Fri 10/7/11	Fri 10/7/11	4 hrs
1905	**ECRP SF Translator Inbound Process**	**Tue 10/4/11**	**Fri 10/7/11**	**40 hrs**
1906	Receive ECRP File	Tue 10/4/11	Tue 10/4/11	1 hr
1907	030_EXE_PROD1025_CLM_SFTranslator.exe	Tue 10/4/11	Tue 10/4/11	8 hrs
1908	**QA validation and Defect Resolution**	**Tue 10/4/11**	**Thu 10/6/11**	**23 hrs**
1909	QA validation	Tue 10/4/11	Tue 10/4/11	4 hrs
1910	**Defect Resolution**	**Tue 10/4/11**	**Wed 10/5/11**	**12 hrs**
1911	Root cause analysis	Tue 10/4/11	Tue 10/4/11	4 hrs
1912	Remediation and Unit testing	Wed 10/5/11	Wed 10/5/11	6 hrs
1913	re-package	Wed 10/5/11	Wed 10/5/11	2 hrs
1914	**Change Management and QA Migration**	**Thu 10/6/11**	**Thu 10/6/11**	**7 hrs**
1915	Team Track - Code migration and QA Object and Doc review	Thu 10/6/11	Thu 10/6/11	4 hrs
1916	Team track - Operation guidance review and building Tidal Jobs	Thu 10/6/11	Thu 10/6/11	2 hrs
1917	Defect Mgt tracking	Thu 10/6/11	Thu 10/6/11	1 hr

ID	Task Name	Start	Finish	Estimated Work Effort
1918	Re- exec process	Thu 10/6/11	Fri 10/7/11	4 hrs
1919	re-Validation	Fri 10/7/11	Fri 10/7/11	4 hrs
1920	**Auto Adjudication**	**Fri 10/7/11**	**Thu 10/13/11**	**51.2 hrs**
1921	045_UX_PRDIND_MAC_pre_autoadj	Fri 10/7/11	Mon 10/10/11	1.6 hrs
1922	046_UX_PRD_INDIANA_BILL_TYPE_UPD	Fri 10/7/11	Mon 10/10/11	1.6 hrs
1923	047_SP_PRD_INDIANA_DIAG_UPD	Fri 10/7/11	Mon 10/10/11	1.6 hrs
1924	050_W2K_PRDIND_MAC_AUTOADJ_2ND	Fri 10/7/11	Tue 10/11/11	16 hrs
1925	090_UX_PRDIND_MAC_post_autoadj	Fri 10/7/11	Mon 10/10/11	1.6 hrs
1926	ACS Acknowledgements	Fri 10/7/11	Mon 10/10/11	0.8 hrs
1927	**QA validation and Defect Resolution**	**Mon 10/10/11**	**Wed 10/12/11**	**20 hrs**
1928	QA validation	Mon 10/10/11	Mon 10/10/11	1 hr
1929	**Defect Resolution**	**Mon 10/10/11**	**Tue 10/11/11**	**12 hrs**
1930	Root cause analysis	Mon 10/10/11	Mon 10/10/11	4 hrs
1931	Remediation and Unit testing	Mon 10/10/11	Tue 10/11/11	6 hrs
1932	re-package	Tue 10/11/11	Tue 10/11/11	2 hrs
1933	**Change Management and QA Migration**	**Tue 10/11/11**	**Wed 10/12/11**	**7 hrs**
1934	Team Track - Code migration and QA Object and Doc review	Tue 10/11/11	Wed 10/12/11	4 hrs
1935	Team track - Operation guidance review and building Tidal Jobs	Wed 10/12/11	Wed 10/12/11	2 hrs
1936	Defect Mgt tracking	Wed 10/12/11	Wed 10/12/11	1 hr
1937	Re- exec process	Wed 10/12/11	Wed 10/12/11	4 hrs
1938	re-Validation	Wed 10/12/11	Thu 10/13/11	4 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1939	**DOCFLO Process**	**Mon 10/10/11**	**Mon 10/10/11**	**0.8 hrs**
1940	010_DS_PROD1025_MAC_intMacessDocFlowCtrl2800	Mon 10/10/11	Mon 10/10/11	0.8 hrs
1941	**IHEALTH**	**Mon 10/3/11**	**Mon 10/17/11**	**26 hrs**
1942	Set up test claims	Mon 10/3/11	Tue 10/4/11	5 hrs
1943	PROD100_iHealthOutboundProcessICM_BEFORE	Thu 10/13/11	Thu 10/13/11	4 hrs
1944	PROD100_iHealthOutboundProcessICMS	Thu 10/13/11	Fri 10/14/11	4 hrs
1945	Send and Process File at Ihealth	Fri 10/14/11	Fri 10/14/11	2 hrs
1946	PROD100_iHealthInboundProcessICMS	Fri 10/14/11	Sat 10/15/11	4 hrs
1947	PROD100_iHealthInboundProcessICM_AFTER	Sat 10/15/11	Sat 10/15/11	4 hrs
1948	Validate Ihealth Recommendations	Sat 10/15/11	Sat 10/15/11	2 hrs
1949	PROD100_iHealthBackOutProcess	Sat 10/15/11	Mon 10/17/11	1 hr
1950	**FINANCE**	**Mon 10/17/11**	**Mon 10/31/11**	**131 hrs**
1951	Claims Batch Verify Process	Mon 10/17/11	Mon 10/17/11	4 hrs
1952	Claim Recon Process	Mon 10/17/11	Tue 10/18/11	4 hrs
1953	Claim Check Process	Tue 10/18/11	Tue 10/18/11	4 hrs
1954	EFT Enroll Process	Tue 10/18/11	Wed 10/19/11	4 hrs
1955	Claims GL Process	Wed 10/19/11	Wed 10/19/11	4 hrs
1956	ABF Process	Tue 10/18/11	Wed 10/19/11	4 hrs
1957	Send test file to ABF (835)	Wed 10/19/11	Wed 10/19/11	1 hr
1958	CAP GL	Wed 10/19/11	Wed 10/19/11	0 hrs
1959	ABF Roster	Tue 10/18/11	Tue 10/18/11	0 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1960	Maternity Kick	Tue 10/18/11	Wed 10/19/11	4 hrs
1961	**QA validation and Defect Resolution**	**Wed 10/19/11**	**Fri 10/21/11**	**23 hrs**
1962	QA validation	Wed 10/19/11	Wed 10/19/11	4 hrs
1963	**Defect Resolution**	**Wed 10/19/11**	**Fri 10/21/11**	**12 hrs**
1964	Root cause analysis	Wed 10/19/11	Thu 10/20/11	4 hrs
1965	Remediation and Unit testing	Thu 10/20/11	Thu 10/20/11	6 hrs
1966	re-package	Thu 10/20/11	Fri 10/21/11	2 hrs
1967	**Change Management and QA Migration**	**Fri 10/21/11**	**Fri 10/21/11**	**7 hrs**
1968	Team Track - Code migration and QA Object and Doc review	Fri 10/21/11	Fri 10/21/11	4 hrs
1969	Team track - Operation guidance review and building Tidal Jobs	Fri 10/21/11	Fri 10/21/11	2 hrs
1970	Defect Mgt tracking	Fri 10/21/11	Fri 10/21/11	1 hr
1971	Re- exec process	Fri 10/21/11	Mon 10/24/11	4 hrs
1972	re-Validation	Mon 10/24/11	Mon 10/24/11	4 hrs
1973	**ECRP_SF_Outbound_CLM_Process_1025**	**Mon 10/24/11**	**Mon 10/31/11**	**71 hrs**
1974	010_UNIX_PROD1025 _CLM_SFStatus File	Mon 10/24/11	Tue 10/25/11	8 hrs
1975	020_DS_PROD1025_CLM_intPAECRPStatusCtrl	Mon 10/24/11	Tue 10/25/11	8 hrs
1976	030_UNIX_PROD1025 _CLM_ecrpformat.ksh	Mon 10/24/11	Tue 10/25/11	8 hrs
1977	040_FTM_PROD1025_CLM_OECRP_SFS_ren_Archive	Mon 10/24/11	Tue 10/25/11	8 hrs
1978	050_FTM_PROD1025_CLM_OECRP_SFS_moveStatus	Mon 10/24/11	Tue 10/25/11	8 hrs
1979	**QA validation and Defect Resolution**	**Tue 10/25/11**	**Fri 10/28/11**	**23 hrs**
1980	QA validation	Tue 10/25/11	Wed 10/26/11	4 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
1981	**Defect Resolution**	**Wed 10/26/11**	**Thu 10/27/11**	**12 hrs**
1982	Root cause analysis	Wed 10/26/11	Wed 10/26/11	4 hrs
1983	Remediation and Unit testing	Wed 10/26/11	Thu 10/27/11	6 hrs
1984	re-package	Thu 10/27/11	Thu 10/27/11	2 hrs
1985	**Change Management and QA Migration**	**Thu 10/27/11**	**Fri 10/28/11**	**7 hrs**
1986	Team Track - Code migration and QA Object and Doc review	Thu 10/27/11	Fri 10/28/11	4 hrs
1987	Team track - Operation guidance review and building Tidal Jobs	Fri 10/28/11	Fri 10/28/11	2 hrs
1988	Defect Mgt tracking	Fri 10/28/11	Fri 10/28/11	1 hr
1989	Re- exec process	Fri 10/28/11	Mon 10/31/11	4 hrs
1990	re-Validation	Mon 10/31/11	Mon 10/31/11	4 hrs
1991	**End Test Cycle 2**	**Tue 11/1/11**	**Tue 11/1/11**	**1 hr**
1992	End Cycle 2 QA sign off	Tue 11/1/11	Tue 11/1/11	1 hr
1993	Turn Over to UAT	Tue 11/1/11	Tue 11/1/11	0 hrs
1994	**Test Cycle3**	**Tue 11/1/11**	**Wed 11/16/11**	**456.6 hrs**
1995	**Change Management and QA Migration**	**Tue 11/1/11**	**Thu 11/3/11**	**16 hrs**
1996	Team Track - Code migration and QA Object and Doc review	Tue 11/1/11	Wed 11/2/11	8 hrs
1997	Team track - Operation guidance review and building Tidal Jobs	Wed 11/2/11	Thu 11/3/11	8 hrs
1998	**Batch 1 - Provider Test 3**	**Thu 11/3/11**	**Wed 11/9/11**	**45.8 hrs**
1999	**Execute QA Test**	**Thu 11/3/11**	**Mon 11/7/11**	**22.8 hrs**
2000	**Core Load processes**	**Thu 11/3/11**	**Mon 11/7/11**	**19.2 hrs**
2001	XPF Load	Thu 11/3/11	Thu 11/3/11	1.6 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2002	NPI Crosswalk	Thu 11/3/11	Thu 11/3/11	1.6 hrs
2003	010_UNIX_PROD1025_npifacetstocrosswalkload	Thu 11/3/11	Thu 11/3/11	1.6 hrs
2004	020_UNIX_PROD1025_npicrosswalk	Thu 11/3/11	Thu 11/3/11	1.6 hrs
2005	030_UNIX_PROD1025_npicrosswlktofacetsload.ksh	Thu 11/3/11	Thu 11/3/11	1.6 hrs
2006	040_UNIX_PROD1025_npicrosswalkloginlockreset.ksh	Thu 11/3/11	Fri 11/4/11	1.6 hrs
2007	Panel Rosters	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2008	Panel Count	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2009	Navimedix	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2010	EXTENSION - PANEL COUNT EXTENSION PCP/GROUP LOOKUP	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2011	EXTENSION - PROVIDER, COMMON PRACT GROUP MEMBER COUNTS DISPLAY	Fri 11/4/11	Mon 11/7/11	1.6 hrs
2012	EXTENSION - PROVIDER GROUP PCP MAXIMUM ASSIGNMENT	Mon 11/7/11	Mon 11/7/11	1.6 hrs
2013	**Extracts**	**Fri 11/4/11**	**Fri 11/4/11**	**1.6 hrs**
2014	Jiva	Fri 11/4/11	Fri 11/4/11	0 hrs
2015	DWH	Fri 11/4/11	Fri 11/4/11	0 hrs
2016	ACS/MACCESS	Fri 11/4/11	Fri 11/4/11	0 hrs
2017	MONTHLY OUTBOUND RECOVERY PROVIDER_2400	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2018	Provider Directory	Fri 11/4/11	Fri 11/4/11	0 hrs
2019	Global Provider Directory	Fri 11/4/11	Fri 11/4/11	0 hrs
2020	QA Validation - 20% failure threshold- 80% loaded	Fri 11/4/11	Fri 11/4/11	2 hrs
2021	**Defect Resolution**	**Fri 11/4/11**	**Tue 11/8/11**	**19 hrs**
2022	Root cause Analysis	Fri 11/4/11	Mon 11/7/11	4 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2023	Remediate and unit test	Mon 11/7/11	Mon 11/7/11	6 hrs
2024	Re- package	Mon 11/7/11	Tue 11/8/11	2 hrs
2025	**Change Management and QA Migration**	**Mon 11/7/11**	**Tue 11/8/11**	**7 hrs**
2026	Team Track - Code migration and QA Object and Doc review	Mon 11/7/11	Tue 11/8/11	4 hrs
2027	Team track - Operation guidance review and building Tidal Jobs	Tue 11/8/11	Tue 11/8/11	2 hrs
2028	Defect Mgt tracking	Tue 11/8/11	Tue 11/8/11	1 hr
2029	Re-Execute Core Load processes	Tue 11/8/11	Tue 11/8/11	2 hrs
2030	Re-Validation	Tue 11/8/11	Wed 11/9/11	2 hrs
2031	**Batch 2 - Member Load**	**Fri 11/4/11**	**Wed 11/9/11**	**46.8 hrs**
2032	**Exec E&E LOAD**	**Fri 11/4/11**	**Mon 11/7/11**	**23.8 hrs**
2033	**Exec Core Membership load process**	**Fri 11/4/11**	**Fri 11/4/11**	**20.8 hrs**
2034	Proprietary Inbound Enrollment Process (834 being developed as a contingency)	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2035	MMS Load	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2036	Member Elig	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2037	Term By Absence	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2038	PCP Assignment	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2039	ID Cards	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2040	Member Labels	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2041	EPSDT	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2042	Newborn Letters	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2043	**Extracts**	**Fri 11/4/11**	**Fri 11/4/11**	**6.4 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
2044	Jiva	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2045	DWH	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2046	ACS/MACCESS	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2047	Recovery Member	Fri 11/4/11	Fri 11/4/11	1.6 hrs
2048	**SUBCON**	**Fri 11/4/11**	**Fri 11/4/11**	**0 hrs**
2049	Family Planning	Fri 11/4/11	Fri 11/4/11	0 hrs
2050	Transportation	Fri 11/4/11	Fri 11/4/11	0 hrs
2051	QA Validation - Threshold of 5% failures	Fri 11/4/11	Fri 11/4/11	2 hrs
2052	Send Member and Provider Files to ACS	Mon 11/7/11	Mon 11/7/11	1 hr
2053	**Defect Resolution**	**Fri 11/4/11**	**Wed 11/9/11**	**23 hrs**
2054	Root cause analysis	Fri 11/4/11	Mon 11/7/11	4 hrs
2055	Remediation and unit testing	Mon 11/7/11	Tue 11/8/11	6 hrs
2056	re-package	Tue 11/8/11	Tue 11/8/11	2 hrs
2057	**Change Management and QA Migration**	**Tue 11/8/11**	**Wed 11/9/11**	**7 hrs**
2058	Team Track - Code migration and QA Object and Doc review	Tue 11/8/11	Tue 11/8/11	4 hrs
2059	Team track - Operation guidance review and building Tidal Jobs	Tue 11/8/11	Wed 11/9/11	2 hrs
2060	Defect Mgt tracking	Tue 11/8/11	Tue 11/8/11	1 hr
2061	Re- exec E&E core load process	Wed 11/9/11	Wed 11/9/11	2 hrs
2062	Re-Validation	Wed 11/9/11	Wed 11/9/11	2 hrs
2063	**Batch 3 -UMI Load Process- Mocked up data**	**Tue 11/1/11**	**Mon 11/7/11**	**49 hrs**
2064	Mock up data	Tue 11/1/11	Tue 11/1/11	4 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2065	**Change Management and QA Migration**	**Tue 11/1/11**	**Wed 11/2/11**	**12 hrs**
2066	Team Track - Code migration and QA Object and Doc review	Tue 11/1/11	Tue 11/1/11	4 hrs
2067	Team track - Operation guidance review and building Tidal Jobs	Tue 11/1/11	Wed 11/2/11	8 hrs
2068	**Care Planner Web**	**Wed 11/2/11**	**Mon 11/7/11**	**33 hrs**
2069	**Exec UMI Load**	**Wed 11/2/11**	**Wed 11/2/11**	**8 hrs**
2070	**UMI Load Process**	**Wed 11/2/11**	**Wed 11/2/11**	**8 hrs**
2071	VB Application	Wed 11/2/11	Wed 11/2/11	1.6 hrs
2072	Void Process	Wed 11/2/11	Wed 11/2/11	1.6 hrs
2073	CP_UMILOAD_PROCESS	Wed 11/2/11	Wed 11/2/11	1.6 hrs
2074	UMI_intUMIRestor	Wed 11/2/11	Wed 11/2/11	1.6 hrs
2075	CP_UMI_UMIRESUBrename	Wed 11/2/11	Wed 11/2/11	1.6 hrs
2076	QA Validation	Wed 11/2/11	Wed 11/2/11	2 hrs
2077	**Defect Resolution**	**Wed 11/2/11**	**Mon 11/7/11**	**23 hrs**
2078	Root cause analysis	Wed 11/2/11	Thu 11/3/11	4 hrs
2079	Remediation and unit testing	Thu 11/3/11	Fri 11/4/11	6 hrs
2080	re-package	Fri 11/4/11	Fri 11/4/11	2 hrs
2081	**Change Management and QA Migration**	**Fri 11/4/11**	**Mon 11/7/11**	**7 hrs**
2082	Team Track - Code migration and QA Object and Doc review	Fri 11/4/11	Fri 11/4/11	4 hrs
2083	Team track - Operation guidance review and building Tidal Jobs	Fri 11/4/11	Mon 11/7/11	2 hrs
2084	Defect Mgt tracking	Fri 11/4/11	Fri 11/4/11	1 hr
2085	Re- execute	Mon 11/7/11	Mon 11/7/11	2 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2086	Re-Validation	Mon 11/7/11	Mon 11/7/11	2 hrs
2087	**Batch 4 - Claims Load process - EDI and Paper**	**Tue 11/1/11**	**Wed 11/16/11**	**299 hrs**
2088	Mock up EDI Data	Tue 11/1/11	Tue 11/1/11	1 hr
2089	**Change Management and QA Migration**	**Tue 11/1/11**	**Wed 11/2/11**	**12 hrs**
2090	Team Track - Code migration and QA Object and Doc review	Tue 11/1/11	Tue 11/1/11	4 hrs
2091	Team track - Operation guidance review and building Tidal Jobs	Tue 11/1/11	Wed 11/2/11	8 hrs
2092	**Exec QA Claims LOAD _paper claims and EDI Claims**	**Fri 11/4/11**	**Wed 11/16/11**	**223 hrs**
2093	**837**	**Fri 11/4/11**	**Thu 11/10/11**	**38.8 hrs**
2094	EDI Claims Support Interface Extension?	Fri 11/4/11	Mon 11/7/11	2.4 hrs
2095	EDI Claims Map HIPAA Gateway	Fri 11/4/11	Mon 11/7/11	2.4 hrs
2096	005_UX_PRDIND_EDI_pre_ediload4010	Fri 11/4/11	Mon 11/7/11	1.6 hrs
2097	010_W2000_PRDIND_EDILOAD4010	Fri 11/4/11	Mon 11/7/11	1.6 hrs
2098	015_UX_PRDIND_EDI_post_ediload4010	Fri 11/4/11	Mon 11/7/11	1.6 hrs
2099	020_VB_PRDIND_EDI_DRGGROUPER	Fri 11/4/11	Mon 11/7/11	1.6 hrs
2100	025_UX_PRDIND_KWD_DELETE	Fri 11/4/11	Mon 11/7/11	1.6 hrs
2101	**QA Validation and Defect Resolution**	**Mon 11/7/11**	**Thu 11/10/11**	**26 hrs**
2102	QA validation	Mon 11/7/11	Mon 11/7/11	2 hrs
2103	**Defect Resolution**	**Mon 11/7/11**	**Tue 11/8/11**	**12 hrs**
2104	Root cause analysis	Mon 11/7/11	Mon 11/7/11	4 hrs
2105	Remediation and Unit testing	Mon 11/7/11	Tue 11/8/11	6 hrs
2106	re-package	Tue 11/8/11	Tue 11/8/11	2 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2107	**Change Management and QA Migration**	**Tue 11/8/11**	**Wed 11/9/11**	**7 hrs**
2108	Team Track - Code migration and QA Object and Doc review	Tue 11/8/11	Wed 11/9/11	4 hrs
2109	Team track - Operation guidance review and building Tidal Jobs	Wed 11/9/11	Wed 11/9/11	2 hrs
2110	Defect Mgt tracking	Wed 11/9/11	Wed 11/9/11	1 hr
2111	Re- exec process	Wed 11/9/11	Thu 11/10/11	4 hrs
2112	re-Validation	Thu 11/10/11	Thu 11/10/11	1 hr
2113	Send Paper to ACS - Work With Dawn D to mock up paper claims	Fri 11/4/11	Fri 11/4/11	1 hr
2114	Receive Claims From ACS	Fri 11/4/11	Mon 11/7/11	1 hr
2115	**ACS CLAIMS LOAD**	**Mon 11/7/11**	**Wed 11/16/11**	**143.8 hrs**
2116	005_VB_PROD100_CLM_XCTRANSLATOR	Mon 11/7/11	Mon 11/7/11	1.6 hrs
2117	020_W2K_PRDIND_MAC_XCLOAD_2ND	Mon 11/7/11	Mon 11/7/11	1.6 hrs
2118	025_UX_PRDIND_MAC_post_xcload_2nd	Mon 11/7/11	Mon 11/7/11	1.6 hrs
2119	030_UX_PRDIND_ACSNPICOL	Mon 11/7/11	Mon 11/7/11	1.6 hrs
2120	028_VB_PRDIND_EDI_DRGGROUPER	Mon 11/7/11	Mon 11/7/11	1.6 hrs
2121	044_UX_PRDIND_ndc_resync	Mon 11/7/11	Mon 11/7/11	1.6 hrs
2122	**QA validation and Defect Resolution**	**Mon 11/7/11**	**Thu 11/10/11**	**23 hrs**
2123	QA validation	Mon 11/7/11	Mon 11/7/11	4 hrs
2124	**Defect Resolution**	**Mon 11/7/11**	**Wed 11/9/11**	**12 hrs**
2125	Root cause analysis	Mon 11/7/11	Tue 11/8/11	4 hrs
2126	Remediation and Unit testing	Tue 11/8/11	Wed 11/9/11	6 hrs
2127	re-package	Wed 11/9/11	Wed 11/9/11	2 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2128	**Change Management and QA Migration**	**Wed 11/9/11**	**Thu 11/10/11**	**7 hrs**
2129	Team Track - Code migration and QA Object and Doc review	Wed 11/9/11	Wed 11/9/11	4 hrs
2130	Team track - Operation guidance review and building Tidal Jobs	Wed 11/9/11	Thu 11/10/11	2 hrs
2131	Defect Mgt tracking	Thu 11/10/11	Thu 11/10/11	1 hr
2132	Re- exec process	Thu 11/10/11	Thu 11/10/11	4 hrs
2133	re-Validation	Thu 11/10/11	Fri 11/11/11	4 hrs
2134	**ECRP SF Translator Inbound Process**	**Mon 11/7/11**	**Thu 11/10/11**	**40 hrs**
2135	Receive ECRP File	Mon 11/7/11	Mon 11/7/11	1 hr
2136	030_EXE_PROD1025_CLM_SFTranslator.exe	Mon 11/7/11	Tue 11/8/11	8 hrs
2137	**QA validation and Defect Resolution**	**Mon 11/7/11**	**Wed 11/9/11**	**23 hrs**
2138	QA validation	Mon 11/7/11	Mon 11/7/11	4 hrs
2139	**Defect Resolution**	**Mon 11/7/11**	**Wed 11/9/11**	**12 hrs**
2140	Root cause analysis	Mon 11/7/11	Tue 11/8/11	4 hrs
2141	Remediation and Unit testing	Tue 11/8/11	Tue 11/8/11	6 hrs
2142	re-package	Tue 11/8/11	Wed 11/9/11	2 hrs
2143	**Change Management and QA Migration**	**Wed 11/9/11**	**Wed 11/9/11**	**7 hrs**
2144	Team Track - Code migration and QA Object and Doc review	Wed 11/9/11	Wed 11/9/11	4 hrs
2145	Team track - Operation guidance review and building Tidal Jobs	Wed 11/9/11	Wed 11/9/11	2 hrs
2146	Defect Mgt tracking	Wed 11/9/11	Wed 11/9/11	1 hr
2147	Re- exec process	Wed 11/9/11	Thu 11/10/11	4 hrs
2148	re-Validation	Thu 11/10/11	Thu 11/10/11	4 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2149	**Auto Adjudication**	**Fri 11/11/11**	**Wed 11/16/11**	**63.2 hrs**
2150	045_UX_PRDIND_MAC_pre_autoadj	Fri 11/11/11	Fri 11/11/11	1.6 hrs
2151	046_UX_PRD_INDIANA_BILL_TYPE_UPD	Fri 11/11/11	Fri 11/11/11	1.6 hrs
2152	047_SP_PRD_INDIANA_DIAG_UPD	Fri 11/11/11	Fri 11/11/11	1.6 hrs
2153	050_W2K_PRDIND_MAC_AUTOADJ_2ND	Fri 11/11/11	Tue 11/15/11	16 hrs
2154	090_UX_PRDIND_MAC_post_autoadj	Fri 11/11/11	Fri 11/11/11	1.6 hrs
2155	ACS Acknowledgements	Fri 11/11/11	Fri 11/11/11	0.8 hrs
2156	**QA validation and Defect Resolution**	**Fri 11/11/11**	**Tue 11/15/11**	**32 hrs**
2157	QA validation	Fri 11/11/11	Fri 11/11/11	1 hr
2158	**Defect Resolution**	**Fri 11/11/11**	**Mon 11/14/11**	**24 hrs**
2159	Root cause analysis	Fri 11/11/11	Fri 11/11/11	4 hrs
2160	Remediation and Unit testing	Fri 11/11/11	Mon 11/14/11	6 hrs
2161	re-package	Mon 11/14/11	Mon 11/14/11	2 hrs
2162	**Change Management and QA Migration**	**Mon 11/14/11**	**Tue 11/15/11**	**7 hrs**
2163	Team Track - Code migration and QA Object and Doc review	Mon 11/14/11	Tue 11/15/11	4 hrs
2164	Team track - Operation guidance review and building Tidal Jobs	Tue 11/15/11	Tue 11/15/11	2 hrs
2165	Defect Mgt tracking	Tue 11/15/11	Tue 11/15/11	1 hr
2166	Re- exec process	Tue 11/15/11	Wed 11/16/11	4 hrs
2167	re-Validation	Wed 11/16/11	Wed 11/16/11	4 hrs
2168	**DOCFLO Process**	**Fri 11/4/11**	**Fri 11/4/11**	**0.8 hrs**
2169	010_DS_PROD1025_MAC_intMacessDocFlowCtrl2800	Fri 11/4/11	Fri 11/4/11	0.8 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2170	**CLAIMS**	**Fri 11/4/11**	**Thu 11/10/11**	**32.8 hrs**
2171	EDI Claims Support Interface Extension	Fri 11/4/11	Mon 11/7/11	1.6 hrs
2172	Claims Time to Pay	Fri 11/4/11	Mon 11/7/11	1.6 hrs
2173	Outbound Recovery Claims	Fri 11/4/11	Mon 11/7/11	1.6 hrs
2174	**QA validation and Defect Resolution**	**Mon 11/7/11**	**Wed 11/9/11**	**20 hrs**
2175	QA validation	Mon 11/7/11	Mon 11/7/11	1 hr
2176	**Defect Resolution**	**Mon 11/7/11**	**Tue 11/8/11**	**12 hrs**
2177	Root cause analysis	Mon 11/7/11	Mon 11/7/11	4 hrs
2178	Remediation and Unit testing	Mon 11/7/11	Tue 11/8/11	6 hrs
2179	re-package	Tue 11/8/11	Tue 11/8/11	2 hrs
2180	**Change Management and QA Migration**	**Tue 11/8/11**	**Wed 11/9/11**	**7 hrs**
2181	Team Track - Code migration and QA Object and Doc review	Tue 11/8/11	Wed 11/9/11	4 hrs
2182	Team track - Operation guidance review and building Tidal Jobs	Wed 11/9/11	Wed 11/9/11	2 hrs
2183	Defect Mgt tracking	Wed 11/9/11	Wed 11/9/11	1 hr
2184	Re- exec process	Wed 11/9/11	Wed 11/9/11	4 hrs
2185	re-Validation	Wed 11/9/11	Thu 11/10/11	4 hrs
2186	**FINANCE**	**Wed 11/16/11**	**Wed 11/16/11**	**4.8 hrs**
2187	ABF Process (without 835 process mapping execution)	Wed 11/16/11	Wed 11/16/11	0.8 hrs
2188	Claim Check Process	Wed 11/16/11	Wed 11/16/11	0.8 hrs
2189	Claims Batch Verify Process	Wed 11/16/11	Wed 11/16/11	0.8 hrs
2190	Claim Recon Process	Wed 11/16/11	Wed 11/16/11	0.8 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2191	EFT Enroll Process	Wed 11/16/11	Wed 11/16/11	0.8 hrs
2192	Claims GL Process	Wed 11/16/11	Wed 11/16/11	0.8 hrs
2193	CAP GL	Wed 11/16/11	Wed 11/16/11	0 hrs
2194	ABF Roster	Wed 11/16/11	Wed 11/16/11	0 hrs
2195	CAP BATCH	Wed 11/16/11	Wed 11/16/11	0 hrs
2196	Maternity Kick	Wed 11/16/11	Wed 11/16/11	0 hrs
2197	Rev Cat	Wed 11/16/11	Wed 11/16/11	0 hrs
2198	PRE Billing	Wed 11/16/11	Wed 11/16/11	0 hrs
2199	Verify Billing Batch	Wed 11/16/11	Wed 11/16/11	0 hrs
2200	CDS Billing Batch	Wed 11/16/11	Wed 11/16/11	0 hrs
2201	1099	Wed 11/16/11	Wed 11/16/11	0 hrs
2202	**Extracts**	**Tue 11/1/11**	**Tue 11/1/11**	**0 hrs**
2203	Billing Extract	Tue 11/1/11	Tue 11/1/11	0 hrs
2204	Transfer Bill Extract to Network	Tue 11/1/11	Tue 11/1/11	0 hrs
2205	Billing Extract BCP	Tue 11/1/11	Tue 11/1/11	0 hrs
2206	**QA validation**	**Tue 11/1/11**	**Thu 11/3/11**	**23 hrs**
2207	**Defect Resolution**	**Tue 11/1/11**	**Wed 11/2/11**	**12 hrs**
2208	Root cause analysis	Tue 11/1/11	Tue 11/1/11	4 hrs
2209	Remediation and Unit testing	Tue 11/1/11	Wed 11/2/11	6 hrs
2210	re-package	Wed 11/2/11	Wed 11/2/11	2 hrs
2211	**Change Management and QA Migration**	**Wed 11/2/11**	**Thu 11/3/11**	**7 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
2212	Team Track - Code migration and QA Object and Doc review	Wed 11/2/11	Thu 11/3/11	4 hrs
2213	Team track - Operation guidance review and building Tidal Jobs	Thu 11/3/11	Thu 11/3/11	2 hrs
2214	Defect Mgt tracking	Thu 11/3/11	Thu 11/3/11	1 hr
2215	Re- exec E&E load process	Thu 11/3/11	Thu 11/3/11	2 hrs
2216	re-Validation	Thu 11/3/11	Thu 11/3/11	2 hrs
2217	Data Warehouse	Tue 11/1/11	Wed 11/2/11	10 hrs
2218	Encounters	Tue 11/1/11	Wed 11/2/11	15 hrs
2219	**End Test Cycle 3**	**Tue 11/1/11**	**Wed 11/2/11**	**15 hrs**
2220	End Cycle 3 QA sign off	Tue 11/1/11	Wed 11/2/11	15 hrs
2221	Turn Over to UAT	Wed 11/2/11	Wed 11/2/11	0 hrs
2222	**Project Manager 3**	**Mon 4/11/11**	**Wed 5/2/12**	**17,675.12 hrs**
2223	**Service Operations**	**Mon 4/11/11**	**Tue 5/1/12**	**17,675.12 hrs**
2224	**Operations and Service Operations Readiness**	**Fri 5/27/11**	**Tue 5/1/12**	**256 hrs**
2225	**Readiness Review Preparation**	**Fri 5/27/11**	**Tue 8/30/11**	**256 hrs**
2226	Develop readiness review guide / checklist	Fri 5/27/11	Thu 6/2/11	40 hrs
2227	System readiness checklist	Fri 6/3/11	Thu 6/9/11	40 hrs
2228	Gather all materials - Process flows and P&P's	Fri 6/10/11	Thu 6/23/11	80 hrs
2229	Systems and Processes prepared for Internal Readiness Review	Mon 8/15/11	Mon 8/15/11	0 hrs
2230	Conduct internal readiness review	Mon 8/15/11	Fri 8/19/11	40 hrs
2231	Complete gap analysis	Mon 8/22/11	Tue 8/23/11	16 hrs
2232	Update readiness review materials	Wed 8/24/11	Tue 8/30/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2233	**Planning**	**Fri 5/20/11**	**Wed 6/29/11**	**344 hrs**
2234	**Business Requirements (All functional areas)**	**Fri 5/20/11**	**Thu 6/9/11**	**120 hrs**
2235	Document performance standards	Fri 5/20/11	Thu 6/9/11	120 hrs
2236	Functional Requirements (All functional areas)	Thu 5/26/11	Fri 6/24/11	176 hrs
2237	Development of project plan	Mon 6/13/11	Wed 6/15/11	24 hrs
2238	Identify Project Risks/Constraints	Sun 6/26/11	Tue 6/28/11	24 hrs
2239	**STAFFING**	**Mon 4/11/11**	**Thu 3/1/12**	**671.12 hrs**
2240	**Create staffing plan**	**Mon 4/11/11**	**Wed 4/20/11**	**128 hrs**
2241	Determine business hours of operations / Staffing Model	Mon 4/11/11	Fri 4/15/11	40 hrs
2242	Create Job Descriptions	Mon 4/18/11	Wed 4/20/11	24 hrs
2243	Create recruitment strategy	Wed 4/20/11	Wed 4/20/11	0 hrs
2244	Recruit staff	Wed 4/20/11	Wed 4/20/11	0 hrs
2245	Identify interviewers	Thu 4/21/11	Thu 4/21/11	8 hrs
2246	Advertise Post positions	Thu 4/21/11	Thu 4/21/11	0 hrs
2247	Source and review resumes	Fri 4/22/11	Fri 4/22/11	8 hrs
2248	Interview candidates	Wed 6/22/11	Sun 6/26/11	32 hrs
2249	Background checks & drug testing	Mon 6/27/11	Fri 7/1/11	40 hrs
2250	Send paperwork to HRIS for associate set-up	Mon 7/4/11	Tue 7/5/11	16 hrs
2251	Extend Offers / Employee notice	Wed 7/6/11	Tue 7/19/11	80 hrs
2252	Hire Contact Center Staff	Mon 11/7/11	Fri 12/30/11	60 hrs
2253	Hire Enrollment Staff	Mon 11/21/11	Fri 12/30/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2254	Hire Claims Processing Staff	Mon 10/31/11	Fri 12/30/11	60 hrs
2255	**"On-Boarding" New Staff**	**Mon 10/24/11**	**Fri 12/30/11**	**199.12 hrs**
2256	Determine User System Access Requirements	Mon 11/7/11	Fri 12/30/11	71.12 hrs
2257	**Set System security by functions and levels**	**Mon 10/24/11**	**Mon 10/24/11**	**0 hrs**
2258	Facets	Mon 10/24/11	Mon 10/24/11	0 hrs
2259	Streamline	Mon 10/24/11	Mon 10/24/11	0 hrs
2260	Macess EXP	Mon 10/24/11	Mon 10/24/11	0 hrs
2261	State System	Mon 10/24/11	Mon 10/24/11	0 hrs
2262	**Determine license requirements**	**Mon 10/24/11**	**Fri 12/30/11**	**128 hrs**
2263	Identify Users	Mon 10/24/11	Fri 10/28/11	40 hrs
2264	Obtain and verify User IDs	Fri 10/28/11	Fri 12/30/11	88 hrs
2265	**FACILITIES (Corporate)**	**Mon 8/1/11**	**Fri 9/30/11**	**280 hrs**
2266	Determine space requirements	Mon 8/1/11	Thu 8/4/11	32 hrs
2267	Identify available space for all business functions	Mon 8/8/11	Fri 8/19/11	8 hrs
2268	Identify space Planner/Design Phase	Mon 8/22/11	Fri 9/2/11	80 hrs
2269	Reconfigure space	Mon 9/5/11	Fri 9/30/11	160 hrs
2270	Space available	Fri 9/30/11	Fri 9/30/11	0 hrs
2271	**REPORTING**	**Mon 7/4/11**	**Fri 12/9/11**	**352 hrs**
2272	**Define Reporting Requirements**	**Mon 7/4/11**	**Fri 7/15/11**	**240 hrs**
2273	State Reports	Mon 7/4/11	Fri 7/8/11	40 hrs
2274	Standard Operations Reporting	Mon 7/4/11	Fri 7/8/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2275	Management Reports	Mon 7/4/11	Fri 7/8/11	40 hrs
2276	Create Report catalog (include distribution methods and schedule)	Mon 7/4/11	Fri 7/8/11	40 hrs
2277	Perform data element gap analysis	Mon 7/4/11	Fri 7/15/11	80 hrs
2278	Design / Develop reports	Tue 7/26/11	Mon 8/29/11	40 hrs
2279	Validate Reports	Tue 8/30/11	Wed 8/31/11	16 hrs
2280	Business lead sign-off	Thu 9/1/11	Fri 9/2/11	16 hrs
2281	Report move into production	Mon 12/5/11	Fri 12/9/11	40 hrs
2282	**Operations**	**Mon 4/11/11**	**Fri 12/23/11**	**6,892 hrs**
2283	**Contact Center (Member Services & Provider Claims Services)**	**Mon 6/13/11**	**Fri 12/9/11**	**3,036 hrs**
2284	Hire Contact Center Staff	Mon 11/7/11	Mon 11/7/11	0 hrs
2285	**Develop Online Help Content**	**Tue 7/26/11**	**Mon 9/5/11**	**240 hrs**
2286	Identify modifications to workflow processes	Tue 7/26/11	Mon 8/22/11	160 hrs
2287	Develop online help file for LA	Tue 8/23/11	Mon 9/5/11	80 hrs
2288	**Call Scripting**	**Mon 8/8/11**	**Wed 8/24/11**	**104 hrs**
2289	Draft Call Scripting in accordance to LA requirements	Mon 8/8/11	Fri 8/12/11	40 hrs
2290	Obtain DHH approval	Mon 8/15/11	Fri 8/19/11	40 hrs
2291	Finalize scripts	Mon 8/22/11	Wed 8/24/11	24 hrs
2292	**Welcome Calls**	**Mon 6/13/11**	**Thu 12/1/11**	**728 hrs**
2293	Develop call scripts	Mon 8/8/11	Fri 8/12/11	40 hrs
2294	Develop workflows	Mon 8/8/11	Fri 8/12/11	40 hrs
2295	Identify vendor	Mon 6/13/11	Fri 6/17/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2296	Determine system license requirements	Mon 8/8/11	Wed 8/10/11	24 hrs
2297	Develop reporting requirements	Thu 8/11/11	Wed 8/24/11	80 hrs
2298	Develop quality auditing process	Thu 8/11/11	Wed 8/24/11	80 hrs
2299	Connectivity to vendor	Tue 11/1/11	Thu 12/1/11	184 hrs
2300	Develop Training program and materials	Mon 9/5/11	Fri 9/23/11	120 hrs
2301	Conduct training	Mon 11/7/11	Fri 11/25/11	120 hrs
2302	**Develop Complaint and Appeals Process**	**Fri 7/29/11**	**Thu 8/11/11**	**160 hrs**
2303	Provider Appeals	Fri 7/29/11	Thu 8/11/11	80 hrs
2304	Member Appeals	Fri 7/29/11	Thu 8/11/11	80 hrs
2305	**Policy and Procedures**	**Mon 7/4/11**	**Fri 8/12/11**	**100 hrs**
2306	Identify Gaps	Mon 7/4/11	Fri 7/8/11	40 hrs
2307	Modify Policies and Procedures	Mon 7/11/11	Fri 8/12/11	60 hrs
2308	**Training**	**Tue 9/6/11**	**Fri 12/9/11**	**336 hrs**
2309	Develop Training Workflows / Materials	Tue 9/6/11	Mon 9/26/11	120 hrs
2310	Schedule Training Session	Tue 9/27/11	Wed 9/28/11	16 hrs
2311	Conduct Contact Center Training	Mon 11/7/11	Fri 12/9/11	200 hrs
2312	Training graduation	Fri 12/9/11	Fri 12/9/11	0 hrs
2313	**Coordinate Telecom Requirements**	**Mon 7/18/11**	**Fri 8/26/11**	**648 hrs**
2314	Obtain '800' telephone number(s) for Contact Center	Tue 7/26/11	Mon 8/1/11	40 hrs
2315	Compose messages	Mon 8/1/11	Wed 8/3/11	24 hrs
2316	Determine Call Flows	Thu 8/4/11	Mon 8/8/11	24 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2317	Configure Call Management System (CMS)	Tue 8/9/11	Mon 8/22/11	80 hrs
2318	Call Tracking - ACD	Tue 8/23/11	Tue 8/23/11	8 hrs
2319	**Telephone recorded messages**	**Mon 8/1/11**	**Fri 8/26/11**	**160 hrs**
2320	Draft scripting language	Mon 8/1/11	Fri 8/5/11	40 hrs
2321	Obtain DHH approval	Mon 8/8/11	Fri 8/12/11	40 hrs
2322	Configure system	Mon 8/15/11	Fri 8/19/11	40 hrs
2323	Set up TDD/TTY	Mon 8/22/11	Fri 8/26/11	40 hrs
2324	**Interactive Voice Response - IVR**	**Mon 7/18/11**	**Thu 8/11/11**	**152 hrs**
2325	Identify IVR enhancements	Mon 7/18/11	Wed 7/20/11	24 hrs
2326	Configure system	Thu 7/21/11	Wed 8/3/11	80 hrs
2327	Test system enhancements	Thu 8/4/11	Wed 8/10/11	40 hrs
2328	Business lead sign-off	Thu 8/11/11	Thu 8/11/11	8 hrs
2329	Configure Call Logger (if applicable)	Fri 8/12/11	Thu 8/25/11	80 hrs
2330	Configure Witness	Fri 8/12/11	Thu 8/25/11	80 hrs
2331	**Work Force Management**	**Mon 9/5/11**	**Fri 10/14/11**	**240 hrs**
2332	Determine LA specific performance criteria	Mon 9/5/11	Fri 9/9/11	40 hrs
2333	Develop required staffing and goal objectives	Mon 9/12/11	Fri 9/16/11	40 hrs
2334	Set up system	Mon 9/19/11	Fri 10/7/11	120 hrs
2335	Generate employee schedules	Mon 10/10/11	Fri 10/14/11	40 hrs
2336	**EXP Macess**	**Mon 7/18/11**	**Fri 9/2/11**	**280 hrs**
2337	Develop EXP Member/Provider Letters	Mon 7/18/11	Fri 7/22/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2338	Develop/Modify EXP CSFS and workflows	Mon 7/25/11	Fri 8/12/11	120 hrs
2339	Determine Workflows	Mon 8/15/11	Fri 8/19/11	40 hrs
2340	Develop Call Tracking Workflows in EXP	Mon 8/22/11	Fri 9/2/11	80 hrs
2341	**Identify language and interpreter service requirements**	**Mon 8/15/11**	**Fri 9/2/11**	**120 hrs**
2342	Ensure appropriate staffing to meet language requirements	Mon 8/15/11	Fri 8/26/11	80 hrs
2343	Contract with Interpreter Service	Mon 8/29/11	Fri 9/2/11	40 hrs
2344	**Member/Provider satisfaction survey process**	**Mon 8/15/11**	**Fri 8/19/11**	**80 hrs**
2345	Provide Feedback to Member Satisfaction Survey	Mon 8/15/11	Fri 8/19/11	40 hrs
2346	Provide Feedback to Provider Satisfaction Survey	Mon 8/15/11	Fri 8/19/11	40 hrs
2347	**Enrollment and Eligibility**	**Mon 7/4/11**	**Tue 12/13/11**	**1,028 hrs**
2348	Hire Enrollment Staff	Mon 11/21/11	Mon 11/21/11	0 hrs
2349	**Develop Online Help Content**	**Mon 7/4/11**	**Fri 9/2/11**	**360 hrs**
2350	Identify modifications to workflow processes	Mon 7/4/11	Fri 7/29/11	160 hrs
2351	Develop Enrollment processing rules	Mon 8/1/11	Fri 8/12/11	80 hrs
2352	Develop on line help file for LA	Mon 8/15/11	Fri 9/2/11	120 hrs
2353	**Policy and Procedures**	**Mon 7/4/11**	**Fri 8/12/11**	**100 hrs**
2354	Identify Gaps	Mon 7/4/11	Fri 7/8/11	40 hrs
2355	Modify Policies and Procedures	Mon 7/11/11	Fri 8/12/11	60 hrs
2356	**Training**	**Mon 9/5/11**	**Tue 12/13/11**	**264 hrs**
2357	Develop Training Workflows / Materials	Mon 9/5/11	Fri 9/23/11	120 hrs
2358	Schedule Training Session	Mon 9/26/11	Tue 9/27/11	16 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2359	Conduct Enrollment Training	Tue 11/22/11	Tue 12/13/11	128 hrs
2360	Training graduation	Tue 12/13/11	Tue 12/13/11	0 hrs
2361	**EXP Macess**	**Mon 7/11/11**	**Wed 8/31/11**	**304 hrs**
2362	Develop EXP Enrollment Forms	Mon 7/11/11	Fri 7/29/11	120 hrs
2363	Determine Workflows	Mon 8/1/11	Wed 8/3/11	24 hrs
2364	Develop/Modify EXP CSFS and workflows in EXP	Thu 8/4/11	Wed 8/17/11	80 hrs
2365	Develop Enrollment Tracking Workflows	Thu 8/18/11	Wed 8/31/11	80 hrs
2366	**Claims Processing**	**Mon 7/4/11**	**Fri 12/23/11**	**1,452 hrs**
2367	Hire Claims Processing Staff	Mon 10/31/11	Mon 10/31/11	0 hrs
2368	**ACS Keying and Imaging**	**Fri 7/29/11**	**Mon 9/5/11**	**216 hrs**
2369	Secure P.O. Box	Fri 7/29/11	Fri 7/29/11	8 hrs
2370	Develop key instructions	Mon 8/1/11	Fri 8/12/11	80 hrs
2371	ACS system enhancements	Mon 8/15/11	Fri 8/26/11	80 hrs
2372	Send test provider files	Mon 8/29/11	Fri 9/2/11	40 hrs
2373	System testing signoff	Mon 9/5/11	Mon 9/5/11	8 hrs
2374	**Develop Online Help Content**	**Mon 7/4/11**	**Fri 9/2/11**	**360 hrs**
2375	Identify modifications to workflow processes	Mon 7/4/11	Fri 7/15/11	80 hrs
2376	Develop claims processing rules	Mon 7/18/11	Fri 7/29/11	80 hrs
2377	Obtain copies of provider pricing templates	Mon 8/1/11	Fri 8/5/11	40 hrs
2378	Develop on line help file for LA Claims	Mon 8/8/11	Fri 9/2/11	160 hrs
2379	**Policy and Procedures**	**Mon 7/4/11**	**Fri 8/12/11**	**100 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
2380	Identify Gaps	Mon 7/4/11	Fri 7/8/11	40 hrs
2381	Modify Policies and Procedures	Mon 7/11/11	Fri 8/12/11	60 hrs
2382	**Training**	**Mon 9/5/11**	**Fri 12/23/11**	**456 hrs**
2383	Develop Training Workflows / Materials	Mon 9/5/11	Fri 9/23/11	120 hrs
2384	Schedule Training Session	Mon 9/26/11	Tue 9/27/11	16 hrs
2385	Conduct Claims Training	Mon 10/31/11	Fri 12/23/11	320 hrs
2386	Training graduation	Fri 12/23/11	Fri 12/23/11	0 hrs
2387	**EXP Macess**	**Mon 7/11/11**	**Fri 9/2/11**	**320 hrs**
2388	Develop EXP Claims Doc-Flo and Imaging	Mon 7/11/11	Fri 7/29/11	120 hrs
2389	Determine Workflows	Mon 8/1/11	Fri 8/5/11	40 hrs
2390	Develop/Modify EXP CSFS and workflows in EXP	Mon 8/8/11	Fri 8/19/11	80 hrs
2391	Develop Claims Tracking Workflows	Mon 8/22/11	Fri 9/2/11	80 hrs
2392	**Testing**	**Thu 6/9/11**	**Wed 11/23/11**	**1,192 hrs**
2393	**Testing Set Up**	**Thu 6/9/11**	**Mon 10/10/11**	**176 hrs**
2394	Identify Business Requirements (All functional areas)	Thu 6/9/11	Thu 6/9/11	0 hrs
2395	Identify Functional Requirements (All functional areas)	Fri 6/24/11	Fri 6/24/11	0 hrs
2396	Test Environment Created	Mon 9/26/11	Mon 10/10/11	88 hrs
2397	Create Test Cases	Mon 9/26/11	Mon 10/10/11	88 hrs
2398	**Train QA testers**	**Mon 9/26/11**	**Sat 10/15/11**	**120 hrs**
2399	Compile UAT Training Documentation	Mon 9/26/11	Fri 10/7/11	80 hrs
2400	Conduct Training	Tue 10/11/11	Sat 10/15/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2401	**Claims UAT**	**Mon 9/5/11**	**Fri 10/28/11**	**328 hrs**
2402	Select claims for Calibration - Large Batch Tests	Mon 9/5/11	Fri 9/9/11	40 hrs
2403	Process Claims Batch	Mon 9/12/11	Tue 9/13/11	16 hrs
2404	Review the Calibration Results	Wed 9/14/11	Fri 9/16/11	24 hrs
2405	Execute Claims Test Scripts	Mon 9/19/11	Fri 9/30/11	80 hrs
2406	Document Results	Mon 10/3/11	Wed 10/5/11	24 hrs
2407	Identify Defects	Thu 10/6/11	Mon 10/10/11	24 hrs
2408	Modify System (if necessary)	Tue 10/11/11	Sat 10/15/11	40 hrs
2409	Retest Scripts (if necessary)	Mon 10/17/11	Fri 10/28/11	80 hrs
2410	Sign Off on UAT	Fri 10/28/11	Fri 10/28/11	0 hrs
2411	**Enrollment UAT**	**Mon 10/3/11**	**Wed 11/23/11**	**312 hrs**
2412	Load Daily 834 File	Mon 10/3/11	Mon 10/3/11	8 hrs
2413	Load Weekly 834 File	Tue 10/4/11	Tue 10/4/11	8 hrs
2414	Load Monthly 834 File	Wed 10/5/11	Wed 10/5/11	8 hrs
2415	Produce all reconciliation reports	Thu 10/6/11	Thu 10/6/11	8 hrs
2416	Execute Enrollment Test Scripts	Fri 10/7/11	Thu 10/13/11	40 hrs
2417	Document Results	Fri 10/14/11	Wed 10/19/11	40 hrs
2418	Identify Defects	Thu 10/20/11	Wed 10/26/11	40 hrs
2419	Modify System (if necessary)	Thu 10/27/11	Wed 11/9/11	80 hrs
2420	Retest Scripts (if necessary)	Thu 11/10/11	Wed 11/23/11	80 hrs
2421	Sign Off on UAT	Wed 11/23/11	Wed 11/23/11	0 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2422	**Contact Center UAT**	**Tue 10/11/11**	**Tue 11/22/11**	**256 hrs**
2423	Execute Contact Test Scripts	Tue 10/11/11	Sat 10/15/11	40 hrs
2424	Document Results	Mon 10/17/11	Wed 10/19/11	24 hrs
2425	Identify Defects	Thu 10/20/11	Mon 10/24/11	24 hrs
2426	Modify System (if necessary)	Tue 10/25/11	Mon 11/7/11	80 hrs
2427	Retest Scripts (if necessary)	Tue 11/8/11	Mon 11/21/11	80 hrs
2428	Sign Off on UAT	Tue 11/22/11	Tue 11/22/11	8 hrs
2429	**Member Materials**	**Mon 6/27/11**	**Thu 7/28/11**	**184 hrs**
2430	**New member welcome packet**	**Mon 6/27/11**	**Tue 7/5/11**	**56 hrs**
2431	Draft material that will be included in the packet	Mon 6/27/11	Mon 6/27/11	8 hrs
2432	Submit information to DHH for approval	Tue 6/28/11	Tue 6/28/11	8 hrs
2433	State approval	Wed 6/29/11	Wed 6/29/11	8 hrs
2434	Submit materials for translation and language tag line	Thu 6/30/11	Thu 6/30/11	8 hrs
2435	Submit material to vendor for production	Fri 7/1/11	Fri 7/1/11	8 hrs
2436	Approval of proofs	Mon 7/4/11	Mon 7/4/11	8 hrs
2437	Material production	Tue 7/5/11	Tue 7/5/11	8 hrs
2438	**Member Handbooks**	**Thu 7/7/11**	**Fri 7/15/11**	**56 hrs**
2439	Draft Member Handbook	Thu 7/7/11	Thu 7/7/11	8 hrs
2440	Internal review	Fri 7/8/11	Fri 7/8/11	8 hrs
2441	Submit to DHH for approval	Mon 7/11/11	Mon 7/11/11	8 hrs
2442	Submit materials for translation and language tag line	Tue 7/12/11	Tue 7/12/11	8 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2443	Submit material to vendor for production	Wed 7/13/11	Wed 7/13/11	8 hrs
2444	Approval of proofs	Thu 7/14/11	Thu 7/14/11	8 hrs
2445	Material production	Fri 7/15/11	Fri 7/15/11	8 hrs
2446	**Member ID Cards**	**Mon 7/18/11**	**Tue 7/26/11**	**56 hrs**
2447	Review ID card requirements	Mon 7/18/11	Mon 7/18/11	8 hrs
2448	Develop draft card	Tue 7/19/11	Tue 7/19/11	8 hrs
2449	Submit internal programming requirements	Wed 7/20/11	Wed 7/20/11	8 hrs
2450	Obtain sample card from vendor	Thu 7/21/11	Thu 7/21/11	8 hrs
2451	Submit ID card to state for approval	Fri 7/22/11	Fri 7/22/11	8 hrs
2452	DHH approval	Mon 7/25/11	Mon 7/25/11	8 hrs
2453	Material production	Tue 7/26/11	Tue 7/26/11	8 hrs
2454	**Material Inventory control Process**	**Wed 7/27/11**	**Thu 7/28/11**	**16 hrs**
2455	Meet with vendors to outline vendor expectation and controls	Wed 7/27/11	Wed 7/27/11	8 hrs
2456	Submit reporting requirements to vendors	Thu 7/28/11	Thu 7/28/11	8 hrs
2457	**Operations Suppport**	**Mon 7/4/11**	**Thu 1/5/12**	**8,880 hrs**
2458	**TPL/Recovery**	**Mon 7/4/11**	**Thu 1/5/12**	**856 hrs**
2459	Develop AMHP standard TPL/Recovery reports	Mon 7/4/11	Tue 8/2/11	176 hrs
2460	Develop AMHP process for recovery	Mon 7/4/11	Thu 9/15/11	40 hrs
2461	TPL - Receive and review pertinent contract language for understanding of scope	Mon 7/4/11	Fri 9/16/11	40 hrs
2462	TPL - Ensure Unit is adequately staffed, equipped and trained	Mon 9/19/11	Thu 11/3/11	40 hrs
2463	TPL - Receive and load all known Member TPL coverage	Mon 12/19/11	Thu 1/5/12	120 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2464	TPL - Establish recurring process to receive and load incoming TPL files from EDS and HMS, including establishing Disposition Reports, tplogs, etc.	Mon 6/27/11	Fri 12/9/11	40 hrs
2465	TPL - Load Carrier file, and establish recurring Carrier File receipt and load process	Mon 7/4/11	Thu 11/3/11	40 hrs
2466	TPL - Establish recurring process to alert Client to new/changed TPL data	Mon 7/4/11	Thu 11/3/11	40 hrs
2467	TPL - Establish all reporting associated with the above	Mon 7/4/11	Mon 11/14/11	40 hrs
2468	TPL - Document and communicate applicable P&Ps/Desk Procedures	Mon 7/11/11	Thu 12/1/11	40 hrs
2469	TPL - Ensure Unit has access to available TPL/Eligibility systems, IHCP website and EDS Web Interchange	Mon 7/11/11	Wed 10/5/11	40 hrs
2470	RECOVERY - Receive and review pertinent contract language for understanding of scope	Mon 6/20/11	Fri 8/26/11	40 hrs
2471	RECOVERY - Establish rules for recovery (when appropriate and inappropriate per contract)	Mon 6/27/11	Thu 8/25/11	40 hrs
2472	RECOVERY - Ensure Unit is adequately staffed, equipped and trained	Mon 9/19/11	Thu 12/8/11	40 hrs
2473	RECOVERY - Establish all reporting associated with the above, including Cost Avoidance Report and TPL Collections Report	Mon 7/4/11	Tue 10/4/11	40 hrs
2474	RECOVERY - Document and communicate applicable P&Ps/Desk Procedures	Mon 7/11/11	Fri 10/28/11	40 hrs
2475	**Provider Maintenance**	**Mon 7/4/11**	**Thu 10/13/11**	**5,100 hrs**
2476	**Documentation/Communication**	**Mon 7/4/11**	**Thu 10/13/11**	**1,152 hrs**
2477	Establish workflow process for receipt of provider information	Mon 7/4/11	Fri 9/9/11	40 hrs
2478	Workflow the transfer of information to the Quality Auditing Department	Mon 7/4/11	Thu 10/13/11	40 hrs
2479	Establishment of service level agreements	Mon 7/4/11	Fri 8/26/11	40 hrs
2480	Access to dW for Local state provider file	Tue 6/21/11	Tue 7/12/11	136 hrs
2481	Access to Local Database for all PM associates(DEV)	Wed 7/13/11	Mon 7/18/11	32 hrs
2482	Access to Local Database for all PM associatesPRD	Tue 7/19/11	Tue 7/19/11	8 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2483	Access to Provider Automation for all PM associates	Wed 7/20/11	Wed 7/20/11	8 hrs
2484	Access to DEV REPORTS dB for PM staff and pm reporting team	Thu 7/21/11	Thu 7/21/11	8 hrs
2485	Develop On-line Help for Provider Maintenance	Mon 7/4/11	Thu 9/29/11	40 hrs
2486	Scope out Information Exchange process flows	Fri 7/22/11	Wed 8/17/11	152 hrs
2487	Crystal Reports Access	Thu 8/18/11	Thu 8/18/11	8 hrs
2488	Create a process for Non Par UM Authorizations	Mon 7/4/11	Mon 8/29/11	40 hrs
2489	Create a Non Par denial letter and Information Sheet	Fri 8/19/11	Fri 8/19/11	8 hrs
2490	**Provider Automation**	**Mon 7/4/11**	**Fri 9/2/11**	**792 hrs**
2491	6/20	Tue 6/21/11	Wed 7/13/11	144 hrs
2492	Create business rule edits in Provider Automation	Thu 7/14/11	Mon 8/8/11	144 hrs
2493	Test Provider Automation for Local	Tue 8/9/11	Thu 9/1/11	144 hrs
2494	**Data Entry**	**Mon 7/4/11**	**Tue 10/4/11**	**796 hrs**
2495	Establishment of Business Rules for Data Entry	Mon 7/4/11	Tue 10/4/11	60 hrs
2496	Business rules for Participating Providers	Mon 7/4/11	Tue 10/4/11	60 hrs
2497	Business rules for non-participating Providers	Mon 7/4/11	Wed 8/31/11	40 hrs
2498	State Requirements for Data Entry	Mon 7/4/11	Mon 8/15/11	40 hrs
2499	Data Entry of Provider information into Facets	Mon 7/4/11	Fri 8/26/11	60 hrs
2500	**Invalid Provider Queue**	**Mon 7/4/11**	**Tue 9/27/11**	**536 hrs**
2501	Invalid Provider and Suspended Claims	Mon 7/4/11	Tue 9/27/11	40 hrs
2502	**Training**	**Mon 7/4/11**	**Tue 9/27/11**	**616 hrs**
2503	Documentation for Training	Mon 7/4/11	Tue 9/27/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2504	Cross-train Provider Maintenance Associates	Mon 7/4/11	Tue 9/27/11	40 hrs
2505	Develop Provider Maintenance Manual	Mon 7/4/11	Tue 9/27/11	40 hrs
2506	**Reporting**	**Mon 7/4/11**	**Tue 9/27/11**	**616 hrs**
2507	Provider Related Reporting (Need definition)	Mon 7/4/11	Tue 9/27/11	40 hrs
2508	Outbound Provider File mapping and testing	Mon 7/4/11	Tue 9/27/11	40 hrs
2509	Create a services of validation queries	Mon 7/4/11	Mon 8/29/11	40 hrs
2510	**UAT Validation (TBI)**	**Mon 7/4/11**	**Wed 11/9/11**	**2,364 hrs**
2511	Obtain Client Provider Manual	Wed 8/24/11	Wed 8/24/11	8 hrs
2512	Hold UAT Session with Internal Team Leads	Tue 9/27/11	Tue 9/27/11	8 hrs
2513	Meet with Internal Team Leads to evaluate reimbursement options to validate PADU adherence	Wed 9/28/11	Wed 9/28/11	8 hrs
2514	Develop PADU Grid	Thu 9/29/11	Fri 9/30/11	16 hrs
2515	Coordinate testing space	Mon 10/3/11	Mon 10/3/11	8 hrs
2516	Obtain UAT Testers	Tue 10/4/11	Wed 10/26/11	144 hrs
2517	Evaluate contract terms with Client (TBI/PADU)	Mon 7/4/11	Fri 9/2/11	180 hrs
2518	Establish UAT requirements for Robot	Mon 7/4/11	Fri 8/19/11	140 hrs
2519	Obtain access to claim processing rules	Thu 10/27/11	Thu 10/27/11	8 hrs
2520	Develop contract summary documents for UAT execution	Mon 7/4/11	Fri 8/12/11	120 hrs
2521	Establish UAT requirements for Testing	Mon 7/4/11	Tue 8/9/11	120 hrs
2522	Obtain access to operational database environment	Fri 10/28/11	Fri 11/4/11	48 hrs
2523	Validate provider and agreement setups	Mon 9/5/11	Thu 10/6/11	192 hrs
2524	Request loading and segregation of claims	Mon 9/5/11	Thu 10/6/11	192 hrs
2525	Perform UAT walkthrough	Mon 9/5/11	Thu 10/6/11	192 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2526	Execute UAT	Fri 10/7/11	Wed 11/9/11	100 hrs
2527	Test Results Approved	Mon 10/10/11	Fri 10/28/11	128 hrs
2528	**Check Reconciliation Unit**	**Mon 7/4/11**	**Sat 10/15/11**	**560 hrs**
2529	Reporting needs identified	Wed 8/3/11	Tue 8/9/11	40 hrs
2530	Creation of Reports	Wed 8/10/11	Tue 8/16/11	40 hrs
2531	Creation of IMAX Workflow and queues	Mon 7/4/11	Fri 7/15/11	80 hrs
2532	Reporting needs identified	Mon 7/4/11	Fri 7/8/11	40 hrs
2533	Creation of Reports	Mon 7/4/11	Fri 7/8/11	40 hrs
2534	Claims Processing Rules Training	Fri 10/14/11	Sat 10/15/11	16 hrs
2535	Deposit Process Identified	Mon 7/4/11	Fri 8/12/11	12 hrs
2536	**Policies & Procedures Completed**	**Mon 7/4/11**	**Fri 8/12/11**	**252 hrs**
2537	Deposit Process Identified	Mon 7/4/11	Fri 8/12/11	12 hrs
2538	Policies & Procedures Completed	Mon 7/4/11	Tue 9/27/11	40 hrs
2539	**Project Manager 4**	**Tue 1/11/11**	**Mon 12/12/11**	**7,331.63 hrs**
2540	**Legal Affairs**	**Tue 4/12/11**	**Fri 7/15/11**	**20 hrs**
2541	Establish LOB/Program Name (if applicable)	Tue 4/12/11	Tue 4/12/11	8 hrs
2542	Establish Tax ID to be utilized on Vendor contracts, SOWs, etc.	Tue 4/12/11	Tue 4/12/11	8 hrs
2543	File/receive HMO License	Mon 5/9/11	Fri 7/15/11	4 hrs
2544	**POLICIES AND PROCEDURES CREATION**	**Mon 5/16/11**	**Fri 8/5/11**	**120 hrs**
2545	Service Operations Policies and Procedures	Mon 5/16/11	Fri 8/5/11	60 hrs
2546	Provider NETWORK MANAGEMENT	Mon 5/16/11	Fri 7/22/11	60 hrs
2547	**HUMAN RESOURCES**	**Mon 5/2/11**	**Fri 12/30/11**	**1,016 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
2548	**Create staffing plan**	**Mon 5/2/11**	**Mon 5/30/11**	**792 hrs**
2549	Create Job Descriptions	Tue 5/10/11	Tue 5/17/11	40 hrs
2550	Evaluate system and software license requirements for new and existing staff	Tue 5/10/11	Fri 5/13/11	24 hrs
2551	Create budget and cost analysis	Fri 5/13/11	Wed 5/18/11	24 hrs
2552	Obtain budget approval for staffing model and recruiting costs	Wed 5/18/11	Mon 5/23/11	24 hrs
2553	Create Staffing Plan	Mon 5/23/11	Mon 5/30/11	40 hrs
2554	**Staffing Model**	**Mon 5/2/11**	**Tue 5/10/11**	**640 hrs**
2555	Determine # of employees at local office	Mon 5/2/11	Tue 5/10/11	160 hrs
2556	Determine # of employees at regional office	Mon 5/2/11	Tue 5/10/11	160 hrs
2557	Determine Position titles	Mon 5/2/11	Tue 5/10/11	160 hrs
2558	Determine Compensation and benefits package for positions	Mon 5/2/11	Tue 5/10/11	160 hrs
2559	**HR PeopleSoft Information Obtain**	**Wed 7/6/11**	**Wed 7/6/11**	**0 hrs**
2560	Establish calendar code of payroll	Wed 7/6/11	Wed 7/6/11	0 hrs
2561	Set-up salary plans	Wed 7/6/11	Wed 7/6/11	0 hrs
2562	Confirm department numbers and names	Wed 7/6/11	Wed 7/6/11	0 hrs
2563	PeopleSoft company code ID	Wed 7/6/11	Wed 7/6/11	0 hrs
2564	Enter physical address for local office	Wed 7/6/11	Wed 7/6/11	0 hrs
2565	Establish ID	Wed 7/6/11	Wed 7/6/11	0 hrs
2566	Business Unit Name	Wed 7/6/11	Wed 7/6/11	0 hrs
2567	PeopleSoft Project ID	Wed 7/6/11	Wed 7/6/11	0 hrs
2568	PeopleSoft Product #	Wed 7/6/11	Wed 7/6/11	0 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2569	Payroll Interface	Wed 7/6/11	Wed 7/6/11	0 hrs
2570	Determine ADP Company Code	Wed 7/6/11	Wed 7/6/11	0 hrs
2571	Earnings Mapping	Wed 7/6/11	Wed 7/6/11	0 hrs
2572	Deduction Mapping	Wed 7/6/11	Wed 7/6/11	0 hrs
2573	Review GI Payroll Actual/Accrual files for customizations	Wed 7/6/11	Wed 7/6/11	0 hrs
2574	Review Time and Labor export to ADP for changes	Wed 7/6/11	Wed 7/6/11	0 hrs
2575	**HIRE Staff**	**Mon 5/30/11**	**Fri 12/30/11**	**224 hrs**
2576	Finalize recruiting strategy	Mon 5/30/11	Tue 5/31/11	8 hrs
2577	Add new location to drug and background check contract	Tue 5/31/11	Wed 6/1/11	8 hrs
2578	Identify interview team/s	Mon 5/30/11	Tue 5/31/11	8 hrs
2579	Advertise Post positions	Tue 5/31/11	Thu 6/2/11	16 hrs
2580	Source and review resumes	Thu 6/2/11	Fri 6/10/11	48 hrs
2581	Interview candidates	Fri 6/10/11	Fri 6/17/11	40 hrs
2582	Background checks & drug testing	Fri 6/17/11	Fri 6/24/11	40 hrs
2583	Send paperwork to HRIS for associate set-up	Fri 6/24/11	Thu 6/30/11	40 hrs
2584	Extend Offers	Thu 6/30/11	Mon 7/4/11	16 hrs
2585	Hire Staff	Fri 12/30/11	Fri 12/30/11	0 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**
2588	**Pre-Implementation Phase**	**Wed 6/1/11**	**Tue 6/14/11**	**34.63 hrs**
2589	Kick-off Meeting with Process Owner(s)	Wed 6/1/11	Thu 6/2/11	16 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2590	Define Project objectives, risks, and success factors	Mon 6/13/11	Tue 6/14/11	10.63 hrs
2591	Define Project Team	Mon 6/13/11	Tue 6/14/11	8 hrs
2592	Determine Scope of Project	Thu 6/2/11	Thu 6/2/11	0 hrs
2593	**Analysis, Architecture and Design**	**Tue 5/31/11**	**Wed 8/31/11**	**44 hrs**
2594	Determine what company associates will be paid from	Tue 5/31/11	Tue 5/31/11	8 hrs
2595	**Human Resources/Position**	**Thu 6/30/11**	**Thu 6/30/11**	**0 hrs**
2596	Complete HR Questionaire	Thu 6/30/11	Thu 6/30/11	0 hrs
2597	**Payroll/GL**	**Wed 8/31/11**	**Wed 8/31/11**	**0 hrs**
2598	Complete Payroll Questionaire	Wed 8/31/11	Wed 8/31/11	0 hrs
2599	**Benefits**	**Wed 6/1/11**	**Wed 6/1/11**	**0 hrs**
2600	Complete Benefits Questionaire	Wed 6/1/11	Wed 6/1/11	0 hrs
2601	**General**	**Thu 6/16/11**	**Wed 7/13/11**	**36 hrs**
2602	Make Security Changes for all modules and set-up of new users	Thu 6/16/11	Thu 6/16/11	4 hrs
2603	Review and determine all queries / reports for change impact	Thu 6/16/11	Wed 7/13/11	16 hrs
2604	Review all customizations for impact, including those under current development	Thu 6/16/11	Wed 7/13/11	16 hrs
2605	Determine updates to any/all forms	Thu 6/16/11	Thu 6/16/11	0 hrs
2606	Determine new policies/procedures for development	Thu 6/16/11	Thu 6/16/11	0 hrs
2607	Determine other necessary communications	Thu 6/16/11	Thu 6/16/11	0 hrs
2608	Document all new functional specifications for each table	Thu 6/16/11	Thu 6/16/11	0 hrs
2609	**Development**	**Thu 7/7/11**	**Fri 7/29/11**	**108 hrs**
2610	**Human Resources/Position**	**Tue 7/12/11**	**Wed 7/13/11**	**32 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
2611	Product Configuration	Tue 7/12/11	Wed 7/13/11	16 hrs
2612	Technical Development	Tue 7/12/11	Wed 7/13/11	16 hrs
2613	**Payroll/GL**	**Tue 7/12/11**	**Wed 7/13/11**	**24 hrs**
2614	Product Configuration	Tue 7/12/11	Wed 7/13/11	16 hrs
2615	Technical Development	Wed 7/13/11	Wed 7/13/11	8 hrs
2616	**Benefits**	**Thu 7/7/11**	**Wed 7/13/11**	**48 hrs**
2617	Product Configuration	Wed 7/13/11	Wed 7/13/11	8 hrs
2618	Technical Development	Thu 7/7/11	Wed 7/13/11	40 hrs
2619	**General**	**Fri 7/29/11**	**Fri 7/29/11**	**4 hrs**
2620	Make Security Changes for all modules and setup of new users	Fri 7/29/11	Fri 7/29/11	4 hrs
2621	**Test and Quality Assurance**	**Mon 8/1/11**	**Wed 8/31/11**	**184 hrs**
2622	Determine and Create test scripts for testing new company setup	Mon 8/1/11	Wed 8/31/11	80 hrs
2623	Test Security Setup and new user access	Mon 8/29/11	Wed 8/31/11	20 hrs
2624	Notify users to begin user acceptance testing	Thu 8/18/11	Wed 8/31/11	80 hrs
2625	Final Review of System configuration to functional specifications	Wed 8/31/11	Wed 8/31/11	4 hrs
2626	**Transition/Roll-out**	**Fri 7/1/11**	**Fri 7/15/11**	**50 hrs**
2627	Set-up Training environment, materials, etc….	Fri 7/1/11	Fri 7/15/11	40 hrs
2628	Develop Transition Activities and Timeline	Fri 7/1/11	Fri 7/15/11	8 hrs
2629	Notify and Train Helpdesk on potential issues	Fri 7/1/11	Fri 7/15/11	2 hrs
2630	**Production**	**Wed 7/13/11**	**Wed 8/31/11**	**8 hrs**
2631	Determine Production Readiness and Activities	Wed 7/13/11	Wed 8/31/11	8 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2632	Communication of Production Environment to Users	Wed 7/13/11	Wed 7/13/11	0 hrs
2633	Initiate Migration Request to HRPRD	Wed 7/13/11	Wed 7/13/11	0 hrs
2634	Obtain Change Management Board Approval	Wed 7/13/11	Wed 7/13/11	0 hrs
2635	**Compliance & Plan Oversight**	**Mon 5/2/11**	**Fri 7/1/11**	**544 hrs**
2636	Interaction with State and/or Federal Regulators	Mon 5/2/11	Mon 5/2/11	8 hrs
2637	Establish oversight, monitoring and distribution of State and/or Federal policies and regulations	Mon 5/2/11	Fri 7/1/11	60 hrs
2638	Fraud, Waste and Abuse (FWA) monitoring	Mon 5/2/11	Fri 7/1/11	60 hrs
2639	**Auditing**	**Mon 5/2/11**	**Fri 5/13/11**	**400 hrs**
2640	Oversee DOI/Contractual audit requirements	Mon 5/2/11	Fri 5/13/11	80 hrs
2641	Engage Audit firm	Mon 5/2/11	Fri 5/13/11	80 hrs
2642	SAS 70	Mon 5/2/11	Fri 5/13/11	80 hrs
2643	NAIC MAR Compliance assessment	Mon 5/2/11	Fri 5/13/11	80 hrs
2644	Accreditation documentation	Mon 5/2/11	Tue 5/3/11	16 hrs
2645	**Certifications and Program Integrity**	**Mon 5/2/11**	**Mon 5/2/11**	**0 hrs**
2646	Data certification	Mon 5/2/11	Mon 5/2/11	0 hrs
2647	Compliance plan to guard against fraud and abuse	Mon 5/2/11	Mon 5/2/11	0 hrs
2648	**FINANCE**	**Tue 5/10/11**	**Wed 7/27/11**	**0 hrs**
2649	**New Product Set Up**	**Tue 5/10/11**	**Thu 6/16/11**	**0 hrs**
2650	Product Chartfield	Wed 7/27/11	Wed 7/27/11	0 hrs
2651	Requisition Management	Wed 7/27/11	Wed 7/27/11	0 hrs
2652	Workflow Set Up	Wed 7/27/11	Wed 7/27/11	0 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2653	Basic Financial Functions	Wed 7/27/11	Wed 7/27/11	0 hrs
2654	Accounts Payable	Wed 7/27/11	Wed 7/27/11	0 hrs
2655	Accounts Receivable	Wed 7/27/11	Wed 7/27/11	0 hrs
2656	Banking/Cash Management	Wed 7/27/11	Wed 7/27/11	0 hrs
2657	Billing (Capitation Reconciliation)	Wed 7/27/11	Wed 7/27/11	0 hrs
2658	Sub-contractor account set up (if applicable)	Wed 7/27/11	Wed 7/27/11	0 hrs
2659	1099s	Wed 7/27/11	Wed 7/27/11	0 hrs
2660	**Payroll**	**Wed 7/27/11**	**Wed 7/27/11**	**0 hrs**
2661	Set up account with ADP	Wed 7/27/11	Wed 7/27/11	0 hrs
2662	Identify local tax set up	Wed 7/27/11	Wed 7/27/11	0 hrs
2663	Tax returns - ADP	Wed 7/27/11	Wed 7/27/11	0 hrs
2664	Set up PeopleSoft interface	Wed 7/27/11	Wed 7/27/11	0 hrs
2665	Update forms (timesheets, policies & procedures, etc.)	Wed 7/27/11	Wed 7/27/11	0 hrs
2666	Orient new staff on policies & procedures	Wed 7/27/11	Wed 7/27/11	0 hrs
2667	Reconcile bi-weekly payroll reports to PeopleSoft interface file	Wed 7/27/11	Wed 7/27/11	0 hrs
2668	Load ADP interface into PeopleSoft	Wed 7/27/11	Wed 7/27/11	0 hrs
2669	**Testing**	**Wed 7/27/11**	**Wed 7/27/11**	**0 hrs**
2670	Create test files	Wed 7/27/11	Wed 7/27/11	0 hrs
2671	Test ADP interface files	Wed 7/27/11	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**

ID	Task Name	Start	Finish	Estimated Work Effort
2674	Kick-off Meeting with Process Owner(s)	Tue 5/31/11	Wed 6/1/11	8 hrs
2675	Define Project objectives, risks, and success factors	Wed 6/1/11	Thu 6/2/11	8 hrs
2676	Define Project Team	Wed 6/1/11	Thu 6/2/11	8 hrs
2677	Determine Scope of Project	Wed 6/1/11	Thu 6/2/11	8 hrs
2678	Develop Project Work Plan	Wed 6/1/11	Mon 6/6/11	16 hrs
2679	**Analysis, Architecture and Design**	**Mon 6/6/11**	**Mon 6/6/11**	**0 hrs**
2680	**GL**	**Mon 6/6/11**	**Mon 6/6/11**	**0 hrs**
2681	Complete Questionnare	Mon 6/6/11	Mon 6/6/11	0 hrs
2682	**AP**	**Mon 6/6/11**	**Mon 6/6/11**	**0 hrs**
2683	Complete Questionnare	Mon 6/6/11	Mon 6/6/11	0 hrs
2684	**AM**	**Mon 6/6/11**	**Mon 6/6/11**	**0 hrs**
2685	Complete Questionnare	Mon 6/6/11	Mon 6/6/11	0 hrs
2686	**PO**	**Mon 6/6/11**	**Mon 6/6/11**	**0 hrs**
2687	Complete Questionnare	Mon 6/6/11	Mon 6/6/11	0 hrs
2688	**General**	**Mon 6/6/11**	**Mon 6/6/11**	**0 hrs**
2689	Determine updates to any/all forms	Mon 6/6/11	Mon 6/6/11	0 hrs
2690	Determine new policies/procedures for development	Mon 6/6/11	Mon 6/6/11	0 hrs
2691	Determine other necessary communications	Mon 6/6/11	Mon 6/6/11	0 hrs
2692	Document all new functional specifications for each table, and obtain appropriate sign-off	Mon 6/6/11	Mon 6/6/11	0 hrs
2693	**Development**	**Mon 6/6/11**	**Thu 6/9/11**	**92 hrs**
2694	**GL Business Unit Setup**	**Mon 6/6/11**	**Thu 6/9/11**	**42 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
2695	Product Configuration	Mon 6/6/11	Tue 6/7/11	8 hrs
2696	Workflow Configuration	Mon 6/6/11	Tue 6/7/11	8 hrs
2697	Security Configuration	Mon 6/6/11	Mon 6/6/11	2 hrs
2698	Hyperion interface development	Mon 6/6/11	Thu 6/9/11	24 hrs
2699	**AP Business Unit Setup**	**Mon 6/6/11**	**Tue 6/7/11**	**24 hrs**
2700	Product Configuration	Mon 6/6/11	Tue 6/7/11	8 hrs
2701	Check Development	Mon 6/6/11	Tue 6/7/11	8 hrs
2702	Positive {ay File Development	Mon 6/6/11	Tue 6/7/11	8 hrs
2703	**AM Business Unit Setup**	**Mon 6/6/11**	**Mon 6/6/11**	**2 hrs**
2704	Product Configuration	Mon 6/6/11	Mon 6/6/11	2 hrs
2705	**PO Business Unit Setup**	**Mon 6/6/11**	**Wed 6/8/11**	**24 hrs**
2706	Product Configuration	Mon 6/6/11	Tue 6/7/11	8 hrs
2707	Workflow Configuration	Mon 6/6/11	Wed 6/8/11	16 hrs
2708	**Test and Quality Assurance**	**Mon 6/6/11**	**Mon 6/20/11**	**80 hrs**
2709	Determine and Create test scripts for testing new company setup	Mon 6/6/11	Mon 6/20/11	80 hrs
2710	User acceptance testing	Mon 6/20/11	Mon 6/20/11	0 hrs
2711	**Transition/Roll-out**	**Fri 7/15/11**	**Wed 7/20/11**	**26 hrs**
2712	Set-up Training environment, materials, etc….	Fri 7/15/11	Mon 7/18/11	16 hrs
2713	Develop Transition Activities and Timeline	Tue 7/19/11	Tue 7/19/11	8 hrs
2714	Notify and Train Helpdesk on potential issues	Wed 7/20/11	Wed 7/20/11	2 hrs
2715	**Production**	**Tue 7/26/11**	**Thu 7/28/11**	**11 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
2716	Determine Production Readiness and Activities	Tue 7/26/11	Tue 7/26/11	2 hrs
2717	Communication of Production Environment to Users	Wed 7/27/11	Wed 7/27/11	1 hr
2718	Initiate Migration Request to FSPRD	Wed 7/27/11	Wed 7/27/11	0 hrs
2719	Obtain Change Management Board Approval	Wed 7/27/11	Thu 7/28/11	8 hrs
2720	**FACILITIES**	**Tue 4/12/11**	**Tue 11/22/11**	**1,006 hrs**
2721	**Pre-construction Phase**	**Tue 4/12/11**	**Mon 10/3/11**	**534 hrs**
2722	Engage Real Estate Broker for assessment of available office space	Tue 4/12/11	Fri 4/15/11	32 hrs
2723	Perform Facilities needs assessment	Tue 4/12/11	Thu 6/9/11	80 hrs
2724	Determine location for permanent space	Tue 4/12/11	Thu 7/14/11	50 hrs
2725	Negotiate/finalize lease	Mon 8/1/11	Mon 10/3/11	60 hrs
2726	Identify space Planner/Design Phase	Mon 8/1/11	Fri 8/12/11	80 hrs
2727	Identify general construction contractor	Mon 8/1/11	Fri 8/5/11	40 hrs
2728	Pre-construction meeting w/subcontractors (obtain certificates of insurance)	Mon 8/8/11	Tue 8/9/11	16 hrs
2729	Review construction documents (prior to submittal or permits)	Tue 8/9/11	Wed 8/10/11	16 hrs
2730	Permit Approval	Tue 8/9/11	Mon 9/5/11	160 hrs
2731	**Construction Phase**	**Mon 9/5/11**	**Tue 11/22/11**	**472 hrs**
2732	Mobilization	Mon 9/5/11	Mon 9/5/11	8 hrs
2733	Demolition	Tue 9/6/11	Mon 9/12/11	40 hrs
2734	Metal stud portion	Tue 9/13/11	Fri 9/16/11	32 hrs
2735	Mechanical rough-ins	Mon 9/19/11	Wed 9/21/11	24 hrs
2736	Electrical rough-ins	Thu 9/22/11	Mon 9/26/11	24 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2737	Plumbing rough-ins	Tue 9/27/11	Thu 9/29/11	24 hrs
2738	Drywall hang/finishes	Fri 9/30/11	Mon 10/10/11	56 hrs
2739	Acoustical ceiling	Tue 10/11/11	Thu 10/13/11	24 hrs
2740	Door frames	Fri 10/14/11	Fri 10/14/11	8 hrs
2741	Painting	Sat 10/15/11	Thu 10/20/11	40 hrs
2742	Floor covering	Fri 10/21/11	Thu 10/27/11	40 hrs
2743	Doors and hardware	Fri 10/28/11	Fri 10/28/11	8 hrs
2744	Mechanical finishes	Fri 10/28/11	Fri 10/28/11	8 hrs
2745	Electrical finishes	Mon 10/31/11	Mon 10/31/11	8 hrs
2746	Plumbing finishes	Tue 11/1/11	Tue 11/1/11	8 hrs
2747	Punch list	Wed 11/2/11	Fri 11/4/11	24 hrs
2748	Municipal inspection	Mon 11/7/11	Tue 11/8/11	16 hrs
2749	Furniture installation	Wed 11/9/11	Tue 11/15/11	40 hrs
2750	Clean-up	Wed 11/16/11	Thu 11/17/11	16 hrs
2751	Move in	Fri 11/18/11	Tue 11/22/11	24 hrs
2752	**Vendor Contracting**	**Wed 6/15/11**	**Thu 7/21/11**	**552 hrs**
2753	Develop list of needed goods and services	Wed 6/15/11	Fri 6/17/11	24 hrs
2754	**Evaluate Goods and Services list and categorize sourcing strategies**	**Tue 6/28/11**	**Thu 7/21/11**	**528 hrs**
2755	**G&S purchased through enterprise contract - no work needed**	**Tue 6/28/11**	**Thu 6/30/11**	**24 hrs**
2756	Coordinate increases in purchases to supplier	Tue 6/28/11	Thu 6/30/11	24 hrs
2757	**G & S purchased through Enterprise contract - Leveraged savings possible**	**Tue 6/28/11**	**Thu 7/21/11**	**168 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
2758	Initiate Supplier Leveraged savings initiative	Tue 6/28/11	Tue 6/28/11	8 hrs
2759	Negotiate new enterprise-wide pricing exhibit	Tue 6/28/11	Tue 7/5/11	48 hrs
2760	Approve contract amendment	Tue 7/5/11	Thu 7/21/11	104 hrs
2761	Coordinate increases in purchases to supplier	Thu 7/21/11	Thu 7/21/11	8 hrs
2762	**G & S the require contractual amendment**	**Tue 6/28/11**	**Thu 7/21/11**	**168 hrs**
2763	Initiate needed amendment through existing contract	Tue 6/28/11	Tue 6/28/11	8 hrs
2764	Negotiate LA-specific amendment	Tue 6/28/11	Tue 7/5/11	48 hrs
2765	Approve contract amendment	Tue 7/5/11	Thu 7/21/11	104 hrs
2766	Coordinate increases in purchases to supplier	Thu 7/21/11	Thu 7/21/11	8 hrs
2767	**G & S that require a complete contract**	**Tue 6/28/11**	**Thu 7/21/11**	**168 hrs**
2768	Initiate needed contract	Tue 6/28/11	Tue 6/28/11	8 hrs
2769	Negotiate LA-specific contract	Tue 6/28/11	Tue 7/5/11	48 hrs
2770	Approve contract	Tue 7/5/11	Thu 7/21/11	104 hrs
2771	Coordinate increases in purchases to supplier or onboard new supplier	Thu 7/21/11	Thu 7/21/11	8 hrs
2772	**Marketing - Communications - Community Outreach - Website**	**Tue 1/11/11**	**Mon 12/12/11**	**3,388 hrs**
2773	**Implementation Plan for Marketing, Outreach - Louisiana RFP**	**Tue 1/11/11**	**Mon 12/12/11**	**2,794 hrs**
2774	**Corporate Communication Project Tasks**	**Tue 1/11/11**	**Mon 12/12/11**	**2,794 hrs**
2775	Identify corporate communications project team	Mon 6/13/11	Mon 6/13/11	8 hrs
2776	Identify communication requirements	Mon 6/13/11	Mon 6/13/11	0 hrs
2777	Develop communications project plan	Tue 6/14/11	Mon 8/1/11	60 hrs
2778	**Brand Development**	**Tue 1/11/11**	**Fri 11/18/11**	**1,036 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
2779	**Hold focus groups**	**Tue 4/12/11**	**Wed 6/15/11**	**820 hrs**
2780	New Orleans	Tue 4/12/11	Thu 4/14/11	40 hrs
2781	Baton Rouge	Tue 6/14/11	Wed 6/15/11	30 hrs
2782	Finalize Name , Develop Logo	Tue 1/11/11	Tue 1/11/11	8 hrs
2783	Conduct formal brand recommendations	Fri 2/11/11	Fri 2/11/11	8 hrs
2784	Develop brand guidelines	Tue 4/12/11	Mon 5/16/11	200 hrs
2785	**Provider Communications**	**Mon 2/7/11**	**Wed 4/6/11**	**416 hrs**
2786	**Develop provider printed materials**	**Fri 2/25/11**	**Thu 3/10/11**	**200 hrs**
2787	Post card	Tue 3/1/11	Tue 3/1/11	0 hrs
2788	intro letter	Tue 3/1/11	Thu 3/3/11	40 hrs
2789	folder	Tue 3/1/11	Thu 3/10/11	120 hrs
2790	flier	Fri 2/25/11	Tue 3/1/11	40 hrs
2791	Develop temporary provider website	Mon 2/7/11	Wed 2/16/11	120 hrs
2792	Gather and format contracts	Tue 2/22/11	Mon 3/7/11	80 hrs
2793	Submit FINAL pieces of Provider Recruitment Packet to DHH for approval	Tue 3/15/11	Tue 3/15/11	8 hrs
2794	Mail materials	Wed 4/6/11	Wed 4/6/11	8 hrs
2795	**Develop & Review Required Plan Materials**	**Tue 6/7/11**	**Sat 10/15/11**	**198 hrs**
2796	**Website:**	**Tue 6/7/11**	**Sat 10/15/11**	**198 hrs**
2797	Purchase and a sign Domain Name	Tue 6/7/11	Mon 6/13/11	40 hrs
2798	Gather Web requirements	Wed 7/27/11	Mon 8/1/11	60 hrs
2799	Develop provider content	Thu 7/28/11	Mon 8/1/11	40 hrs

ID	Task Name	Start	Finish	Estimated Work Effort
2800	Develop member content	Thu 7/28/11	Mon 8/1/11	40 hrs
2801	Review and approve Web site design and content	Fri 9/30/11	Sat 10/1/11	12 hrs
2802	Submit to DHH for approval	Sat 10/15/11	Sat 10/15/11	6 hrs
2803	**Develop Other Needed Materials**	**Tue 4/12/11**	**Tue 11/15/11**	**540 hrs**
2804	Plan Brochure	Thu 7/14/11	Tue 11/15/11	120 hrs
2805	Letterhead	Mon 6/13/11	Thu 6/30/11	120 hrs
2806	Envelopes (large & small)	Mon 6/13/11	Thu 6/30/11	120 hrs
2807	Folders	Mon 6/13/11	Thu 6/30/11	120 hrs
2808	Business Cards	Tue 4/12/11	Mon 6/13/11	60 hrs
2809	**Outdoor Advertising**	**Wed 11/2/11**	**Mon 12/12/11**	**240 hrs**
2810	Develop billboard concept	Tue 11/15/11	Mon 12/12/11	160 hrs
2811	Investigate other advertising opportunities (bus shelter, etc.)	Wed 11/2/11	Tue 11/15/11	80 hrs
2812	Prepare for Readiness Review	Mon 8/29/11	Thu 9/1/11	60 hrs
2813	Develop Marketing, Outreach Plan	Fri 7/29/11	Mon 8/1/11	20 hrs
2814	Develop a team, schedule weekly team conference calls	Tue 6/7/11	Mon 6/13/11	40 hrs
2815	**Contract Award Internal Communications**	**Mon 8/1/11**	**Wed 8/3/11**	**88 hrs**
2816	Draft internal communications announcing contract	Mon 8/1/11	Wed 8/3/11	40 hrs
2817	Distribute internal communications announcing contract	Mon 8/1/11	Mon 8/1/11	8 hrs
2818	**Contract Award External Communications**	**Mon 8/1/11**	**Wed 8/3/11**	**88 hrs**
2819	Draft internal communications announcing contract	Mon 8/1/11	Wed 8/3/11	40 hrs
2820	Distribute internal communications announcing contract	Mon 8/1/11	Mon 8/1/11	8 hrs
2821	**Corporate Communication**	**Tue 1/11/11**	**Tue 10/4/11**	**594 hrs**

ID	Task Name	Start	Finish	Estimated Work Effort
2822	Review and approve logo/branding	Tue 4/12/11	Mon 4/18/11	40 hrs
2823	Review and approve design of letterhead, folders, business cards, etc.	Tue 4/19/11	Mon 4/25/11	40 hrs
2824	Review and approve initial Web site design and AMFC-related content	Tue 4/26/11	Mon 5/16/11	120 hrs
2825	Review and approve press announcements during rollout/activation	Tue 5/17/11	Thu 5/19/11	24 hrs
2826	Review and approve any external materials mentioning or referring to AMFC	Fri 5/20/11	Tue 5/24/11	24 hrs
2827	Facilitate all national news media outreach and inquiries related to AMFC (ON GOING)	Wed 5/25/11	Wed 5/25/11	8 hrs
2828	Draft and distribute enterprise-wide communications	Thu 5/26/11	Wed 6/1/11	40 hrs
2829	ERC review of Corporate-related materials and other materials as needed (ON GOING)	Thu 6/2/11	Mon 6/6/11	24 hrs
2830	**Develop Website for Client**	**Tue 1/11/11**	**Tue 10/4/11**	**274 hrs**
2831	Gather requirements	Fri 4/1/11	Tue 4/12/11	120 hrs
2832	Purchase and assign Domain Name	Wed 4/6/11	Tue 4/12/11	80 hrs
2833	Identify items to be presented per contract	Tue 1/11/11	Thu 1/27/11	50 hrs
2834	Review & approve website design and content	Tue 4/12/11	Tue 4/12/11	24 hrs
2835				
2836	review tasks			0 hrs
2837	Create Readiness Checklist from Appendix JJ	Mon 6/20/11	Fri 6/24/11	0 hrs
2838	Use Readiness Checklist to insure preparedness for Readiness Review	Mon 6/27/11	Fri 9/2/11	0 hrs
2839	Perform Readiness Review	Mon 9/5/11	Tue 10/4/11	0 hrs

Table 4: AmeriHealth Mercy DHH Dependencies

ID	Task Name	Resource Names	Start	Finish
0	**Louisiana Implementation Schedule**		**Tue 1/11/11**	**Fri 2/1/13**
1	**Leadership Team**		**Mon 4/11/11**	**Tue 5/1/12**
2	**Leadership Team Activities**		**Mon 4/11/11**	**Mon 7/25/11**
3	Public Notice of RFP	DHH Louisiana	Mon 4/11/11	Mon 4/11/11
4	Pre-Proposal Conference (Mandatory)	DHH Louisiana	Tue 4/12/11	Mon 4/18/11
5	Deadline for Receipt of Written Questions (Initial timeline)	DHH Louisiana	Fri 4/29/11	Fri 4/29/11
6	Response to Written Questions (revised timeline)	DHH Louisiana	Mon 5/23/11	Mon 5/23/11
8	Proposal Evaluation Period	DHH Louisiana	Tue 6/28/11	Mon 7/25/11
57	**DHH On-site Demonstrations**		**Mon 7/25/11**	**Sun 1/1/12**
58	Contract Award Announced	DHH Louisiana	Mon 7/25/11	Mon 7/25/11
59	Contract Negotiations Begin	DHH, Government Relations/Legislative	Tue 7/26/11	Mon 8/8/11
60	Contract scheduled to begin	DHH Louisiana	Sun 1/1/12	Sun 1/1/12
61	**Implementation Schedule**		**Thu 9/1/11**	**Tue 5/1/12**
62	**GSA A**		**Thu 9/1/11**	**Sun 1/1/12**
63	DHH Readiness Review - GSA "A"	DHH, Louisiana Project Team	Thu 9/1/11	Fri 10/14/11
64	GSA Network Adequacy Documentation Deadline	DHH, Louisiana Project Team	Tue 11/8/11	Tue 11/8/11
65	CCN Network & Control Submitted to CMS for approval	DHH, Louisiana Project Team	Mon 10/17/11	Tue 11/15/11

ID	Task Name	Resource Names	Start	Finish
66	CCN Network Provider Directory and one page brochure to enrollment broker	DHH, Louisiana Project Team	Tue 11/8/11	Tue 11/8/11
67	Choice Letters Mailed to Enrollees - Enrollment begins	DHH Louisiana Project Team	Tue 11/15/11	Tue 11/15/11
68	Deadline for Member Enrollment	DHH, Louisiana Project Team	Fri 12/23/11	Fri 12/23/11
69	GSA A Go-Live	DHH, Louisiana Project Team	Sun 1/1/12	Sun 1/1/12
70	**GSA "B"**		**Mon 9/19/11**	**Thu 3/1/12**
71	DHH Readiness Review - GSA "B"	DHH, Louisiana Project Team	Mon 9/19/11	Mon 10/31/11
72	GSA Network Adequacy Documentation Deadline	DHH, Louisiana Project Team	Fri 10/7/11	Fri 10/7/11
73	CCN Network & Control Submitted to CMS for approval	DHH, Louisiana Project Team	Fri 12/16/11	Thu 1/12/12
74	CCN Network Provider Directory and one-age brochure to enrollment broker	DHH, Louisiana Project Team	Fri 1/6/12	Fri 1/6/12
75	Choice Letters Mails to Enrollees - Enrollment begins	DHH, Louisiana Project Team	Mon 1/16/12	Mon 1/16/12
76	Deadline for Member Enrollment	DHH, Louisiana Project Team	Thu 2/23/12	Thu 2/23/12
77	GSA B Go-Live	DHH, Louisiana Project Team	Wed 2/29/12	Thu 3/1/12
78	**GSA "C"**		**Thu 9/1/11**	**Tue 5/1/12**

ID	Task Name	Resource Names	Start	Finish
79	DHH Readiness Review - GSA "C"	DHH, Louisiana Project Team	Thu 9/1/11	Fri 10/14/11
80	GSA Network Adequacy Documentation Deadline	DHH, Louisiana Project Team	Thu 9/1/11	Thu 9/1/11
81	CCN Network & Control Submitted to CMS for approval	DHH, Louisiana Project Team	Fri 12/16/11	Thu 1/12/12
82	CCN Network Provider Directory and one-age brochure to enrollment broker	DHH, Louisiana Project Team	Fri 1/6/12	Fri 1/6/12
83	Choice Letters Mails to Enrollees - Enrollment begins	DHH, Louisiana Project Team	Thu 3/15/12	Thu 3/15/12
84	Deadline for Member Enrollment	DHH, Louisiana Project Team	Wed 4/25/12	Wed 4/25/12
85	GSA B Go-Live	DHH, Louisiana Project Team	Tue 5/1/12	Tue 5/1/12
86	**Readiness Review**		**Mon 7/25/11**	**Fri 12/9/11**
93	**LA RFP: Appendix JJ - Transition Period Requirements (Readiness Review)**		**Mon 7/25/11**	**Thu 9/1/11**
94	**Contract Start-Up and Planning**		**Mon 7/25/11**	**Thu 9/1/11**
95	Submit updated and detailed Transition/Implementation Plan to DHH	DHH Louisiana	Mon 7/25/11	Thu 9/1/11
139	**PM team**		**Tue 4/12/11**	**Mon 8/22/11**
175	**Develop File Layout Mock-ups**		**Thu 6/30/11**	**Mon 8/22/11**
177	820 Companion Guide	DHH	Thu 6/30/11	Thu 6/30/11
178	837i Matkick Companion Guide	DHH	Thu 6/30/11	Thu 6/30/11

ID	Task Name	Resource Names	Start	Finish
179	835 Matkick Companion Guide	DHH	Thu 6/30/11	Thu 6/30/11
180	Historical Claim File Format	DHH	Thu 6/30/11	Thu 6/30/11
181	Authorization File Format	DHH	Thu 6/30/11	Thu 6/30/11
183	**Project Manager 1**		**Mon 2/7/11**	**Fri 2/1/13**
184	**MEDICAL MANAGEMENT**		**Wed 6/1/11**	**Fri 2/1/13**
193	**Care Coordination**	**Medical Management Team**	**Fri 7/1/11**	**Tue 1/31/12**
312	**DHH approval**	**Medical Management Team**	**Thu 9/1/11**	**Mon 10/31/11**
313	Policies	Medical Management Team, DHH Louisiana	Fri 9/2/11	Mon 10/31/11
314	Letters	Medical Management Team, DHH Louisiana	Mon 10/3/11	Mon 10/31/11
315	Educational Materials	Medical Management Team, DHH Louisiana	Mon 10/3/11	Mon 10/31/11
316	**Rapid Response**	**Medical Management Team**	**Wed 6/8/11**	**Tue 1/31/12**
362	**DHH approval**	**Medical Management Team**	**Thu 9/1/11**	**Mon 10/31/11**
363	Policies	Medical Management Team, DHH Louisiana	Fri 9/2/11	Mon 10/31/11
364	Letters	Medical Management Team, DHH Louisiana	Mon 10/3/11	Mon 10/31/11
365	Scripts	Medical Management Team, DHH Louisiana	Fri 9/30/11	Fri 10/28/11
366	**Utilization Management**	**Medical Management Team**	**Sun 10/30/11**	**Sun 10/30/11**

ID	Task Name	Resource Names	Start	Finish
414	**DHH approval**	**Medical Management Team**	**Thu 9/1/11**	**Mon 10/31/11**
415	Policies	Medical Management Team, DHH Louisiana	Fri 9/2/11	Tue 9/13/11
416	Letters	Medical Management Team, DHH Louisiana	Mon 10/3/11	Fri 10/7/11
417	**Appeals**	**Medical Management Team**	**Fri 7/1/11**	**Tue 1/31/12**
444	**DHH approval**	**Medical Management Team**	**Thu 9/1/11**	**Mon 10/31/11**
445	Policies	Medical Management Team,DHH Louisiana	Fri 9/2/11	Mon 10/31/11
446	Letters	Medical Management Team, DHH Louisiana	Mon 10/3/11	Mon 10/31/11
447	**Quality Management**	**Medical Management Team**	**Wed 6/8/11**	**Fri 2/1/13**
495	**DHH approval**	**Medical Management Team**	**Thu 9/1/11**	**Mon 10/31/11**
496	Policies	Medical Management Team, DHH Louisiana	Fri 9/2/11	Mon 10/31/11
497	Letters	Medical Management Team, DHH Louisiana	Mon 10/3/11	Mon 10/31/11
502	**Credentialing**	**Medical Management Team**	**Wed 6/1/11**	**Tue 1/31/12**
533	**DHH approval**	**Medical Management Team, DHH Louisiana**	**Thu 9/1/11**	**Mon 10/31/11**
534	Policies	Medical Management Team, DHH Louisiana	Fri 9/2/11	Mon 10/31/11

ID	Task Name	Resource Names	Start	Finish
535	Letters	Medical Management Team,DHH Louisiana	Mon 10/3/11	Mon 10/31/11
646	**REPORTING**		**Wed 6/1/11**	**Fri 3/30/12**
653	**Statutory Reporting**		**Mon 8/1/11**	**Thu 1/19/12**
654	Receive Reporting Requirements from DHH	Wendy Dolan, DHH Louisiana	Mon 8/1/11	Mon 8/1/11
677	**PROVIDER NETWORK MANAGEMENT**		**Mon 2/7/11**	**Thu 8/9/12**
678	**Identify and establish resources needed**		**Wed 2/9/11**	**Fri 7/15/11**
683	**Train staff in accordance with DHH and Operational Requirements**	**Jocelyn Bayliss, DHH Louisiana**	**Tue 3/1/11**	**Mon 5/2/11**
684	**Network Development**		**Mon 2/7/11**	**Fri 4/22/11**
687	Develop provider agreement templates in accordance with regulatory (DHH, CMS and DOI), contractual and operational requirements	Suzanne Craig, DHH Louisiana	Wed 2/9/11	Wed 3/23/11
690	Submit FINAL pieces for Provider Recruitment Packet to DHH for approval	Donna Burtanger, DHH Louisiana	Tue 2/22/11	Fri 4/22/11
691	**Create provider mailing lists**		**Wed 2/16/11**	**Fri 7/1/11**
692	Obtain and format DHH Provider Data to create statewide provider mailing list	Jocelyn Bayliss, DHH Louisiana	Tue 3/1/11	Wed 3/23/11
693	Ensure providers selected include all DHH required services	Jocelyn Bayliss, DHH Louisiana	Tue 3/1/11	Wed 3/23/11
695	Identify providers in updated DHH file that were not in original mailing	Jocelyn Bayliss, DHH Louisiana	Tue 4/12/11	Fri 6/17/11
714	**Create provider directories**		**Wed 2/16/11**	**Tue 7/26/11**
715	Create Provider Directory template based on DHH and business requirements	Jocelyn Bayliss, DHH Louisiana	Mon 5/23/11	Fri 7/1/11
719	**Outreach to Statewide Providers**		**Wed 2/16/11**	**Fri 6/17/11**

ID	Task Name	Resource Names	Start	Finish
721	Partner with DHH Office of Public Health and establish LOI to enter into MOU with Public Health Departments.	Jocelyn Bayliss, DHH Louisiana	Wed 3/23/11	Thu 6/9/11
724	**Prepare for Readiness Review**		**Mon 4/4/11**	**Thu 9/1/11**
726	Develop Network Policies and Procedures in accordance with DHH and regulatory requirements	Administrator, DHH Louisiana	Mon 4/4/11	Fri 8/19/11
741	Develop a DRAFT Provider Manual for DHH review and approval	Administrator, DHH Louisiana	Mon 4/11/11	Mon 8/1/11
742	Submit template provider directory to DHH	Administrator, DHH Louisiana	Mon 7/25/11	Tue 8/23/11
743	Submit Network Development Strategy Plan to DHH	Administrator, DHH Louisiana	Mon 8/15/11	Thu 9/1/11
744	Submit DRAFT Provider Manual for DHH review	Administrator, DHH Louisiana	Mon 8/15/11	Thu 9/1/11
745	Submit a copy of the Provider Training Manual training schedule to DHH for approval.	Administrator, DHH Louisiana	Mon 7/25/11	Thu 9/1/11
746	Create Provider Training Manual training schedule to DHH for approval.	Jocelyn Bayliss, DHH Louisiana	Mon 7/25/11	Thu 9/1/11
747	**Prepare for Readiness Review-GSA A**		**Wed 3/30/11**	**Mon 1/30/12**
748	Ensure network capacity and availability meet DHH standards	Jocelyn Bayliss, DHH Louisiana	Wed 7/13/11	Fri 10/7/11
750	Submit to DHH, a Network Provider and Subcontractor Registry listing of all contracted and credentialed Providers	Administrator, DHH Louisiana	Fri 9/23/11	Fri 10/7/11
752	Provide sufficient copies of final Provider Directory to the DHH's Enrollment Broker in sufficient time to meet the enrollment schedule.- GSA A	Administrator, DHH Louisiana	Tue 11/8/11	Tue 11/8/11
754	Send PCP Linkage File to DHH-EB GSA A	Jocelyn Bayliss, DHH Louisiana	Tue 11/8/11	Tue 11/8/11
757	**Prepare for Readiness Review-GSA B**		**Wed 6/15/11**	**Fri 3/30/12**
758	Ensure network capacity and availability meet DHH standards	Jocelyn Bayliss, DHH Louisiana	Wed 8/31/11	Mon 11/7/11

ID	Task Name	Resource Names	Start	Finish
759	Submit to DHH, a Network Provider and Subcontractor Registry listing of all contracted and credentialed Providers	Jocelyn Bayliss, DHH Louisiana	Mon 11/7/11	Mon 11/7/11
761	Provide sufficient copies of final Provider Directory to the DHH's Enrollment Broker in sufficient time to meet the enrollment schedule.- GSA B	Jocelyn Bayliss, DHH Louisiana	Tue 12/6/11	Fri 1/6/12
763	Send PCP Linkage File to DHH-EB GSA B	Administrator, DHH Louisiana	Mon 12/19/11	Fri 1/6/12
766	**Prepare for Readiness Review-GSA C**		**Wed 6/15/11**	**Fri 3/30/12**
767	Ensure network capacity and availability meet DHH standards	Jocelyn Bayliss, DHH Louisiana	Wed 6/15/11	Mon 1/9/12
768	Submit to DHH, a Network Provider and Subcontractor Registry listing of all contracted and credentialed Providers	Jocelyn Bayliss, DHH Louisiana	Mon 1/9/12	Mon 1/9/12
770	Provide sufficient copies of final Provider Directory to the DHH's Enrollment Broker in sufficient time to meet the enrollment schedule. - GSA C	Jocelyn Bayliss, DHH Louisiana	Fri 2/24/12	Fri 3/9/12
773	**Project Manager 2**		**Tue 2/8/11**	**Wed 5/2/12**
774	**Information Services Team**		**Tue 2/8/11**	**Wed 5/2/12**
1134	**ENCOUNTERS**		**Tue 2/8/11**	**Mon 3/19/12**
1185	**Phase 3 - Final QA**		**Fri 11/25/11**	**Fri 12/2/11**
1187	Systems Integration & Final QA with DHH	Tester, DHH Louisiana	Fri 11/25/11	Fri 12/2/11
1188	**Phase 4 - Deployment & Stabilization**		**Thu 1/12/12**	**Mon 3/19/12**
1190	**Production Processing**		**Tue 1/31/12**	**Mon 3/19/12**
1191	Prep and Submit First Production Encounters Files to DHH	Analyst, DHH Louisiana	Tue 1/31/12	Mon 2/13/12
1192	Post DHH response files; identify problematic claims and claims that have been coded as rejections for certain reasons	Analyst, DHH Louisiana	Tue 2/14/12	Mon 2/27/12

ID	Task Name	Resource Names	Start	Finish
2222	**Project Manager 3**		**Mon 4/11/11**	**Wed 5/2/12**
2223	**Service Operations**		**Mon 4/11/11**	**Tue 5/1/12**
2282	**Operations**		**Mon 4/11/11**	**Fri 12/23/11**
2283	**Contact Center (Member Services & Provider Claims Services)**		**Mon 6/13/11**	**Fri 12/9/11**
2288	**Call Scripting**		**Mon 8/8/11**	**Wed 8/24/11**
2290	Obtain DHH approval	DHH Louisiana	Mon 8/15/11	Fri 8/19/11
2313	**Coordinate Telecom Requirements**		**Mon 7/18/11**	**Fri 8/26/11**
2319	**Telephone recorded messages**		**Mon 8/1/11**	**Fri 8/26/11**
2321	Obtain DHH approval	DHH Louisiana	Mon 8/8/11	Fri 8/12/11
2429	**Member Materials**		**Mon 6/27/11**	**Thu 7/28/11**
2430	**New member welcome packet**		**Mon 6/27/11**	**Tue 7/5/11**
2432	Submit information to DHH for approval	DHH Louisiana	Tue 6/28/11	Tue 6/28/11
2433	State approval	DHH Louisiana	Wed 6/29/11	Wed 6/29/11
2438	**Member Handbooks**		**Thu 7/7/11**	**Fri 7/15/11**
2441	Submit to DHH for approval	DHH Louisiana	Mon 7/11/11	Mon 7/11/11
2442	Submit materials for translation and language tag line	DHH Louisiana	Tue 7/12/11	Tue 7/12/11
2446	**Member ID Cards**		**Mon 7/18/11**	**Tue 7/26/11**
2451	Submit ID card to state for approval	DHH Louisiana	Fri 7/22/11	Fri 7/22/11
2452	DHH approval	DHH Louisiana	Mon 7/25/11	Mon 7/25/11
2539	**Project Manager 4**		**Tue 1/11/11**	**Mon 12/12/11**
2772	**Marketing - Communications - Community Outreach - Website**		**Tue 1/11/11**	**Mon 12/12/11**

ID	Task Name	Resource Names	Start	Finish
2773	**Implementation Plan for Marketing, Outreach - Louisiana RFP**		**Tue 1/11/11**	**Mon 12/12/11**
2774	**Corporate Communication Project Tasks**		**Tue 1/11/11**	**Mon 12/12/11**
2785	**Provider Communications**		**Mon 2/7/11**	**Wed 4/6/11**
2793	Submit FINAL pieces of Provider Recruitment Packet to DHH for approval	Evan Johnstone ,DHH Louisiana	Tue 3/15/11	Tue 3/15/11
2795	**Develop & Review Required Plan Materials**		**Tue 6/7/11**	**Sat 10/15/11**
2796	**Website:**		**Tue 6/7/11**	**Sat 10/15/11**
2802	Submit to DHH for approval	Cristina Graham, EvanJohnstone DHH Louisiana	Sat 10/15/11	Sat 10/15/11

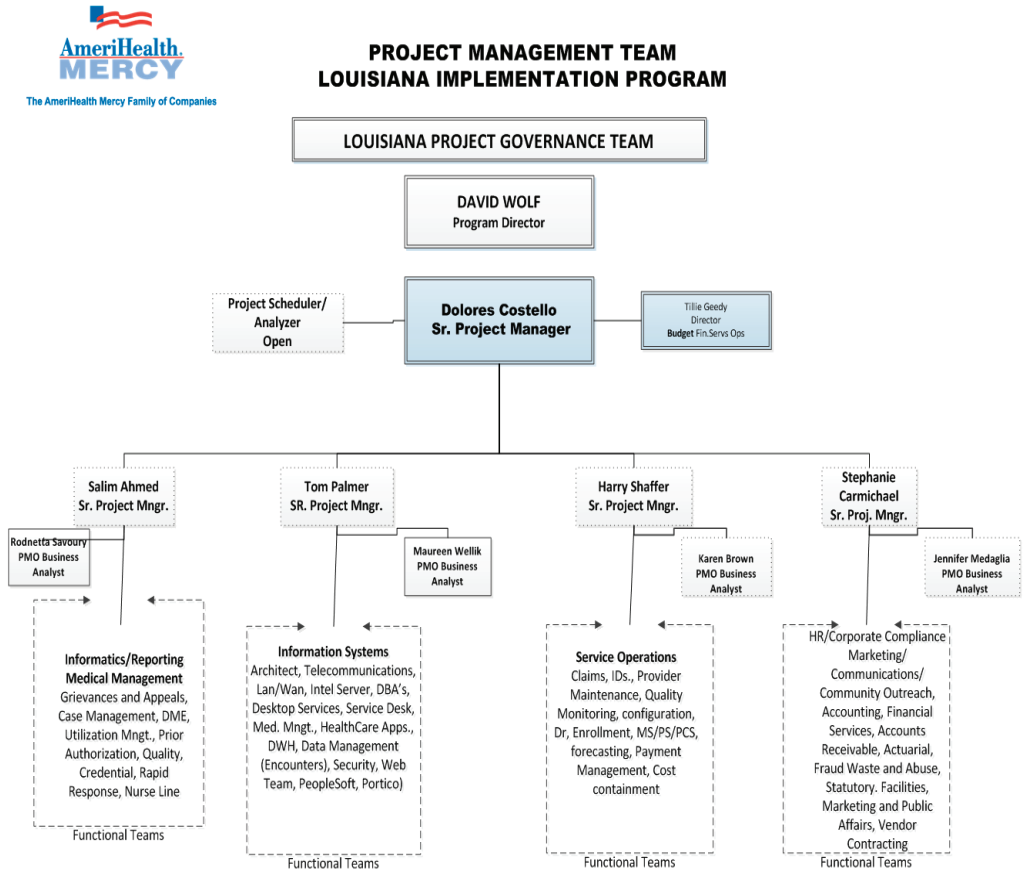
C.5: Implementation Team Roster

C.5 Provide a roster of the members of the proposed implementation team including the group that will be responsible for finalizing the Provider network.

Implementation Team

AmeriHealth Mercy has an established, innovative Enterprise Portfolio Management Office (EPMO) which incorporates methodologies enabling our organization to not only prioritize activities and execute implementation projects but to do so with key personnel focused exclusively on serving the needs of the CCN Program. AmeriHealth Mercy's Louisiana Implementation Team, with support from the EPMO, understands the critical nature of this implementation for the State and our future members in each of the three GSAs.

The AmeriHealth Mercy CCN implementation team will consist of the following resources:



The responsibilities of each position are described below.

Senior Project Manager (Dolores Costello)

Reporting to the Governance Team, the Senior Project Manager is a full-time resource responsible for the overall success of the LaCare business implementation and successful preparation and completion of the Readiness Review **for all three GSAs**.

The duties of the Senior Project Manager include:

- Oversight of all activities to ensure that the project remains on target

- Oversight to ensure that the AmeriHealth Mercy mission is incorporated throughout the implementation
- Management of the Communications Plan
- Monitoring the master project schedule
- Serving as the point of escalation for all issues, risks and decisions
- Oversight and coordination of Day One go-live implementation
- Monitoring the stabilization period after go-live

Project Scheduler/Analyst (not yet filled)

Also a full-time resource, the Project Scheduler/Analyst is responsible for the master project schedule and resource management plan.

In brief, the duties of the Project Scheduler/Analyst include:

- Development, tracking and maintenance of the master project schedule
- Coordination of resources, equipment and information
- Collation and consolidation of all workgroup status reports
- Development of standard reports for workgroup meetings
- Development of ad-hoc reports for workgroup meetings

Project Managers

Four full-time Project Managers will be responsible for managing the work of the various work teams supporting the Louisiana implementation. Each resource will be responsible for one or more functional areas as listed below, and each Project Manager will be responsible for the following duties:

- Management of the project plan for workgroup/functional area
- Development and management of the project scope and schedule for workgroup/functional area
- Management of issues, risks and decisions
- Coordination with project teams for status updates
- Ensuring that all deliverables for Readiness Review are on track
- Ensuring that all activities are completed for go-live

Project Manager 1: (Salim Ahmed)

- Informatics/Reporting
- Medical Management (Grievances and Appeals, Integrated Care Management, DME, Utilization Management, Prior Authorization, Quality, Credentialing, Rapid Response, Nurse Line)
- Provider Network Management (Network Development, Network Analysis and Reporting, Provider Relations, Provider Education, Provider Communication, Network Operations)

Project Manager 2: (Tom Palmer)

- Information Systems (Architecture, Telecommunications, LAN/WAN, Intel Server, Database Administration, Desktop, Service Desk, Medical Management applications, HealthCare applications, Data Warehouse, Data Management/Encounters, Security, Web Team, PeopleSoft, Provider applications)

Project Manager 3: (Harry Shaffer)

- Human Resources/Corporate Compliance (includes training)
- Marketing/Communications/Community Outreach
- Finance (Accounting, Financial Services, Accounts Receivable, Actuarial, Fraud, Waste and Abuse, Statutory Reporting)
- Facilities
- Vendor Contracting

Project Manager 4: (Stephanie Carmichael)

- Operations (Claims, Enrollment, Member Services/Provider Services/Provider Claims Services, ID Cards, Provider Data Maintenance, Quality Monitoring, Configuration, Disaster Recovery, Forecasting, Payment Management/Cost Containment, TPL/Recovery

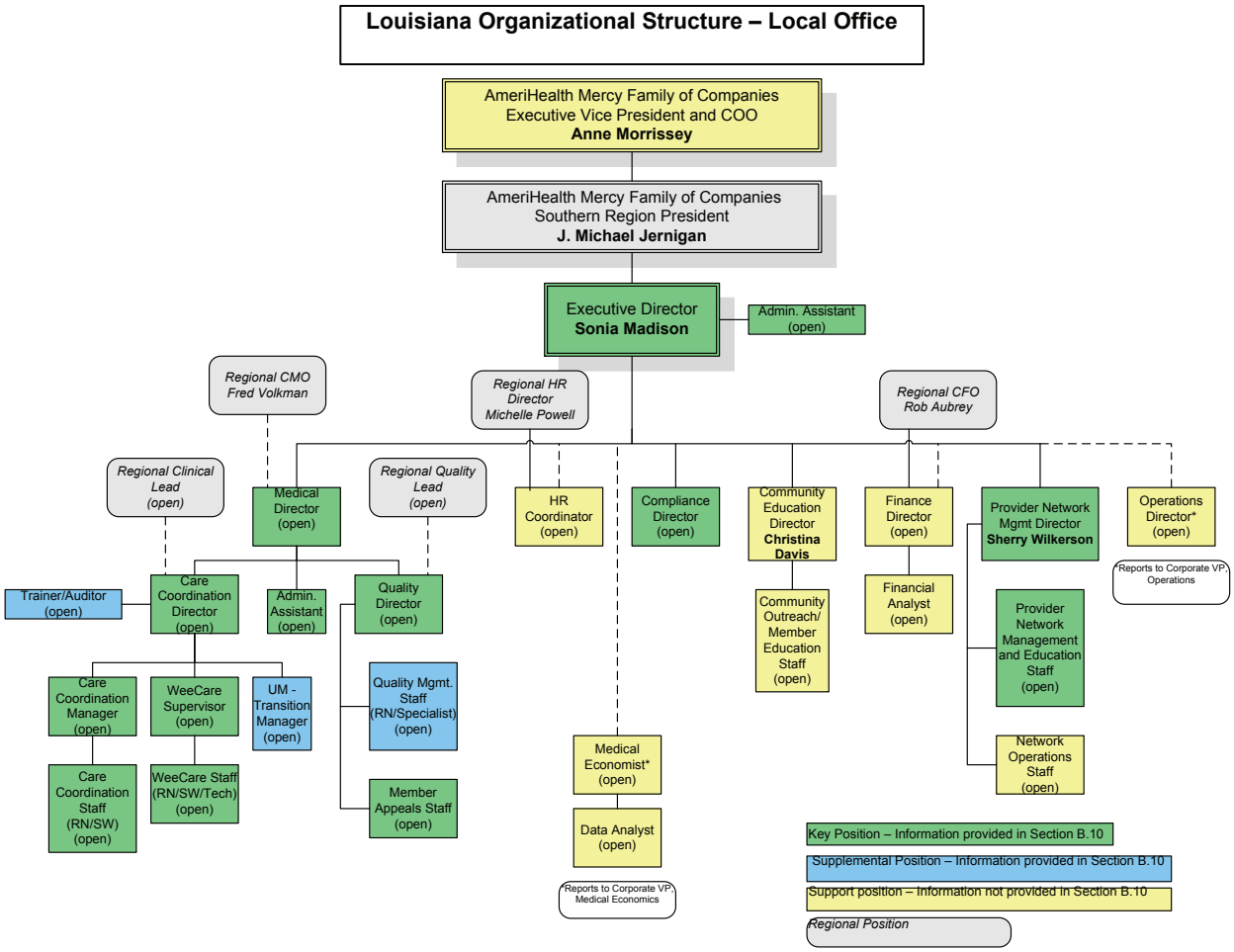
Business Analysts

Four full-time resources dedicated to supporting the Project Managers in each of the functional areas listed above. Duties include:

- Gathering and developing all business requirements
- Managing the traceability of business requirements through to testing
- Assisting with the coordination of User Acceptance Testing activities
- Verification that all items are sufficiently and successfully tested during User Acceptance Testing

Local Office

AmeriHealth Mercy of Louisiana has been building the foundation of a Medicaid managed care program in Louisiana for the better part of a decade and in the process has developed a clear understanding of the local health care environment. Led by Sonia Madison, who has had a distinguished, three-decade career in health plan administration in Louisiana and other parts of the country, our AmeriHealth Mercy local office will be focused on the hands-on approach to managing our CCN Program across all three GSAs. Among the functions managed at the local level will be the finalization of the Provider network. The organizational chart below depicts the assignment of resources at the local level including our Provider Network Management Director, Sherry Wilkerson.



C.6: Implementation Manager

C.6 Provide the resume of the Implementation Manager (the primary person responsible for coordinating implementation activities and for allocating implementation team resources).

Below, please find the resume of the Implementation Manager, Joanne G. McFall.

Joanne G. McFall

Managed care executive with 20 years experience in health care operations, strategic planning, medical cost containment, information technology, and financial oversight. Areas of expertise include project management (from project planning through stabilization), financial analysis, strategy development, and issue resolution. Broad background includes information systems, cash management, billing and collections, and marketing/promotion of services. Excellent written and verbal communication skills with ability to coordinate among all levels of the organization.

Experience

Vice President and Chief of Staff, AmeriHealth Mercy Family of Companies, Philadelphia, PA
2009–present

- Serve as the liaison between the corporate Chief Operating Officer and all direct reporting departments as well as all other corporate functions.

- Direct oversight of enterprise Portfolio Management Office (PMO) with implementation responsibility for 30+ corporate projects and a budget of $27 million.
- Responsible for continuous improvement of the enterprise portfolio management function and realization of benefits for all project work.
- Represent COO on various enterprise corporate governing bodies and partner with executive leadership to identify and implement ongoing service delivery model improvements.
- Provide oversight and ownership for the corporate Operating Plan that drives execution of the organization's Strategic Plan and Annual Operating Plan goals.

Associate Vice President, AmeriHealth Mercy Family of Companies, Philadelphia, PA 2007–2009

- Responsible for high-level project oversight and the alignment of corporate strategy with tactical initiatives.
- Coordinated oversight of operational functions and process improvement/cost containment opportunities.
- Served as a liaison to other health plans in the AmeriHealth Mercy Family of Companies for identification and resolution of common issues, standardization of plan functions, and implementation of process improvement opportunities and efficiencies.

Strategic Project Director, AmeriHealth Mercy Family of Companies, Philadelphia, PA 2004–2007

- Responsible for a full range of project oversight responsibilities, including initial project review and prioritization, resource analysis, cost/benefit analysis, and management from project initiation through stabilization.
- Worked with project executive sponsors and project teams to ensure that all projects met stated financial, operational, and timeline goals.

Project Manager, AmeriHealth Mercy Family of Companies, Philadelphia, PA 2002–2004

- Responsible for the oversight of system implementation projects, from project initiation through stabilization. Worked with project stakeholders to determine system requirements, design specifications, test plans, and deployment schedules.
- Served as the primary contact for issue identification, tracking, and resolution throughout the project life cycle.
- Provided ongoing support for certain processes after stabilization had been completed.

Business Analyst, AmeriHealth Mercy Family of Companies, Philadelphia, PA 2000–2002

- Responsible for the configuration, testing, deployment, and stabilization of the financial components of the organization's new information system (Facets).
- Worked with internal and external customers to document system requirements, plan system configuration, and test the completed system.
- Served as the point of contact for issues related to system stabilization following deployment to the customers.
- Served as corporate liaison for Mission Partnership charitable activities and community projects.

Cash and Collections Manager, Novacare, Inc./Hanger Orthopedic Group, King of Prussia, PA 1997–1999

- Responsible for the management of cash collection activities at 350 orthotics and prosthetics facilities nationwide.
- Served as the primary contact for the integration of all newly-acquired businesses into corporate cash management functions.
- Worked extensively with the in-house billing and collection software program (TOPS).
- Worked with accounting, finance, and treasury departments to troubleshoot cash-related issues.
- Tracked accounts receivable balances on a monthly basis for potential collection issues.

- Served as corporate liaison for Red Cross, Juvenile Diabetes and community charity activities.

Business Manager, Penn Care At Home/University of PA Health System, Philadelphia, PA **1991-1997**

- Administered all financial operations of a hospital-based home health agency including billing, collections, budget development and analysis, account reconciliation, and financial analysis.
- Supervised medical records and billing staff.
- Coordinated all departmental management information systems including industry-specific billing program (STAT 2).
- Participated in agency performance improvement program, policy and procedure development, and JCAHO survey preparation activities.
- Facilitated special projects between agency and health system administration.
- Coordinated all agency marketing activities including provider relations, community affairs, publicity, special events planning, and program research and development.
- Served as medical center Teambuilding, Delegation, and Communication facilitator, United Way and Red Cross coordinator, and department publicist; wrote for employee publications.

Public Relations Assistant, Mercy Catholic Medical Center, Darby, PA **1991**

- Wrote and edited articles for employee publications, corporate communications, and press placement. Coordinated special events and community relations activities. Assisted with other corporate publicity functions.

Education

- Masters of Business Administration, Health and Medical Services Administration, Widener University, Chester, PA
- Bachelor of Arts, Communication, University of Delaware, Newark, DE

Section D – Member Enrollment and Disenrollment

Currently, the AmeriHealth Mercy Family of Companies serves almost one million active members across five Medicaid managed care organizations throughout the United States and we are prepared to enroll more Medicaid recipients in Louisiana. Maintaining complete and accurate membership data critical to ensure that we deliver high-quality, cost effective care to our members. Our enrollment process is built around nationally-accepted, HIPAA-compliant transactions and file layouts that allow us to effectively process and reconcile eligibility information. Accordingly, we have developed rigorous processes to utilize the daily, weekly and monthly files we receive to enroll new members, disenroll members, re-enroll members, update member demographic data and assign primary care physicians in a timely and accurate manner.

AmeriHealth Mercy has extensive experience in working with states and enrollment brokers to handle state-specific eligibility requirements, and will work with the State of Louisiana to comply with all of its specific requirements. For example, the Commonwealth of Kentucky has no time limits for retroactive eligibility. We developed specific criteria to accommodate retro-enrollment that date back to the original date of eligibility. Another example is that the Commonwealth of Pennsylvania initially did not assign newborns with an ID number for 30 plus days. We developed a process to pay claims under the mother's ID number and subsequently enroll and reconcile data with the newborn ID issued at a later date.

We have the systems, tools and experience to accurately process eligibility data for Louisiana. We also welcome the opportunity to discuss programs from other states that may be of interest to DHH.

D.1: Enrollment Procedures

D.1 Describe your enrollment procedure requirements, including how you will ensure that you will coordinate with DHH and its Agent.

Processing Eligibility Files

Daily Eligibility File Process (Inbound)

AmeriHealth Mercy will receive a Daily Membership File from the Enrollment Broker in an ASC X12N 834 Benefit Enrollment and Maintenance transaction. This file is automatically processed each night in our Facets® health care application. (Facets is our core eligibility and claims processing system, serving as the central repository for all member data.) This process automatically applies changes to the membership data and updates information about members so that the information in Facets is reconciled with the information from the Department of Health and Hospitals (DHH) or Enrollment Broker. Any online modification of demographic information, category in assistance, change of medical assistance, eligibility, new enrollment, disenrollment or PCP change automatically updates our member records. In order to effectively manage the accuracy of our membership data, we process files in the order in which they are received, and we process records in chronological order for each member.

Designated employees in the Enrollment Department will create, review, and reconcile reports. On a daily basis, we compare eligibility transactions to our existing member records, and update or add them as necessary. Specifically, the member data on the daily inbound file is loaded into the Facets system within 24 hours of receipt of the file. Members assigned on or before the third to last working day of a given month will be effective at 12:01 a.m. on the first calendar day of the month following assignment. Members that are assigned after the third to last working day in a given month will be effective at 12:01 a.m. on the first calendar day of the second month following assignment.

If any data does not match as expected, the record defaults to a daily error report which is resolved by the Enrollment Department within 24 hours – sooner than the time required by Section 11.15 of the Louisiana

CCN-P RFP. An example of this type of error would be a reported end date that is a date prior to recorded eligibility begin date. This information is accumulated into categories and reported to the Enrollment Department. The Enrollment Department proactively reviews, researches, and updates any discrepancies to reconcile our system with the Louisiana State System. Once the reconciliation is complete, we continue the process for generation of PCP panel lists and PCP capitation.

Our Enrollment Department will provide the Enrollment Broker with written notification of all discrepancies that are identified during the reconciliation process within 10 calendar days. The actual layout of the report or reconciliation file layout will be determined during implementation and in consultation with DHH and the Enrollment Broker.

Monthly Eligibility File Process (Inbound)

Similar to the Daily Eligibility File, AmeriHealth Mercy is prepared to receive a Monthly Eligibility File from the Enrollment Broker that contains the most current record for each recipient who becomes managed care-eligible within the next month. This file is a complete reconciliation of all of the daily files. Regardless of the file frequency, the detail reconciliation process described above remains the same.

Eligibility Information from Other Sources

In our current process, eligibility discrepancies are identified through a number of sources: medical records, discharge planning, PCP notification, member self-reported, and EOB's, claims and return mail. The most common discrepancies are: address changes, name spelling errors, e-mail address, changes to third party insurance coverage or telephone numbers. Our employees enter these updates into our Facets system using a custom-designed front-end graphical user interface called Streamline. These demographic changes are communicated to the Enrollment Broker within five business days via the weekly outbound file process. Demographic changes will trigger communication to a member to validate.

Weekly Eligibility File Process (outbound)

AmeriHealth Mercy will produce a Membership Enrollment and Disenrollment Outbound File to DHH within five business days, which contains alerts and notifications regarding change of status, such as information about newborns, returned mail, death notifications, Third Party Liability (TPL) changes and demographic changes. These alerts are a means to communicate changes in membership data to DHH for incorporation into the Louisiana State System.

The Enrollment Broker will return the enrollment/disenrollment file weekly with a disposition of each record that was sent to them on file. Each returned record contains an edit code indicating whether the record processed, and the type of processing that was completed. AmeriHealth Mercy's Enrollment Department manually reviews all edit codes that require additional research. These edit codes are automatically updated and stored in the Facets system for future reference.

Communication with Members to Reconcile Discrepancies

On occasion, members have to be contacted to help resolve eligibility discrepancies. AmeriHealth Mercy's dedicated Enrollment Department will follow the same processes as exist in our affiliates. Representatives will place a call to the member to validate or obtain additional information. All of the information collected will be used to update the member's eligibility file in the system.

Additionally, we utilize an internal Enrollment Hotline to provide our Customer Service Representatives direct access to resolve member questions related to eligibility and enrollment that require immediate attention. This has greatly improved real-time issue resolution and increased member satisfaction because the eligibility issue is resolved while the member is still on the telephone and, if eligible, the member can immediately access care. Upon member request, the member's demographic information will be sent via multiple communication channels to the member for validation.

Extra Value to Louisiana

If DHH is interested, AmeriHealth Mercy can utilize its eligibility and claim data to help identify members who may be eligible for additional State services. For instance, in our Pennsylvania plan we utilize claim, authorization and eligibility data to help determine if members are in the appropriate category of aid. Shifting members to the most appropriate aid category ensures they have access to the appropriate benefits and the appropriate reimbursement is given to the CCN to provide needed care. AmeriHealth Mercy will work with DHH to develop similar and additional processes to help DHH and the member access appropriate services

Acceptance of all Eligibles

AmeriHealth Mercy will enroll any mandatory CCN-eligible member who self-selects the plan or is assigned to the plan without discrimination against the member based on their health history, health status, need for health care services or adverse change in health status, religious belief, sex/gender, or sexual orientation.

In addition, we will accept potential enrollees in the order in which they are assigned without restriction, up to the enrollment capacity limits set under the contract with Louisiana DHH.

Coordination with DHH and Agencies

Our past experiences have demonstrated that an open and ongoing dialogue early in the implementation process is critical for a successful launch. The Enrollment Department will take the lead for scheduling joint meetings with DHH and the Enrollment Broker to:

- Establish an open line of communication
- Develop testing strategy and plan
- Develop key milestones
- Identify a point person for each agency who will be accountable for tracking the progress and resolving issues
- Develop file schedules for data transfers and loading into AmeriHealth Mercy systems

Once systems are in place, we will continue ongoing discussions with the Enrollment Broker to enhance processes, as needed, to ensure timely updates of member information. As an example, in Pennsylvania, AmeriHealth Mercy has worked closely with the Commonwealth's County Assistance offices to enhance the enrollment and re-certification process. AmeriHealth Mercy initiated meetings with the County Administrator and staff to develop a process to ensure member updates were performed timely. This resulted in a reduction in the numbers of members who temporarily lost eligibility due to not completing the appropriate paperwork or meeting with their Case Worker.

D.2: Newborn Enrollment

D.2 Describe your approach to meeting the newborn enrollment requirements, including how you will:

- *Encourage Members who are expectant mothers to select a CCN and PCP for their newborns: and*
- *Ensure that newborn notification information is submitted, either by you or the hospital, to DHH or its Agent within twenty-four (24) hours of the birth of the newborn.*

Expectant Mothers

AmeriHealth Mercy's WeeCare program, described in Section F, includes processes to encourage members who are expectant mothers to select a primary care provider for their newborn. The primary purpose of the WeeCare program is to provide services to pregnant members and to encourage members to have the healthiest pregnancy possible.

The WeeCare Supervisor will also serve as the Maternal Health/EPSDT Coordinator. He or she will be a Louisiana Registered Nurse and will supervise the WeeCare program and nursing staff supporting the program. All of these positions will be located in our Baton Rouge office and will report ultimately to the Louisiana Medical Director (also licensed and located in Louisiana).

As part of their routine outreach, WeeCare staff will contact pregnant members at least sixty (60) calendar days prior to the projected delivery date to reinforce healthy pregnancy guidelines for the last trimester and identify any barriers to needs. As part of that contact, the WeeCare staff will review the process for selecting a primary care physician for their newborn and enrolling the newborn in the Louisiana Medicaid program. Some of the questions that are asked during the interaction include:

- Have you called the Contact Center to select a doctor for your child?
- If the member states "no," the WeeCare Department will offer to personally connect the member to a Customer Service Representative to select a primary care physician for their newborn.
- Have you scheduled your baby's first appointment with the pediatrician?
- If the member states "yes," the Wee Care staff member will ask the member when the appointment is scheduled. If the member states "no," the Wee Care staff member will offer to assist the member with scheduling an appointment with the pediatrician.

We understand the importance for members who are expectant mothers to select a CCN and PCP for their newborn. And if necessary, the WeeCare program will provide the additional assistance some pregnant members need in choosing a pediatrician, or other appropriate PCP. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, AmeriHealth Mercy will assign one based on our standard policies and procedures, as outlined in Section G.

If AmeriHealth Mercy is not aware that the member was pregnant until she presented for delivery, AmeriHealth Mercy will assign a pediatrician or a PCP to the newborn baby in accordance with policies required by DHH. The WeeCare team will work with the member to choose a different PCP if the PCP selected does not meet her needs or if the member wants to make a change.

Newborn Notification to DHH

All participating network hospital providers will be contractually obligated to report the births of newborns within 24 hours of birth for enrolled members through LEERS (Louisiana Electronic Event Registration System) administered by DHH/Vital Records Registry. This requirement is outlined in the Provider Manual, and will be reinforced at hospital orientation and ongoing training programs.

To monitor hospital performance, AmeriHealth Mercy will cross check newborn enrollment received on the eligibility file against delivery admissions. Provider Network Management Representatives will work with any hospitals found not in compliance with the requirements around the reporting of newborn birth information. Additional information on our processes for monitoring and addressing provider performance can be found in Section G.

We will monitor the inbound eligibility feed from the Enrollment Broker to ensure the newborn has been enrolled in the State's system. If after 30 days the newborn has not been enrolled, we will reach out to the Enrollment Broker and to DHH to follow up.

D.3: CCN Initiated Member Disenrollment

D.3 Describe the types of interventions you will use prior to seeking to disenroll a Member as described in CNN Initiated Member Disenrollment, Section 11 of this RFP. If applicable, provide an example of a case in which you have successfully intervened to avert requesting the disenrollment of a member.

Behaviorally Challenging Members

Behaviorally challenging members enrolled in Medicaid programs present a multitude of issues for the clinical and non-clinical staff with whom they interact. Some members have difficulty processing information, poor problem-solving and interpersonal skills on a history of maladaptive, self-destructive responses to stress. They also tend to be chronically dissatisfied with care in any setting and are extremely high utilizers of staff time, energy and resources, often depleting the staff caring for them. When working with such members there is a tendency to engage in non-productive, redundant efforts which do little or nothing to improve the member's situation and often can make it worse. When members feel anxious, frightened or worried these feelings can come out as anger, intense dependency, neediness, avoidance and anxiety. These members lack the internal and external resources to successfully negotiate the increasingly complex terrain of medical care in our society.

With some minor modifications in work flows and clinical approaches, we can identify behaviorally challenging members and provide them with the structure and information that they need while significantly reducing staff efforts that increase staff frustration and yield little or no return.

Characteristics of the Behaviorally Challenging Member

- They may display angry, needy, blaming, manipulative, or self-destructive behavior
- They evoke anxiety, frustration and anger in staff and caretakers
- They adhere poorly to treatment recommendations
- They present with one issue after the next
- They ask for assistance, then reject it
- They develop severe anxiety, depression or intractable physical complaints
- They may present with concurrent alcohol and drug abuse problems and other behavioral health issues
- They are often unable to realize the role of their own behaviors in creating their difficulties
- They are often interpreted by those around them as difficult or 'bad' rather than as clinically dysfunctional or impaired
- They often have lower levels of satisfaction with care
- They have difficulty forming trusting/helping relationships and taking support from those trying to help
- They have deficient problem-solving skills
- They often lack empathy or understanding of their impact on others

Disenrollment Process

In the event that AmeriHealth Mercy has to initiate involuntary disenrollment of a member because the member misuses or loans their ID card, or because their behavior is disruptive, unruly, abusive or uncooperative, AmeriHealth Mercy will notify the member in writing and submit the reports required by DHH, using the CCN-Initiated Request for Member Disenrollment, to the Enrollment Broker. AmeriHealth Mercy will continue to provide services to the member until AmeriHealth Mercy receives notice from the Enrollment Broker.

AmeriHealth Mercy's Approach

However, AmeriHealth Mercy will submit such requests only as a very last resort. Rather, AmeriHealth Mercy will use a proprietary program that was designed and perfected over the last three years. Staff from our Integrated Care Management programs and our Contact Center staff utilize the following process prior to seeking to disenroll a member as described in CCN Initiated Member Disenrollments.

The first step in supporting a behaviorally challenging member is to identify when a member may benefit from a specific, directed approach to care. Customer Service Representatives will be trained to identify

patterns of behavior and refer members to the Integrated Care Management team based on the following trigger(s):

- Chronic difficulties/dysfunctional patterns
- Multiple previous psychiatric diagnoses/hospitalizations
- Multiple therapists
- Chronic, repetitive marital difficulties/multiple marriages
- Shifting friendships and relationships
- Abusive/abusing relationships
- Any kind of substance abuse or eating disorders
- Suicide attempts/self-destructive behaviors
- Legal difficulties

Once the member has been identified, the following approach is implemented with the agreement and understanding from the member.

1. Management of the case will be confined to one Care Manager (contact person). With support of an integrated customer management platform and care management platform, all calls related to a specific member's case are directed to the single, assigned key point-of-contact.
2. The Care Manager and the member agree to abide by pre-defined communication guidelines.
    a. All calls are responded to or returned within 24 hours by the assigned contact person.
    b. No long (>1minute) voicemails from member.
    c. Abusive language and tone are not appropriate and will not receive a response.
3. The Care Manager provides reassurance that medical needs will be met and assists with coordination of care, as needed.
4. The Care Manager will explore feelings of anxiety (or other related behavior/feelings) the member may be experiencing regarding medical issues to help them talk about this more directly and proactively before it turns into an undesirable behavior.
5. Member agrees to reach out to contact person when they need assistance (reduces increased and redundant requests).

Through this structured approach, we have developed more effective processes and standardized responses aimed at improving the treatment experience, efficiently utilizing staff resources, and reducing conflict and unnecessary utilization of medical resources.

Case Study

A male member, Mr. X, from one of AmeriHealth Mercy's plans was identified and managed within the described approach to Care Coordination:

- 50-year old, single male who lives with his elderly, failing parents
- History of dozens of admissions (often for months at a time) for issues related to his morbid obesity (hernias, wound issues, infection)
- More than 1,500 phone calls to the health plan since becoming a member in 2001
- Threatening, angry, belligerent behavior towards staff and medical providers - often pitting staff against each other particularly around hospital discharge or the end of services (home care)
- Refused ongoing case management
- Rejects any mention of behavioral health referral (behavioral health services are carved-out in this state)

Mr. X was introduced to our Care Coordination Department in 2005 with one brief period of ongoing care management through Special Needs/Episodic unit. He has had other brief periods of management around

urgent medical issues. Mr. X's issues center around a very conflicted relationship with his elderly parents, who are his primary caregivers but are both quite ill. It appears to be a relief for the whole family (including Mr. X) when he is admitted and when the time comes for discharge he will go to great lengths to avoid discharge, including infecting his central lines, eating feces, calling politicians and threatening staff.

Mr. X has historically been a very challenging member for staff and has thousands of phone calls logged over the years. He will leave numerous 4-6 minute long voicemails and will work on pitting all of his caregivers against each other until someone relents. It is very difficult to end calls with Mr. X, and staff and providers on the outside have gone to great lengths to please him only to have him reject the assistance or not follow through with instructions.

Mr. X had been calling a specific Customer Services Representative for a number of years. This employee referred him to Care Coordination for added support around a hernia repair earlier this year. Initially, the member would continue to call the Customer Services Representative and Care Coordination departments when upset and leave numerous lengthy voicemails at both locations.

A plan was made to confine his care to one contact person and all calls and voicemails to the Contact Center were immediately sent to his designated Care Manager or their voicemail. It was explained to Mr. X that one person would be handling his case management needs and that if he called, this assigned contact person would respond promptly (if available) or a supervisor would respond in the event that the contact person was out of the office. A limit was also set with the member about leaving lengthy voicemails. Since this plan has been implemented with the member, the following results have been noted:

- He is receptive to the limits that have been set concerning requests to do things for him which he can do for himself. He responds well to this approach and has gained some self-management skills.
- Demanding, dissatisfied calls have dramatically decreased and duplicative calls have also decreased (total inbound calling from 15-20 per week to 1-2 every 2-3 weeks).
- There is a reduction in angry, acting-out behaviors despite the fact that Mr. X's health remains quite tenuous.
- He is showing improved ability to express his feelings when he is anxious and can accept some support (although continuously rejects Behavioral Health referrals).

Mr. X has made significant gains with this approach, which has resulted in him receiving better and more appropriate care. Mr. X remains at almost constant risk of medical and emotional regression given his own fragile health coupled with his parents advancing age and decreased ability to care for him.

While Mr. X has quite serious medical issues, presently he has lost considerable weight, is driving himself to and from appointments and is complying with lymphedema therapy. Despite a history of frequent complaints about the health plan and state government, both formally and informally, the majority of his medical needs have been met and his care has been appropriately managed. The most challenging issue for Mr. X is his very limited ability to tolerate distress, coupled with great difficulty communicating his needs to family and providers who care for him. He will continue to be supported through the described process while he remains eligible with the health plan.

D.4: Member Re-assignment

D.4 Describe the steps you will take to assign a member to a different Provider in the event a PCP requests the Member be assigned elsewhere.

If a primary care physician (PCP) requests that one of their members be assigned elsewhere, the current PCP must submit in writing the reason for the request. AmeriHealth Mercy will work with the PCP and the member to determine if there is any opportunity to prevent the transfer. The relationship between the PCP and member is critical. Switching to a different PCP during an active course of treatment may impact care. If there is anything we can do to address the PCP's concerns, such as how we will help challenging members, we will. However, in some cases, we cannot assist in addressing the PCP's concerns and will need to proceed with the member re-assignment.

The written request will be submitted to our Provider Network Management Department. The PCP will continue to provide covered services for 30 days, or until the member selects or is assigned to another PCP.

The following steps will be taken as part of the PCP reassignment:

- The information is verified and documented in the physician's Practice File.
- The request from the PCP is scanned into the member's and practitioner's EXP Macess folder along with any supporting documentation. (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 and department communication.) The request is documented on a service form and sent to the Enrollment Department for processing.
- The member will be contacted and informed of the PCP's request to shift the member to another provider and reason for the change. The member will once again be informed of their right to file a complaint and/or grievance.
- The member will be given the option to select another PCP. If one is not selected in 10 days, the member will be assigned a PCP.
- Once a new PCP is selected, the update will trigger the system to generate a new ID card, which will be mailed in accordance with the ID card issuance process. The ID card will show the new PCP information. The member will receive a letter with the ID card informing them for the reason why a new ID card was issued.

Section E – Chronic Care/Disease Management

AmeriHealth Mercy's comprehensive proven Chronic Care Management programs will effectively address the complex health care needs of Louisiana Medicaid recipients with asthma, diabetes, heart failure, chronic obstructive pulmonary disease and sickle cell anemia, as well as other programs identified by the Department of Health and Hospitals (DHH). Our Chronic Care Management programs have a history of improved health outcomes, increased quality of care, and reduced avoidable hospital admissions.

E.1: Chronic Care/Disease Management Programs

E.1 Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for the Louisiana CCN Program that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Disease Management programs' data are analyzed and the results utilized by your organization to improve member outcomes.

Our Chronic Care Management program is only one component of our overall Integrated Care Management (ICM) strategy. We understand that most Medicaid members with a chronic condition have secondary medical or behavioral health conditions and environmental factors that limit their ability to successfully manage their health. For this reason, we use a holistic approach, working with high-risk chronic care management members and their providers to develop care plans that address the members' multiple disease states and help members return to managing their own health.

Our Chronic Care Management approach is embedded in every arm of our ICM program: pediatric preventive health care, episodic care management, WeeCare (maternity), complex case management (CCM) and Rapid Response.

Pediatric Preventive Health Care – Described more fully in Section I, the Pediatric Preventive Health Care Program (PPHC) is designed to improve the health of members under age 21 by increasing adherence to Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program guidelines through the identification of growth and development needs and coordination of appropriate healthcare services. The PPHC combines scheduled written and telephonic outreach with state-of-the art informatics that provides point-of-contact notification of EPSDT needs to employee and providers.

Episodic Case Management – Described more fully in Section F, the Episodic Care Management (ECM) Program provides coordination of services to newly eligible adult and pediatric members and existing members with short-term and/or intermittent needs who have single problem issues and/or co-morbidities.

WeeCare (Maternity) Program – Described more fully in Section F, the Wee Care (Maternity) Program is managed by a dedicated team of Care Managers and Care Connectors. WeeCare employees outreach to and engage pregnant members into the program based on internal and external assessments that level members into high and low risk categories. Care Managers coordinate care and address various issues throughout the member's pregnancy and post-partum period, including dental screenings and depression screenings.

Complex Care Management - Described more fully in Section F, members identified for Complex Care Management (CCM) receive comprehensive and disease-specific assessments and reassessments, along with the development of short-term and long-term goals and an individual plan of care, created with input from the member/caregiver and the physician.

Rapid Response Team - Described more fully in Section F, Rapid Response (RR) is an important component of the ICM model, the Rapid Response (RR) team was developed to address the urgent needs

of our members and to support our providers and their staff. The RR consists of registered nurses, social workers, and non-clinical Care Connectors.

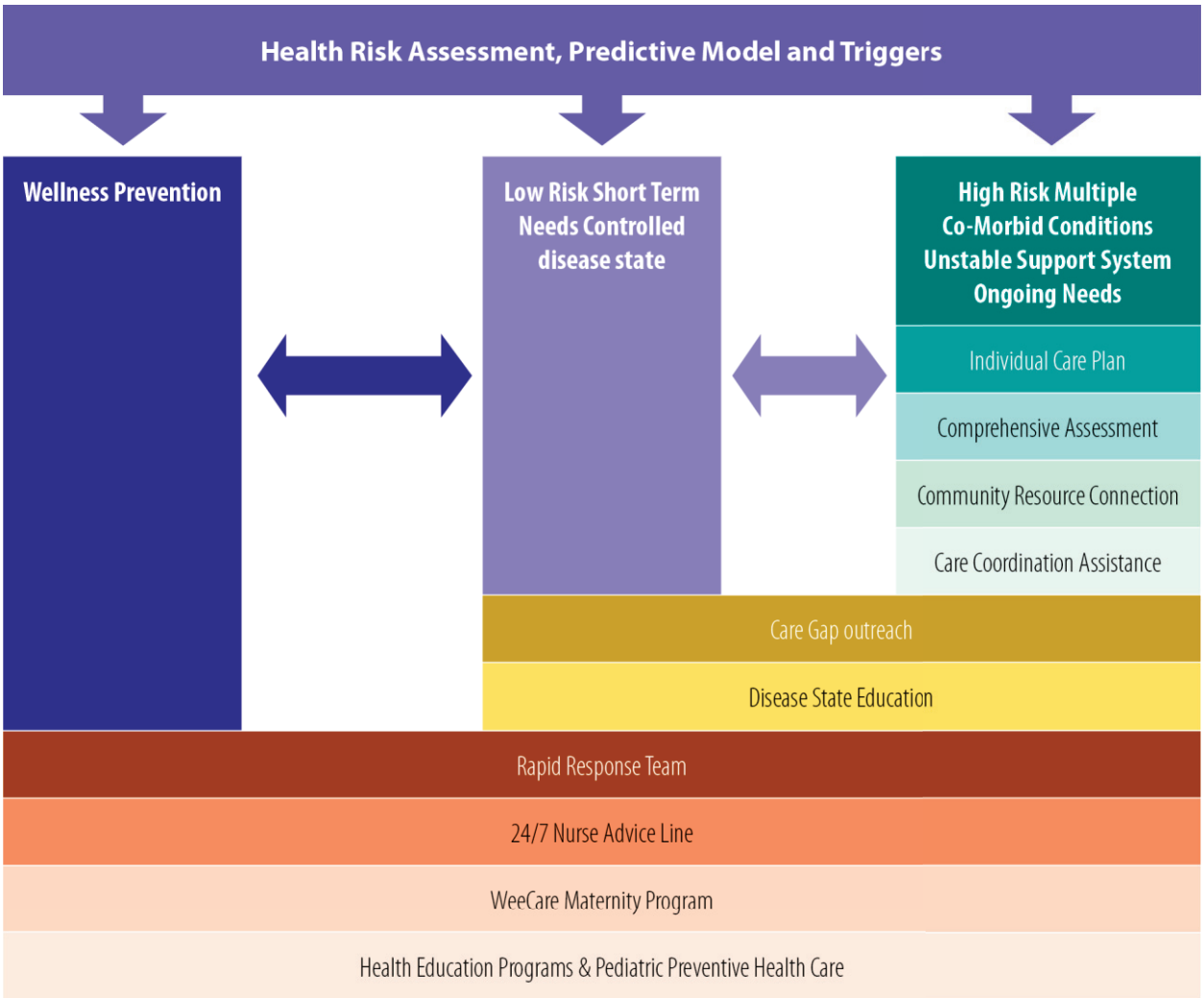


Figure 1: Integrated Care Management Overview

AmeriHealth Mercy ICM staff will be located in the company's Baton Rouge office, reporting to the Louisiana-based Medical Director, the Care Coordination Director (Medical Management Coordinator) will lead a staff of Registered Nurses and Social Workers who will be engaged in care management for chronic disease, prenatal care and care transitions.

AmeriHealth Mercy will identify members for Chronic Care Management through data mining and predictive modeling techniques, new member assessments, referrals from providers and other health plan activity. Members will be stratified based on the complexity of their needs and their propensity to return to self-management. Participation in our programs is voluntary.

Existing Chronic Care Management Programs

AmeriHealth Mercy's Chronic Care Management Program will be based on the successful programs currently operating in AmeriHealth Mercy's Pennsylvania, South Carolina and Indiana Medicaid plans. The Pennsylvania plan is the longest running program and serves as the basis for AmeriHealth Mercy's approach. The program has received NCQA accreditation under the Disease Management section of the Managed Care Organization accreditation standards. The asthma, diabetes, heart failure and COPD

programs are fully accredited under URAC's Disease Management standards. In total, we manage more than 94,000 Medicaid members across all of our Chronic Care Management programs (See Table 1).

Table 1: AmeriHealth Mercy Chronic Care Management Programs

Condition	Southeastern Pennsylvania	Central Pennsylvania	South Carolina	Indiana	Total
Diabetes	15,118	4,109	3,038	2496	24,761
Heart Failure	1,186	143	671	171	2,171
Heart Failure Risk	17,028	5,056	12,132	217	34,433
Asthma (ages 5-56)	8,926	2,378	13,498	3,477	28,279
COPD (age 42 and over)	2,505	515	N/A	545	3,565
Sickle Cell Anemia	973	107	432	61	1,573
Total	45,736	12,308	29,771	6,967	94,782

Program Design

Our blended ICM model combines case and disease management into a holistic approach. We create a "Blue Print" for our strategy to address the specific issues surrounding each targeted condition and to form the basis of our interventions. Each Blue Print outlines the population management approach and metrics used to manage that particular condition and includes the following sections:

- Importance – the relevance of the condition to the membership
- Clinical guideline – the guideline on which the program is based
- Program goals – specific goals related to the condition
- Outcome measures – specific metrics used to evaluate the program's success
- Stratification – logic used to stratify members into low and high risk groups
- Interventions – program interventions by stratification level
- Priority interventions – focused interventions for inclusion in all care plans and assessments
- Educational materials/resources – materials available for employees to use in providing disease-state education
- Innovations– synergistic initiatives that support the program goals
- Provider connection – method for involving provider in the program
- Internal education – list of internal education programs for staff
- External education – list of member and provider education related to program goals
- Reporting – list of dates program updates and evaluation provided for review

A comprehensive evaluation of each condition management program is conducted annually as part of the ICM program evaluation, and each Blue Print is modified accordingly.

AmeriHealth Mercy's blended ICM program integrates physical health, behavioral health and social/environmental aspects of the member's care into one plan of care. AmeriHealth Mercy care management employees include individuals with backgrounds and expertise in behavioral health, physical health and social work. The member's level of health needs is evaluated as part of the assessment and triage process, utilizing a four-quadrant approach. The diagram below outlines the triage approach and resulting resource assignment.

Figure 2: Integrated Care Approach

Through discussions with Dr. Michael Kaiser, Chief Medical Officer of Louisiana State University Health Systems (LSU), AmeriHealth Mercy understand that LSU has a robust infrastructure directing their approach to the management of chronic conditions. Interdisciplinary clinical teams meet quarterly to review performance against evidence-based guidelines and evaluate chronic care management protocols. LSU has agreed to allow a member of the AmeriHealth Mercy care management team to participate in the quarterly LSU program meetings to promote integration between LSU's program and AmeriHealth Mercy's approach.

Our care plans go beyond primary medical diagnosis to address multiple disease states, co-morbidities and non-medical aspects of wellness. One of our Care Managers will work with a member to define the central focus for as many aspects of care as possible, including:

- Functional independence
- Access to care
- Condition management
- Psychosocial support

LSU has agreed to allow a member of the AmeriHealth Mercy Care Management team to participate in the quarterly LSU program meetings to promote integration between LSU's program and AmeriHealth Mercy's approach.

By designing practical assessments and soliciting member input, our Care Managers can focus on various activities of daily life that need enhancement (such as the member's ability to shop for food, get medications, transportation to appointments, etc.), as well as condition management (blood sugar monitoring, antipsychotic medication adherence). We document each problem area in Jiva, our care management system, along with specific goals and associated interventions.

We use a blended model to address the targeted conditions (asthma, diabetes, heart failure and sickle cell anemia) within the member's care plan. Our materials, guidelines and care plans were reviewed by URAC as part of our Disease Management Accreditation and NCQA during our multiple health plan NCQA accreditation submissions and are consistent with the NCQA Disease Management requirements.

Member Identification

AmeriHealth Mercy will use a combination of data-mining, information gathering and referrals to identify members appropriate for our chronic care management programs. Details on our member identification strategies appear in Section E.2, below.

The Rapid Response (RR) team will serve as the intake point for referrals from providers and internal health plan activity. Staffed by experienced Care Managers and non-clinical Care Connectors, RR employees serve as front line contacts for members and providers who need assistance accessing or coordinating care. The RR team is trained to identify and address urgent needs, while probing to uncover ongoing issues and connect the member to the appropriate AmeriHealth Mercy program or community resource. Enrollment for all levels in the care management program is automatic, with the ability for the member to opt-out.

Stratification

Once the population is identified, AmeriHealth Mercy will use predictive modeling algorithms as an initial risk stratification to identify each member's prospective risk score. (Additional information on AmeriHealth Mercy's predictive modeling methodology can be found at the end of this section.) If awarded a contract, AmeriHealth Mercy will submit a formal document outlining the specifications of our predictive modeling methodology, as described in Section 6.37.2 of the Louisiana CCN-P RFP. Members who are newly diagnosed with a targeted condition, those with high prospective risk scores or service utilization, and those identified with a potentially destabilizing event are placed in the high-risk arm of the program.

Please see Table 2, below, for an overview of the stratification approach used for our identified condition management programs.

Table 2: Predictive Modeling Stratification

Condition	Low Risk	High Risk
Diabetes	Eligible member and one of the following ▪ Claim Diagnosis of Diabetes (250.xx) on two occasions ▪ New Member assessment disclosure ▪ Prospective Risk Score < 2.0*	In addition to low risk any of the following: ▪ HgbA1C > 8.5% ▪ No HgbA1C screening in the prior year ▪ Inpatient admission or ER visit in the last 3 months ▪ New diagnosis of diabetes ▪ New diagnosis of diabetic complication ▪ Prospective Risk Score > or = 2.0* ▪ Unstable medical, behavioral health or support situation
Heart Failure Risk	Eligible Member and one of the following: ▪ Claim diagnosis of HTN, CAD, Metabolic Syndrome, Hyperlipidemia (277.7, 278-278.02, 394-397.9, 401, or 410-416.9) ▪ New Member Assessment disclosure ▪ Prospective Risk Score < 2.0*	In addition to low risk: ▪ Inpatient admission/ER visit in the last 3 months ▪ New diagnosis: hypertension, CAD, metabolic syndrome, hyperlipidemia ▪ Prospective Risk Score > or = 2.0* ▪ Unstable medical, behavioral health or support situation

Condition	Low Risk	High Risk
Heart Failure	Eligible Member and one of the following: ▪ Claim diagnosis of Stage C or D Heart Failure (428.xx) ▪ New Member Assessment disclosure ▪ Prospective Risk Score < 2.0*	In addition to low risk: ▪ Inpatient admission/ER visit in the last 3 months ▪ New diagnosis: Heart Failure Stage C or D ▪ New diagnosis: Heart Failure complication ▪ Prospective Risk Score > or = 2.0* ▪ Unstable medical, behavioral health or support situation
Asthma	Eligible Member over age 5 and one of the following: ▪ Claim diagnosis of Asthma on two claims (493.xx) ▪ Prospective Risk Score < 2.0* ▪ 0 to 3 rescue meds filled in 4 months ▪ New Member Assessment disclosure ▪ Pharmacy data showing controller medication ▪ New diagnosis of Asthma	In addition to low risk any of the following: ▪ Prospective Risk Score > or = 2.0* ▪ New diagnosis of Asthma ▪ Two or more inpatient admissions or ER visits for asthma within the last year. ▪ 4 or more rescue meds filled in 4 months ▪ No pharmacy data for controller meds ▪ Unstable medical, behavioral health or support situation
COPD	Eligible Member > age 40 and one of the following: ▪ Claim diagnosis of COPD (492.xx or 496) ▪ New Member Assessment disclosure ▪ Mild or Moderate COPD (FEV1/ FVC, 70%; FEV1 > 50% predicted), if known ▪ Prospective risk score < 2.0*	In addition to low risk, any of the following: ▪ Severe or Very Severe COPD FEV1/FVC <70%; FEV1 <30% predicted; or FEV1 <50% predicted plus chronic respiratory failure, if known ▪ Respiratory status interfering with functional status ▪ Two or more inpatient admissions or ER visits for COPD in the last year ▪ Prospective risk score > or = 2.0* ▪ Unstable medical, behavioral health or support situation

Condition	Low Risk	High Risk
Sickle Cell Disease	Eligible Member and one of the following: ▪ Claim diagnosis of Sickle Cell Disease(282.6x) ▪ New Member Assessment disclosure ▪ Prospective risk score < 2.0*	In addition to low risk, any of the following: ▪ Two or more inpatient admissions or ER visits for Sickle Cell Disease or pain management in the last year ▪ Prospective risk score > or = 2.0* ▪ Most recent lab work more than 6 months ago ▪ BMI < normal or use of supplemental nutrition ▪ Pain level >5/10 5 or more times per week ▪ Blood transfusion within the past 6 weeks ▪ Unstable medical, behavioral health or support situation

*A predictive risk score of 1.0 is the population average

After individual Medicaid members are identified as a potential candidate for a high risk group, our Care Managers contact the member to obtain additional information, and if necessary, develop an individualized plan of care.

Members with controlled chronic conditions and short-term needs are assigned to the low-risk group. The low-risk group receives educational materials in the mail, access to the 24/7 nurse line and on-demand care management services through the Rapid Response team.

Through AmeriHealth Mercy's robust analytic and information dissemination processes, both high-risk and low-risk members will be continually monitored for adherence to clinical practice guidelines. For example, members missing recommended chronic condition management services, or demonstrating an uncontrolled disease condition, such as high use of short-acting asthma medications, will be identified and receive outreach from RR employees. This same information will also be disseminated to the provider portal (a website for providers to obtain confidential information) and internal AmeriHealth Mercy systems, where it will be utilized in unique programs that communicate "alerts" to providers and staff who check eligibility or look-up a member in our systems. More detail on our Care Gap strategy and processes can be found below.

Evidence-Based Clinical Guidelines

We utilize evidence-based practice guidelines to help reduce unnecessary variations in care and to improve the quality of care for our members. These guidelines are intended to inform – not replace – the provider's clinical judgment. The provider remains ultimately responsible for determining the applicable treatment for each individual, and our goal is to support and complement the provider-patient relationship.

The Quality Assessment Performance Improvement Committee (QAPIC), which is part of the Quality Program described in Section J, will identify and formally adopt nationally-recognized clinical guidelines for use in members' care plans. These guidelines form the basis for the priority focus areas, self-management skills sets, and critical Care Gaps associated with each program. Additional information on our Care Gap strategy and deployment system can be found below.

We consider and select guidelines based on the following criteria:

- Incidence of the identified disease state in the target population
- Ability of guideline adherence to improve the health state of the affected member
- Current professional standards, supported by scientific evidence and research

- Approval and support by relevant professional medical organizations

Table 3 describes the National Clinical/Practice Guidelines that we will propose to the QAPIC, and if approved, utilize for key chronic disease conditions and maternity management.

Table 3: National Clinical Guidelines

Condition	Clinical Evidence-Based Guidelines
Diabetes	▪ American Diabetes Association: Clinical Practice Recommendations 2010 http://care.diabetesjournals.org/content/33/Supplement_1
Heart Failure	▪ 2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults http://circ.ahajournals.org/cgi/content/full/119/14e/e391 ▪ Treatment of Hypertension in the Prevention and Management of Ischemic Heart Disease http://ahajournals.org/cgi/content/full/115/21/2761
Asthma	▪ Global Initiative for Asthma (GINA) 2009 http://www.ginasthma.com/Guidelineitem.asp??l1=2&l2=1&intId=60 ▪ National Institute of Health (NIH) 2009 http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm
COPD	▪ Global Strategy for the Diagnosis, Management and Prevention of COPD, Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2008. http://www.goldcopd.com/guidelineitem.asp?l1=2&l2=1&intId=989
Sickle Cell Disease	▪ National Heart, Lung, and Blood Institute: Division of Blood Diseases and Resources: The Management of Sickle Cell Disease http://www.nhlbi.nih.gov/health/prof/blood/sickle/sc_mngt.pdf
Pregnancy	▪ Institute for Clinical Systems Improvement: Routine Prenatal Care, 14th ed. July 2010 http://www.icsi.org/prenatal_care_4/prenatal_care_routine_ful_version_2.html

To ensure that we use the most recent guidelines and metrics, AmeriHealth Mercy will review each condition annually and as updates are published. We will also solicit input from physicians and other providers on the guidelines. We present new or revised guidelines to QAPIC for approval. Once we approve the new or revised guidelines, we will notify providers through provider newsletters and broadcast emails (if they subscribe), through annual or quarterly seminars, and via updates to the Provider Portal.

Treatment Plans

The evidence-based clinical guidelines associated with each program form the basis of our program's treatment plan and metrics. These treatment plans are the basis for the development of the individualized plan of care. AmeriHealth Mercy treatment plans are compliant with NCQA's disease management standards, and are part of the information reviewed by NCQA resulting in the excellent accreditation level held by AmeriHealth Mercy. A summary of the treatment plans associated with our programs appear on the following page:

Table 4: Summary of Treatments Plans

Condition	Treatment Plan
Diabetes	***HgbA1c control*** ▪ Member should have HgbA1c test every six months ▪ If result is > 7.0, there should be an appropriate change in treatment regimen under their provider's guidance and a retest in 3 months. ***Sick day plan*** ▪ Member should have a plan for diabetic medications when sick ***Medication*** ▪ Member should be refilling prescriptions timely/report taking accurately ▪ If HgbA1c > 7.0, there should be a discussion of a change in medications with the provider. ***Diet and Exercise*** ▪ Member should have nutritionist visit for diet plan within last 6 months ▪ Member should exercise minimum of 30 minutes walking (or equivalent) 5 days/week ***PCP visit schedule/screening measures*** ▪ Member with type II diabetes should see physician at least every 4 months (TIY) ▪ Member with type I diabetes should see physician at least every 3 months (QIY) ▪ Every physician visit should include a peripheral neuropathy exam, foot exam and a blood pressure screening ▪ Every six months, lipid test (if LDL-c result is > 100 mg/dl, member should be receiving treatment) ▪ Annual dilated retinal exam (DRE), urine test for micro albumin ▪ HbA1c measurement should be in the physician chart at least every six months (BIY) ***Behavioral Risk Management*** Consistent message surrounding impact of: ▪ Diet ▪ Exercise ▪ Cigarette smoking ▪ ETOH use ▪ Illicit Drug (e.g. cocaine) use ***Self-Management*** ▪ Consistent message to encourage members' self-management skills related to the chronic illness: ▪ Members have a sick day plan and understand when to call PCP/Specialist ▪ Members monitor and record blood sugar in log and understand when to call PCP/Specialist

Condition	Treatment Plan
Asthma	***Asthma Control*** ▪ Asthma Action Plan ▪ Appropriate controller and rescue medications ▪ Medication compliance ▪ Reducing triggers in the home (may need allergy testing for diet and environmental triggers) ***Medication*** Member should be refilling prescriptions timely/report taking accurately ▪ Member should have at least one portable rescue medication at all times ▪ If member has a need for a rescue med more than twice a week, there should be a change in medications ***Sick Day Plan*** ▪ Member should have a plan for asthma medications when sick ***Behavioral Risk Management*** Consistent message surrounding impact of : ▪ Cigarette smoking ▪ Environmental triggers ***Self-Management*** Consistent message to encourage members' self-management skills related to the chronic illness: ▪ Members should have an asthma action plan and understand when to call PCP/Specialist
COPD	***Behavioral Risk Management*** Member receives a consistent message on the impact to his/her condition of: ▪ Tobacco use ▪ Occupational Exposure ▪ Indoor and outdoor air pollution ***Medication Management*** ▪ Member refills medications timely ▪ Member is able to use inhaler to receive optimum dose of inhaled medications ***Health Promotion*** ▪ Member understands the role of exercise and nutrition in COPD ▪ Member receives annual flu vaccination; ▪ Member 50 years and older receive pneumococcal vaccine. ***COPD Management*** ▪ For members with a SaO2 < 90%; oxygen therapy is discussed with the treatment team ▪ Obtain baseline spirometry values (spirometry readings taken at 12 month intervals can monitor disease progression)

Condition	Treatment Plan
COPD (continued)	***Self-Management*** ▪ Member identifies one applicable risk factor and takes action to change ▪ If member smokes tobacco products; member initiates program to stop smoking ▪ Member knows medications, knows why he/she is taking each medication and when to take each medication ▪ Member has rescue medication available at all times ▪ Member follows daily exercise/activity regimen ▪ Member knowledge of COPD status – mild, moderate or severe. ▪ Member will know their O2 saturation values if applicable. ▪ Member on oxygen implements safety plan related to presence of oxygen therapy in the home
Heart Failure Risk	***Blood Pressure:*** ▪ Blood Pressure should be taken at every visit ▪ Member should know blood pressure and individual blood pressure goal ▪ If blood pressure > 130/80 – Patient should be receiving treatment (medication) ▪ If LVEF < 40%, target BP is <120/80 ***Lipid Monitoring:*** If lipid level > 100 mg/dl ▪ Member should be on lipid-lowering strategy (diet/medication) ▪ Repeat measurement every 6 weeks until LDL < 100 mg/dl ▪ Behavioral Risk Management: ▪ Consistent message surrounding impact of: ▪ Cigarette smoking ▪ Excessive ETOH use ▪ Illicit Drug (e.g. cocaine) use ▪ Lack of exercise ▪ Diet ***Self-Management*** Consistent message to encourage members' self- management skills related to the chronic illness: ▪ Medication adherence ▪ Monitor and record blood pressure
Heart Failure	***Medication Management:*** < 40% LVEF: ▪ ACE/ARB – Member should be taking ACE or ARB – If not: Member should have documented contraindication for or failure of trial of ACE/ARB ▪ Beta-blocker – Member should be taking a beta-blocker. If not: Member should have documented contraindication for or failure of trial of beta-blocker ▪ Diuretic- If member has history/physical findings of fluid overload; member should be taking a diuretic.

Condition	Treatment Plan
Heart Failure (continued)	> 40% LVEF ▪ Co-morbid conditions should be managed according to individual guidelines (e.g., HTN, CRF) ***Blood Pressure:*** ▪ Blood Pressure should be taken at every visit ▪ Member should know blood pressure and individual blood pressure goal ▪ If blood pressure > 130/80 – Patient should be receiving treatment (medication) ▪ If LVEF < 40%, target BP is <120/80 ***Lipid Monitoring:*** If lipid level > 100 mg/dl ▪ Member should be on lipid-lowering strategy (diet/medication) ▪ Repeat measurement every 6 weeks until LDL < 100 mg/dl ***Behavioral Risk Management:*** Consistent message surrounding impact of: ▪ Cigarette smoking ▪ Excessive ETOH use ▪ Illicit Drug (e.g. cocaine) use ▪ Lack of exercise ▪ Diet ***Self-Management*** Consistent message to encourage members' self- management skills related to the chronic illness: ▪ Member should weigh self daily, record weights, have threshold of weight gain that prompts call to physician ▪ Member should know baseline activity/exercise tolerance ▪ Member should know individual signs/symptoms of fluid overload or activity intolerance; If sign/symptom experienced – member should call physician ▪ Medication adherence ▪ Monitor and record blood pressure
Sickle Cell Disease	***Medication adherence*** ▪ Member should be refilling prescriptions timely/report taking accurately ***Pain Management*** ▪ Member aware of the importance of hydration, oxygen and analgesics ***PCP/Specialist visit schedule/screening measures/labs*** ▪ Member with sickle cell disease should see physician (PCP)/Specialist at least every 3 months ▪ Every physician visit should include preventative health care: physical exams, eye exams, pap smears annually. Immunizations/vaccinations and other healthcare gaps

Condition	Treatment Plan
Sickle Cell Disease (continued)	▪ Monitor iron levels for overload institute chelation therapy as directed by PCP/Specialist ***Behavioral Risk*** Consistent message surrounding impact of: ▪ Diet ▪ Exercise ▪ Cigarette smoking ▪ ETOH use ▪ Illicit Drug (e.g., cocaine) use ▪ Pain medication abuse ***Self-Management*** ▪ Consistent message to encourage members' self-management skills related to the chronic illness: pain management ▪ Members schedule PCP/Specialist visits at least annual (birthday month) to address preventative care and more frequently as directed by PCP/Specialist ▪ Members understand when to call PCP/Specialist for conditions such as infection and other life threatening complications of SCD ▪ Member referred to sickle cell association (community resources)

High Risk Management

As part of the interaction between the Care Manager and member, data is collected to complete a comprehensive assessment for each high risk member. Samples of the these assessment tools are supplied at the end of this section. These tools are developed specifically for the Medicaid population and are designed to collect information associated with the following critical elements:

- Basic needs and requirements
- Psychosocial concerns
- Behavioral health diagnoses
- Issues that prevent full self-management of their chronic medical conditions
- Overall medical condition profile, based on their disease states
- Medication regimens
- DME requirements
- Geographic situation
- Support systems
- Cultural/linguistic needs

By employing practical assessments and soliciting member input, our Care Managers can individualize the above treatment plans to focus on various activities of daily life that need enhancement (such as the member's ability to shop for food, get medications, transportation to appointments, etc.), as well as condition management (blood sugar monitoring, antipsychotic medication adherence).

Once we identify all of a member's concerns or needs, we will use them as we develop the care plan. We also solicit input and recommendations from all other key stakeholders, such as other family members or key providers. We use all information and assessment results to create the ongoing goals and objectives used for care management and, ultimately, to develop an effective and personalized care plan.

The plan of care incorporates disease-state and self-management education questions appropriate for the member's level of knowledge and ability to incorporate new knowledge. The individual plan of care focuses on all of the member's chronic and acute conditions, encompassing medical issues, behavioral health conditions and needs, and environmental and social support deficits. This holistic approach allows Care Managers to prioritize interventions in a way that supports the Member's needs and goals.

Mr. "B" was referred to care management from our Customer Services area with a diagnosis of Type II Diabetes. Our Care Manager tried unsuccessfully to engage Mr. "B" in our diabetes management program through phone and mail contact. Mr. "B" did not return messages left with his wife. He eventually responded to a letter by calling to decline any assistance. Our Care Manager was able to provide him with information on the insulin products covered through his prescription benefit and left the door open for him to call if he needed further assistance.

Approximately six months later, Mr. "B" called to say he was having issues with his diabetes including blood sugar readings as low as 36. When he decreased his Lantus in the evenings per his doctor's direction, his blood sugar reading would climb to 110-130 and he was worried about his blood sugar being too high. Our Care Manager explained our care management program and this time he agreed to participate. She was able to determine through her assessment of Mr. "B" that he was essentially noncompliant with the management of his diabetes. He did not monitor his dietary intake, was not checking his blood sugar as often as he should, nor did he check his blood pressure or adhere to his medication regimen. He was also having vision problems.

Our Care Manager taught him the range for normal blood sugar readings, educated him on the need for routine foot care, signs and symptoms of hypoglycemia and hyperglycemia and how to treat both. The Care Manager also arranged for him to attend diabetes education classes and followed up to verify his attendance. Mr. "B" was seen by a nephrologist, ophthalmologist, podiatrist and cardiologist. He was diagnosed with retinopathy, mild kidney disease, coronary artery disease (CAD) and peripheral vascular disease.

Since engaging in our care management program and working with our Care Manager, he successfully underwent eye surgery resulting in improved vision and has gone from a pants size of 44 to 40. His last HgbA1C result demonstrated controlled blood sugar and his kidney function stabilized.

Mr. "B" had a mild set back when he got a piece of wood stuck in his toe which initially seemed as if it might result in an amputation. However, with good wound management and continued compliance with his diabetes regimen, Mr. "B's" toe healed. After more than a year in the care management program, Mr. "B" was taken off insulin by his physician and is controlled with an oral agent twice daily. He sees his primary care physician every 3 months and started working with the diabetes educator at his local hospital to initiate a support group for diabetics

Interventions are tailored to the member's Patient Activation Measure®. The Patient Activation Measure is used to assess the member's confidence, skills and knowledge for managing health and healthcare services. Low PAM levels (Level 1 and Level 2) require plan of care approaches that focus on building the member's confidence and basic understanding of their chronic condition(s). At higher PAM scores, the plan of care focuses on empowering members to take action and providing support and coaching to maintain behaviors.

Care Managers incorporate Motivational Interviewing into the assessment and care plan process. We use this approach to make sure members are following the plan and positively reinforce successful outcomes.

These could include improvements in a lab value or adhering to a goal of increased physical activity for a weeklong period.

One of the keys to our success in other Medicaid markets has been to establish a trusting relationship between the member and the care management team – before engaging an individual in any behavior change. By establishing a relationship of mutual trust, AmeriHealth Mercy helps the member become more comfortable, promoting more active participation in his/her care.

One of the best ways to build a collaborative relationship is for the Care Manager to discuss the member's biggest concern with his/her current health state. (That concern may not be related to the issue identified in the member's assessment findings and utilization data.) Often, the Care Manager will ask the member to identify *personal* goals as opposed to *health care* goals. By focusing on the member's desire to go to a restaurant or become a better soccer player, for example, the Care Manager can address items like exercise to build endurance or proper use of asthma medication.

Transition Between Risk Levels

High-Risk Members – those with the highest risk and multiple co-morbidities – will be moved to the Low- Risk category when their assessment indicates that a reduction in care management activities is warranted. Members who are transitioned to low-risk management continue receive reminders and educational materials, monitoring and outreach for Care Gaps and focused interventions to support adherence to clinical guidelines. Each condition blue print contains focused education and outreach that takes place regardless of the member's level of risk.

In addition, members in Low-Risk categories who exhibit an abrupt change in their circumstances or deterioration in their condition will be moved to High-Risk management. This may occur when there is a temporary loss of caregiver support, the addition of a diagnosis and corresponding treatment regimen or an exacerbation of a previously stable condition. This transition can be triggered by an unplanned event, a call from a provider or the findings from routine contact with the member.

Identifying and Managing Care Gaps

To optimize chronic care management, AmeriHealth Mercy has implemented procedures that focus on preventing exacerbation and complications based on evidence-based clinical practices. One key initiative that we have successfully utilized to accomplish this goal is our Care Gaps program. In addition to interventions to communicate and proactively close gaps in care, we provide ongoing evidence-based education that empowers members to manage their chronic conditions, prevent complications and avoid exacerbations, as well as assist providers in helping members manage their chronic conditions.

Care Gaps are clinically recommended services based on evidence-based clinical practice guidelines for which there is no claim evidence that the member received the service. We evaluate claim data at least monthly for all members. Care Gap algorithms exist for a full range of preventive services and chronic disease states. In the event that there is no claim for a service, the system will send an automatic notice of the Care Gap. (Table 4 contains a chart listing the commonly targeted conditions and services in our Care Gap program).

Table 5: Care Gap Services

Condition	Service
Asthma	▪ Medication Management ▪ Low Controller to Short Acting Medication Ratio
Coronary Artery Disease	▪ ACEI/ARB Therapy (CAD) ▪ Antiplatelet Therapy

Condition	Service
	▪ Beta Blocker 6 Months Post MI ▪ Beta Blocker 7 Days Post MI ▪ Beta Blocker Prior MI (CAD) ▪ Cholesterol Test ▪ LDL Lowering Drug Therapy ▪ Lipid Test
Diabetes	▪ Eye Exam ▪ HgbA1c Test ▪ Lipid Test ▪ Micro albumin Test
Heart Failure	▪ ACEI/ARB Therapy (HF) ▪ Beta Blocker Therapy (HF) ▪ LVF Assessment ▪ Warfarin Therapy
Preventive Health Services	▪ Breast Cancer Screen ▪ Cervical Cancer Screen ▪ Colorectal Cancer Screen ▪ Lead Screening in Children ▪ Primary Care Visit 1 to 2 years ▪ Primary Care Visit 2 to 6 Years ▪ Primary Care Visit 7 to 11 Years ▪ Well Adolescent Care
Preventive Health Vaccine	▪ Chicken Pox Vaccine ▪ Diphtheria/Tetanus Vaccine ▪ H Influenza Type B Vaccine ▪ Hepatitis B Vaccine ▪ Measles/Mumps/Rubella Vaccine ▪ Pneumonia Vaccine ▪ Polio Vaccine

Information on each member's Care Gaps is loaded into our internal information systems where it is visible to care management and Customer Service staff. When an ID number or name of a member with a Care Gap is entered into our care management or Customer Service system, a color-coded message appears on the screen alerting staff to the member's Care Gaps. Each employee has a role-specific protocol to follow to address the care gap with the member.

A Customer Service Representative that receives an alert for a female member who is overdue for a breast cancer screening mammogram will initiate a scripted exchange with the member designed to allow the representative to move the call to a Care Connector who will make an appointment at an upcoming mammography screening event. The protocols contain decision and escalation points, providing staff with the ability to transfer the call directly to a clinical Care Manager if the member has questions that are clinical in nature.

Quote from a member with a mammography care gap: "I would have been scared to go to the hospital for this test. Everyone on the van was so nice and they made me feel relaxed. The person at Keystone Mercy who helped me schedule the appointment encouraged me to come and she even helped me with transportation."

Figure 3: Mammography Screening Event

Providers and members will see a similar alert through their respective web portals. In addition, PCPs will be able to access the information at the panel level, allowing them to use population management techniques within their practice. This panel-level information will be available as a printable report or a CSV (Comma Separated Value) file for compatibility with other electronic systems.

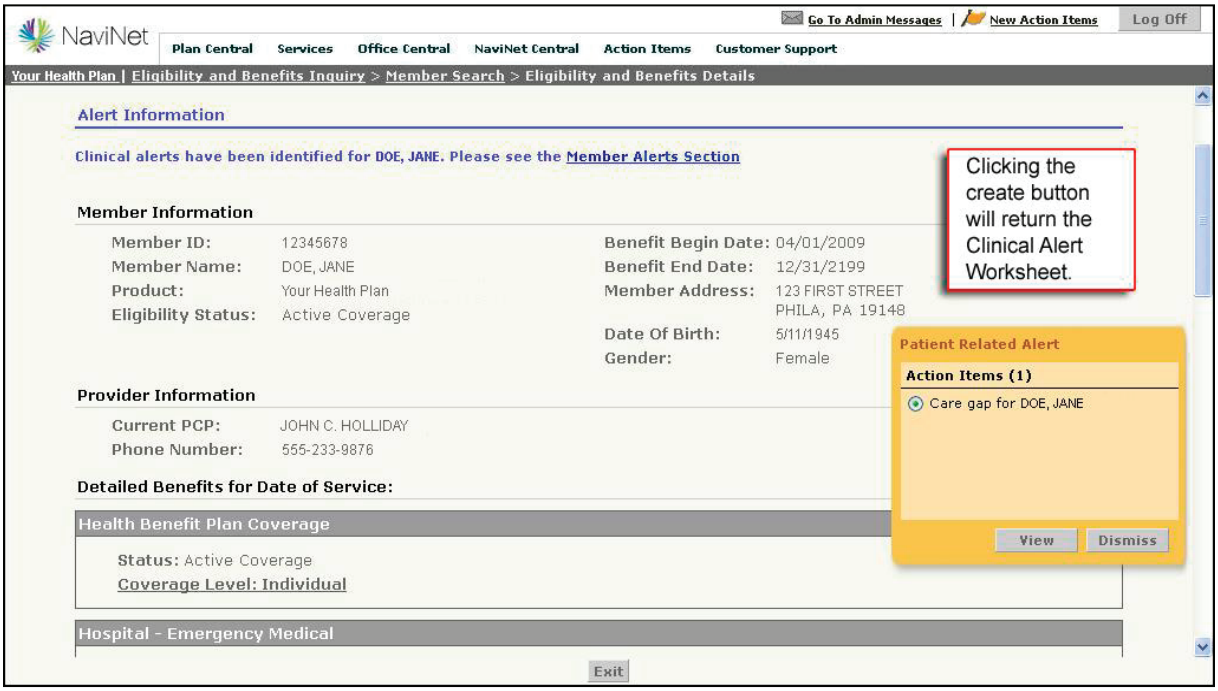


Figure 4: Care Gap Alerts Display on the Provider Portal

Clicking on the alert displays a member-specific Care Gap Worksheet that identifies the missing or overdue service, along with a list of up-to-date care gaps for the provider's reference. The Care Gap Worksheet is formatted to allow for easy printing and inclusion in the member's chart.

As part of the care management process, the Care Manager will regularly review members' care gaps. The manager will discuss identified gaps with the member, and stress the importance of making the necessary preventive or routine appointments to address the gap. For members who require assistance with scheduling and keeping appointments, staff will schedule an alert in Jiva, our care management system, that notifies the Care Manager to remind the member of his/her appointment. This process will also allow the Care Manager to make sure there are no barriers, such as transportation issues, that might interfere with the appointment. After the appointment, staff will make a follow-up call to the member to encourage his/her continued participation and collect any new clinical or intervention information.

The Care Manager will be able to utilize this outreach opportunity to discuss the results of the appointment and identify new medications or treatments. This informal discussion will allow the Care Manager to make sure that the member is adhering to care plan changes. During these conversations, the Care Manager will discuss the member's adherence to the revised care plan, and develop interventions to support the member's medical and non-medical needs. AmeriHealth Mercy will provide the referral and visit follow-up report to DHH upon request and in the monthly operations report. The information will also be available to the member's provider through the password-protected web portal.

Addressing Medication Issues

Medication adherence is a critical element of chronic condition management. AmeriHealth Mercy will use a multi-pronged approach to address medication issues. During member assessments, we will collect information on the member's medication regimen from the member and the provider. We will compare this information to the pharmacy claim data housed in Jiva and received from DHH. Through this comparison, the Care Manager will be able to determine whether the member is filling the medications prescribed by the physician. In addition, the medication list will be available to the PCP through the web interface, allowing them to view medications that have been prescribed from other providers.

Care Managers will have a variety of available resources on hand that can be used to educate members on individual medications and the importance of adhering to prescribed medications. Through the Jiva care plan, AmeriHealth Mercy will have the ability to set tasks that alert the care management team to call a member monthly with a reminder to obtain prescription refills. Members with internet access will also be able access a comprehensive health education library through the Member Portal (a website where members may obtain information).

AmeriHealth Mercy will also use medication data to identify needed medical services, such as lipid monitoring for members receiving antipsychotic medication and HgbA1c testing for members on antihypoglycemic medication. We will share these recommended services with providers in the printed care plan and as Care-Gap Alerts in the

SR is a 17-year old who was identified as having asthma and a high predicative risk score. The Care Manager proactively contacted SR to assess his care management needs. SR reported that he was out of his daily medication and unable to see the PCP that the rest of his family used and that was close to his home. The PCP did not want to see the member unless the member brought his records from the pediatric clinic he used in the past. The clinic was requesting payment for the record.

The Care Manager arranged to have the clinic forward the records so that SR could be seen by his new PCP and get his medication. As a result of this success, the Care Manager was able to engage SR in care management for his asthma. The Care Manager educated SR on the disease process and self-management techniques, and worked with the new PCP to have SR see an allergist. SR now gets his allergy shots routinely and uses a peak-flow meter to monitor his asthma. He has not had any asthma-related emergency room visits and is still open to follow-up calls from the Care Manager, which is not often the case for a person his age.

Provider Portal. The Care Manager will also address each recommendation in the care plan. Members who use the member web portal will be prompted to discuss the opportunity with their physician.

WeeCare (Maternity Management)

Discussed fully in Section F, our WeeCare maternity management program focuses on identifying and helping high risk pregnant women have a healthy, full-term pregnancy. Managed by a dedicated team of Care Managers and Care Connectors, the WeeCare program is built on the prenatal care guidelines from the Institute for Clinical Systems Improvement. WeeCare employees focus on: promoting early identification of pregnancy and prenatal care; assisting pregnant mothers to adopt healthy behaviors and control risk factors; and educating the mother on infant care and health needs. The WeeCare Supervisor (Maternal Health/EPSDT Coordinator), a Louisiana registered nurse, will supervise the WeeCare program and nursing staff supporting the program. All of these positions will be located in the Baton Rouge office and will report ultimately to the Louisiana medical director (also licensed and located in Louisiana).

CR was pregnant with a history of a delivery at 25 weeks in 2007 of a baby who died due to extreme prematurity. When the WeeCare nurse called to assess CR, the Care Manager identified CR as a candidate for 17 Alpha Hydroxyprogesterone Caproate (17P) injections. The nurse talked CR and contacted the provider to explain the situation and suggest that CR be considered for 17P therapy. The WeeCare nurse continued to work with CR through her pregnancy, coaching her on healthy pregnancy behaviors and educating her on the immunizations and screenings her newborn would need. CR delivered a healthy 6-pound, 12-ounce infant at 38+ weeks.

We use a variety of mechanisms to identify and promptly engage members who are pregnant as early as possible in their pregnancy. All new female members are asked about their pregnancy status as part of the new member assessment, and during calls made to or by the Rapid Response team.

AmeriHealth Mercy will also analyze claim data from pharmacy files and laboratories for drugs and Logical Observation Identifiers Names and Codes (LOINC) that indicate pregnancy and/or the onset of pregnancy complications. LOINC are a data set of universal identifiers for laboratory and other clinical observations that facilitate communication of clinical results. In addition, AmeriHealth Mercy will highlight the need for early prenatal care in member communications including the Member Handbook and newsletters. We will also include education on the need for early care at community events. Our social media Mom-2-b club is another avenue used to engage and educate our pregnant women.

We also promote the nationally-recognized Text-4-Baby program, a no-cost text education service, to our membership. Expectant mothers are grouped into high- and low-risk categories based on the presence of risk factors, including chronic illnesses, problems with a previous pregnancy, age and lifestyle considerations. Ongoing monitoring occurs to identify any new conditions or changes in risk status.

Members assessed as low-risk receive information via mail with access to a Care Manager as necessary. Members identified as high-risk are managed by the plan with a team of both Care Managers and Care Connectors. Care Managers coordinate care and address various issues throughout the member's pregnancy and post-partum period. All members receive reminders about dental screening and are screened for depression in addition to education on healthy pregnancy habits, smoking and alcohol cessation, choosing a pediatrician and the importance of immunizations and infant medical care during the first two years of life.

An offshoot of the WeeCare Program, the Neonatal Intensive Care Unit (NICU) Graduate Program identifies and follows infants who have a hospital stay involving NICU care. These infants are at risk for an increased incidence of readmission due to their medical, developmental and psychosocial needs. The NICU Graduate Care Manager works with the family during the hospital stay and follows the member for up to six months post discharge to ensure all barriers to care are addressed.

The Care Manager collaborates with the UM nurse, WeeCare Care Manager, and hospital Care Manager to engage member's parent during the newborn's inpatient stay and post discharge. Oversight for the NICU Graduate program is provided by maternal fetal medicine (MFM) physicians who serve as medical directors for AmeriHealth Mercy's Pennsylvania health plan.

Program Evaluation

The Chronic Care Management program has, through its use in our affiliated Medicaid health plans, documented a strong track record of improving health outcomes and lowering costs for Medicaid populations. To ensure the validity of our reported outcomes, we look at a variety of measures and actively seek external scrutiny of our methodologies. We use a combination of process and outcome measures, including assessment timeframes, utilization rates, clinical outcomes and satisfaction surveys. To evaluate the effectiveness of the program interventions, we use HEDIS and HEDIS-like measures. Additional measurements used include, ER utilization/redirection, provider visits, hospitalization rates, per-member-per-month costs, functional status (SF-12) and medication adherence.

Our evaluation procedures have been successful for a wide variety of Medicaid programs. AmeriHealth Mercy has the capability and flexibility to customize our evaluation process to meet the needs of the Louisiana CCN.

Background of Success

In order to obtain an early and objective assessment of our approach, Reden & Anders, an independent actuarial firm, validated our care management results at the conclusion of our Southeastern Pennsylvania plan's first year using the program. They concluded:

> *"In our opinion, based on the criteria explained above and the caveats listed, [the care management program] was integral to AMHP [AmeriHealth Mercy Health Plan] being able to control the medical and pharmacy trend of the Medicaid population it manages for the PA DPW in Southeastern PA. The difference in medical and pharmacy trend achieved by AMHP as compared to its similarly situated competition was material over the study period."*

In another summary, which covered a later period, Reden & Anders noted:

> *"Based on the outcomes study described, we have determined the financial outcomes for AmeriHealth Mercy's Care Management Program:*
> - *$122 per member per month (PMPM) gross savings, which equates to over nine percent gross savings of projected costs absent intervention, over the 12-month period ending June 2005.*
> - *Representing $6.1 million, or over 9 percent in gross savings over the same period.*
> - *Resulting in an ROI of 2.05 to 1 based on program fees reported by AMH [AmeriHealth Mercy]."*

One of the main indicators of a care management program's success in treating a chronically ill population is the ability to reduce primary admissions and emergency room visits for common chronic conditions. In 2008, we submitted three years of program results for a population review by the Disease Management Purchasing Consortium (DMPC). 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 biostatics into understandable and transparent terms. The analysis evaluated the program's ability to reduce inpatient admissions for chronic illnesses, including asthma, chronic obstructive pulmonary disease (COPD), heart failure, coronary artery disease (CAD) and diabetes. We asked DMPC to update the analysis in 2010 with data from two additional years.

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. 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."

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.

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.

In 2008, AmeriHealth Mercy requested an actuarial review from Health Management Associates (HMA), an independent national research and consulting firm specializing in complex health care program and policy issues. HMA used an adjusted historical control design endorsed by the Society of Actuaries (SOA). The study design was based on the premise that the cost of the patients in the care management intervention can be predicted by their pre-case management yearly cost, on a per-member-per-month (PMPM) basis, adjusted for the population's cost trend. This approach provides an estimate of the costs the care-managed patients would have incurred had the intervention not occurred. The estimate was then compared to the actual costs that were incurred.

Program members were identified for the evaluation using a closed cohort methodology. A continuous coverage test was applied to both the study population and the baseline population. The target population was drawn from persons with Medicaid coverage from Southeastern Pennsylvania and averaged four-and-a-half chronic conditions and one behavioral health condition. Members with less than 11 months of continuous coverage in the program in any year were excluded from the study. This continuous coverage methodology was used to account for the fact that members are identified through administrative claims data, and the identification of newly-chronic members takes several months due to claims processing and operational lags. In addition, newly-identified or new health plan members require a start-up period to be contacted, enrolled, and started in the program. As a general matter, the profile of a care management member in the HMA study included:

- Predictive Risk Scores of 4.5 times plan average
- Utilize services at three to four times the rate of an average health plan member
- Complex psychosocial needs
- Three or more chronic illnesses, plus one behavioral health diagnosis
- Five or more prescription medications (not including prescribed OTC medications)
- Receiving care from three or more physicians

Consistent with SOA guidelines, the study also excluded members or claims meeting specific criteria. A care management program aims to intervene with health plan members who are at risk for medical events for their conditions (e.g., emergency room visits, specialist visits and hospital admissions). However, in any system, these members could also consume resources for conditions that are not subject to management by the program.

On the whole, members included in the measure chart experienced a $14.16 PMPM reduction in medical costs during the first year of program enrollment. Members enrolled for two years had more modest savings, while those enrolled for four or more years had the highest savings.

In 2008 Health Management Associates conducted an actuarial review of the care management plan and found that it provides a $14 per-member-per-month savings, and a return on investment of $5.01 for every one dollar invested into the program.

In the Indiana Care Select Program, AmeriHealth Mercy was responsible for improvements in health outcomes and managing the medical cost trend for the contract awarded to MDwise, Inc. The Care Select Program provided care management services to Indiana Medicaid Recipients in the aged/blind/disabled category, many of whom had multiple chronic conditions.

In order to measure the effectiveness of the Care Select program in reducing costs, the Indiana Office of Medicaid Policy and Planning (OMPP) asked Milliman, Inc. to create actuarial cost models comparing fiscal year 2007 (July 1, 2006 through June 30, 2007) with calendar year 2008, the first full calendar year of the Program. Milliman used a sophisticated risk adjustment analysis to be sure that differences in demographics were not responsible for differences in cost.

OMPP asked Milliman to study the cost trend for five Care Select populations who were members with affected by the following:

- Developmentally disabled
- Suffering from serious mental illness
- Aged, blind or disabled (ABD)
- Wards, foster children or children receiving adoption assistance
- Others that had received significant services at least one month prior to the measurement period.

The study reported:

- The annualized Medical cost trend for the AmeriHealth Mercy/MDwise Care Select portion of the population was 0.7 percent compared with the anticipated five percent increase.
- AmeriHealth Mercy/MDwise estimates this reduction in cost trend saved Indiana taxpayers approximately $20.7 million in medical costs.

Evaluation Methods

AmeriHealth Mercy is committed to systemic collection and analysis of data to provide objective evidence of our program's effectiveness. We will use a variety of measures to evaluate our success with Chronic Care management.

- We will use standardized HEDIS measures to define and monitor adherence to recommended care, and to evaluate our performance. Selected measures, appropriate to the population of concern, will be monitored over time as well as compared to the total plan-wide membership.
- We will identify all clinical outcomes for the identified disease states that will be used to measure improvement in adherence to evidence-based guidelines for care, and clinical variables and outcomes will be measured for participants at baseline, after an initial six-month period, and annually thereafter.
- We will report health processes and outcome indicators that we will use to measure improvements in adherence with evidence-based guidelines for care and care coordination, and such indicators will be measured for the population at baseline, after an initial six-month period, and annually thereafter.
- We will measure net savings using our predictive model of expected expenditures and comparing the expected expenditures to actual expenditures, less program costs, covering all members that have been identified.
- We will measure participant satisfaction with our programs and changes in functional status.
- We will provide data identified by specific sub-groups (e.g., children and adults), and will work with DHH to develop the characteristics of any other desired groups.

Table 6: Sample Measures included in the evaluation

Measure
▪ Persistence of Beta Blocker After a Heart Attack
▪ Cholesterol Management After Acute Cardiovascular Events – LDL-C Screening ▪ Cholesterol Management After Acute Cardiovascular Events – LDL-C level<100
▪ Comprehensive Diabetes Care – HbA1C testing ▪ Comprehensive Diabetes Care – Poor HbA1C Control ▪ Comprehensive Diabetes Care – Eye Exam ▪ Comprehensive Diabetes Care – LDL-C Screening ▪ Comprehensive Diabetes Care – Eye Exam (retinal) performed ▪ Comprehensive Diabetes Care – LDL-C level<100 ▪ Comprehensive Diabetes Care – Monitoring for Nephropathy ▪ Comprehensive Diabetes Care – HbA1C Good Control (<7.0 percent) ▪ Comprehensive Diabetes Care – Blood Pressure <130/80 ▪ Comprehensive Diabetes Care – Blood Pressure <140/90
▪ Use of Appropriate Medications for people with Asthma – 5-9 Years ▪ Use of Appropriate Medications for people with Asthma – 10-17 Years ▪ Use of Appropriate Medications for people with Asthma – 18-56 Years ▪ Use of Appropriate Medications for people with Asthma – All Ages
▪ Adult Access to Preventative/Ambulatory Health Services – 20-44 Years ▪ Adult Access to Preventative/Ambulatory Health Services – 45-64 Years ▪ Adult Access to Preventative/Ambulatory Health Services – 65+ Years
▪ Rate of inpatient admissions by disease state population
▪ Rate of emergency room admissions by disease state population
▪ Participant Satisfaction

In addition, we will seek out and partner with Louisiana providers on projects to measure and evaluate effectiveness of interventions with this population. As part of our preparation for Louisiana, our clinical leadership and Dr. Michael Kaiser, Chief Medical Officer of Louisiana State University Health System (LSU) discussed working together on projects to evaluate the effectiveness of telehealth monitoring and focused care management interventions on members with heart failure or other chronic conditions. LSU has current initiatives in place that use a combination of home monitoring devices and nurse contact for patients with heart failure and patients with hypertension. They have successfully reduced inpatient admissions and to a lesser degree, emergency room visits, while increasing physician contact, in the one heart failure program. LSU and AmeriHealth Mercy will explore combining efforts to provide these programs for members, combining nurse care management resources from AmeriHealth Mercy with home monitoring through LSU.

Participant Satisfaction

We will measure member/participant satisfaction (by disease state and otherwise). We will use a customized tool for the collection of member satisfaction data, and will work with DHH to implement a system that reflects the needs of participants and the goals of the department.

Results from our latest care management member satisfaction survey appear in Table 7. We received a response rate of 10 percent (660 members) for this survey.

Table 7: Member Satisfaction Survey Results

Measure	Total	Asthma	Heart Failure	Diabetes
Do you feel the Care Manager helped you with your health care needs?	90%	90%	87%	93%
Was it easy to contact the Care Manager?	87%	86%	87%	87%
Was the information you received helpful?	92%	94%	90%	94%

E.2: Identifying Recipients for Chronic Care/Disease Management Programs

E.2 Describe how recipients will be identified for inclusion into the Chronic Care/Disease Management program. Identify which disease states/ recipient types will be targeted for the Chronic Care/Disease Management program. Describe how the Chronic Care/Disease Management program will coordinate information and services with the PCP.

Target Populations

As mentioned in section E1, AmeriHealth Mercy's Chronic Care Management program will target Louisiana members with asthma, diabetes, chronic obstructive pulmonary disease (COPD), heart failure and sickle cell anemia, and other programs identified by DHH. We will define the target populations using the following criteria:

- Members with asthma are members who were identified on assessment or have claims with diagnosis codes of 493.0 through 493.9
- Members with COPD who were identified on assessment or have claims with diagnoses 492-492.8 or 496
- Members with diabetes are members who identified on assessment or have claims with diagnoses codes of 250.0 through 250.9
- Member with heart failure risk (stage A or B) are members who were identified on assessment or have claims with diagnoses codes of 277.7, 278-278.02, 394-397.9, 401, or 410-416.9
- Members with heart failure stage C or D or members who were identified on assessment or have claims with diagnoses codes of 428.0 through 428.9
- Members with sickle cell anemia are members who were identified on assessment or have claims with diagnoses codes of 282.6-282.69

Member Identification Strategies

AmeriHealth Mercy will identify members in need of chronic care management using five distinct mechanisms:

- **Data mining** - AmeriHealth Mercy will analyze current and historic medical and pharmacy claim data to identify members belonging to the target populations. Our approach incorporates analysis of medical, behavioral health (as available) and pharmacy claims to identify members who are actively diagnosed with the condition, and avoid false-positive identification of members who are being ruled-out for a condition. Historical claim data received from DHH will be loaded into our data warehouse, where it can be accessed for data-mining and viewed as part of our Jiva care management system for individual Care Manager use.

- **New member assessment –** AmeriHealth Mercy will encourage all its members to complete a health assessment contained in the new member welcome packet, on the secure member portal, or through telephonic outreach campaigns. Information gathered during the assessment will be used to triage members into appropriate components of our Intensive Care Management program. Those with chronic conditions will be enrolled in the corresponding Chronic Care Management program.
- **Provider referrals** - We will encourage our providers to refer members to the Chronic Care Management program through several different avenues, including telephone and fax referrals. We will outline all of our available referral services to providers during an initial provider training program and through regular and ongoing provider-focused communications. Throughout these ongoing communications initiatives, we will explain the services available through the Chronic Care Management program and encourage providers to refer patients who may benefit from our services.
- **Member requests** - Members can contact the care coordination department to request chronic care management services. Information on available programs is published in the member handbook and the member web site. Member newsletters also routinely highlight available programs and services. We also publicize our programs at community events, encouraging members to self-refer.
- **Health plan activity** - Members are also referred to the care coordination program through internal processes such as utilization management, provider service calls and Customer Service calls. All staff will be trained on available programs and the referral mechanism. Audits of member interactions include elements to screen for appropriate internal handling of a member call or request for service.

In addition, AmeriHealth Mercy will request information on members who are transferred to AmeriHealth Mercy from another CCN. We will use the information received to supplement the data gathered through AmeriHealth Mercy's new member assessment process to identify appropriate chronic care management needs.

Once identified, members will be stratified into a program tier based on their relative future risk score, as determined through predictive modeling (if available), and their assessment findings. Members in the program will be periodically reassessed and moved into different program arms as their needs change.

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 then 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.

Coordination with the PCP and Medical Home

AmeriHealth Mercy recognizes that the PCP/Medical Home is the cornerstone of the member's care coordination and delivery system. AmeriHealth Mercy employs several mechanisms to coordinate information and services with the PCP/Medical Home to optimize effectiveness and avoid duplication of services. We provide PCPs with a range of automated to hands-on services designed to complement the services available at the medical home site.

Our care management staff will contact each PCP during the member's initial enrollment into the chronic care management program, as part of the comprehensive assessment and plan of care development process. We will create the member's plan of care using the PCP's treatment plan as a foundation. This will allow us to complement the PCP's recommendations to develop an enhanced and holistic plan specific to the chronic care management program. The Care Manager will remain in close communication with the PCP during the implementation of the plan of care should issues or new concerns arise.

Chronic care management nurses will also contact the member's key/current providers of care. We may contact the member's behavioral health care providers and other case managers involved with the member's care to determine the best process to use to support the member. This process will help to reduce any redundancies and identify areas to coordinate and support efficiencies for both programs. We will engage key providers and provide them with the opportunity to be part of the development of the member's treatment plan. At any point when we reassess a member and update the treatment plan we will supply a copy to both the provider and member.

We will also use our experience with Health Information Exchange (HIE) technology to provide the PCP/Medical Home with member- and panel-level information at their fingertips. Through our provider web portal providers can quickly obtain a Member Clinical Summary (MCS) report listing the member's chronic conditions, medications, Care Gaps missing or overdue services, specialist visits, ER visits, and other details. This summary provides useful information at all phases of the member's care. For a member who is new to the PCP/Medical Home, the MCS provides a snapshot of health care needs and services the member has received in the past.

For established patients, the MCS alerts the PCP/Medical Home to inpatient admissions or Emergency Room visits the patient forgot to mention. More importantly, the MCS serves as a way for the PCP to verify that the member filled the prescriptions that s/he received during the last visit and alerts the PCP to medications the patient is receiving from other providers. The MCS can be printed for addition to a paper chart or downloaded as a Continuity of Care Document (CCD) into an electronic medical record.

As described above, the Provider Portal also has an alert functionality that places a pop-up alert box on the screen when the member has a missing recommended service or "Care Gap." Clicking on the alert brings up a Care Gap Worksheet that details the recommended services and identifies the last date the service was done, if known. The worksheet can be printed and placed on the member's chart for review by the PCP during the office visit. This allows a Medical Home office to identify needed care while checking eligibility at the time of the visit; allowing the office to address the member's needs while the member is in the office.

Finally, the robust reporting functionality of the provider portal allows a PCP/Medical Home to proactively review their performance against clinical guidelines. The office can pull reports detailing members with chronic conditions and listing the member's adherence to recommended clinical services. The report can be filtered by condition, member age range, and status of the service (e.g. overdue, missing, up-to-date). This allows a PCP/Medical Home office to review their performance on diabetes; identify members in need of monitoring; and plan outreach campaigns. The report can be printed or saved as an Adobe PDF document or downloaded as a CSV file for integration into other electronic systems. The report contains the member's address and phone number, making it simple to upload the CSV file into a mail-merge program for automated postcard generation or an automated phone dialer for a telephonic outreach campaign.

Predictive Modeling: Overview

The prompt and accurate analysis of claims data is one of the most critical elements of the entire care management process, from initial identification through the actual work with the member. Using data transfers from the Louisiana Medicaid Management Information System (MMIS) for our initial

membership, and claims data thereafter, AmeriHealth Mercy will employ our predictive modeling tool and methodology as another vehicle to identify members who may benefit from our various programs.

Brief History of the Tool's Development and Historical and Current Uses

AmeriHealth Mercy's predictive modeling system is based on Diagnostic Cost Groups (DCGs). [1] AmeriHealth Mercy uses Verisk Health's Diagnostic Cost Groups (DCGs) and predictive model system, generally referred to as "DxCG."[2] Verisk's Health Division is the original developer of the Diagnostic Cost Groups (DCGs) predictive model system. The DxCG model is well documented, and is the most widely validated risk adjustment research methodology.[3]

Medicaid Data Elements for Predictors and Dependent Measure(s)

Although the DxCG model is often used by commercial and Medicare payers, it is also utilized for Medicaid. In addition to the traditional elements for predictors available for commercial and Medicare, Medicaid models are further divided by managed care models and fee for service (FFS) models. Since the eligibility characteristics vary significantly between enrollees in Medicaid managed care and those who typically remain in FFS delivery programs, separate models are developed to better predict risk and cost in both program types.

DxCG models are also characterized by the nature of available data, referred to as the model variant. AmeriHealth Mercy tracks the following model variants:

- **Age/Sex** – Age and sex demographic information. (For Medicaid populations, these models also use eligibility categories.) These models use traditional actuarial measures of risk assessment and provide a comparative baseline for the clinical models.
- **Inpatient** – Age, sex and hospital inpatient diagnoses using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). This variant predicts the likelihood of hospitalization within the next six months.
- **All-encounter** – Use age, sex and all diagnoses–both inpatient and outpatient–recorded on any claim that involved contact with clinically-trained medical Providers.
- **Likelihood of Hospitalization (LOH)**

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[1] A DCG is more specifically defined as a family of risk assessment and risk adjustment tools designed for population-based health management. Using medical claim data, each member-year is characterized by cataloging the range and intensity of medical problems present during the year. Demographic information is added to help predict each member's resource use for either the concurrent year (retrospective/concurrent) or the following year (prospective). In population-based analysis, every individual is described clinically and assigned a risk score based on expected health care costs. The DCG all-encounter models capture each comorbidity, and can be used to identify patients with all types of clinical conditions. DCG (Diagnostic Cost Group) models generate individual and group level output.

[2] The original Diagnostic Cost Group (DCG) model research began in 1984. Researchers used two years (1979-80) of Medicare data. Reflecting the limited availability of diagnostic information at that time, only inpatient diagnoses were incorporated into these first DCG models. Building upon this early work, DCG models were further refined and recalibrated using 1984-85 Medicare data by Arlene Ash, Ph.D., and Randall Ellis, Ph.D., of Boston University and Lisa Iezzoni, M.D., M.S., of Harvard Medical School.

DCG models, both those relying exclusively on inpatient diagnoses and those that use diagnoses from other sites of service (outpatient, physician office, and so on.), were further refined and fit to 1991-92 Medicare data. That project had Randall Ellis as Principal Investigator and Gregory Pope, M.S. of Health Economics Research, Inc. (HER) as Project Director. Arlene Ash and Randall Ellis, as co-principal investigators, later extended the DCG framework to under-age-65 privately-insured (commercial) and Medicaid populations. CMS continues to use a derivation of the DCG model in its Medicare program.

[3] The most recent comparative study on risk adjustment and predictive modeling tools was conducted by the Society of Actuaries ("SOA") in 2007. The SOA study group compared industry leading models and concluded that DxCG model performance ranks among the best-in-class.

The DxCG model uses diagnostic and NDC code information commonly captured on claims, cost of services, plus age and gender of the individual to calculate a health risk score which equates to a person's expected cost per year. Clinical conditions have an associated risk weight which is a valid and accurate estimator of current and future health care costs. Pharmacy based models have a similar construction and the pharmacy categories are used to calculate total medical cost. Pharmacy models are especially useful if encounter data captured is less than robust. They also serve as a measure of data quality against the medical claim data since it is not uncommon to have a prescription drug refill indicate the presence of a clinical condition, yet the condition is not coded by providers in the same data period.

These risk adjustment and predictive models inform a wide variety of business processes including but not limited to actuarial risk assessment, financial planning, program evaluation, provider efficiency analysis, the development of risk adjusted capitation, risk stratification, prospective identification of high cost claimants, and targeted case management.

Assessment of Data Reliability and Model Validity

AmeriHealth Mercy has a long history of providing effective chronic care management to Medicaid populations with a variety of chronic conditions and associated co-morbidities, including asthma, diabetes, congestive heart failure, and sickle cell anemia[4]

Claim data for more than 21,000,000 member months support our predictive modeling approach.

AmeriHealth Mercy takes a dual approach to chronic care management. We review concurrent risk scores, but we have an additional focus on *prospective* scores. [5].This allows us to target actions toward those who likely would consume more resources in the coming year before that year is upon us. That change in direction and perspective — from "reactive to proactive" — has saved literally millions of dollars and improved the lives of thousands of people.

Our use of DCGs for predictive modeling spans eight years across a wide range of chronic conditions, exclusively for Medicaid populations. We have member, provider and claim data for five plans in our system and retain this data for a minimum of three years, or for longer periods as required by our customers. This translates to claims data for more than twenty-one (21) million member months.

An example of our use of DCGs to identify high-risk members for case management may be found in our work in our southeastern Pennsylvania, which serves some 300,000 Medicaid consumers. Below are examples of ways we have used DCGs for predictive modeling and risk adjustment for that plan. We will tailor similar offerings to the needs of members and providers:

- **PCP Profiling -** We use risk adjustment for PCP profiling and identification of the illness burden of PCP panels. This allows us to compare actual practice utilization rates with those of a PCP's peers and with the expected rates for that practice, allowing us to provide useful feedback to the PCP.
- **Population Profiling -** We have the capacity to risk stratify and evaluate the populations of our integrated care management programs in a variety of ways. This provides us with insight that would not otherwise be available to us in a "one size fits all" approach.

[4] AmeriHealth Mercy has received multiple awards for its work in predictive modeling, including:2009 Thomson Reuters Healthcare Advantage Award for AmeriHealth Mercy Health Plan's use of Predictive Modeling technology to improve member care. 2009 "overall" Medstat Innovator Award for Keystone Mercy Health Plan's Care Gaps program. 2007 - 2009 Thomson Reuters Healthcare Advantage Award for Keystone Mercy Health Plan's use of technology to improve member care, and was named one of six finalists in 2006. Both AmeriHealth Mercy Health Plan and Keystone Mercy Health Plan also won NCQA Quality Profile awards in 2010. We were also published in NCQA's Quality Profiles: The Leadership Series, Focus on Supporting Quality Improvement Through the Use of Health Information Technology.

[5] Concurrent models are used for provider profiling and other retrospective analyses, whereas prospective models are useful for care management (population stratification) and payment/budgeting purposes. The Diagnosis Groups are clinically homogeneous groups of ICD diagnosis codes in the Diagnostic Cost Group (DCG) models. Generally, each ICD falls into 184 DxGroups. There are 784 DxGroups within the DCG clinical classification system. DxGroups are grouped into Conditions Categories (CCs).

- **By Geography -** We analyze cost, utilization and risk score/illness burden of populations across geographical regions of a plan's coverage area. Areas with higher utilization and costs are not always areas which exhibit higher risk or a more severe illness burden (due to the impact of unit costs.) With that information in hand, we can better evaluate the significance of any variance (and then address the implications of such an inconsistency). We will work closely with DHH to explore the reasons for any differences we identify between risk and utilization by geography, potentially exposing high-risk gaps in care for specific population cohorts and disease states; and determine where specialist and/or home nurse visits might be beneficial.
- **By Health System -** We are able to evaluate assertions by hospitals and health systems that they are treating individuals with the highest medical need, by using DCGs to risk adjust patients seen by those organizations. This data assists us in dealing with those institutions and help us educate hospitals about the patients they treat.

- **By Selected Diseases/Conditions -** By using DCGs to produce risk scores for members with selected single disease states or conditions, AmeriHealth Mercy can, for example, confirm that asthma is generally less severe than CHF, or that COPD could be a higher risk than diabetes.
- **By Duration of enrollment (i.e., new vs. old) –** AmeriHealth Mercy's analyses have shown that new plan members exhibit disproportionately higher inpatient utilization than do existing members, even taking into account the atypical utilization that we see among new enrollees. Our application of DCGs to newer members indicates an aspect of generally accepted risk adjustment/predictive model functionality that we have been able to address. Often new members will not have many claims, and thus will not generate a high DCG risk score, while at the same time often requiring hospitalization soon after joining.

As available, data from prior authorization and medical necessity review processes are incorporated into our database allowing us to produce provider profiles based on the member's medical claim data and authorization history.

Aggregated individual scores by groups of interest (Medicaid aid category, disease cohorts, physician risk panels and similar groups) create predictive modeling results specific to many medical management applications. Overall predictive modeling development encompasses many years of research with AmeriHealth Mercy utilizing specific considerations of population group (Medicaid) and model variant data (age, RxGroup, Inpatient, all-encounter, etc.).

The Society of Actuaries study found that "The DCG model produces the highest R-squared and lowest MAPE [Mean Actual Prediction Error – lower is better] of the diagnosis input data models." (page 5)

Additionally, AmeriHealth Mercy's predictive modeling tools take turnover into consideration. This is an important feature because there is constant enrollment and disenrollment in insured (or covered) populations. While commercial populations typically have eight to eleven months of average eligibility, average eligibility in Medicaid populations is typically shorter, while in Medicare it is longer. Cost weights for concurrent models were estimated using all members, provided they had one month of eligibility. Cost weights for prospective commercial and Medicaid models were estimated using only those with at least one month of eligibility in both years one and two of the sample periods.

The actuarial soundness of the DxCG predictive models have been studied and proven by the Society of Actuaries, most recently in "A Comparative Analysis of Claims-based Tools for Health Risk Assessment," a 2007 study conducted by Milliman USA.

Rules and Strategy for Achieving Clinical Outcomes and Measuring Outcomes

Based on our years of experience with using predictive modeling for the Medicaid population, we have learned to stratify the population in order to optimize clinical outcomes. Our approach is not cookie-cutter, but rather takes into account that different individuals will have different needs and require

different degrees and levels of intervention. For example, an individual with a single condition such as asthma will have different needs than an individual who has diabetes and congestive heart failure. Some individuals with developmental disabilities or others with very difficult socio-economic conditions may be less likely to benefit from education or instruction on self-management. These members will require coordination with other supporting and community organizations or more intensive intervention.

We measure clinical outcomes using established HEDIS measures and industry-accepted utilization metrics. Using HEDIS allows us to not only trend measures over time but to compare outcomes among different population segments. Measurement of clinical outcomes supplements our measures of cost and utilization, providing us with a more comprehensive multifaceted outcomes analysis. We use our predictive modeling software to risk-adjust our outcomes, allowing us to compare different interventions or provider groups.

Optimization of the Model and Constraints on Intervention

Our use of predictive modeling has evolved over the years since we began using it in 2003-2004. Any model or tool is only as good as its practical application. Our Informatics and Integrated Care Management areas have worked closely together so that each area has adequate understanding of the other while working for the overarching goal of better health outcomes for our members. Rather than relying solely on risk scores, we integrate clinical data such as diagnoses and demographics to strengthen our Integrated Care Management model, in order to better prioritize outreach efforts.

Unfortunately, not all individuals are receptive or amenable to being contacted or to changing their behavior. Our approach acknowledges this reality. We consider ourselves stewards of taxpayer dollars and use predictive modeling to guide our use of resources in ways that yield optimal results. We have used newer models exclusively for the Medicaid population when available and appropriate, such as the Likelihood of Hospitalization Model, to further enhance our outreach prioritization.

Sample Assessment Forms

The below assessments are samples that will be customized to meet the needs of the population and program requirements.

Table 8: Sample Assessments/Initial – Complex

Initial Assessment		
Question		**Answers**
1	Who is providing responses to this assessment and questionnaire?	▪ Member ▪ Spouse ▪ Parent ▪ Child of adult member ▪ Other family member ▪ Friend ▪ Other
2	Program description given.	▪ Completed ▪ Not Completed (specify reason) ▪ Free text
3	Will participate in program? If no, please explain	▪ Yes ▪ No ▪ Free Text

Initial Assessment			
Question		**Answers**	
4	Privacy and HIPAA Rights explained.	▪ Completed ▪ Not Completed (specify reason) ▪ Free text	
5	Purpose/process of Care Management explained.	▪ Completed ▪ Not Completed (specify reason) ▪ Free text	
6	Explained dissatisfaction/ disenrollment procedures.	▪ Completed ▪ Not Completed (specify reason) ▪ Free text	
7	What health problems do you (does the child) have now? *(Repeat for up to 6 diagnoses)*	▪ Mental Health ▪ MI ▪ MR ▪ Obesity ▪ Pancreatitis ▪ Para/Quadriplegia ▪ Pneumonia ▪ Pregnancy Pre-term labor ▪ PVD ▪ RAD ▪ Seizure Disorder ▪ Sepsis ▪ Sickle Cell Disease ▪ Spinal Bifida ▪ Substance Abuse ▪ Technology Defect ▪ Vision Impaired ▪ Other ▪ Free Text Field	▪ Arthritis ▪ Asthma ▪ Autism ▪ Bronchiolitis ▪ CAD ▪ Cancer ▪ Cellulitis ▪ Cerebral Palsy ▪ Chest Pain ▪ CHF ▪ COPD/Emphysema ▪ ESRD/CRF ▪ Failure to Thrive ▪ Hearing Impaired ▪ Hemophilia ▪ HIV/AIDS ▪ HTN ▪ Labor/Delivery ▪ Lymphadema
8	How long have you (or your child) had this diagnosis? *(Repeat for up to 6 diagnoses)*	▪ Less than or equal to 6 ▪ months ▪ 7 to 11 months ▪ 1 to 5 years ▪ Longer than 5 years	
9	What do you know about your (or your child's) diagnosis? *(Repeat for up to 6 diagnoses)*	▪ Correct explanation ▪ Partially correct explanation ▪ Incorrect explanation.	
10	What medicines do you take for your diagnosis? What is the dosage/frequency/date dispensed? *(Repeat for up to 6 diagnoses)*	▪ Free text	
11	Why does your doctor have you taking the medication? *(Repeat for up to 6 diagnoses)*	▪ Free text	

Initial Assessment		
Question		**Answers**
12	Was the explanation correct based on the diagnoses? *(Repeat for up to 6 diagnoses)*	▪ Correct ▪ Incorrect
13	Do you use any cultural/traditional or home health remedies to treat your diagnosis? If yes, please explain. *(Repeat for up to 6 diagnoses)*	▪ Yes ▪ No ▪ Free text field
14	What other medical treatments do you (or your child) currently receive for your diagnosis? *(Repeat for up to 6 diagnoses)*	▪ Medication ▪ Home Care ▪ Doctor visits ▪ Special diet ▪ Equipment (i.e. nebulizer, CPAP, etc.) ▪ Regular laboratory tests
15	What prevents you from taking the medication(s) the way your doctor asked you to?	▪ No medications prescribed. ▪ No problems with taking medications. ▪ Difficulty or unable to administer. ▪ Needs more medication than what is ordered. ▪ Medication side effects ▪ Does not want to take ▪ Forgets to take the medications. ▪ Did not obtain the medications ▪ Not near the medication when it is due. ▪ Refill or original prescription denied. ▪ Told too soon to refill. ▪ Doesn't have pharmacy benefit. ▪ Other (explain)
16	If you or your child requires assistance taking your medication, please specify who assists you?	▪ Member ▪ Parent ▪ Spouse ▪ Other family members ▪ Licensed Nurse ▪ Paid Caregiver ▪ Unpaid caregiver ▪ Friend
17	Do you wear a medical bracelet or necklace that alerts others that you have a medical condition? If Yes, what conditions are on the alert?	▪ YES ▪ NO ▪ Free text

Initial Assessment		
Question		**Answers**
18	How often do you see your doctor?	▪ Every week ▪ Twice a month. ▪ Every month ▪ Every other month ▪ Every 3 months ▪ Two times a year ▪ Yearly ▪ Not specified
19	What is the date of your next doctor appointment?	▪ Free text
20	What do you do if you are not feeling well and think that you need to be seen?	▪ Call my doctor for same day appointment ▪ Go to the Emergency Room ▪ Call the doctor to see when I can be fit in ▪ Wait and see if I feel better ▪ Call doctor's office for advice ▪ Nothing ▪ Other ▪ Free text
21	Which doctor do you call when you are having a problem? Explain if needed.	▪ Free text
22	Has anyone in your household been to the ER in the last 3 months?	▪ Yes ▪ No ▪ Relationship ▪ Free text
23	What was the ER visit for?	▪ Free text
24	Do you have any problems with: Personal Needs/ADL's?	▪ Bathing ▪ Dressing ▪ Eating ▪ Shopping for food ▪ Food preparation ▪ Making telephone calls ▪ Housework ▪ Other ▪ No Needs ▪ Free Text
25	Do you (your child) have any difficulty with Mobility? Check all that apply. If other, please explain.	▪ No difficulty ▪ Difficulty with entering or leaving the house ▪ Stairs make it difficult or impossible to leave the house ▪ To weak to leave the house ▪ In Wheelchair with no ramp or elevator ▪ Use a walker or cane ▪ Other ▪ Free text

Initial Assessment		
Question		**Answers**
26	When you are given things to read about your health, do you have problems reading or understanding them?	▪ No problem ▪ Can't read at all ▪ Unable to read some of the words ▪ Can't see well enough to read ▪ Not in main/preferred language ▪ Can't understand concepts or medical language
27	What is your most recent height?	▪ Number Field
28	What is your most recent weight	▪ Number field
29	How often do you check your own weight? If Never or Rarely, please explain.	▪ Once a day ▪ Once a week ▪ Once a month ▪ Rarely ▪ Never ▪ Free text field
30	Has your doctor recommended a special diet? If so, what type of diet?	▪ Low Protein ▪ Reduced Calorie ▪ Pediatric enteral ▪ Other ▪ Free text ▪ Diabetic ▪ Low Sodium ▪ Low Fat ▪ Cardiac ▪ Renal
31	Sometimes people are not able to follow their diets exactly as the doctor recommend. What are those times for you?	▪ Special occasions ▪ Don't want to be left out. ▪ Don't follow diet at all ▪ When I am upset ▪ When I eat out at a restaurant. ▪ Certain foods are tempting ▪ Inadequate supply of proper foods ▪ Always follows diet ▪ Other ▪ Free text
32	What types of products do you use?	▪ Cigarettes ▪ Cigars ▪ Chewing tobacco ▪ Beer ▪ Wine ▪ Hard liquor ▪ Street drugs
33	If you smoke or chew tobacco, how often?	▪ Don't smoke/chew ▪ 1-3 times ▪ 3-6 times ▪ More than 6 times

Initial Assessment		
Question		**Answers**
34	If you drink alcohol, how much do you drink?	▪ 1 drink a day ▪ 2-3 drinks a day ▪ 4-6 drinks a day ▪ More than 6 drinks a day
35	How often do you exercise?	▪ At least once a day ▪ 4-6 times a week ▪ 2- 3 times a week ▪ 1 time a week ▪ Rarely exercise ▪ Don't exercise
36	What do you see as cultural practices that may affect your health care decision-making? Select all that apply. If "Other," please explain.	▪ Religious/Cultural Reasons ▪ Examination by a male/female practitioner ▪ Foods to avoid (e.g., pork) ▪ Blood transfusions ▪ Other (please explain)
37	What type of transportation do you use to get to your doctor's appointments?	▪ Ambulance ▪ Caregiver ▪ Friend ▪ Para transit ▪ Self
38	What do you see as barriers or reasons why you can't get the health care you feel that you need?	▪ No barriers identified ▪ Doctor office hours ▪ Issues with medication benefits ▪ Transportation ▪ Lack of support from family ▪ Lack of DME supplies ▪ Don't know what I need ▪ No available/convenient providers ▪ Doctor not responsive ▪ Other ▪ Free text
39	What do you see as cultural practices that may affect your health care decision-making? Select all that apply. If "Other," please explain.	▪ Religious/Cultural Reasons ▪ Examination by a male/female practitioner ▪ Foods to avoid (e.g., pork) ▪ Blood transfusions ▪ Other (please explain)
40	During the past month, have you often been bothered by feeling down, depressed or hopeless?	▪ Yes ▪ No ▪ Free Text
41	During the past month, have you often been bothered by little interest or pleasure in doing things?	▪ Yes ▪ No ▪ Free Text

Initial Assessment		
Question		**Answers**
42	For CM - Based upon your assessment of the member, what are the cognitive skills for daily decision making?	▪ Independent (decisions consistent, reasonable and safe) ▪ Modified Independence (some difficulty) ▪ Minimally impaired (needs cues) ▪ Moderately Impaired (decisions poor/needs cues all the time) ▪ Severely Impaired (rarely makes decisions) ▪ Not Applicable
43	For CM - Did the assessment and/or discussion with member/respondent indicate issues other than identified in assessment that should be included in member's care coordination care plan?	▪ Yes ▪ No ▪ Free Text

Additional assessment components are administered based on the findings of the initial assessment

Table 9: Sample Assessments/Asthma

Asthma Assessment - Base			
Question		**Answers**	
1	Do you have a peak flow meter?	▪ Yes ▪ No	
2	Do you know how to use your peak flow meter?	▪ Yes ▪ No	
3	How often do you check your peak flow?	▪ Not at all ▪ At least once a week ▪ At least once a month ▪ As directed by Doctor/Specialist ▪ Per the Asthma Action Plan	
4	If you check your peak flow, what is your range?	▪ Free text	
5	What environmental triggers are you exposed to?	▪ pets ▪ crawling insects ▪ tobacco smoke ▪ household sprays ▪ paint fumes ▪ carpet in the home	▪ cockroaches in home ▪ dust mites ▪ allergy to pollen ▪ allergy to mold ▪ symptoms worsen during various seasons ▪ occupational exposure (chemicals) ▪ other ▪ Free text field

Asthma Assessment - Base		
	Question	**Answers**
6	Which of the following activities are affected by your Asthma? (Select all that apply)	▪ bathing ▪ dressing ▪ exercising ▪ housework ▪ shopping ▪ other ▪ Free text field
7	How often have you missed time scheduled at work or school?	▪ None ▪ One or two days per ▪ month ▪ 3 to 4 days per month ▪ 5 or more days per ▪ month
8	How often have you coughed, wheezed, felt short of breath, or had chest tightness during the day?	▪ None ▪ One or two days per ▪ month ▪ 3 to 4 days per month ▪ 5 or more days per ▪ month
9	How often have you coughed, wheezed, felt short of breath, or had chest tightness during the night, causing you to wake up?	▪ None ▪ One or two days per ▪ month ▪ 3 to 4 days per month ▪ 5 or more days per ▪ month

Table 10: Sample Assessments/COPD

COPD Assessment - Base		
	Question	**Answers**
1	When was the last time you went to the Emergency Department for problems associated with COPD?	▪ Within the last 2 ▪ months ▪ Within the last 3 to 6 ▪ months ▪ Within the last 6 ▪ months to a year ▪ Greater than a year ▪ N/A ▪
2	Have you or your child had any COPD related in-patient stays? If yes, when?	▪ Yes ▪ No ▪ Free text
3	Who is the doctor that manages your COPD?	▪ Pulmonologist ▪ PCP ▪ Free text
4	When is your next appointment with the doctor who manages your COPD?	▪ Scheduled (specify) ▪ Not scheduled ▪ Free text
5.	In the past 4 weeks, how much of the time did your COPD keep you from getting as much done at work, school or home?	▪ All of the time ▪ Most of the time ▪ Some of the time ▪ A little of the time ▪ None of the time
6.	During the past 4 weeks, how often have you had shortness of breath?	▪ More than once a day ▪ Once a day ▪ 3 to 6 times per week ▪ Once or twice a week ▪ Not at all
7.	During the past 4 weeks, how often did your COPD symptoms (wheezing, shortness of breath, chest tightness or pain) wake you up at night or early in the morning?	▪ 4 or more nights a ▪ week ▪ 2 or 3 nights a week ▪ Once a week ▪ Once or twice ▪ Not at all
8.	Have you had your O2 saturation (pulse-ox) checked? If yes, when was it checked?	▪ YES ▪ NO ▪ Don't know
9.	What was the result of your O2 saturation (pulse-ox)?	▪ 93-100% ▪ 88-92% ▪ 80-87% ▪ Don't know

COPD Assessment - Base		
	Question	**Answers**
10.	Was your O2 saturation (pulse-ox) done while you were on oxygen?	▪ YES ▪ NO ▪ Unknown
11.	Are you on oxygen therapy now?	▪ Yes ▪ No, but I used to be ▪ Never
12.	If yes, how often do you use oxygen therapy? If other, explain.	▪ Less than 4 hours per ▪ day ▪ Only during exertion ▪ All day ▪ All day and night ▪ Other (Comment) ▪ Free text
13.	When did you or your child have a Pulmonary Function Test completed?	▪ Within the last year ▪ Within the past 3 years ▪ Within 3 to 5 years ▪ Never had it ▪ Not sure ▪ NA (not appropriate for age)
14.	Have you ever had a spirometry test? If yes, when?	▪ Yes ▪ No ▪ Free text
15.	Have you had a flu shot? If yes, when?	▪ Yes ▪ No ▪ Free text
16.	Have you had a pneumococcal vaccine? If yes, when?	▪ Yes ▪ No ▪ Free text
17.	Do you have a daily medication to control COPD symptoms? If yes, list the medication, dosage and frequency.	▪ Yes ▪ No ▪ Free text
18.	Do you have a rescue inhaler/medication (short acting bronchodilator)? If yes, list the medication and dosage.	▪ Yes ▪ No ▪ Free text
19.	How often do you use your rescue medication? If other, explain.	▪ Never ▪ Daily ▪ Every 4 to 6 hours ▪ Other, please specify ▪ Free text

COPD Assessment - Base		
	Question	**Answers**
20.	Do you have a long acting bronchodilator? If yes, how often do you take this medication? If other, explain	▪ YES ▪ NO ▪ Never ▪ Daily ▪ Every 12 hours ▪ Other (please specify) ▪ Free text
21.	Based on assessment, CM and member identified the following educational needs. Select all that apply.	▪ Diagnosis ▪ Signs/Symptoms ▪ Complications ▪ Medications ▪ DME/Equipment ▪ Resources ▪ Lifestyle Choices ▪ Other (please explain) ▪ Free text

Table 4: Sample Assessments/Diabetes

Diabetes Assessment - Base		
	Question	**Answers**
1	Do you have a blood glucose monitor?	▪ Yes ▪ No
2	How often do you check your blood sugar level?	▪ Never ▪ Rarely ▪ Weekly ▪ Daily ▪ Several times during the day
3	What was your last HgbA1c result and when was it done? If result known list result.	▪ Never had the test done ▪ Less than 7 ▪ Greater than 7 ▪ Unknown ▪ Free text
4	Do you take insulin to manage your Diabetes (sugar)?	▪ Yes ▪ No
5	What was the last result for a blood test to measure your lipids?	▪ Never had test ▪ Less than 100 ▪ Between 100-130 ▪ Between 130-200 ▪ Greater than 200 ▪ Unknown
6	When was the last time you had your eyes checked?	▪ Never had checked ▪ Within past year ▪ Free text

Diabetes Assessment - Base		
	Question	Answers
7	Have you had your feet examined by a Podiatrist? If yes, when?	▪ Yes ▪ No ▪ Free text

Table 5: Sample Assessments/Heart Failure

Heart Failure Assessment – Base		
	Question	Answers
1	Have you ever been told that you have "heart failure" or a heart condition for which you take water pills?	▪ Yes ▪ No ▪ Free text field
2	Have you ever experienced difficulty breathing? If yes, describe the symptoms that you have experienced.	▪ Yes ▪ No ▪ Free text field
3	Have you and your doctor or nurse talked about weight gain due to the fluid in your lungs and feet?	▪ Yes ▪ No ▪ Free text field
4	Do you know when you should call your doctor about the weight gain?	▪ Yes ▪ No ▪ Free text field
5	Is there any activity or exercise that you used to do but you can no longer do because of heart failure?	▪ Free text field
6	Do you experience difficulty breathing when exercising or with activity?	▪ Yes ▪ No ▪ Free text field
7	Do you wake up at night short of breath?	▪ Yes ▪ No ▪ Free text field
8	How often do you monitor your blood pressure and heart rate?	▪ Yes ▪ No ▪ Free text field
9	What were your last 3 blood pressure, heart rate and weight readings?	

Table 6: Sample Assessments/Sickle Cell Disease

	Question	Answers
1.	Can you explain to me what you know about Sickle Cell Disease?	▪ Good understanding ▪ Poor understanding
2.	When was the last time you went to the Emergency Department for complications from Sickle Cell?	▪ Within the last 2 months ▪ Within the last 3 to 6 months ▪ Within the last 6months to a year ▪ Greater than a year ▪ N/A ▪
3.	Have you had any Sickle Cell in-patient stays? If yes, when?	▪ Yes ▪ No ▪ Free text
4.	What do you do when you are having signs/symptoms of a Sickle Cell crisis?	▪ Check for a fever ▪ Increase my medication dosage ▪ Take my narcotic pain medication ▪ Call my PCP/SCP for a same day appointment ▪ Go to the ER ▪ Other ▪ Free text
5.	Do you know the signs/symptoms of a stroke? If member does not know, educate the member.	▪ States the signs/symptoms correctly ▪ Does not know the signs/symptoms of a stroke.
6.	Do you take medications as instructed?	▪ Yes ▪ No
7.	Does your child (if under 10 years old) take antibiotics and Folic Acid? If no, explain.	▪ Yes ▪ No ▪ Free text
8.	How often do you see PCP/SCP?	▪ Every week ▪ Twice a month ▪ Every Month ▪ Every Other month ▪ Every 3 months ▪ Two times a year ▪ Yearly ▪ As specified by the provider ▪ Not specified ▪
9.	What is the date of your next PCP/SCP appointment? If not scheduled, assist with	▪ Scheduled (specify date) ▪ Not scheduled

	Question	Answers
	making an appointment.	▪ Free text
10.	Specify all preventive health screenings/immunizations completed within recommended time frames.	▪ Females: PAP Smear ▪ Females: Breast Exam ▪ Females: Mammograms ▪ Child lead test ▪ Colon test ▪ Dental exam ▪ Flu vaccine ▪ Pneumonia vaccine ▪ Routine immunizations ▪ Well Child visit ▪ Well Adolescent Visit ▪ Vision ▪ N/A ▪ None ▪ Other ▪ Free text
11.	When was your last blood transfusion and how many units?	▪ Free text
12.	Did you receive testing for excessive iron (iron overloading? If yes, what was the result?	▪ Yes ▪ No ▪ Free text
13.	Did the PCP/SCP prescribe a treatment for the excessive iron overload? If yes, explain.	▪ Yes ▪ No ▪ N/A ▪ Free text
14.	Do you know the latest results of your Hgb/Hct? If yes, what was the result?	▪ Yes ▪ No ▪ Free text
15.	What pain medication do you have available for pain relief? List medication, dosage and frequency.	▪ Free text
16.	Do you use any of the following: If other, explain. If yes, when is the last time you used? Select all that apply.	▪ Use street drugs ▪ Methadone ▪ Alcohol ▪ Overuse of prescription drugs (such as pain medication) ▪ N/A ▪ Other ▪ Free text
17.	Do you need professional help with any of the following? Select all that apply. If other,	▪ Use street drugs

	Question	Answers
	explain. Refer as needed to appropriate agency.	▪ Methadone ▪ Alcohol ▪ Overuse of prescription drugs (such as pain medication) ▪ N/A ▪ Other ▪ Free text
18.	Do you use any tobacco products? If yes, select type	▪ Yes ▪ No ▪ Cigarettes ▪ Chewing tobacco Cigars ▪
19.	If you use any tobacco products are you interested in quitting? (Provide smoking cessation resources and number)	▪ Yes ▪ No ▪ Not at this time
20.	How many glasses of liquid do you drink per day?	▪ Less than 4 glasses per day ▪ 4 to 6 glasses per day ▪ Greater than 6 glasses per day
21.	How many meals do you eat a day? (CM may ask for a dietary recall as needed)	▪ Free text
22.	From which of the following do you receive support? Select all that apply. Refer to Sickle Cell association if applicable.	▪ Family ▪ Church ▪ Community/Neighborhood ▪ Sickle Cell Association ▪ Parent Support Groups ▪ Other ▪ None ▪ Free text
23.	Based on assessment, CM and member identified the following educational needs. Select all that apply.	▪ Diagnosis ▪ Signs/Symptoms ▪ Complications ▪ Medications ▪ DME/Equipment ▪ Resources ▪ Lifestyle Choices ▪ Other ▪ Free text

Section F – Service Coordination

F.1 DHH intends to provide CCNs with two years of historic claims data for members enrolled in the CCN effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your CCN effective the start date of operations. The description should include:

- *How you will identify these enrollees, and how you will use this information to identify these enrollees, including enrollees who are receiving regular ongoing services;*
- *What additional information you will request from DHH, if any, to assist you in ensuring continuation of services;*
- *How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation;*
- *What information, education, and training you will provide to your providers to ensure continuation of services; and*
- *What information you will provide your members to assist with the transition of care.*

AmeriHealth Mercy has implemented many new managed Medicaid plans and understands that transitioning required health care services must be seamless to the member. There should never be an interruption in required services, and thanks to DHH's commitment to provide two years of claim data, AmeriHealth Mercy has established mechanisms to ensure that (a) we can identify members with special health care needs, and (b) that we are able to ensure that those members continue receiving any medically necessary services.

Identifying Members with Special Health Needs

AmeriHealth Mercy will use several methods to identify members with special health needs so that we can ensure continuity of medically necessary services and connect the member with the appropriate level of care management. Our processes will focus on identification of conditions that require ongoing management, such as cancer treatment, and specific services, including home health care, therapy, and equipment or oxygen rental, that may indicate an ongoing course of treatment.

Analysis of historical data

We will load the historical data received from DHH into our data management systems so that we can run queries against diagnoses, services and provider types to identify those members with special health needs. We will look for diagnostic and procedure code indicators of chronic conditions, as well as services and bills from select provider types. In addition, we will use the data to produce a predictive model of the population, identifying members who are at risk for future avoidable episodes of care. More information on our Predictive Modeling software and systems can be found in Section E. We will also analyze diagnostic data and risk scores to identify individuals with chronic or at-risk conditions who have not seen a specialist or need to have their conditions brought to the attention of their primary care provider and Care Manager for priority follow-up and assessment.

Table 1: Special Health Needs Indicators

Diagnoses	Services	Provider Types
▪ Pregnancy ▪ Asthma ▪ Autism ▪ Cardiac Artery Disease ▪ Chronic Obstructive Pulmonary Disease ▪ Depression ▪ Diabetes	▪ Cancer Treatment (chemotherapy or radiation therapy) ▪ Home Health Care ▪ Oxygen ▪ DME rental ▪ Therapy ▪ Dialysis	▪ Home Health Agency ▪ DME Company ▪ Transportation ▪ Dialysis Facility ▪ Hospice

Diagnoses	Services	Provider Types
▪ Heart Failure ▪ HIV/AIDS ▪ Sickle Cell Anemia		

New Member Outreach

We welcome new members to our program through our New Member Calls, Member Welcome Packet and Member Handbook, encouraging them to let us know if they have a special health need or are receiving ongoing care. The New Member Assessment, contained in the Member Welcome Packet, contains questions about current health conditions and health care services. As described in Section D, the New Member Outreach process actively encourages members to complete the assessment. Members can complete the assessment on paper and return it using an enclosed postage-paid envelope or they can call the toll-free number printed on the assessment and complete it over the phone. Members can also register on the Member Portal and complete the assessment via our secure internet site. For members who do not have an assessment on record, we use technology-driven automated calls followed by a warm transfer to Contact Center employees to make sure they complete the assessment.

Provider Notification

We will encourage our providers to assist us in identifying members who have special health needs and/or are currently receiving care and to inform us of the current services so that we can arrange for continuity of coverage. We educate providers on this process during our Provider Orientation process, discussed in Section G, and in the Provider Handbook and our provider website. The website is accessible to participating and non-participating providers. For non-participating providers who are providing treatment or services to AmeriHealth Mercy members, the site includes instructions on alerting AmeriHealth Mercy so that continuity of coverage can be evaluated and arranged.

AmeriHealth Mercy will identify these members as early as possible (within 180 days of enrollment during the phase-in implementation and within 90 days of enrollment following that) for assessment and referral to appropriate programs within our Integrated Care Management program.

Additional Information from DHH

In order for AmeriHealth Mercy to best assist new incoming members, AmeriHealth Mercy requests that the DHH claim data file include:

- Member date of birth
- Member gender
- Number of months enrolled (or eligibility start/end date)
- Category of aid
- Provider name
- Provider ID number
- Location of facility/provider
- Diagnosis codes (primary and all present on the claim)
- CPT code/revenue code
- Place of service code
- Amount paid (or cost)
- Start date of the service

This information will allow us to identify members with special needs, identify episodes of ongoing care and run predictive modeling algorithms to identify the high-risk members for priority outreach, as well as generate baseline provider reports for our physician groups.

Continuation of Services

AmeriHealth Mercy acknowledges and accepts the requirements for continuity of care outlined in sections 6.26 through 6.31 of the Louisiana CCN-P Request for Proposal. We will maintain internal policies outlining the specific requirements regarding continuation of medically necessary services for new members transitioning into AmeriHealth Mercy, whether from a prior Medicaid program or another Coordinated Care Network. We have well-established systems to process requests for continued services, ensuring that there is no disruption in care and that the providers involved are paid for the services they deliver. We will actively seek out members involved in ongoing care and their providers to ensure they receive any needed assistance.

Out of Network Services

Our internal process for our medical management and claims processing systems will be programmed to assure that pregnant women, individuals with special health needs, and members with behavioral health needs, continue to receive services, and that members requiring DME, prosthetics, orthotics and certain supplies continue to receive them as specified in sections 6.26, 6.27, 6.28, 6.29, 6.30 and 6.31 of the Louisiana CCN-P RFP. For out-of-network services that are medically necessary, AmeriHealth Mercy will enter an authorization for up to 30 days, or until such time as we can safely transition the member to an in-network provider. AmeriHealth Mercy will not deny prior authorization beyond 30 days only because the provider is a non-participating provider, or if a woman is in her second or third trimester of pregnancy. AmeriHealth Mercy will also continue to authorize services for up to 90 days, or until the member is reasonably transferred without interruption of care, whichever is less, for members receiving treatment for chronic and acute medical conditions if the in-network provider goes out of network.

If a member's current provider is out-of-network, we will initiate contact with the provider to obtain demographic and clinical information needed for claim payment to facilitate continuation of services. We will also investigate whether the provider is willing to become part of our network.

Transportation

For members who lack the means necessary to meet scheduled appointments, AmeriHealth Mercy will arrange for transportation to and from the service provider. We will work with our transportation subcontractor to arrange for the type of transportation needed, in addition to any special accommodations or supportive personnel that are needed to assist with the transportation. Our Rapid Response team will assist members to access the Louisiana Medicaid's Medical Transportation Service and Louisiana Medicaid's Friends and Family Transportation Program, when appropriate. Additional information on transportation can be found in Section G. A summary of our Rapid Response team is available below, as part of our response to Section F.2.

Provider Education and Training

During our initial meetings with providers, AmeriHealth Mercy will educate providers on all applicable procedures and review the Provider Manual, including the procedure to request an authorization of services. Providers will be instructed to contact AmeriHealth Mercy to request authorizations for ongoing services for the following individuals:

- Members that are assigned to them
- Members who have been receiving treatment from them

Upon request from a provider, our employees will enter an authorization and/or claim payment instructions for the medically necessary services. We will also make this information available on our Provider Portal. Provider training will also include sharing information on the services available to assist members in transitioning care through our Integrated Care Management department and how to contact the department.

In addition to entering authorizations and/or claim payment instructions for out-of-network providers for continuation of care needs, we refer out-of-network providers to our provider contracting area to inquire

about their interest in joining the network. We also make ourselves available to providers via telephone to discuss any issues regarding service authorization, referrals, or continuity of care issues.

Member Communication

AmeriHealth Mercy will communicate with our members in a number of ways to help them with transition of care related matters, referrals or other issues. Our printed Member Handbook outlines the procedures for transitioning care and the steps to take if members are receiving care from an out-of-network provider. The Member Handbook and instructions are also available on our Member Portal. Finally, our Customer Service team will make welcome calls to new members within 14 days of receipt of enrollment (21 days during the phase-in implementation), which will include information on how to obtain assistance in transitioning their services. As part of the initial Welcome Call, the Customer Service Representative will assist the member with completing the New Member Assessment, which includes questions on current conditions and ongoing care and services. AmeriHealth Mercy will enter information gleaned during the call and the results of the New Member Assessment into the information system for review and action by our Integrated Care Management team.

In an effort to understand the communications preferences of Medicaid recipients in Louisiana, AmeriHealth Mercy conducted focus group research with Medicaid recipients in Baton Rouge, Metairie (New Orleans) and Shreveport, Louisiana in the fall of 2010. 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. Perhaps surprisingly, only one of the nearly100 research participants indicated they did not have access to electronic communication via either a smart phone or computer.

F.2: Case Management

F.2 Describe your approach to CCN case management. In particular, describe the following:

- *Characteristics of members that you will target for CCN case management services;*
- *How you identify these members;*
- *How you encourage member participation;*
- *How you assess member needs;*
- *How you develop and implement individualized plans of care, including coordination with providers and support services;*
- *How you coordinate your disease management and CCN case management programs;*
- *How you will coordinate your case management services with the PCP; and*
- *How you will incorporate provider input into strategies to influence behavior of members.*

AmeriHealth Mercy's Integrated Care Management (ICM) program is a holistic solution that uses a population-based health management program to provide comprehensive care management services. This fully integrated model allows members to move seamlessly from one component to another, depending on their unique needs. From this integrated solution AmeriHealth Mercy will deliver and coordinate its case and disease management services.

Our model incorporates a member-based decision support system that drives both communication and care plan development through a multidisciplinary approach to management. The ICM process includes reassessing and adjusting the care plan and its goals as needed. AmeriHealth Mercy uses leading technology to integrate our medical management departments and functions, including pharmacy management, informatics and operations.

AmeriHealth Mercy's ICM team will include nurses, social workers, Care Connectors, clinical pharmacists, plan medical directors, primary care practitioners (PCPs), specialists, members and

caregivers, parents or guardians. This team will work to meet our members' needs at all levels in a proactive manner that is designed to maximize health outcomes.

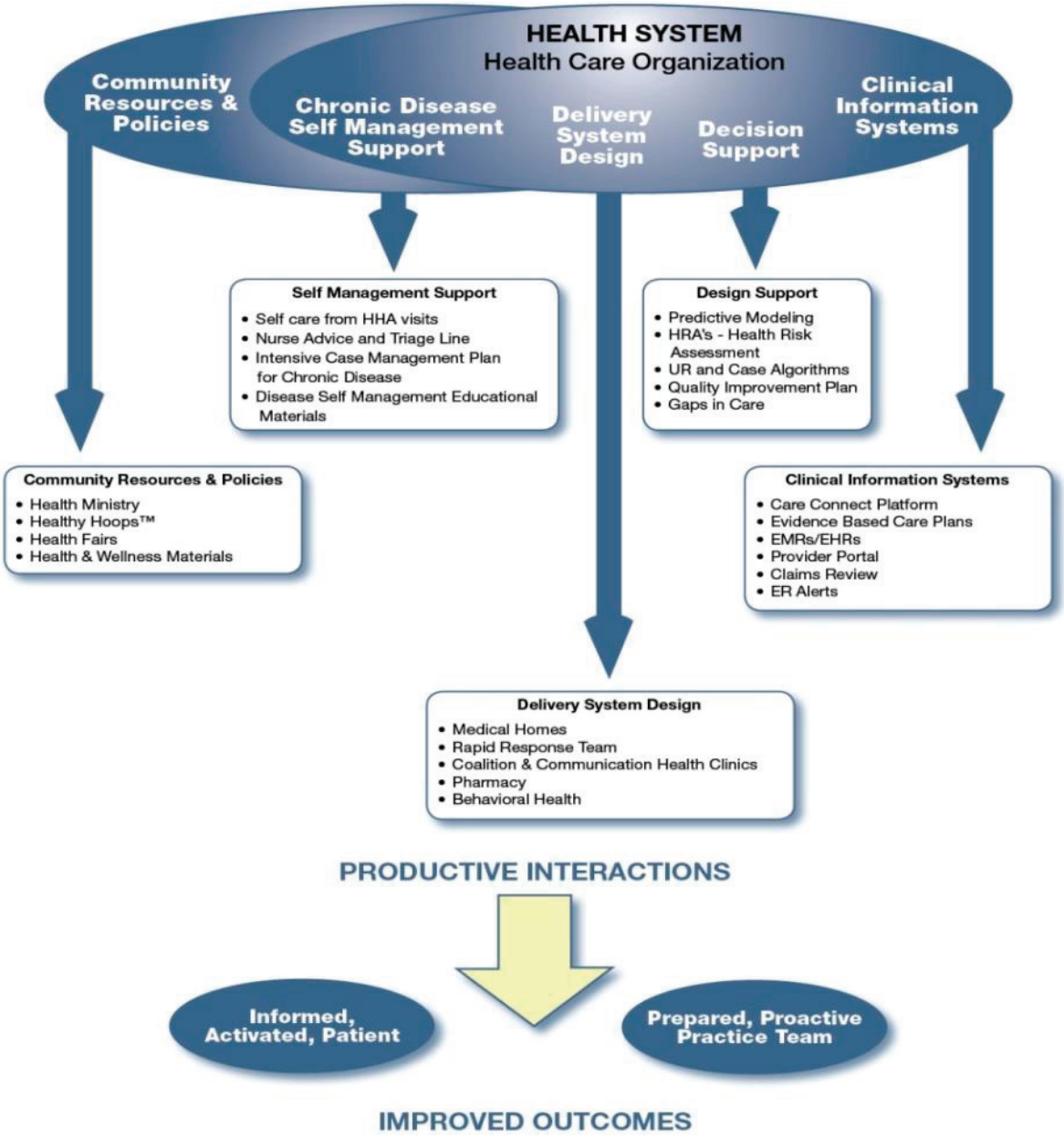


Figure 1: AmeriHealth Mercy's Care Management Model

Characteristics for Targeted Members

The ICM program provides specialized services that support and assist members with the medical, behavioral and/or social issues that impact their quality of life and health outcomes. Identified issues/diagnoses that result in a referral to the ICM program include, but are not limited to:

- Multiple diagnoses (three or more actual/potential major diagnoses)
- Risk score indicating over- or under-utilization of care and services
- Pregnancy

- Pediatric members requiring assistance with EPSDT services
- Pediatric members in, or receiving, foster care or adoption assistance
- Infants receiving care in the NICU
- Members with dual medical and behavioral health needs
- Members who are developmentally or cognitively challenged
- Members with a special health care need
- Members with chronic diseases including:
    - Heart Failure
    - Diabetes
    - Asthma
    - Chronic Obstructive Pulmonary Disease
    - Sickle Cell

Integrated Care Management

There are five core components to our Integrated Care Management (ICM) program: Pediatric Preventive Health Care, Episodic Care Management, WeeCare (Maternity Management), Complex Care Management (CCM), and Rapid Response. Each of these is summarized below.

Pediatric Preventive Health Care

Described more fully in Section I, the Pediatric Preventive Health Care Program (PPHC) is designed to improve the health of members under age 21 by increasing adherence to Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program guidelines. We accomplish this by identifying and coordinating preventive services for these members. The PPHC combines scheduled written and telephonic outreach with state-of-the art informatics that provides point-of-contact notification of EPSDT needs to employees and providers.

Episodic Care Management

The Episodic Care Management (ECM) program coordinates services for new adult and pediatric members of the plan and existing members with short-term and/or intermittent needs who have single problem issues and/or co-morbidities. The Care Manager supports members in the resolution of pharmacy, DME and/or dental access issues, transportation needs, identification of and access to specialists, or referral and coordination with behavioral health providers or other community resources. Care Managers perform comprehensive assessments, address short-term and long-term goals, and develop a plan of care with input from the member and the physician(s). The ECM team has both RN and MSW Care Managers. ECM employees provide support for regulatory and contractual requirements by serving as a contact for DHH employees, members and providers.

WeeCare (Maternity Management)

Described more fully below, the WeeCare (maternity) Program is managed by a dedicated team of Care Managers and Care Connectors. The WeeCare team outreaches to pregnant members and engages them into the program based on internal and external assessments that stratify them into high- and low-risk categories. Care Managers coordinate care and address various issues throughout the member's pregnancy and post-partum period, including dental screenings and depression screenings. Members assessed as low-risk receive information via mailings with access to a Care Manager as necessary. Members identified as high-risk are managed by the plan with a team of both Care Managers and Care Connectors.

Complex Care Management

Members identified for Complex Care Management (CCM) receive comprehensive and disease-specific assessments, and reassessments, along with the development of short-term and long-term goals and an individual plan of care, created with input from the member/caregiver and the physician(s). The CCM

process includes reassessing and adjusting the care plan and its goals as needed. Care Connectors are assigned tasks to assist the member with various interventions under the direct supervision of the Care Manager. Care Managers coordinate care and address various issues including but not limited to: pharmacy, DME and/or dental access, assistance with transportation, identification of and access to specialists and referral and coordination with behavioral health providers or other community resources. The Complex Care Management team contains both nurse and social worker Care Managers.

Under the direction of the Louisiana-based Medical Director, the Care Coordination Director (Medical Management Coordinator) and Care Coordination Manager (Case Management Administrator/Manager) oversee employees providing ICM services in the plan's offices located in Baton Rouge. AmeriHealth Mercy believes strongly that health care is local and therefore values the involvement of individuals throughout the local area. AmeriHealth Mercy will make every effort to recruit and hire employees from Louisiana for care management positions.

Rapid Response Team

An important component of the ICM model, the Rapid Response (RR) team was developed to address the urgent needs of our members and to support our providers and their staff. The RR team consists of registered nurses, social workers, and non-clinical Care Connectors.

There are three key service functions performed in the RR unit:

Inbound Call Service – Members and AmeriHealth Mercy providers may request RR support via a direct, toll-free Rapid Response line. Referrals to RR will also be received through many sources, such as Customer Services, pharmacy services, utilization review, and provider services. The RR toll-free number will be provided as a contact point for all member mailings and automated messaging, encouraging members who need additional support or information to call. The number will also be publicized to providers through provider newsletters, provider orientation and interactions between the provider relations employees and the provider.

Outreach Service – Outreach activities include telephonic survey or assessment completion and support of special projects or quality initiatives. RR employees also initiate follow-up calls to members recently discharged from the hospital and members who contacted the 24-hour Nurse Line the previous day.

Avoiding Readmission

S is a 62 year-old Spanish-speaking female diagnosed with metastatic cervical cancer. A bilingual RR Care Connector contacted S the next day to review her discharge instructions, verify that her home health care was in place, that she had a follow-up medical appointment and to identify any barriers to following her plan of care.

S's daughter was providing some of her care. The daughter indicated that S had her new pain medication, that the home health nurse had visited and established a visit schedule and that the wound care supplies were delivered. However, the daughter was in need of irrigation syringes and a drainage bag for her mother's care. The Care Connector contacted the equipment company to arrange for the missing supplies and marked S's case for a follow-up call to check on the supplies and S's pain control.

During the follow-up call, the Care Connector uncovered that the additional supplies had not arrived. After several unsuccessful calls to the equipment vendor, the Care Connector arranged for the home health nurse to deliver the supplies.

Care Management Support – Care Connectors support Care Managers by completing tasks and reminder calls in support of the individualized plan of care. These include appointment scheduling and reminders, transportation support, member educational mailings, and other administrative tasks assigned by Care Managers.

Care Managers are also part of the RR unit and provide care management services for members with urgent health concerns that are clinical in nature. Calls are triaged by the Care Connector, who involves the Care Manager when indicated by the urgent needs assessment or clinical situation.

Rapid response employees are trained to assist members in investigating and overcoming the barriers to achieving their health care goals. Staff can address questions concerning how to obtain medications, supplies or medical equipment, offer assistance in finding a PCP or specialist physician or how to get help with making physician appointments. Both Care Managers and Care Connectors are well informed of available community services and are available to assist with the application process and follow-through until service delivery.

Several services overlap all five core components. Each component includes targeted interventions for chronic conditions (detailed in Section E), special needs populations and EPSDT-eligible populations. Additionally, all of the core components coordinate and collaborate with the Rapid Response (RR) team. Data analysis and reporting are an integral part of every aspect of ICM, from population identification through evaluation and effectiveness monitoring. In order to maximize the efficient use of resources, the ICM program balances services provided by vendors and community agencies with those provided by AmeriHealth Mercy employees.

Identifying Members

The ICM program is driven by the use of predictive modeling software to identify AmeriHealth Mercy members that are appropriate for the various components of the program. However, members are also identified through referrals from providers, requests from members and other health plan activities. Each of our identification processes are summarized below:

- Data mining and predictive modeling - AmeriHealth Mercy will use software algorithms provided by DxCG, Inc. (Boston, MA), along with claims and pharmacy data. The data will be analyzed to identify individuals who are expected to have higher-than-average health care needs in the future. Prospective risk scores will be used to trigger assessments for different care management programs. Predictive modeling will be run on current claim data as well as historical data, as available. We will also use data such as Logical Observation Identifiers Names and Codes (LOINC®) for pregnancy and drug therapy management (DTM) algorithms as other sources of member identification. Commonly found in laboratory billing data, LOINC data facilitate the exchange of clinical results, such as maternal risk conditions. Detailed information on the our predictive modeling tool can be found in Section E.
- New member assessment – AmeriHealth Mercy will collect assessment data on members who are new to the plan to identify ongoing conditions and potential health risks. Based on the assessment responses, members will be triaged into the appropriate care management program.
- Provider referrals - Providers will be encouraged to refer members to the ICM program. Information provided during the initial provider training program, as well as ongoing information given to providers, will explain the services available through the ICM program and encourage referrals.
- Member requests – Members can contact the ICM department to request care management services.
- Health plan activity - Members are also referred to the ICM program through internal processes such as utilization management, provider service calls and member service calls.

Enrollment for all levels in the Integrated Care Management program is automatic, with the ability for the member to opt out.

Encouraging Member Participation

In our 26-year history working with Medicaid populations, we have found that establishing a trusting relationship with members is the cornerstone in helping them become involved in their health care and adopt recommended lifestyle changes. Our Care Managers and other employees will work on a one-to-one basis with members to help them become comfortable and active in their own care. We will discuss their primary concerns, review assessment findings and utilization data, identify goals, and then develop a plan that addresses all of these elements. The member becomes an active participant in the creation of the plan, and therefore has a stake in adhering to the recommended course of action.

One key to influencing a member's behavior is establishing a trusting relationship between the member and the care management team. Through this relationship-building process, the member will become comfortable and active with the management of his or her own care. In an attempt to build a collaborative relationship, the Care Manager will begin by addressing the primary concern of the member. The first step for each situation is to identify the member's biggest concern with his/her current health state. That concern may not be related to the issue identified in the member's assessment findings and utilization data.

Often, the Care Manager will ask the member to identify personal goals (as opposed to health care goals). By focusing on the member's concerns, like wanting to walk a child to school or go dancing with friends, the Care Manager can address items like nutrition for healing of a foot wound or proper use of asthma medication. Once plans are in motion to address the member's personal goal, the Care Manager will work toward addressing additional issues revealed in the assessment findings and utilization data. For each intervention, the Care Manager will focus the discussion on how the particular intervention will benefit the member.

T is a 38-year old woman with heart failure, coronary artery disease, high blood pressure, hyperlipidema, obesity, lupus anticoagulant with anemia, agoraphobia and anxiety. She has history of multiple (9) myocardial infarctions and stents, deep vein thrombosis and pulmonary emboli with a Greenfield filter. She takes 14 medications, including an anticoagulant and has a Methicillin-resistant Staphylococcus aureus infection on her buttocks. T states that she has a lot of stress in her life and that she helps her 17-year old daughter care for the daughter's 8-month old child. T is easily overwhelmed. She recently stopped smoking. T has a history of non-compliance with specialist and Primary Care provider appointments, lab work and diagnostic tests due to her agoraphobia and anxiety.

The Care Manager began by establishing a rapport with T, slowly helping her through her fears. On several occasions, T was in tears while talking with the Care Manager, sobbing that she doesn't like living in fear of going out of her house and wants help. The Care Manager arranged for Quest Lab to do blood draws at the home to foster compliance with the ongoing blood tests necessary to manage T's warfarin (anticoagulant) medication.

The next goal the Care Manager worked on with T was going to the primary physician's office. The Care Manager contacted the office and explained T's fears and potential for anxiety attacks along with ways the office employees could assist to make the visit less threatening for T. The Care Manager asked the office to keep T in less populated areas of the office, having her wait in an examination room, instead of the waiting room. Arrangements were made for T to have the first appointment of the day, to minimize the number of other patients who would be in the office.

T successfully completed the visit, her first in years. Next, T and the Care Manager are working on a visit to the specialist.

For members who can actively participate in the plan, the Care Manager will assign the member to a specific role in the care plan. For instance, the Care Manager may ask a member with heart failure to call each week and report his/her weight. During the call, the care management team supports the member by positively reinforcing his/her activities, helping to instill a sense of accomplishment. These interactions often help members maintain an open, active dialogue with Care Managers that leads to improved care.

Although the primary method of service for the ICM program is telephonic outreach, assessment and intervention, Care Managers and Care Connectors will be able to communicate with members via secure email or text messaging, depending on the member's preference. ICM employees make outreach calls to the member and/or authorized member representative, as indicated, and collaborate with the PCP and specialist to develop an individualized plan of care. We use outreach letters and home visits, as appropriate, to engage members and address and resolve issues. ICM employees participate in interdisciplinary team meetings that will include other employees, members, practitioners, inpatient and outpatient providers, community resource representatives, community behavioral health providers, and other county and/or state entities from which the member may be receiving services. These meetings ensure the member-specific treatment plan addresses all issues impacting a member's access to appropriate care and services.

DHH approved care management brochures and member welcome letters will include information on the Patient-Centered Medical Home and the benefits of participating in a medical home. Care Managers proactively facilitate PCP/Medical Home appointments for members to ensure regular evaluation by the PCP. Appointment dates are entered into the member's care plan, automatically setting up work queue activities for the Care Manager and RR Care Connector to remind the member of the appointment, verify transportation arrangements and assess other barriers that may keep them from making the appointment.

AmeriHealth Mercy also has experience using low-dollar member incentives, such as movie tickets and $5 phone cards to encourage member participation. Through the incentive programs proposed in Section S, we will work with DHH to leverage this experience for the AmeriHealth Mercy membership.

AmeriHealth Mercy's program won the Medicaid Health Plans of America (MHPA) 2011 Innovations Award for successfully reducing inpatient admissions and readmissions.

In locations where we have a high volume of members, we will seek provider partners willing to embed a Care Manager in their office. This approach was successfully implemented as a pilot program in our Pennsylvania affiliate, and Health Affairs chose the program for presentation to the Centers for Medicare and Medicaid Services during November's Health Innovations Conference. The pilot, which was also selected by the Medicaid Health Plans of America (MPHA) for MHPA's 2011 Innovation Award, significantly reduced inpatient admissions and readmissions.

Louisiana State University Health System (LSU) and AmeriHealth Mercy are discussing an arrangement that places a Care Manager on site at LSU's Bogalusa Medical Center in Washington Parish. Created by the merger of the public St. Tammany Charity Hospital and the private Bogalusa Community Medical Center, Bogalusa Medical center hosts a rural family medicine residency training program and recently expanded their Family Medicine Center. We are exploring similar opportunities with Rene Ragus, Director of Special Projects for the Franciscan Missionaries of Our Lady Health System and Les Tompkins, Louisiana Regional Director of Managed Care for CHRISTUS Health.

AmeriHealth Mercy will work with the practice to provide onsite care coordination services for members. The Care Manager will follow up with members in between office visits to reinforce key elements of the plan of care; assist the practice to reach out to members who have not been in for routine care and provide the practice with aggregate and member-specific data on performance with respect to clinical practice guideline recommendations. In addition, the Care Manager will connect the member to programs and community resources that address the member's needs.

Assessment

We stratify members using a combination of predictive risk score and assessment findings. Members with predictive risk scores greater than 2.0 (twice the population average) or those with an unstable medical, behavioral health or support situation are assigned to the high-risk group.

Members identified for the high-risk tier undergo a more comprehensive holistic assessment with additional focus on any identified problem areas. The assessment incorporates subjective findings from the member, such as perception of health (utilizing the SF-12 tool) and level of activation (using the Patient Activation Measure [PAM]) which screens for functional level, depression and literacy, with input from treating providers and findings from review-of-claim and utilization activity. The assessment includes health literacy level, lifestyle choices (such as tobacco use, alcohol and drug use, and weight management), cultural and linguistic needs, and contact preferences. The topics addressed through our assessment are listed below.

Table 2: AmeriHealth Mercy Comprehensive Assessment Topics

Health Problems	Current health problems Length of time Knowledge related to cause and treatment
Medications	Medications used Dose/frequency Understanding of reason for the medication
Other Treatment	Cultural/traditional or home health remedies Other medical treatments
Medication Barriers	Reasons medication not taken Assistance needed for medications
Awareness	Medication/condition alert bracelet/card Emergency support system
Physician Care	How often sees doctor Date of next appointment Plan if not feeling well
Hospital/ER use	History of use Reason for event
Functional status	Problems with daily activities Mobility limitations
Health literacy	Problems reading or understanding information
BMI	Height/weight Frequency monitored
Nutrition	Type of diet Ability to adhere to diet
Substance Use	Tobacco use Drug use Alcohol use Frequency of each
Lifestyle	Exercise frequency Cultural practices
Health care access	Available transportation Barriers to care
Behavioral Health	Depression Anxiety Suicide risk Trauma exposure Autism (children)
Cognitive Assessment	Care Manager assessment of cognition

Condition-Specific: Asthma COPD Diabetes Heart Failure Pregnancy Sickle Cell	For each identified target condition: • Understanding of condition • Adherence to recommended clinical guidelines • Lifestyle factors • Self-management skills

AmeriHealth Mercy will also screen high-risk members over age five for behavioral health conditions using a tool based on the Adults Needs and Strengths Assessment (ANSA; Lyons 2009) or the Child and Adolescent Needs and Strength (CANS; Lyons, 2004). Adults are screened for depression, anxiety, trauma exposure, suicide risk and substance abuse. Children and adolescents are screened for depression, disruptive behavior, trauma, substance abuse, autism and suicide risk. A detailed assessment is performed for any item in the assessment that screens positive.

Copies of sample assessments can be found in Section E.

Stratification

Members with controlled chronic conditions and short-term needs are assigned to the low-risk group. The low-risk group receives educational materials in the mail, access to the 24/7 Nurse Line and on-demand care management services through the Rapid Response team. Members without chronic conditions will receive wellness and health promotion services, in addition to support from the Rapid Response team and 24/7 nurse line.

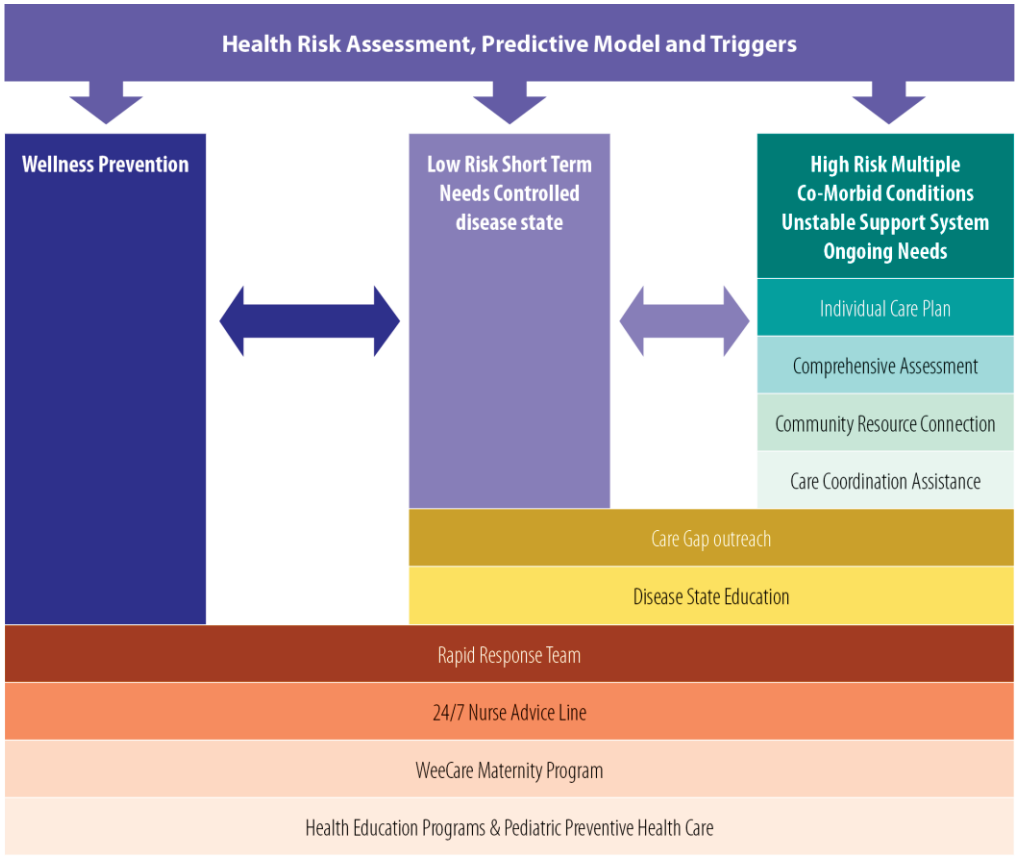


Figure 2: Care Management Stratification Levels

AmeriHealth Mercy will submit quarterly reports to DHH, which provide the following information:

- Number of members identified with potential special health care needs utilizing historical claims data
- Number of members identified by PCP's with special health care needs
- Number of members assessed for case management during the quarter
- Number of members assessed for case management who were referred to a Case Manager
- Number of members who had treatment plans completed during the quarter
- Number of members with assessments resulting in a referral for Case Management

Individualized Plans of Care

In developing the plan of care, the Care Manager will integrate assessment data, physician findings, and input from the member and/or authorized family members or guardians, specialists or subspecialists and other involved health care and community-based service providers, to form an overall picture of the member. Care plans will be structured around evidence-based guidelines and barrier-resolution strategies designed to optimize the member's health through direct intervention and development of self-management skills. The plan of care addresses medical, behavioral and social service issues, consistent with the PCP's clinical treatment plan and medical diagnosis. As appropriate, the plan of care will include interventions to refer potentially eligible women to the Women, Infants and Children (WIC) program and provide any required diagnosis or medical information.

AmeriHealth Mercy will identify short- and long-term goals, expected completion dates and interventions for each problem. Activities to complete the interventions will be assigned to the appropriate member of the care team. A summary of the plan of care is sent to the member/caregiver and the primary care physician.

Addressing Co-Morbid Behavioral and Physical Health Needs

TS is a 16 year old with a history of childhood obesity (500lbs), sleep apnea and clinical depression secondary to her obesity. She is the oldest of three children residing with her mother with no active involvement from her father. The mother has a history of substance abuse and was not very supportive in previous plans of care.

TS was hospitalized three times in the previous year for sleep apnea complicated by her obesity. During her multiple hospitalizations, TS increasingly demonstrated signs of depression and suicidal thoughts. Identified for Care Management, a Care Manager at our affiliated Pennsylvania plan began working with the mother, PCP and behavioral health provider.

Interdisciplinary meetings with the behavioral health provider revealed that the participant had tried and failed multiple weight loss initiatives over the past three years, contributing to her depression. As a result of the multidisciplinary meetings between the medical and behavioral health providers, a plan to send the participant to a facility that would concentrate on weight loss, monitor and treat her sleep apnea and also provide psychological interventions for her depression was developed.

TS is now 17 years old. She spent 14 months in the facility, losing over 250 pounds, stabilizing her sleep apnea and is now attending ongoing outpatient treatment for weight management and depression. TS returned to school in a traditional setting and has not had any further hospitalizations for sleep apnea or depression.

Case and Disease Management Integration

As described above and in Section E of this proposal, AmeriHealth Mercy uses a blended Integrated Care Management (ICM) model that combines case and disease management into a holistic approach. A "blueprint" is developed for each targeted condition. The blueprint outlines the population management approach and metrics used to manage that condition. Each blueprint includes the following sections:

- Importance – the relevance of the condition to the membership
- Clinical guideline – the guideline on which the program is based

- Program goals – specific goals related to the condition
- Outcome measures – specific metrics used to evaluate the program's success
- Stratification – logic used to stratify members into low- and high-risk groups
- Interventions – program interventions by stratification level
- Priority interventions – focus interventions for inclusion in all care plans and assessments
- Educational materials/resources – materials available for employees to use in providing disease-state education
- Innovations – synergistic initiatives that support the program goals
- Provider connection – method for involving provider in the program
- Internal education – list of internal education programs for employees
- External education – list of member and provider education related to program goals
- Reporting – list of dates program updates and evaluation provided for review

A comprehensive evaluation of each condition management program is conducted annually as part of the ICM program evaluation.

AmeriHealth Mercy's blended ICM program will integrate physical health, behavioral health and social/environmental aspects of the member's care into one plan of care. The care management team includes individuals with backgrounds and expertise in behavioral health, physical health and social work. The member's level of health needs is evaluated as part of the assessment and triage process, utilizing a four-quadrant approach. Figure 3 below outlines the triage approach and resulting resource assignment.

Figure 3: Integrated Care Approach

WeeCare Maternity Management

Our WeeCare program is managed by a dedicated team of Care Managers and Care Connectors that assist expectant mothers. Built on the Prenatal Care guidelines from the Institute for Clinical Systems Improvement, the WeeCare program is dedicated to promoting healthy behaviors and controlling risk factors during pregnancy, with the goal of delivering a healthy, full-term infant.

Identification

AmeriHealth Mercy will use a variety of mechanisms to identify and promptly engage members who are pregnant as early as possible in their pregnancy. All new female members are asked about their pregnancy status as part of the new member assessment, and during every call made to or by the Rapid Response team.

AmeriHealth Mercy will also analyze claims data from laboratories for Logical Observation Identifiers Names and Codes (LOINC) that indicate pregnancy identifiers. LOINC are a data set of universal identifiers for laboratory and other clinical observations that facilitate communication of clinical results. LOINC occur in the claims data when testing is done at the onset of pregnancy and when complications occur. This weekly report is used to identify newly pregnant members and to identify those whose risk status has changed.

As discussed in Section S, AmeriHealth Mercy will implement a member incentive program for pregnant women, part of which is designed to encourage early prenatal care, which will aid in our ability to identify members for our WeeCare program. In addition, AmeriHealth Mercy will highlight the need for early prenatal care in member communications including the Member Handbook and newsletters. During community events, we will educate our members on the need for early care. We also give away pregnancy test kits during these events, which contain a message asking AmeriHealth Mercy members to call our toll-free WeeCare phone number, especially if the result of the test is positive.

> *"Select Health's [AmeriHealth Mercy's South Carolina affiliate's] efforts to improve health outcomes for infants across the state have made them a significant partner in South Carolina's efforts to reduce infant mortality."*
>
> - *Doug Bryant, Former Commissioner, South Carolina Department of Health and Environmental Control*

One of the programs we will implement to reach expectant moms is our Community Baby Shower. The program helps identify pregnant members who have not yet started prenatal care, by providing a venue, such as a baby shower, to talk to the expectant mother in person. One of AmeriHealth Mercy's affiliate plans, Keystone Mercy Health Plan, recently won the Outreach Award from the Medicaid Health Plans of America for this program. Keystone Mercy's Community Baby Shower program was recognized for proactively connecting pregnant African-American women with health care providers, Care Managers and community organizations.

AmeriHealth Mercy will also evaluate a provider incentive program in use at its affiliated plans for use in Louisiana. With the early identification incentive, OB/GYN providers receive an additional payment for submission of an OB Needs Assessment Form to the plan outlining the expectant mother's health status, pregnancy risks and expected delivery date. The information on the form allows plan employees to identify and get involved with high-risk pregnancies as early as possible.

Stratification

As we outreach to pregnant mothers and collect information for internal and external assessments, we group the expectant women into high- and low-risk categories. Members with any of the following are considered high-risk:

- Asthma
- Spontaneous bleeding
- History of preterm labor
- Pre-eclampsia or history of pre-eclampsia
- Cerclage
- Diabetes (all types)
- Domestic abuse
- Drug or alcohol use
- High blood pressure

- HIV
- Lupus
- Multiple gestations
- PIH (pregnancy induced hypertension)
- Placentia previa
- Sexually transmitted disease
- Smoking or tobacco use
- Thromboembolitic disease
- Unstable living situation
- Mental/behavioral health condition (including depression)

In addition, AmeriHealth Mercy will use a weekly report combining the LOINC analysis, discussed above, with pharmacy files to identify changes to the woman's risk level. The system uses a combination of age, LOINC, and medications, identifying conditions such as gestational pregnancy. It is important to note that the highest risk factors for a preterm delivery are prior preterm delivery, shortened cervix, and preterm labor, none which can be identified through pharmacy and LOINC mining.

CR was pregnant with a history of a delivery at 25 weeks in 2007 of a baby who died due to extreme prematurity. When the WeeCare nurse called to assess CR, the Care Manager identified C as a candidate for 17 Alpha Hydroxyprogesterone Caproate (17P) injections. The nurse talked CR and contacted the provider to explain the situation and suggest that CR be considered for 17P therapy. The WeeCare nurse continued to work with CR through her pregnancy, coaching her on healthy pregnancy behaviors and educating her on the immunizations and screenings her newborn would need. CR delivered a healthy 6-pound, 12-ounce infant at 38+ weeks.

In April 2010, CR became pregnant again and called her WeeCare nurse. CR had a different obstetrician for this delivery. The WeeCare nurse contacted the physician, explained CR's history and facilitated the order for 17-P injections. CR delivered at 37wks and the child weighed 7-pound, 1 ounce.

Interventions

Members assessed as low-risk receive educational information via mail and phone reminders with access to a Care Manager as necessary. Members identified as high-risk are managed by the plan with a team of both Care Managers and Care Connectors. Care Managers coordinate care and address various issues throughout the member's pregnancy and post-partum period. All members receive reminders about dental screening and are screened for depression in addition to education on healthy pregnancy habits, smoking and alcohol cessation, choosing a pediatrician and the importance of immunizations and infant medical care during the first two years of life.

AmeriHealth Mercy will also promote the no-cost Text4Baby service to our pregnant members. Text4Baby provides ongoing prenatal education reminders in English and Spanish via text message direct to the pregnant woman's phone. Nationally recognized, Text4Baby is supported by CMS, as well as leading maternal child health organizations.

Pregnant? New Mom?
Text BABY to 511411 for Free Info

In addition, AmeriHealth Mercy will work with DHH to promote our moms2b social media program. The moms2b Club utilizes a social media and mobile technology platform to promote prenatal and post-partum care. Through a partnership with a mobile phone service provider, OB/GYN providers, community partners and the WeeCare maternity program, moms2b will engage high-risk pregnant members to keep them connected to WeeCare Care Managers and their available services.

moms2b

An offshoot of the WeeCare program, the Neonatal Intensive Care Unit (NICU) Graduate program identifies and follows infants who have a hospital stay involving NICU care. These infants are at risk for

an increased incidence of readmission due to their medical, developmental and psychosocial needs. The NICU Graduate Care Manager works with the family during the hospital stay and follows the member for up to six months post discharge to ensure all barriers in care are addressed. The Care Manager collaborates with the UM nurse, maternity Care Manager, and hospital Care Manager to engage member's parents during the newborn's inpatient stay and post discharge. The NICU Graduate program draws on the expertise of a maternal fetal medicine physician employed as a Medical Director by AmeriHealth Mercy.

Coordinating Case Management Services with the PCP

The PCP is the cornerstone of the member's care coordination and delivery system. Our ICM employees will contact each PCP during the member's initial enrollment into the program, and as part of the comprehensive assessment and treatment plan development process. We will create the member's treatment plan using the PCP's treatment plan as a foundation. This allows us to complement the PCP's recommendations to develop an enhanced and holistic treatment plan specific to the ICM program. The ICM Care Manager will remain in close communication with the PCP during the implementation of the treatment plan, should issues or new concerns arise.

Care management employees will contact all the member's key/current providers, including specialists and behavioral health clinicians, involved with the member's care to determine the best process to use to support the member. This process helps to reduce any redundancies and identifies areas to coordinate and support efficiencies. We will engage key providers and provide them with the opportunity to be part of the development of the member's treatment plan.

AmeriHealth Mercy clinical employees and Dr. Michael Kaiser, Chief Medical Officer of LSU, discussed other possible areas of coordination between AmeriHealth Mercy and the physician practices. Dr. Kaiser identified medication adherence as an area where AmeriHealth Mercy can assist LSU and other physician practices. Through the Member Clinical Summary, AmeriHealth Mercy will give LSU providers access to DHH's member-level prescription data. Dr. Kaiser affirmed that physicians currently face a barrier when managing a patient's medication because the physician cannot confirm if the patient is receiving medications from another physician or which medication prescriptions the patient actually filled. Through the AmeriHealth Mercy Provider Portal, the physician and office employees can retrieve a list of medications and the date the prescription was filled. More information on AmeriHealth Mercy's Member Clinical Summary can be found in Section E.

Incorporating Provider Input into Strategies to Influence Member Behavior

AmeriHealth Mercy routinely solicits provider feedback and input regarding our ICM program. At the member level, Care Management employees routinely contact providers to gain their perspective on the member's needs and to understand approaches that have worked or not worked with the member in the past. The information gathered is used in formulating the member's plan of care and guides the approach used with the member.

In addition, AmeriHealth Mercy will implement Partnership Councils in Louisiana as a forum to give providers a voice in our programs. Through the Councils, providers and other stakeholders offer input and direction regarding AmeriHealth Mercy's policies, procedures and programs, including mechanisms AmeriHealth Mercy can use to influence member behavior. For example, a similar program by one of our plans used provider input to design a program for encouraging adolescent members to complete well care visits. (Movie ticket vouchers were given to primary care physician offices who distributed the tickets to the adolescents at the end of the office visit). This program helped increase adolescent well visit rates from 49.54% to 60.83% in the year it was in place.

We also conduct an annual Provider Satisfaction Survey, collecting feedback on how we can improve the effectiveness of our program. As part of the provider questionnaire, we solicit input on methods we can implement to improve the program from all perspectives, including influencers of member behavior.

We have used provider feedback extensively to shape our Care Gap strategy, described in Section E. Care Gaps are services recommended by nationally-accepted clinical practice guidelines for which there is no claim evidence of completion. Providers are alerted to these "gaps" when they perform an eligibility check through our Provider Portal, and through the Member Clinical Summary and Provider Reports available on the portal. Providers use this information to reinforce the need for these important services during the office visit. Their feedback has helped us improve the program to display only the critical information needed to effectively intervene with the member.

Integrating Behavioral Health Provider Feedback

We spoke with behavioral health care providers throughout the state to introduce AmeriHealth Mercy and explore opportunities to collaborate while assessing behavioral health service delivery capabilities. As part of these discussions, we focused on the integration of physical and behavioral health and how important it was to treat the patient in a holistic manner. Since AmeriHealth Mercy's PCP panel will be responsible for behavioral health screening and referrals, we understand the importance of obtaining advice from behavioral health providers regarding optimal referral patterns, as well as discussing our behavioral health screening tool that we intend to use to identify depression, anxiety, bipolar and post-traumatic stress disorder.

Behavioral health providers we have met with, include:

- 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
- Barry Chauvin, CEO, Options for Independence
- Judge Calvin Johnson (retired), 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
- National Alliance on Mental Illness, Louisiana Chapter

AmeriHealth Mercy is aware of DHH's intention to introduce a Coordinated Systems of Care program, and we believe that our experience in New Jersey (through our affiliate organization, PerformCare) is extremely relevant and important to Louisiana's stated plans.

F.3: Coordinating Carved-Out Services

F.3 Describe your approach for coordinating the following carved out services which will continue to be provided by the Medicaid fee-for-service program:

- *Dental*
- *Specialized Behavioral Health*
- *Personal Care Services*
- *Targeted Case Management*

AmeriHealth Mercy has extensive experience coordinating care with outside vendors, including dental, behavioral health providers, personal care agencies and targeted case management entities.

Dental

Dental care is important to the health of our members, and although we will not directly manage the benefit, we will have procedures to assess the needs of the member and make timely referrals to the dental vendor.

Our Care Managers will monitor dental services as part of the overall care plan for members. In addition, if the dental vendor is willing to do so, we would welcome the opportunity for seamless collaboration to support the member from a holistic view.

If a member needs help with scheduling dental visits, our nurses, Care Connectors and our Customer Services Representatives will assist in helping the member coordinate care with the dental vendor. We will also assist with arrangements for members who need assistance coordinating anesthesia and other supportive services for members with special needs. In addition to publishing the numbers on the Member Portal, our Customer Service Representatives will be able to provide the member with important numbers related to the dental vendor. In our affiliated health plans, we post links to the dental directory on our website, and will do the same for LaCare members.

One potential collaborative opportunity with dental vendors involves developing a program similar to one we have in two of AmeriHealth Mercy's other Medicaid plans. We worked with the OB/GYN network to raise awareness of and adherence to dental care during pregnancy, engaging a dental vendor to launch a prenatal dental education and outreach program called Smiling Stork. This program is designed to educate physicians and members to teach them that pregnant woman can receive dental care while pregnant. We sent each OB/GYN a letter and Rx reminder pad to use when "prescribing" a dental visit for their pregnant members, as shown in Figure 4. We also provided pregnant members who were in their first or second trimester with educational mailers and follow-up reminder calls to schedule dental appointments. Following the program, we analyzed dental visit activity pre- and post-intervention, which showed significant increases once members had completed the program.

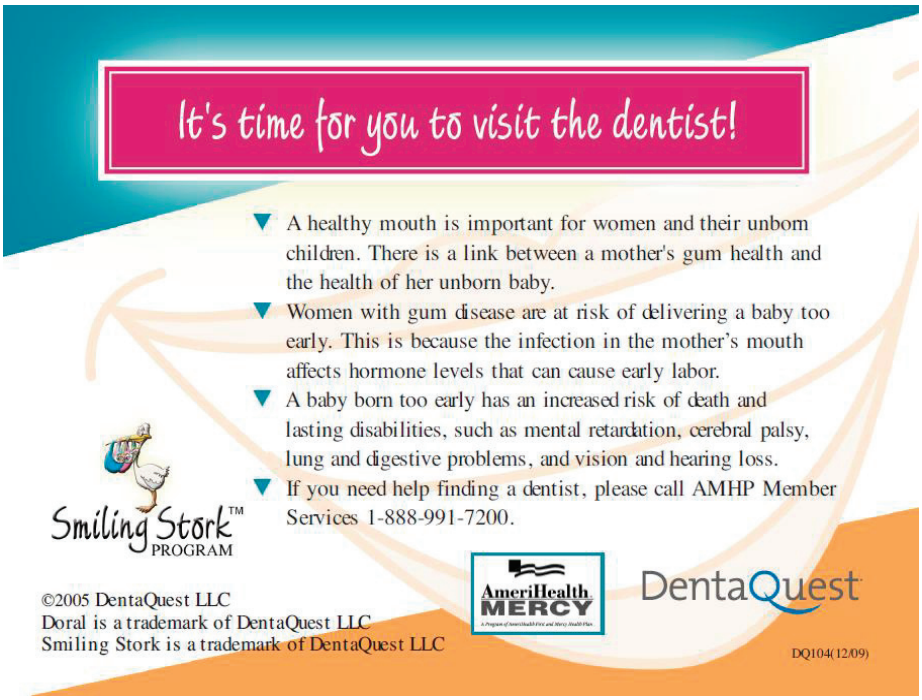


Figure 4: "Prescription" Pad for Dental Care Given to OB/Gyn Practitioners

Figure 5 highlights our analysis of dental visit activity pre- and post-intervention showing significant increases in dental visits for cleaning and treatment in the seven months after the intervention, when compared to the prior year.

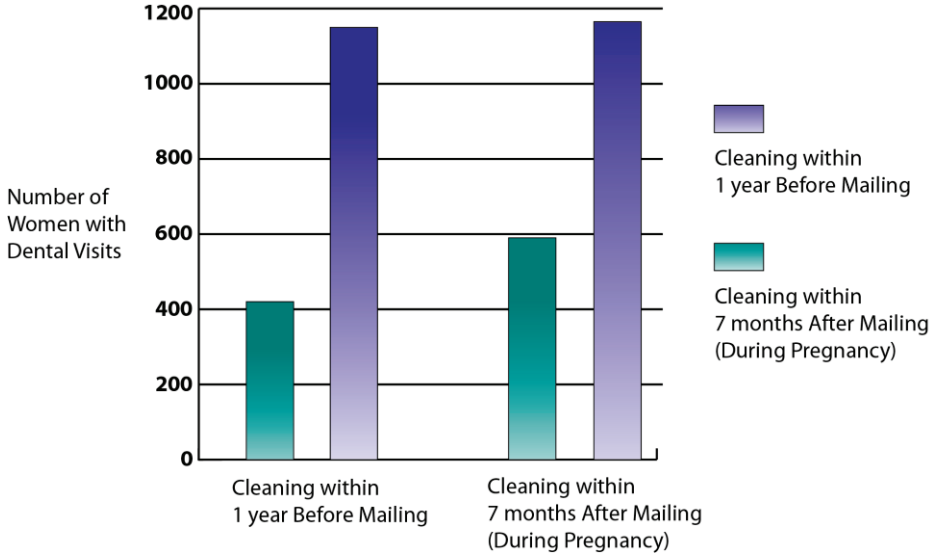


Figure 5: Dental Visit or Cleaning Before and After Mailing

AmeriHealth Mercy would like to discuss with DHH's dental vendor a similar program and coordinating it with our providers and pregnant members.

Behavioral Health Coordination

Similar to the response above related to dental coordination, we will have processes in place to seamlessly interface with behavioral health providers for services not covered by AmeriHealth Mercy. We are committed to working in partnership with the behavioral health community to provide holistic care for the member. We have significant experience coordinating behavioral health services for members in our affiliate plans, working directly with behavioral health providers or with a separately contracted vendor. Our experience in these markets has allowed us to develop a firm understanding of the requirements and procedures for ensuring that members have access to these services.

To address the complex issues surrounding care of members with behavioral health issues, AmeriHealth Mercy's model will draw on the following elements:

- 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
- Integrated software support to facilitate an active ICM 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.

We have already initiated discussion with several behavioral health organizations to identify programs of common interest and benefit to Medicaid members. Details can be found at the end of Section F2, above.

We are also well versed in coordinating with a behavioral health care vendor based on our experiences in Pennsylvania and South Carolina, where most behavioral health services are provided by separately contracted entities. We will be ready to partner with the state's behavioral health vendor, should the behavioral health RFP move forward.

In Pennsylvania, for instance, the administration of behavioral health benefits for Medicaid recipients is contracted to each county. Some counties administer the benefit themselves, while others subcontract it to a Behavioral Health Managed Care Organization. To better serve members with concomitant physical health, behavioral health and pharmacy needs, we have established a number of cross-functional initiatives, including:

- **Co-Management** –We work jointly with the behavioral health entity to create cost-sharing agreements so that appropriate services are delivered without arguments over whether the service is purely "medical" or "behavioral."
- **Behavioral Condition Screening** – Our Care Managers screen members for multiple behavioral health conditions, including depression, anxiety, trauma exposure, suicide risk, substance abuse and autism (for children). We set up referral pathways for members who screen positive to connect them with clinical and behavioral health resources for further assessment and intervention.

Personal Care

AmeriHealth Mercy's Care Managers will work directly with waiver coordinators and personal care agencies assigned to shared participants through a collaborative coordination process. As we identify a member receiving these services, either through the assessment process or historical claim data, we will begin the process of reaching out to the involved coordinators and personal care employees immediately. We will send letters to them introducing the program and our role with the participants, request a meeting and/or conference call to review their processes and policies so that we can support their work with the participant as well.

AmeriHealth Mercy employees have extensive experience coordinating care for children with special needs. For example, our Pennsylvania plan provides services to SSI children placed in residential settings. We work with these facilities to coordinate the delivery of all services provided inside/outside of the facility, and in some instances, the plan is responsible for coordinating and paying for the residential placement. This requires us to be flexible and creative in the way we deliver health care services. As a result, we have:

- Helped identify and recruit primary care physicians to provide on-site primary care for enrollees in these settings
- Coordinated out-of-network care in many instances so as to maintain continuity of care
- Spent considerable time educating these facilities about managed care in general and the plan in particular.

At our Indiana affiliate, Care Managers are often called by the Waiver Coordinator for assistance in resolving an issue.

At the request of a Waiver Coordinator, the Care Manager became involved in the case of CO, a 6-year-old male adopted from foster care, who was born prematurely and had a feeding tube, a tracheotomy and mental retardation. CO was receiving home support services through a waiver Monday through Friday, 6:30 a.m. to 3:30 p.m. The mother had also adopted CO's brother, another special needs child. When the Care Manager contacted the member's mother, she was in tears. She had been told by the Waiver Coordinator that the nursing services were being cancelled, although the waiver case worker did not know why and had been unable to resolve the issue.

The AmeriHealth Mercy Care Manager contacted the agency coordinating the care. When she was unable to make contact, she escalated the issue to the supervisor. Following an investigation into the member's file, the agency determined that at the time of the last review, the case was coded incorrectly, which resulted in a cancellation of the waiver services. The Care Manager was able to have the services reinstated with no break in coverage.

By working collaboratively with personal care agencies, one of our Care Managers was able to quickly reinstate medically necessary home services for this 6-year-old boy.

Targeted Case Management

AmeriHealth Mercy will identify enrollees in the current waiver programs for case management services using the same methodology outlined for non-waiver participants:

- Predictive modeling
- Screening
- Detailed health assessments
- Stratification

During the assessment phase, we will identify recipients on waivers and those already receiving case management services through their current waiver program. The Care Manager, being familiar with the enrollee's health status and needs, will review the services provided by the waiver program and determine if the member has any treatment gaps or duplications in services. A comprehensive, coordinated care plan will be developed in collaboration with the enrollee's PCP and behavioral health provider, when applicable, enrollee/family or enrollee representative, Waiver Case Manager and other service or support providers.

We will establish relationships with the Targeted Case Management agencies serving the Louisiana Medicaid population to facilitate communication and collaboration. In addition, we will work with the agencies to provide the Targeted Case Managers (TCM) with access to Member Clinical Summary and care plan through our Provider Portal. This will allow the TCM to view information on the member's medications, chronic conditions, care gaps, inpatient admissions, emergency room visits and office visits, in addition to key assessment answers and the current plan of care. This type of access worked extremely effectively with the Care Select program operated by AmeriHealth Mercy's Indiana affiliate.

AmeriHealth Mercy will also work collaboratively with Nurse Family Partnership (NFP) in Louisiana, as AmeriHealth Mercy plans do in Pennsylvania and South Carolina, by identifying first time mothers prior to the 28th week of gestation and referring them to this Targeted Care Management program in those parishes in which Nurse Family Partnership is able to provide services. Those members that are identified after 28 weeks gestation, who reside in a parish that is not serviced by NFP, or who have a history of a prior live birth will be identified for engagement in AmeriHealth Mercy's WeeCare maternity program. AmeriHealth Mercy is happy to provide referrals to NFP for eligible members as we understand the importance of an evidence-based maternity care management program and want to use every resource available to maximize our birth outcomes for Louisiana members.

In addition, AmeriHealth Mercy will invite key members from the agencies providing Targeted Care Management and the disability advocacy community to participate in our Member Advisory Council (MAC). The MAC serves as a mechanism for stakeholders to have a voice in AmeriHealth Mercy's programs and policies.

AmeriHealth Mercy recognizes the importance of collaborating with the Taeget Case Managers to effectively serve this population and is committed to working closely with disability advocates in coordinating and communicating about the enrollees we all serve.

F.4: Home Health Services upon Discharge

F.4 For members who need home health services upon discharge from an acute care hospital, explain how you will coordinate service planning and delivery among the hospital's discharge planner(s), your Case Manager(s), your disease management employees member(s), and the home health agency. Further, explain how you will monitor the post-discharge care of enrollees receiving home health services in remote areas.

AmeriHealth Mercy's comprehensive hospital discharge program ensures that members are effectively transitioned after a hospital visit. The program includes outreach, education, patient monitoring, and use of Transition Managers to ensure that members obtain the required care following a hospitalization.

AmeriHealth Mercy will also work with providers during the patient transition, keeping them informed of critical patient information, simplifying authorizations and payment, and providing support when needed to arrange for necessary home services.

Hospital Outreach

AmeriHealth Mercy will offer to collaborate with hospital care management and discharge planning teams to provide contact information and understand how the facility's care management function is organized. We will also take the opportunity to educate hospital employees on the network home health and equipment providers, and demonstrate the tools available on our Provider Portal.

We have commenced discussions with key hospital providers and started developing plans to coordinate the care of our AmeriHealth Mercy members. For example, we have initiated discussions with the hospitals associated with Louisiana State University (LSU) to gain an understanding of their needs and challenges around discharge planning for patients covered by Medicaid. We understand their concerns regarding coverage for patients who need multiple or long-term IV medications in order to be discharged and also require transportation assistance.

Hospital Collaboration

T is a 45-year old male paraplegic with a colostomy, large sacral decubitus and bipolar disorder. The AmeriHealth Mercy transition manager met T during his hospitalization for wound care following his discharge from prison. Although T had a place to go, he did not have a phone, a wheelchair or furniture for his room. Working with the hospital Case Manager, the AmeriHealth Mercy transition manager arranged for a wheelchair, electric bed, donated furniture, home nursing visits, home health aid visits and physician appointments. T is followed by a Care Manager for ongoing assessment and intervention.

Coordinating Service Planning and Delivery

Our discharge planning process begins with a review of the member's history using our Integrated Care Management information system. Through our platform, we identify prior health care issues, the types of services the member received in the past, as well as any services received immediately prior to admission. Information on available family and support systems is gathered from the New Member Assessment, or other care management assessments and interactions documented in the system and from the information obtained from the hospital Care Manager. All of this data is used to form a picture of the member's needs and available supports. For members who are involved in one of the components of our care management program, this review also helps us understand which pieces of the member's plan of care are working, and which need improvement.

Our care management employees gather additional information from the member's treating physician, the hospital social worker, and additional providers and professionals working with the member. As needed we will speak directly with the member in the hospital, and/or, with the member's position, to family members to gather additional information and ensure everyone is aligned regarding the care the member will need post discharge, and the supports available. As the physicians, nurses and therapists assisting the member in the hospital arrive at firm understanding of the timing and physical needs of the member for discharge, we will facilitate communication of the member's clinical condition and treatment plan to the identified home health, durable medical equipment and specialty home care providers. To simplify the authorization process, we encourage home health or hospital providers to submit home health authorization requests over our provider portal. For those who do not use the portal, we maintain toll-free phone and fax numbers.

Provider Portal

Our Provider Portal allows all providers to request and receive automatic approval and authorization numbers for home health and DME services through a simple online process. The system provides a

confirmation to home health providers verifying that they have the authorization number needed for payment.

Toll-Free Line

AmeriHealth Mercy will maintain dedicated toll-free phone and fax lines for hospitals, physicians and home health providers. The lines, which are accessible 24 hours a day, 7 days a week, help providers make the necessary arrangements for a member's home services. All information, including faxed and mailed documents, received through our toll-free lines is entered into our Integrated Care Management information system.

Follow-up After a Behavioral Health Admission

All members discharged after a behavioral health admission will be followed through our Complex Care Management program, describe above in Section F2. As part of the discharge process, the Care Manager, working with the discharge planner from the behavioral health hospital, will identify appropriate outpatient behavioral health services and ensure the member has a post discharge appointment. The Care Manager will contact the member daily after discharge to check in, assess for any urgent needs, emphasize post-discharge instructions, such as medication schedules and reinforce the importance of connecting to outpatient care. The Care Manager will introduce the assigned Care Connector to the member. Although the Care Manager remains the primary contact for the member, we find that it is helpful for the member to be comfortable with contacts and reminders from another care management employee. This lowers the member's stress when the he or she initiates a call to us, and the Care Manager is on vacation or not available.

With the member's consent, the Care Manager will contact the outpatient mental health provider, to introduce AmeriHealth Mercy and ensure that these providers have information on how to contact us to arrange for additional care or get assistance for any other needs they identify. We will also actively promote AmeriHealth Mercy and our Rapid Response team to behavioral health staff through introductory contacts at the start of the AmeriHealth Mercy program. We know that often members with behavioral health conditions see their behavioral health provider much more often than they see their PCP. We want Louisiana's outpatient behavioral health providers to use our Rapid Response team as a contact point and resource for their patients who have coverage through AmeriHealth Mercy.

Transition Success

J is a 44-year-old male who became eligible for Medicaid following a massive stroke. He had no prior medical coverage and had a feeding tube, tracheostomy, and multiple medications at the time of discharge. The AmeriHealth Mercy Care Manager assisted his family in coordinating skilled nursing and home health aide visits so he could return home, arranged for ambulance transportation to physician appointments after discharge, and worked closely with his Provider prior to discharge to discuss his ongoing needs.

After speaking with our Care Manager, his provider agreed to complete a home visit to follow up, evaluate and coordinate his care. Our Care Manager also referred J to a community agency to evaluate his needs and determine what type of services would be beneficial. As a result of this referral, his sisters have been designated as his primary caregivers and are being paid by the community agency to provide personal care services. With these supports, J has successfully been cared for in his home since discharge.

Transition Managers

AmeriHealth Mercy will also place Transition Managers at high-volume hospitals to help coordinate care for members who are in the emergency room. The Transition Managers will visit members who are patients in the hospital, assessing them for discharge needs, assisting with arrangements and setting up post-discharge physician appointments. As mentioned above, we are in discussions with Dr. Michael Kaiser, Chief Medical Officer for Louisiana State University Health System (LSU) and other LSU representatives around the placement of an on-site Transition Manager one of their facilities.

Member Outreach

AmeriHealth Mercy will also make follow-up phone calls to members who are discharged from the hospital. Care Managers will contact members who are currently in a care management relationship, while our Rapid Response team will contact all other members. The calls focus on medication reconciliation, checking the status of ordered home services, confirming the post-discharge physician appointment and determining how well the member understands the discharge instructions.

Monitoring Patient Outcomes

In order to ensure that our members are progressing toward healthy outcomes, AmeriHealth Mercy will monitor members' physician visits within seven and 30 days of discharge. We will then evaluate the results and set goals to improve performance. We will analyze detailed data reports to identify facilities and/or practices that need improvements. Finally, we will identify key performance drivers so that we can work with the involved parties to improve the results.

AmeriHealth Mercy will also monitor patient readmissions in the 30-day period following discharge. For members who have been readmitted within the 30-day period, we will work with their PCPs and hospitals to implement preventive measures that address their particular conditions and improve their health. Data on readmissions is tracked and trended to identify patterns in diagnosis, attending physician, type of procedure and/or facility. This data is shared with the hospital as part of our ongoing communication around performance. Additional information on hospital and provider performance monitoring can be found in Section G.

Avoiding Readmission

C is a 60 year-old with a history of heart failure, COPD, diabetes, hypertension, gastroesophageal reflux, coronary artery disease, gait imbalance due to an old ankle fracture and two cardiac stents who was discharged from the hospital after being admitted with chest pain. The RR Care Connector contacted C the next day to review her discharge instructions, verify that she had her medications and a follow-up PCP appointment and identify any barriers to following her plan of care.

During routine probing, C identified that she did not have her glucometer anymore. The Care Connector arranged for delivery of a new glucometer to be delivered and marked C's case for a follow-up call to check on the glucometer and the upcoming physician appointment. During the follow-up call, the Care Connector verified that the glucometer arrived.

In conversation with C about the upcoming physician appointment, C identified that she was not sure she could get to the doctor's office due to her inability to walk meaningful distances. The Care Connector initiated the process to connect C to the county transportation service, making multiple phone calls to the PCP office, C and the transportation provider to get the paperwork completed prior to C's appointment.

Monitoring Post-Discharge Care of Enrollees Receiving Home Health Services in Remote Areas

To ensure that members in rural areas are receiving the necessary home health services, AmeriHealth Mercy will make outreach calls to all discharged members. If it is apparent that no home health providers are available in the area, we work with the member and the PCP to provide alternate arrangements, such as extending the hospital stay or finding a lower level of care for the member until a safe discharge is in place. As needed, we will make case-specific arrangements with available out-of-network providers to coordinate the necessary care.

These arrangements will be made by the member's Care Manager, if assigned one, or by our Rapid Response team (RR). As outlined in detail in our response to section F2, the RR consists of registered nurses, social workers, and care coordinators. The employees of the RR are trained to assist members in investigating and overcoming the barriers to achieving their health care goals. Staff can address questions concerning how to obtain medications, supplies or medical equipment, offer assistance in finding a PCP or specialist physician or help with making physician appointments.

F.5: Access to Specialty Care in Rural Parishes

F.5 Aside from transportation, what specific measures will you take to ensure that members in rural parishes are able to access specialty care? Also address specifically how will you ensure members with disabilities have access?

AmeriHealth Mercy is very aware of the importance of reaching out to providers and members of rural communities. We plan to work closely with the DHH Bureau of Primary Care and Rural Health. Its mission of improving the health status of Louisiana residents in rural and underserved areas is an ideal fit and we believe there is much to be gained by working in coordination with their efforts. The Executive Director of AmeriHealth Mercy, Sonia Madison, gained valuable knowledge and experience on rural health issues when she worked with the former Director of the Bureau, Kristy Nichols. AmeriHealth Mercy is committed to providing a complete network of providers, even in Louisiana's most rural parishes. Our network development group has been actively working with providers across the state to develop a network that adequately serves members in all areas of the state. Our provider contracting efforts include all providers on the DHH Medicaid listings with a focused effort on rural areas to ensure access to care. We have worked with many providers and hospital associations to build partnerships and understand the rural parish needs and delivery systems. We plan to contract with the specialty providers necessary to make this transition as seamless as possible.

Despite our best efforts to contract with providers, we know that in some rural parishes, there are a limited number of providers with which to contract. To resolve this concern, we have entered into discussions with LSU as a key telemedicine provider in the rural areas. LSU is already actively supporting the Louisiana Rural Hospital Coalition (LARHC). AmeriHealth Mercy is pleased to have a signed Letter of Intent with LSU.

For members with disabilities, AmeriHealth Mercy will work with the member, family and providers to facilitate timely access to needed specialty care. Where possible, and clinically appropriate, we will leverage telemedicine to minimize the travel for our disabled members. Where telemedicine is not available or is not a good alternative, we will make transportation arrangements for the member and an accompanying caregiver or family member.

F.6: Strategies to Influence Member Behavior to Access Resources

F.6 Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid CCN members.

Our mission is to help people get care, stay well, and build healthy communities. A key component of that mission is helping people "get care." Our strategies to influence the adoption of healthy behavior focus on the three "E"s: *Engagement, Education,* and *Empowerment.*

Engagement

Our extensive experience with the Medicaid population has taught us the importance of engaging members where they live and in a way that fosters respect and trust. We sponsor and participate in more than 1,000 local health related events annually to bring health care directly into the communities we serve. We understand that the key to influencing a member's behavior is building a trusting relationship between the member and the health plan. By partnering with community leaders, faith-based organizations and agencies already trusted by residents of the neighborhood, AmeriHealth Mercy will establishes connections with members that result in improved health outcomes.

We will capitalize on our successes in other states, bringing wellness care, chronic condition monitoring and preventive screenings to our membership. Some of our activities include:

- **Mobile mammography** - We bring a mobile mammography unit to neighborhood locations, reaching out in advance to members in the immediate area to schedule mammograms for our most needy members.
- **Dedicated schedule blocks** - We engage provider sites to reserve days for our members to get their cervical cancer screenings, schedule the appointments, and remind members to complete required screenings.
- **Community fairs and festivals** – We participate in existing community events and festivals to sponsor health screenings for cholesterol, blood pressure, and blood sugar. Our teams work in advance to make arrangements to that our chronically ill members and their families can attend. Care management employees at the event make sure that the results are shared with our members' PCPs and assist with coordinating any indicated follow-up care after the event.
- **Community baby showers –** Held in neighborhood churches and community centers, these events provide a mechanism for identification and engagement of pregnant mothers. WeeCare (maternity) Care Managers attend the events to assess for pregnancy-related risks and begin the process of establishing a bond with the expectant mother. Described more fully in Section E, this program was recently recognized by URAC as a winner of its 2011 Outreach Award.

In addition, we infuse "edutainment" in our events, marrying education with entertainment to draw members to the event and engage them in health-related activities and learning. Several of our programs have received NCQA and URAC recognition for their success in this area.

- **Healthy Hoops®** – Our NCQA award-winning program uses basketball as a mechanism to engage pediatric members with asthma and their families in education on asthma management and obesity prevention.
- **Lose-to-Win** – Our URAC award-winning program uses a contest format loosely mirrored on TV's Biggest Loser to educate and engage members with type-2 diabetes and obesity around nutrition and exercise.
- **Women's Health Ministry: 40-day Journey** – This NCQA-recognized program focuses on improving the health of African-American women and their families through a mulyi-week educational series emphasizing nutrition, exercise, medication compliance and water intake.

More information on these and other AmeriHealth Mercy programs can be found below in the section titled "Outreach Programs."

Finally, our high-touch care management, rapid response, and EPSDT units engage members on a one-to-one basis to ensure that needed services are provided and members have the ability to keep their appointments. By working on goals important to the member, our Care Managers create the trusting relationship necessary to achieve behavior change.

Education

Our member education focus is multi-faceted. We use print, electronic, telephonic, and in-person resources to touch our members where they are. We understand the relationship between low health literacy and poor health outcomes and the associated impact on health care costs. Members with low health literacy – those who cannot read, understand, or act on health information and instructions – face multiple health risks. Confusion about or lack of health care information may result in poor control of chronic illnesses such as diabetes, more hospitalizations and longer lengths of stay, and improperly taken medications.

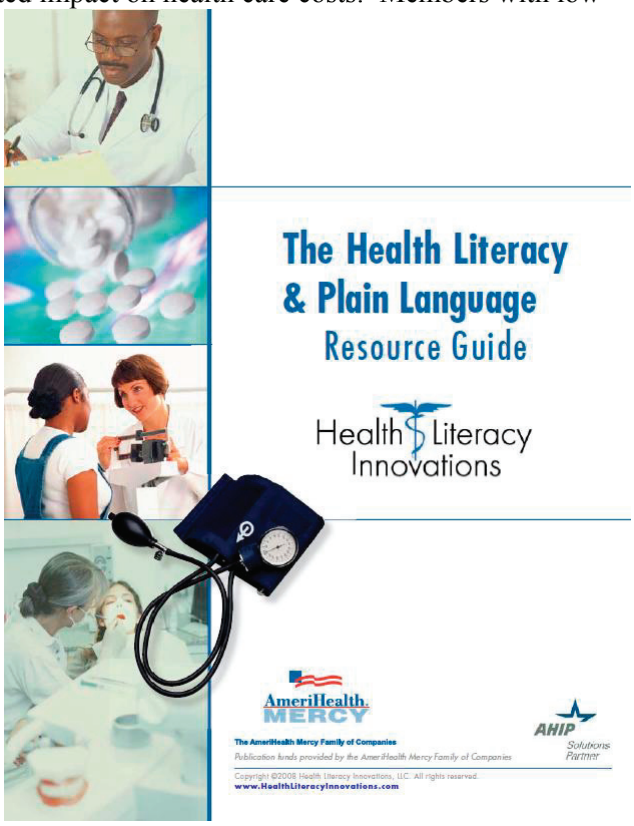


Figure 6: Health Literacy and Plain Language Resource Guide

To assist providers with tools and resources to address health literacy, AmeriHealth Mercy partnered with Health Literacy Innovations (HLI), a social entrepreneurship company that creates tools to enhance health literacy, to produce the nation's first comprehensive guide on health literacy. Available free to providers, members, and the public, the "Health Literacy and Plain Language Resource Guide" was created using hundreds of national and international resources.

In designing programs and educational pieces for our adult population, we employ select adult learning principles, customized to address the Medicaid membership. We know that most adult learners respond best to activities that allow them to "learn on their own." The goal is to introduce members to new concepts via lecture, reading or other media and then provide activities that allow them to use the new information to achieve a goal. This adult learning concept is often referred to as "self-discovery." We leverage the following concepts:

- **Relevance** - Presenting new information that is meaningful and practical. We strive to make the material relevant to the member's environment and experience. We use focus groups to help us understand ideas that are meaningful to the population. Talking about car seat safety with a woman who lives in an urban immigrant neighborhood where everything is accessed by walking will not resonate with that member.
- **Bite-Sized Chunks** - Presenting only one idea or concept at a time. Limiting the information taught at one time prevents overload and allows the member to gain the confidence of learning one block of information.
- **Continuity** - recognizing that learning is continuous/continual. We know that members will pass over learning plateaus and obstacles, and may get bogged down or stopped. We continue to work with them, helping them to start up and begin the learning process again.
- **Motivation** - Enhancing learning through positive reinforcement. We set short-term goals and milestones, celebrating success when one is reached. By continually reinforcing success, we motivate the member to remain engaged in the process.

- **Doing** - Following the concept that people learn by doing. We give members set tasks to perform before our next call or meeting, giving them the ability to participate and reinforce the skill.

In addition, our printed materials use the principles of health literacy and adhere to each state regulatory agency's requirements for grade level and graphic standards. As a family of companies, all member materials are written at a fourth grade reading level with font sizes no smaller than 12 point. Our educational handouts follow health literacy guidelines for use of white space, helpful graphics, simplified terminology and sentence structure, and "living room" language. To enhance our effectiveness, we will partner with LSU to tailor our educational materials to Louisiana residents. With the assistance of LSU experts, we will adjust the examples and illustrations to address common experiences of Louisiana residents. As an example, we may alter our heart disease education pieces to include heart-healthy catfish recipes or exercise strategies for high-humidity months.

We have regular member newsletters, routine mailings to newly identified members with chronic diseases, and semi-annual mailings to all members with a chronic disease. At all community health fairs, we distribute awareness pieces for chronic disease states that always direct the member to their primary care doctor.

Empowerment

All of our campaigns and educational pieces include a call to action, defining a clear path for the member to use in addressing the target behavior or care need. By enabling the member to take simple steps toward improved health, we build confidence and trust for future activities.

At every opportunity, we emphasize available self-management resources, such as the 24/7 Nurse Line and Rapid Response call center to help members make the appropriate choice of where to get care. Our programs are focused on strengthening each member's self-management capacity, through removal of barriers, knowledge augmentation and skill development.

One of our latest initiatives provides young mothers with hands-on training and education on how to care for a sick child at home. Focused on reducing inappropriate emergency room utilization, "4 Your Kid's Care" holds educational sessions in local community venues and train-the-trainer sessions for community-based organizations who can spread the curriculum among their constituents. Additional information on "4 Your Kid's Care" can be found in Section J.

In addition to the one-on-one engagement and coaching described in Section F2, above, AmeriHealth Mercy will employ a series of outreach and education programs to promote appropriate access to health care services and the adoption of healthier lifestyles.

Outreach Programs

As part of the AmeriHealth Mercy Family of Companies, AmeriHealth Mercy has access to a number of innovative, established, and successful programs that engage members and improve health outcomes. Our programs target members with asthma, diabetes, weight issues, and encourage individuals to adopt healthy lifestyles that reduce likelihood of medical issues. Regardless of member age, we have a program that can help Louisiana residents stay well and build healthy communities. Below are just a few of our existing programs.

Healthy Hoops®

Healthy Hoops® is an innovative, NCQA-recognized asthma management program that uses basketball as a platform to teach children with asthma and their families how to manage the disease through proper nutrition, exercise, and appropriate medication use. The program features hands-on asthma education, asthma and various other health screenings, nutrition education, plus basketball clinics for the children taught by local and regional basketball legends. The program also aims to decrease childhood obesity and increase cardiovascular activity.

The Healthy Hoops program was first developed by our Philadelphia affiliate in 2003, targeting 3- to 16-year-old asthmatic children and their families in the Philadelphia region. Since then, Healthy Hoops has expanded to eight cities in five states, with more than 8,000 children and their family members participating in the program nationally.

Healthy Hoops was recognized by the NCQA for the 2006 Innovative Practices in Multicultural Health Care Award and the Public Relations Society of America's Health Academy Innovation Award for Excellence in Community Relations, Special Events, and Observance.

The Healthy Hoops program promotes childhood asthma control through education and timely use of medication, to reduce emergency episodes brought on by physical exertion. The keys to the program are the physical assessment and screening of each of the children participating in the program and the close monitoring by the medical employees at all of the Healthy Hoops basketball games. All participants undergo full physicals and pre- and post- program health screenings. The health screenings assess each participant's health status and medications, review appropriate medication use, establish a personalized action plan and evaluate results. The diagnostic test include: spirometer readings; peak air flow; pulse rate; respiratory rate; and breath-sounds to identify wheezing.

The Healthy Hoops program works directly with the parents and the extended families of the program's enrollees. Once their child's Body Mass Index (BMI) is calculated, the program counselors discuss the child's eating habits and general diet with each family. Specific suggestions are made in a culturally conscious way, assisting the family to re-direct the child to less fatty foods and less sugar and carbohydrate intake.

Based on Predictive Modeling Analysis, members are stratified into a low-risk or high-risk group based on the likelihood that they will experience symptomatic asthma. Members who are categorized as low-risk receive information via mailings with access to a Care Manager as necessary. Members who are identified as high-risk are given targeted education and fact sheets on their disease along with a comprehensive health risk assessment and individualized care plan and are followed by a Care Manager specializing in asthma through the intensive care management program. Care Managers address short- and long-term goals and augment the plan of care with input from the member, parent/guardian and physician.

Although it is not unusual for health plans to experience an increase in ambulatory primary care and pharmacy utilization as emergency room visits and inpatient admissions decrease, our Healthy Hoops members have experienced a decrease in utilization and costs in multiple service and pharmacy categories as noted below. The Healthy Hoops members' participation in the program and the combination of our use of health screening results and patient education on topics such as use of spacers, peak flow meters,

and asthma action plans markedly improved asthma control as evidenced by decreases in acute health care utilization and a decreased need for specialist visits. Due to this enhanced control, no additional primary care visits or intensification of controller therapies was required.

Results for the 124 members enrolled in the last full cycle of the program are as follows:

- Primary care visits remained relatively unchanged, decreasing by 0.83 percent
- Specialist visits decreased 23.44 percent
- Emergency Room visit rates were unchanged, however related emergency room costs decreased 6.21 percent
- Inpatient admissions decreased 62.5 percent and related inpatient costs decreased 45.86 percent

Women's Health Ministry Program

The Health Ministry Program for Women is a non-denominational, multifaceted, faith-based, health education and awareness program that aims to address health disparities among minority women. Developed to address the effect of stress in triggering chronic disease, Women's Health Ministry events include coaching and education from behavioral health and medical personnel. The focus is on incorporating simple, preventive and positive health behaviors into everyday life in order to prevent, control and reverse chronic diseases and stress. The delivery mechanism and name of the Health Ministry Program for Women is customized to meet the needs of the local population. In Pennsylvania, it is known as the *40-Day Journey* and in South Carolina, it is called the *Health Ministry Empowerment Tour: Marching into Wellness*. Since 2000, the Health Ministry Program has touched the lives of 80,000 women in three states.

Women gather to learn about health-related issues during the Health Ministry Program for Women.

The program works with faith-based organizations because they are often the most consistent and trusted point of contact among minority women and their families. By bringing local health care providers to churches, synagogues and mosques, the Health Ministry program provides women with a safe and supportive setting in which to learn about their health. The program has been successful in encouraging members to obtain preventive screenings, be aware of chronic diseases, and educating others about the importance of adopting a healthy lifestyle.

The Health Ministry's goals are to:

- Educate women and their families about the importance of prevention and early detection through community-based partnerships
- Promote regular health screenings and check-ups to specifically identify and target women at risk
- Increase participant knowledge of stress triggers and stress management techniques
- Empower women to be health advocates by knowing the risks and warning and signs of chronic diseases

The National Committee for Quality Assurance (NCQA) recognized The Health Ministry Program with the "Recognizing Innovation in Multicultural Health Care Award."

Gift for Life

Member incentives, combined with a high-touch health program, can also improve access to health care services. In our affiliate plan in Philadelphia, Keystone Mercy, we took an aggressive approach to ensure

that eligible members received recommended mammography screenings for breast cancer through our Gift for Life program. We developed this program to address higher-than-average breast cancer rates in Pennsylvania, the fact that breast cancer is the second most common cancer among women, and expert reports indicating that African-American women have higher mortality rates because the cancer often goes undiagnosed.

The Gift for Life program engages and educates members who have not had screenings in the past two years and encourages them to have a mammogram. In our discussions with members who were overdue or had no record of receiving a mammogram, we learned that these members were primarily focused on what those around them -- their children, significant other or parents -- needed, with no time or energy to address their own health needs. This understanding led us to change the message for this program, focusing on the need for our female members to take care of themselves so that they would be available and able to care for the others in their life. We encouraged them to give their family the Gift of their Life for the future.

To reach our members, we provide screenings in the neighborhoods where they live. Keystone Mercy partnered with mobile mammography vans and local providers to arrange accessible locations throughout the plan's service area. Employees analyzed plan data to identify members who meet the requirements for a mammogram but have not had a claim within the last two years. They contact the members to explain the importance of the screening, help them schedule the test and assist with transportation needs. Prior to the event, outreach team members make reminder calls to maximize participation, and following the mammogram, members receive a gift card incentive for their participation.

A "Gift for Life"

At a mobile mammography event in West Philadelphia, our outreach worker was approached by J who expressed a concern regarding the screening. She stated that she had several women in her family die from breast cancer and she was convinced the mammogram and the treatment caused her mother's and sister's cancer to spread. The outreach worker explained to J that it was even more important for her to receive the screening because she had a history of immediate family members with breast cancer. J had a strong belief in the myth of radiology screening having a direct correlation with breast cancer. The outreach representative shared with J literature and information about breast cancer awareness, early detection and prevention. The outreach worker stayed with J through the screening process.

Following the event, a representative from the cancer center called our outreach supervisor because J did have a finding on her mammogram and the cancer center was not able to contact J for a follow- up appointment. Unable to contact J by phone, our outreach department made arrangements for a home visit. We connected J to her PCP, assigned a Care Manager and helped J work through her fear of attending the follow-up appointment. J did have cancer in both breasts, but thanks to the early detection and treatment she is a cancer survivor.

Our outreach team encountered J at a Praise is the Cure event several months later. J expressed her sincere gratitude for increasing her awareness of the importance of preventive care and early intervention and how much she appreciated the Gift for Life program and our Care Management services. She credited the program with saving her life.

Safe Playgrounds

In keeping with our mission to build healthier communities, the Safe Playground program was designed to address a growing concern surrounding the lack of secure play spaces in the neighborhoods that we serve. According to Safe Kids Worldwide, preventable injuries are the leading cause of death for children under the age of 14 in the United States and more than 14 million children sustain preventable injuries that require medical attention each year. We know from our experience that such injuries are one of the leading causes of emergency room visits for children.

In addition, play is extremely important to the physical and mental health of children and is especially helpful in preventing obesity. Physical activity has also been shown to increase academic performance,

reduce youth violence and enhance social development. In addition to reducing injuries, providing secure areas for exercise also has a positive impact on the growing concern about childhood obesity.

Using our knowledge of our communities, we identify areas in which high percentages of the student body are at or below the poverty level and do not have access to safe play areas. Our leadership team, employees and community partners plan and build the structures from the ground up, completing the work in one day. To date, we have built 11 playgrounds for our members' communities. This month, a member of our Corporate Public Affairs employees was certified as a Playground Inspector. Her added expertise will enable us to improve our processes for this community program.

Figure 7: A Member Community Playground

Lose to Win

The Lose to Win program is a health management program for adults with type II diabetes. Developed in cooperation with the YMCA's Activate America Program, the program was designed to educate high-risk urban families on the benefits of a healthy lifestyle. The program combines health screenings, nutrition and weight management, preventive diabetes/obesity ICM and monitored exercise.

The program enrolled 137 members and assigned them to a YMCA site based on their geographic location. Participants took part in activities such as nutritionist-guided supermarket tours, cooking demonstrations, nutrition workshops and dance classes.

A total of 115 participants completed the 12-week program and the average weight loss was 10-15 pounds. Several members, however, lost more than 50 pounds and many reduced their need for diabetes and cardiovascular medications. On average, participants improved their BMI by 3.8 percent and the average improvement in HDL was 5.5 percent.

The program culminated with a celebration for the 115 participants who completed the program. All program participants received a one-year membership to the YMCA, and those who demonstrated the most improvement in measured categories received additional prizes.

The Lose to Win program received URAC's Gold Award at the 2010 Quality Summit.

Figure 8: A Lose to Win Program Graduate

Media Smart

In the summer of 2010, our Philadelphia affiliate provided the Media Smart Facilitators program to 15 youth in the Blue Print Leadership program from the city of Chester, Pennsylvania. Media Smart is an interactive after-school program that helps young people ages 11-13 to understand the complex media world and its nutritional or physical impact on their health. Media Smart is a component of the National *We Can*® Obesity Prevention Program.

In Chester – one of the poorest urban areas in Pennsylvania – 51 percent of children under 18 live below the poverty level and 32 percent of all families (48 percent of families with a female head of household) have incomes below the poverty level. Twenty-three percent of adults did not complete high school. The public transportation system consists of two main bus routes that travel in and out of the city, and there are no large supermarkets located in Chester City. This impacts the transportation opportunities and creates a "food desert" area, making it hard for residents to obtain healthy food. Chester City is also facing a startling increase in violent crimes, believed to be related to the introduction of a new PCP-laden drug called "Wet."

The leadership program began with 15 Blue Print Leadership participants who were also Keystone Mercy members and ended with 11 of the teens completing the program. The objective is for the Leadership teens to implement the Media Smart curriculum in several middle school classes in their community.

Healthy You … Healthy Me!

Our affiliate plan in Central Pennsylvania implemented the Healthy You … Healthy Me! program to teach children how to make healthy lifestyle choices. The program combines a classroom presentation with physical activities and a nutritional snack. The curriculum was developed using the Coordinated Approach to Child Health (CATCH) Kids for children ages 7 - 13. Healthy You … Healthy Me! focuses on increasing physical activity, improving nutrition through smart snacking and increasing healthy lifestyle awareness. AmeriHealth Mercy also offers the Healthy Heart program, which focuses on the functions of the heart and its importance. It also includes physical activity and healthy snacks.

Young Philly Fit

Our Philadelphia-based affiliate partnered with City Year to add "Young Philly Fit," a nutrition- and exercise-focused program to City Year's mentoring curriculum. Founded in 1988, City Year brings together young adults for an eight-month period to serve as tutors, mentors and role models to help students stay on track, and get back on track, to graduate. These "near-peers" are able to help students improve attendance, behavior and coursework, increasing their likelihood of graduating. One of the important ways City Year members share their belief in service and their commitment to helping children is by leading programs that teach elementary, middle school and high school students about how to be active citizens in their communities and make a difference.

Young Philly Fit was launched in 22 schools in the Philadelphia region. Health and Wellness representatives from each school participated in a train-the-trainer program. City Year members served as Wellness Mentors for the school-based trainers, supporting the delivery of the Young Philly Fit program in each school. In addition to an assessment and baseline BMI, height, and weight, eating habits and exercise pattern screenings, Young Philly Fit participants attend monthly two-hour sessions that include meal planning, exercise, and pedometer use, in addition to fun motivational activities. The schools hold competitions for students around activity levels and weight/BMI improvement.

Community Education Programs

Our affiliates offer a wide variety of educational programs delivered at existing venues and meetings. Our community liaisons work with churches, civic organizations, homeless shelters, food pantries and meal programs to deliver the content at their site to their constituents.

Culturally Competent Approach

Cultural backgrounds play a significant role in the way members approach their health as well as the way they seek health care. AmeriHealth Mercy, as part of the AmeriHealth Mercy Family of Companies, will ensure that all health-related information and services are tailored to meet the unique needs of the Louisiana population.

Multicultural Health Care Distinction

Three of AmeriHealth Mercy's affiliate plans have been at the forefront of the National Committee for Quality Assurance (NCQA) Multicultural Health Care initiative, as three of the six plans nationwide to earn its Multicultural Health Care Distinction. This initiative is a way for health plans to monitor and improve culturally and linguistically appropriate services and reduce health care disparities. The review examines 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 will use this experience to establish programs that connect members with providers that are sensitive to their needs. This could involve a particular spoken language or an understanding of certain cultural traditions. In addition, LaCare member materials will be produced in multiple languages, including Spanish, Vietnamese and others as required by DHH and the needs of our members.

We are committed to delivering care that respects the uniqueness of each member and to eliminating cultural disparities in health care and for years have dedicated human and financial resources to close gaps, reach the underserved, support growth in the community, and empower individuals and their families to better health.

National Conference on Health Disparities

AmeriHealth Mercy is a dedicated sponsor and active participant in the Annual National Conference on Health Disparities. We were proud to host the most recent conference November 10-13, 2010 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

The 2010 National Conference on Health Disparities featured keynote speakers from the Department of Health and Human Services and Whole Life Associates.

In Louisiana, we will continue our tradition of actively addressing health disparities in the communities we serve. Should we receive a contract award, we plan to offer programs that help address specific health disparities.

As an example of programs we have implemented previously, in 2009 our South Carolina affiliate identified a disproportionate number of African-American women with diabetes. To improve the health of these members, the plan implemented a culturally competent diabetes program called *Type You*: *First Choice Women in Control*. 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.

Additional examples of our programs addressing healthcare disparities can be found in Sections J and L.

F.7: Leveraging Outreach Activities

F.7 Many faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services (e.g., through visiting nurses, etc.). Describe what specific ways would you leverage these resources to support the health and wellness of your members.

AmeriHealth Mercy plans to work in close collaboration with community advocacy organizations to connect our members with medical services and develop health education opportunities. In fact, AmeriHealth Mercy has already established relationships with organizations such as the United Way and the March of Dimes in Louisiana.

As described in the previous section, AmeriHealth Mercy has access to a wide range of successful outreach programs that encourage members to take control of their health. Often times, the programs are held in conjunction with medical groups, religious organizations, and community organizations. By combining our resources, we are better able to reach members in an environment where they are comfortable and more likely to engage.

We have already started forming partnerships and exploring opportunities to collaborate with community-based organizations in Louisiana to incorporate health education and outreach into their events. Specific examples are listed below:

Catholic Charities Archdiocese of New Orleans – We are in discussions with Aaron Portier, Director of Planning and Evaluation, regarding collaborative alliances for their Adult Day Health Care Centers, Padua Pediatric program, and St. Vincent Maternity Clinic.

Consumer Advocates – In addition to the outreach discussed in section F2, above, related to behavioral health care providers, AmeriHealth Mercy spoke with consumer advocates to get their opinion on how CCNs would serve their at-risk populations. We covered issues such as access to care, at-home treatment versus institutional care, and development of support groups. Individuals we spoke with included:

- Gordon Wadge, CEO, Catholic Charities
- Talvin Paul, SW Vice President, and William Walker, Program Director, Youth Advocate Programs
- Sherri Houin, Program Director, Families Helping Families

"Thank you so much for your investment to the lives of Louisiana's babies. We were elated to work with you during our March for Babies campaign. We look forward to working with you and continuing talks of an aggressive program centered partnership in the coming months."

Frankie G. Robertson, State Director March of Dimes -Louisiana Chapter

Earl K. Long Hospital-Baton Rouge Children's Health Project – AmeriHealth Mercy will work with LSU's mobile health units in Baton Rouge to complement services provided by the units. This relationship also gives AmeriHealth Mercy members quick access to Rapid Response resources, who can help members make follow-up appointments or arrange for additional services after their visit to the mobile unit.

Louisiana Consumer Healthcare Coalition – We have communicated with Moriba Karamoko, Director to forge a positive working relationship with their membership. We believe this will be an excellent way to work with various consumer groups.

Louisiana Medical Association – We developed a relationship with this group of physicians who have provided care to the Medicaid population in their local communities for years. Dr. Joia Creir, the group's president worked with our Executive Director Sonia Madison on the Louisiana Collaborative. We will continue to work

with this group to benefit from the many community social services and support groups they have used. AmeriHealth Mercy was one of the sponsors of the group's annual meeting in June.

March of Dimes – AmeriHealth Mercy sponsored the March of Dimes' *Walk for Babies* in Baton Rouge and New Orleans during the months of April and May. Not only did we provide sponsorship funding, our Louisiana-based employees participated in both walks as well. We reached out to Dr. Frankie Robertson, Louisiana State Director of the March of Dimes, even before the RFP was posted. Based on our experience in other states, we are well aware that a partnership with the March of Dimes not only demonstrates our commitment to improved birth outcomes for the most vulnerable of populations, but is a cost-effective investment in the future.

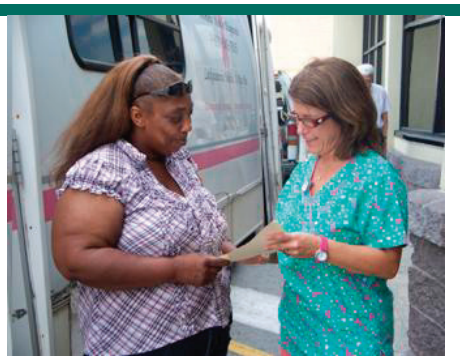
Metropolitan Human Services District – We are working with Barry Pollock from the Metropolitan Human Services District (MHSD) mobile unit to provide mental health workers on the unit with access to AmeriHealth Mercy's Rapid Response team. MHSD provides mental health services to Plaquemines and St. Barnard parishes, placing them in contact with some of our more isolated members. By accessing the Rapid Response team, MHSD employees will be able to activate AmeriHealth Mercy resources to address medical needs they identify in our members.

Greater New Orleans Immunization Network– AmeriHealth Mercy contacted Barry Landry to collaborate with the Greater New Orleans Immunization Network's mobile immunization services in the seven parishes they serve.

Louisiana Chapter National Association of Social Workers - We have had conversations with Carmen Weisner Executive Director of Louisiana Chapter of National Association of Social Workers to identify leaders in each of the nine regions of the State. We plan to work with each regional chapter to partner with them in their outreach work. We will also identify local community resources that AmeriHealth Mercy members can use.

MICAH Project – AmeriHealth Mercy employees worked with Denise Graves, Community Organizer of the Project in New Orleans. MICAH (Moving In Courage and Hope) is a faith-based social organization working to create solutions to problems facing people of New Orleans and surrounding communities. We were invited and participated in their recent anniversary event where United States Surgeon General Dr. Regina M. Benjamin was the keynote speaker.

Mobile Mammography – In addition to the mobile mammography services provided directly through LSU for the New Orleans and Baton Rouge areas, AmeriHealth Mercy has contacted the Louisiana Rural Hospital Coalition to arrange for collaborative mammography events in the 40 rural parishes in northern Louisiana that they serve and the Greater New Orleans Mobile Unit Consortium, sponsored by Tulane, LSU and Children's Hospital.



The mobile mammography service provides mammograms to women in the communities where they live.

Mom and Baby – AmeriHealth Mercy will work with LSU on their Mom and Baby mobile health unit, which brings prenatal and postnatal care into the community. AmeriHealth Mercy affiliates work with centering programs in other markets and we look forward to assisting LSU with this program.

United Way – We have a signed commitment from Charmaine Caccioppi, President of the Louisiana Association of United Ways (LAUW) to partner with AmeriHealth Mercy to host a series of health program best practices roundtable discussions in various regions of Louisiana.

F.8: Statement of Moral and Religious Objections

F.8 Submit a statement of any moral and religious objections to providing any services covered under Section §6 of RFP. If moral and religious objections are identified describe, in as much detail as possible, all direct and related services that are objectionable. Provide a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc. If none, so state. Describe your plans to provide these services (e.g. birth control) to members who are entitled to such services.

AmeriHealth Mercy abides by the principles set forth in the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Bishops. In accordance with its ethical obligations, AmeriHealth Mercy does not provide, support or participate in the delivery of any service including family planning services, which is inconsistent with these directives. Moreover, this limitation precludes AmeriHealth Mercy from performing care management, quality management and utilization review services in relation to family planning services.

The Louisiana Medicaid Fee-For-Service program ("MA-FFS Program"), through its network of family planning providers, will provide AmeriHealth Mercy members with family planning services. AmeriHealth Mercy will (a) advise potential members, AmeriHealth Mercy members and AmeriHealth Mercy providers that AmeriHealth Mercy does not provide family planning services because of moral or religious objections and (b) and direct members to contact the Enrollment Broker for instructions on how and where to obtain family planning services. AmeriHealth Mercy will communicate this information through member and provider materials, including member and provider manuals, the AmeriHealth Mercy website, member and provider call centers, and as otherwise required by DHH and applicable law. AmeriHealth Mercy will also make this information available to the Enrollment Broker, to ensure potential enrollees have the information. In addition, should AmeriHealth Mercy's policies change with respect to these or other services not furnished due to an objection on moral or religious grounds, we will notify DHH and provide notification to our members within ninety (90) of adopting the policy, in accordance with Section 2.4.1 of the CCN-P RFP.

The family planning and related diagnosis and service codes in the following table will not be covered by AmeriHealth Mercy.

Table 3: Family Planning Contraceptive Management/Sterilization Diagnosis Codes Not Covered

Code	Description
V25.01	Prescription of Oral Contraceptives
V25.02	Initiation of Other Contraceptive Measures (Fitting of Diaphragm, prescription of foams, creams, or other agents)
V25.03	Encounter for Emergency Contraceptive Counseling and Prescription
V25.09	Family Planning Advice
V25.1	Insertion of Intrauterine Contraceptive Device
V25.2	Sterilization (Admission for interruption of Fallopian Tubes or Vas Deferens)
V25.4	Surveillance of previously prescribed contraceptive methods (Checking reinsertion, or removal of contraceptive device) (Repeat Prescription for Contraceptive Method) (Routine Examination in connection with contraceptive maintenance)
V25.40	Contraceptive Surveillance, Unspecified

Code	Description
V25.41	Contraceptive Pill
V25.42	Intrauterine Contraceptive Device (Checking, Reinsertion, or Removal of Intrauterine Device)
V25.43	Implantable Sub dermal Contraceptive
V25.5	Insertion of implantable sub dermal contraceptive
V25.8	Other specified contraceptive management (Post Vasectomy Sperm Count)
V25.9	Unspecified contraceptive management
V26.51	Tubal Ligation Status (Used as a secondary dx code Only)
V26.52	Vasectomy Status (Used as a secondary dx code Only)
V45.51	Intrauterine Contraceptive Device (IUD)
V45.52	Sub dermal Contraceptive Implant
V45.59	Other
996.32	Mechanical complication of due gentitourinary device, implant, and graft (Due to IUD)

Table 4: Family Planning Abortion Diagnosis Codes Not Covered

Code	Description
635.80	Legally Induced Abortion with Unspecified Complication
635.81	Legally Induced Abortion With Unspecified Complication (Incomplete)
635.82	Legally Induced Abortion With Unspecified Complication (Complete)
635.90	Legally Induced Abortion Without Mention of Complication
635.91	Legally Induced Abortion Without Mention of Complication (Incomplete)
635.92	Legally Induced Abortion Without Mention of Complication (Complete)

Table 5: Family Planning Procedure Codes Not Covered

Code	Description
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopym not otherwise specified
00851	Anesthesia for tubal ligation/transection
00920	Anesthesia for procedures on male genitalia (including open urethral procedures) not otherwise specified
00921	Anesthesia
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix, or endometrium) not otherwise specified

Code	Description
00952	Hysteroscopy and/or hysterosalpingography
11975	Insertion, implantable contraceptive capsules
11976	Removal, implantable contraceptive capsules
11977	Removal, with reinsertion, implantable contraceptive capsules
11981	Insertion, non-biodegradable drug delivery implant
11982	Removal, non-biodegradable drug delivery implant
11983	Removal, with reinsertion, non-biodegradable drug delivery implant
36415	Collection of venous blood by venipuncture
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination
56501	Destruction of lesion(s), vulva; simple (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)
57061	Destruction of vaginal lesion(s); simple (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)
57100	Biopsy of vaginal mucosa; simple (separate procedure)
57105	Biopsy of vaginal mucosa; extensive, requiring suture (including cysts)
57170	Diaphragm or cervical cap fitting with instructions
57421	Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix
57452	Colposcopy of the cervix including upper/adjacent vagina;
57454	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage
57455	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix
57460	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix
57461	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix
57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)
57505	Endocervical curettage (not done as part of a dilation and curettage)
57510	Cautery of cervix; electro or thermal
57511	Cautery of cervix; cryocautery, initial or repeat
57513	Cautery of cervix; laser ablation
58300	Insertion of intrauterine device
58301	Removal of intrauterine device

Code	Description
58340	Catheterization and introduction of saline or contrast material for saline infusion Sonohysterography or histerosalpingography
58555	Hysteroscopy, diagnostic (separate procedure)
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and or poly
58562	Hysteroscopy with removal of impacted foreign body
58565	Hysteroscopy with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum unilateral or bilateral, during same hospitalization (separate procedure)
58611	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, when done at time of cesarean delivery or intra-abdominal surgery (not a separate procedure (list separately in addition to code for primary procedure)
58615	Occlusion of fallopian tube(s) by device (e.g., band clip, falope ring) vaginal or suprapubic approach
58670	Laparoscopy, with fulguration of oviducts (with or without transection)
58671	Laparoscopy, with occlusion of oviducts by device (band, clip, or falope ring)
59840	Induced abortion, by dilation and curettage
59841	Induced abortion by dilation and evacuation
59850	Induced abortion by one or more intra-amniotic injections (amniocentesis-injections) including hospital admission and visits, delivery of fetus and secundines
59855	Induced abortion by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria) including hospital admission and visits, delivery of fetus and secundines
74000	Radiologic examination, abdomen; single anteroposterior view
74150	Computed tomography, abdomen; without contrast material
74740	Hysterosalpingography, radiological supervision and interpretation
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (14 weeks 0 days), transabdominal approach; single or first gestation
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses
76816	Ultrasound, pregnant uterus, real time with image documentation, follow- up (e.g., re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid

Code	Description
	volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal
76817	Fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete ultrasound, pelvic (nonobstetric), real time w/ image documentation
76857	Limited or follow-up (e.g., for follicles)
76998	Ultrasonic guidance, intraoperative
77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in ad)
90649	Human papilloma virus (hpv) vaccine, types 6, 11, 16, 18, (quadrivalent 3 dose schedule for intramuscular use)
96372	Therapeutic, prophylactic or diagnostic injection subcutaneous or intramuscular
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: - a problem focused history; - a problem focused examination; Usually, the presenting problems are self-limited or minor. Physicians typically spend 10 minutes face to face with the patient and/or family
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: - a problem focused history; - a problem focused examination; and Straightforward medical decision counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patients family and/or family's needs
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: - a detailed history; - a detailed examination; and - medical decision making of low complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient’s family and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face to face with the patient or family
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of moderate complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient’s family and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face to face with the patient or family
99205	Office or other outpatient visit for the evaluation and management of a new patient,

Code	Description
	which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's family and/or family's needs usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face to face with the patient or family
99211	Office or other outpatient visit for the evaluation and management or an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent preforming or supervising these services
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a problem focused history; - a problem focused examination; - straightforward medical decision making Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face to face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - an expanded problem focused history; - an expanded problem focused examination; - medical decision making of low complexity Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a detailed history; - a detailed examination; and - medical decision making of moderate complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's family and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face to face with the patient or family
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's family and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face to face with the patient or family
99241	Office consultation for a new or established patient, which requires these three components: - a problem focus history; - a problem focused examination; and - straight forward medical decision making Counseling and/or coordination of care with other providers or agencies are provided

Code	Description
	consistent with the nature of the problems and the patient's family and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes face to face with the patient and/or family
99242	Office consultation for a new or established patient, which requires these three components: - an expanded problem focus history; - an expanded problem focused examination; and - straight forward medical decision making Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's family and/or family's needs. Usually, the presenting problem(s) are low severity. Physicians typically spend 30 minutes face to face with the patient and/or family
99243	Office consultation for a new or established patient, which requires these three components: - a detailed history; - a detailed examination; and - medical decision making of low complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patients family and/or family's needs. Usually, the presenting problem(s) are low severity. Physicians typically spend 30 minutes face to face with the patient and/or family
99244	Office consultation for a new or established patient, which requires these three components: - a comprehensive history; - a comprehensive examination; and - medical decision making of moderate complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's family and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Physicians typically spend 60 minutes face to face with the patient and/or family
99245	Office consultation for a new or established patient, which requires these three components: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's family and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Physicians typically spend 80 minutes face to face with the patient and/or family
99281	Emergency department visit for the evaluation and management of a patient which requires these three components: - a problem focus history; - a problem focused examination; and - straight forward medical decision making Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's family and/or family's needs. Usually, the presenting problem(s) are self-limited or minor
99282	Emergency department visit for the evaluation and management of a patient which requires these three components: - an expanded problem focus history;

Code	Description
	- an expanded problem focused examination; and - medical decision making low complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's family and/or family's needs. Usually, the presenting problem(s) are low to moderate
99283	Emergency department visit for the evaluation and management of a patient which requires these three components: - an expanded problem focus history; - an expanded problem focused examination; and - medical decision making moderate complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patients family and/or family's needs. Usually, the presenting problem(s) are of moderate severity
99284	Emergency department visit for the evaluation and management of a patient which requires these three components: - a detailed history; - a detailed examination; and - medical decision making of low complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's family and/or family's needs. Usually, the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of laboratory/diagnostic procedures new patient (adolescent 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of laboratory/diagnostic procedures new patient (adolescent 18 through 39 years)
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of laboratory/diagnostic procedures new patient (adolescent 40 through 64 years)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of laboratory/diagnostic procedures established patient (late childhood age 5 through 11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of laboratory/diagnostic procedures established patient (adolescent age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of laboratory/diagnostic procedures established patient (18 through 39 years)

Code	Description
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of laboratory/diagnostic procedures established patient (40 through 64 years)
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual Including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of laboratory/diagnostic procedures established patient (65 and older)
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure) approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure) approximately 30 minutes
A4266	Diaphragm for contraceptive use
A4267	Contraceptive supply, condom male, each
A4268	Contraceptive supply, condom, female, each
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg
J7300	Intrauterine copper contraceptive (paragard IUD 10 year)
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
J7303	Contraceptive supply, hormone containing vaginal ring, each
J7304	Contraceptive supply, hormone containing patch, each
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies

Table 6: Laboratory Procedure Codes Not Covered

Code	Description
80061	Lipid panel. This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct meas
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, prot
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein
81025	Urine pregnancy test, by visual color comparison methods
82105	Alpha-fetoprotein; serum
82465	Cholesterol, serum or whole blood, total
82626	Dehydroepiandrosterone (DHEA)
82948	Glucose; blood, reagent strip
82951	Glucose; tolerance test (GTT), three specimens (includes glucose)

Code	Description
83001	Gonadotropin; follicle stimulating hormone (FSH)
83020	Hemoglobin fractionation and quantitation; electrophoresis (e.g., A2, S, C, and/or F)
83898	Molecular diagnostics; amplification of patient nucleic acid, each nucleic acid sequence
84138	Pregnanetriol
84144	Progesterone
84146	Prolactin
84270	Sex hormone binding globulin (SHBG)
84481	Triiodothyronine (T3); free
84702	Gonadotropin, chorionic (hCG); quantitative
84703	Gonadotropin, chorionic (hCG); qualitative
85014	Blood count; hematocrit (Hct)
85018	Blood count; hemoglobin (Hgb)
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85660	Sickling of RBC, reduction
86255	Fluorescent noninfectious agent antibody; screen, each antibody
86317	Immunoassay for infectious agent antibody, quantitative, not otherwise specified
86592	Syphilis test; qualitative (e.g., VDRL, RPR, ART)
86701	Antibody; HIV-1
86702	Antibody; HIV-2
86762	Antibody; rubella
86781	Antibody; Treponema Pallidum, confirmatory test (e.g., FTA-abs)
87070	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification
87075	Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates
87076	Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate
87086	Culture, bacterial; quantitative colony count, urine
87110	Culture, chlamydia, any source
87166	Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection
87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi,

Code	Description
	or cell types
87207	Smear, primary source with interpretation; special stain for inclusion bodies or parasites (e.g., malaria, coccidia, micro)
87210	Smear, primary source with interpretation; wet mount for infectious agents (e.g., saline, India ink, KOH preps)
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
87536	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification
87591	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
87621	Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, amplified probe technique
87797	Infectious agent detection by nucleic acid (DNA or RNA) not otherwise specified; direct probe technique, each organism
88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation
88161	Cytopathology, smears, any other source; preparation, screening and interpretation
88164	Cytopathology slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation
88305	LEVEL IV - Surgical pathology, gross and microscopic examination Abortion - Spontaneous/Missed Artery, Biopsy Bone Marrow

Section G – Provider Network

AmeriHealth Mercy has been diligently creating a statewide network of providers through a combination of Letters of Intent and executed Provider Contracts. As of the submission of this response, AmeriHealth Mercy is proud to have almost 7,000 providers that have signed Letters of Intent or executed a Provider Contract. AmeriHealth Mercy has had many provider network management staff working throughout Louisiana meeting, educating and recruiting physicians, vendors, clinics and hospitals. We are aggressively implementing our provider network development plan as detailed in section C.2. And, we will continue to add providers to the AmeriHealth Mercy network to ensure the best possible access for our future members.

G.1: Proposed Provider Network

G.1 Provide a listing of the proposed provider network using the List of Required In Network Providers as described in this RFP, including only those providers with whom you have obtained a signed LOI or executed subcontract. LOIs and signed subcontracts will receive equal consideration. LOIs and subcontracts should NOT be submitted with the proposal. DHH may verify any or all referenced LOIs or contracts. Along with the provider listing, provide the number of potential linkages per PCP.

Using providers with whom you have signed letters of intent or executed contracts, provide individual GeoAccess maps and code by GSA for:1) hospitals, 2) primary care providers, FQHCs, and RHCs; and3) Specialists. You should provide individual maps as well as overlay maps to demonstrate distance relationships between provider types.

The CCN should provide an Excel spreadsheet of their proposed provider network and include the following information: (Sample spreadsheet is available in the Procurement Library)

1. *Practitioner Last Name, First Name and Title – For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD,NP (Nurse Practitioner), PA (Physician Assistant), etc.*
2. *Practice Name/Provider Name – Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.*
3. *Business Location address – Indicate the business location address where services are provided including but not limited to, 1st line of address, 2nd line of address, city, state, postal code*
4. *Provider type and specialty Code –indicate the practitioner's specialty using Medicaid provider type and specialty codes.*
5. *New Patient –Indicate whether or not the provider is accepting new patients.*
6. *Age Restriction – Indicate any age restrictions for the provider's practice. For instance, fi a physician only sees patients up to age 19, indicate <19; if a physician only sees patients age 13 or above, indicate >13.*
7. *If PCP – the number of potential linkages.*
8. *If LOI or contract executed.*
9. *Designated if Significant Traditional Provider*
10. *GEO coding for this location.*

Unmatched Provider Relationships and Network

At the heart of the AmeriHealth Mercy provider network rests special relationships built on years of discussion and collaboration with the largest providers of care to the Medicaid population: hospitals, primary care physicians, specialists and others. We understand that a successful CCN program depends on true collaboration with traditional providers of care to our target population, not just a commercial-

style managed care contract. As a result, we have invested years of relationship building with some of the largest provider entities in the State. A summary of these relationships is listed below.

LSU Health Services Division (LSU)

Our relationship began in 1994 when Tom Lyman, Senior Vice President, Market Expansion met Patrick O'Connor, Director of Research and Development for the LSU Health Services Division. Over the past 17 years, we have maintained that relationship through changes in LSU leadership from Jim Brexler through Dr. Fred Cerise.

Since 2008, we have had regular discussions with Dr. Cerise and others in the organization about working together on a managed Medicaid program. We have listed many of the LSU senior executives who have been working with AmeriHealth Mercy to prepare for this proposal below:

- **Fred Cerise, MD**, Executive Vice President, LSUHSC
- **Roxane Townsend, MD**, Executive Vice President, LSU Community Hospital, New Orleans
- **Frank Opelka, MD,** Vice Chancellor Clinical Affairs
- **Liz Sumrall,** Vice President, LSUHSC
- **Pat O'Connor, PhD,** Director, Research & Development
- **Jaquetta Clemons, Dr PH,** Assistant Vice President, Finance
- **Michael Kaiser, MD,** Medical Director, LSUHSC
- **Mike Carter,** HSCD Reimbursement Director
- **Cindy Rives,** HSCD Budget Director
- **Cathi Fontenot, MD,** Medical Director MCLNO LSUHSC
- **Melanie H. Sotak, MHSA,** Administrative Director of Shared Business Services
- **Christopher Vidrine,** Director of External Relations
- **Jeannine F. Hinton, LCSW, MHA,** Project Coordinator, Health Care Services Division, HQ
- **Bonnie Wibel,** Director Marketing & Provider Enrollment Administration
- **Steve Fertitta,** HCSD
- **Kyle Viator,** HCSD
- **Hugh Mighty, MD,** Vice Chancellor for Clinical Affairs-Shreveport
- **Carol Brown,** Director of Hospital Billing
- **Robert Barish,** Chancellor, LSUHSC-Shreveport
- **Harold White,** Vice Chancellor, LSUHSC-Shreveport
- **Steve Nelson, MD,** Dean, LSU Medical School-New Orleans
- **Larry Hollier, MD,** Chancellor LSUHSC-New Orleans

In addition to the letters of intent, Fred Cerise MD, LSU Executive Vice President, wrote a letter to Michael Rashid, AmeriHealth Mercy President & CEO stating,

> *"LSU Health System is committed to working with the AmeriHealth Mercy Family of Companies (AMFC) through participation in a statewide partnership for the DHH Medicaid Coordinated Care Network managed care initiative. LSU Health appreciates the effort made by AMFC for the past five years, and its interest in developing a preferred relationship with our health system to participate in Louisiana's Medicaid managed care program."*

The letter also highlights the meetings when LSU staff and representatives from AmeriHealth Mercy discussed care coordination, case management, and information sharing. These discussions resulted in a special collaboration that will not only meet the goals of DHH for the CCN program, but give LSU the tools to prepare for all patient populations under Medicaid reform.

The Franciscan Missionaries of Our Lady Health System (FMOLHS)

The FMOLHS and Our Lady of the Lake Regional Medical Center share many of the same components of the mission and values of AmeriHealth Mercy. This shared mission drew our organizations together when it became clear in 2008 that a managed care program was on the horizon. As a result, we have had

regular discussions with John Finan, President and CEO of FMOLHS and others in the organization about working together on a managed Medicaid program. Below is a list of FMOLHS senior executives who have worked with AmeriHealth Mercy to prepare for this proposal:

- **John Finan,** President & CEO, FMOLHS
- **Scott Wester,** President & CEO, Our Lady of the Lake
- **Rene Ragas,** Director of Special Assignments
- **Dee LeJune,** President & CEO, St. Elizabeth's Hospital
- **Bob Ramsey,** Chief Financial Officer, FMOLHS
- **Lolly Martin,** Vice President, Health Care Reform
- **Kevin Guidry,** Director of Payor Relations
- **Dr. Stephanie Mills,** CEO of Franciscan Health and Wellness
- **Dr. Redfield Bryan,** FMOLHS Physician Consultant
- **Vindell Washington,** CMIO/CAO

In addition to the letters of intent, AmeriHealth Mercy of Louisiana and FMOLHS entered into a Memorandum of Understanding on June 9, 2011. This Memorandum of Understanding states, "the parties desire to establish a relationship pursuant to which FMOLHS, and identified providers affiliated with FMOLHS, will be participating providers with the AmeriHealth Mercy of Louisiana CCN and, as a component of that relationship, FMOLHS will participate in the programmatic direction, clinical policies, quality improvement initiatives and the risk associated with serving the enrolled CCN population."

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

The main provisions in the agreement include FMOLHS providers contracting with the AmeriHealth Mercy of Louisiana CCN, participating in a provider leadership council, collaborating on an approved marketing plan to the extent permitted under DHH rules, and developing a compliant quality incentive and risk sharing arrangement, whereby significant upside potential is available to FMOLHS providers. This Memorandum of Understanding lays the foundation and framework for AmeriHealth Mercy to work in a unique partnership with FMOLHS to improve the quality and value of care delivered to AmeriHealth Mercy members and FMOLHS patients. This special collaboration will not only meet the goals of DHH for the CCN program, but give FMOLHS tools to prepare for all patient populations under Medicaid reform.

CHRISTUS Health (CHRISTUS)

CHRISTUS Health, like FMOLHS share many of the same components of the mission and values of AmeriHealth Mercy. This shared mission was apparent in several meetings between CHRISTUS corporate team members and AmeriHealth Mercy leadership held in San Antonio, Texas and Alexandria, Louisiana earlier this year. The list below names just some of the CHRISTUS senior executives who have worked with us to formulate a possible role in the AmeriHealth Mercy CCN in their service area:

- **Stephen Wright,** CEO, CHRISTUS LOUISIANA
- **William Lunn, MD**, Administrator, CHRISTUS Schumpert (Shreveport region)
- **Bernard Leger,** Administrator, CHRISTUS St. Patrick (Lake Charles region)
- **Lisa Lauve,** Administrator, CHRISTUS Cabrini (Alexandria region)
- **Susan Tudor,** Regional Vice President Business Development and Strategic Planning
- **Grady Mullins,** Vice President of Finance

- **Linda Smith,** Provider Enrollment/Billing Specialist CHRISTUS Provider Network
- **Les Tompkins,** Louisiana Regional Director of Managed Care
- **Kevin Parsley,** Senior Director Managed Care for Southern Region
- **Mark E. Marley,** CEO, Natchitoches Regional Medical Center

Woman's Hospital

AmeriHealth Mercy is acutely aware of the importance of Woman's Hospital in Baton Rouge. As a result, in 2008, we began a dialogue with Terri Fontenot, President & CEO, Stephanie Anderson, CFO, and Sherry Poss, Director of Managed Care, in conjunction with LSU and FMOLHS senior leadership to begin developing an approach that will result in better outcomes for our members.

Tulane University Medical Group

AmeriHealth Mercy understands that Tulane University Medical Group is a critical component of the care delivery system for the citizens of New Orleans. As a result, in 2008, staff began a dialogue with Dr. Ben Sachs, MD, Dean & Senior Vice President and Jerold Feddersen, CEO Tulane Medical Group to begin developing an approach that will result in increased access to care and better outcomes for our members. We have obtained letters of intent from Tulane Medical Group and expect contracts from all of their related entities after an award announcement.

HCA Healthcare

We have received a contract proposal from HCA Healthcare for their hospitals and affiliated providers. HCA has decided to pursue contracts instead of signing an LOI, and we are currently reviewing the terms of the proposal. We feel confident that we will be able to come to terms with HCA which will enhance our network across the state. We have not included the HCA facilities and providers in the RFP submission, but once the contracts have been completed, our networks will include:

- Dauterive Hospital, New Iberia
- The Regional Medical Center of Acadiana, Lafayette
- Women's and Children's Hospital, Lafayette
- Tulane University Hospital and Clinic, New Orleans
- Lakeview Regional Medical Center, Covington
- Lafayette Surgicare, Lafayette
- Women's Imaging Centre, Lafayette
- Garden Park Hospital, Gulfport, Mississippi

HCA will also bring 38 primary care physicians and 160 specialists.

OPH and Ochsner Health System

In addition to these significant providers, we have obtained letters of intent from Ochsner Health System and the Louisiana Office of Public Health to participate in the AmeriHealth Mercy CCN.

Provider Network Maps

Taking network adequacy time and distance standards into consideration, AmeriHealth Mercy mapped the participating providers (based on receipt of either a Letter of Intent or a contract) by provider type and overall. The distance for hospital access is currently based on 30 miles. We plan to utilize the 30 minute standard once the time/distance requirement is confirmed. We included the maximum number of PCP linkages in our Provider Listing as a placeholder. We have reviewed the maps to ensure any network improvement opportunities are addressed in the outreach plan. We will continue to refine this information along with open/closed panels and age restrictions as we prepare for Readiness Review.

In an effort to align our provider and specialty types with those in Appendix E, we utilized specialty codes that came closest to the provider's actual specialty and the Appendix E specialty listing. For example, all Urgent Care, Pediatric Critical Care, Critical Care Medicine and Critical Care / Trauma

Surgery practitioners are rolled-up into Emergency Medicine since there was not a category for Urgent or Critical Care. Pediatric Endocrinology is listed with the code for Endocrinology since Pediatric Endocrinology is not included in Appendix E. Also, many providers are listed with their correct specialty name but with a Specialty Code 87 for All Other or Specialty Code 00 for All Specialties. Partnering with DHH to map the complete list of specialties and provider types will be an important step as we report additional provider data.

In the following pages, we have inserted the relevant and required GeoAccess maps showing provider network coverage. In addition, we have inserted a provider roster listing of 6,710 provider records who have either signed an LOI or executed a provider contract with AmeriHealth Mercy. This provider listing also identifies if the provider is listed as a Significant Traditional Provider (STP).

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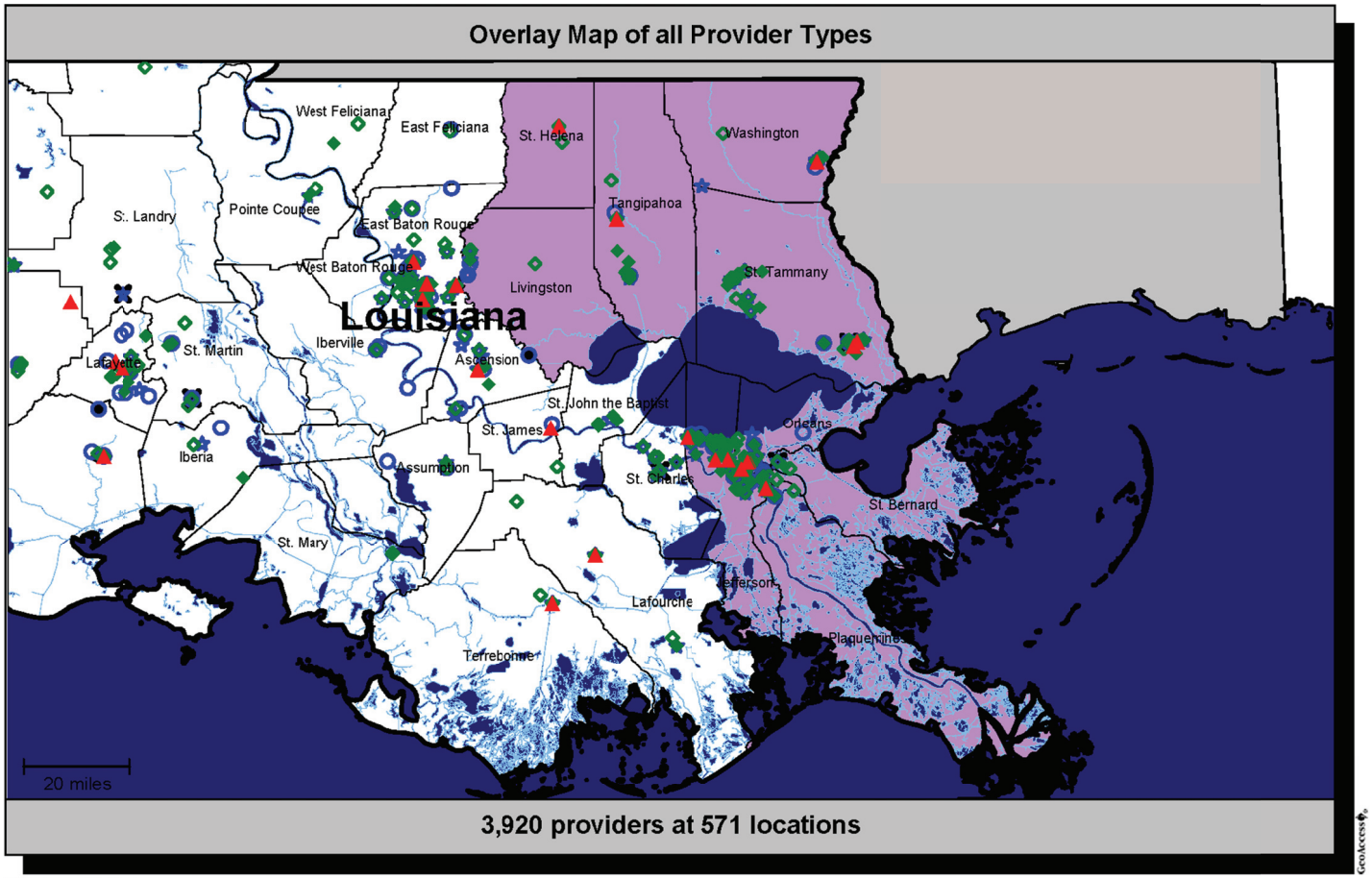
GSA "A" - Regions 1 & 9



Single	Multiple	
▲	△	1. Hospitals (41) (3)
●	✖	2. RHC/FQHC Providers (16) (5)
○	★	3. Primary Care Providers (111) (156)
◆	◇	4. Specialist Providers (150) (256)

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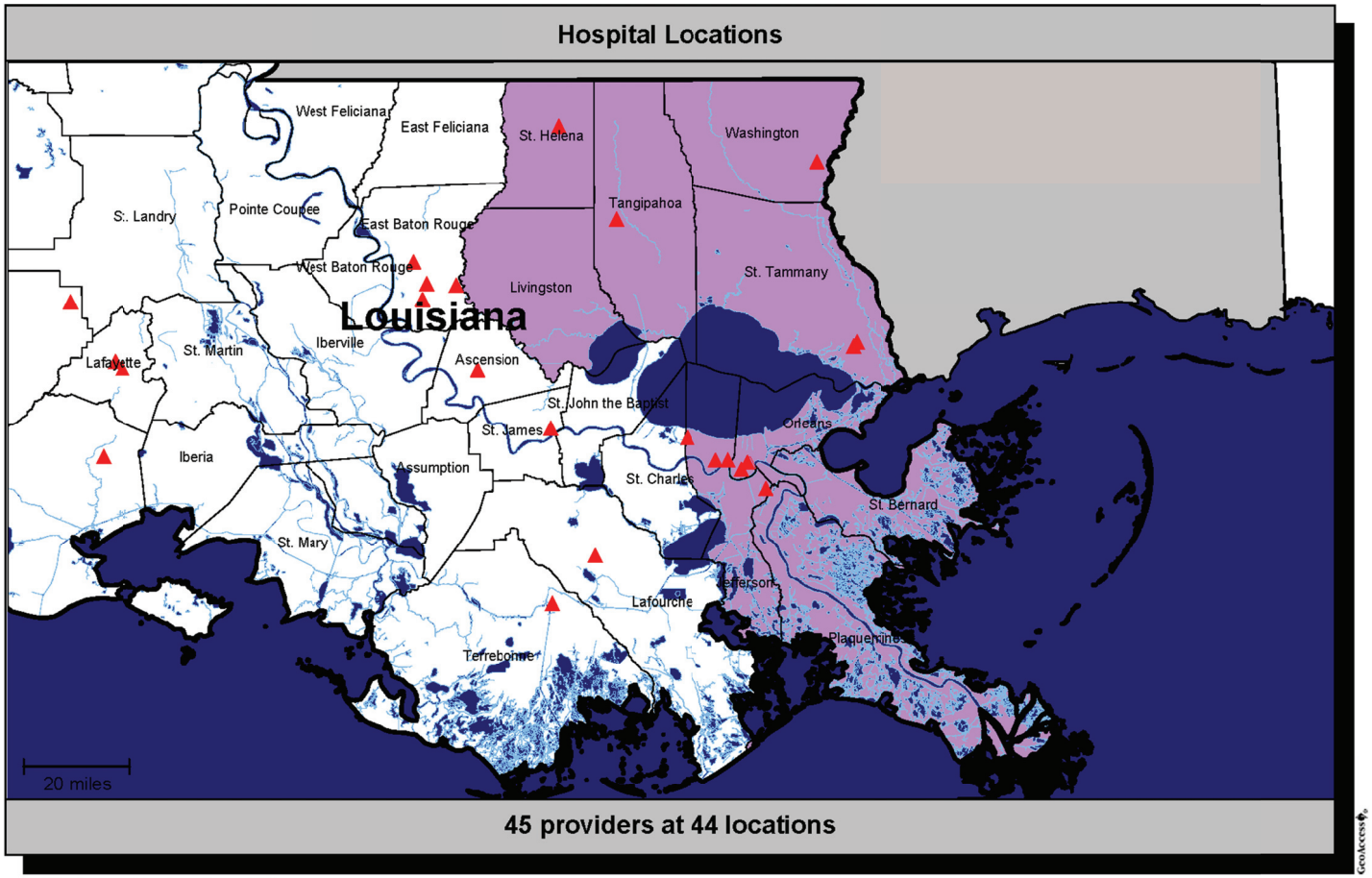
GSA "A" - Regions 1 & 9



▲ Single provider locations (41)
△ Multiple provider locations (3)

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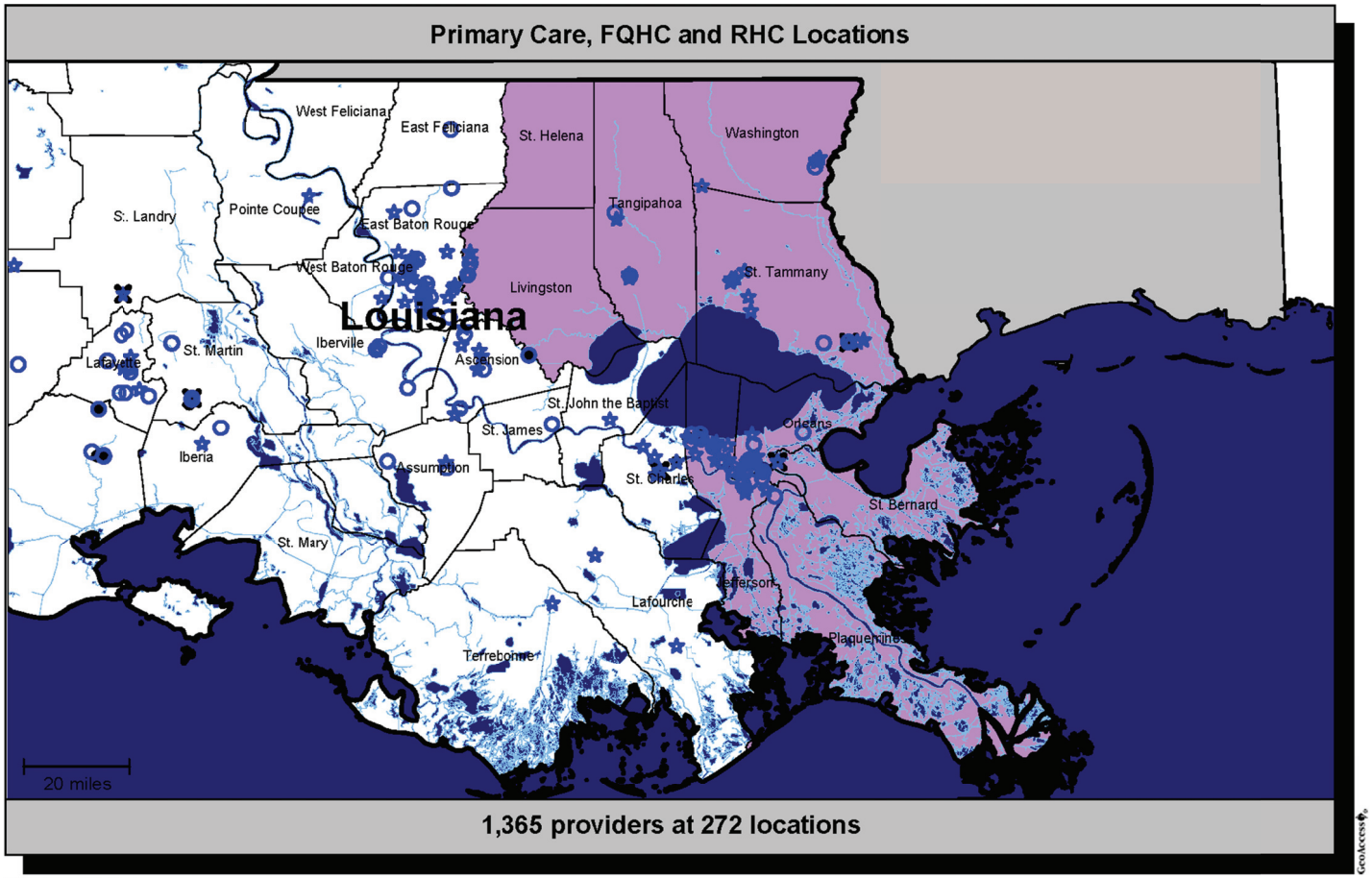
GSA "A" - Regions 1 & 9



Single	Multiple	
○	★	1. Primary Care Providers (111) (156)
●	✖	2. RHC/FQHC Providers (16) (5)

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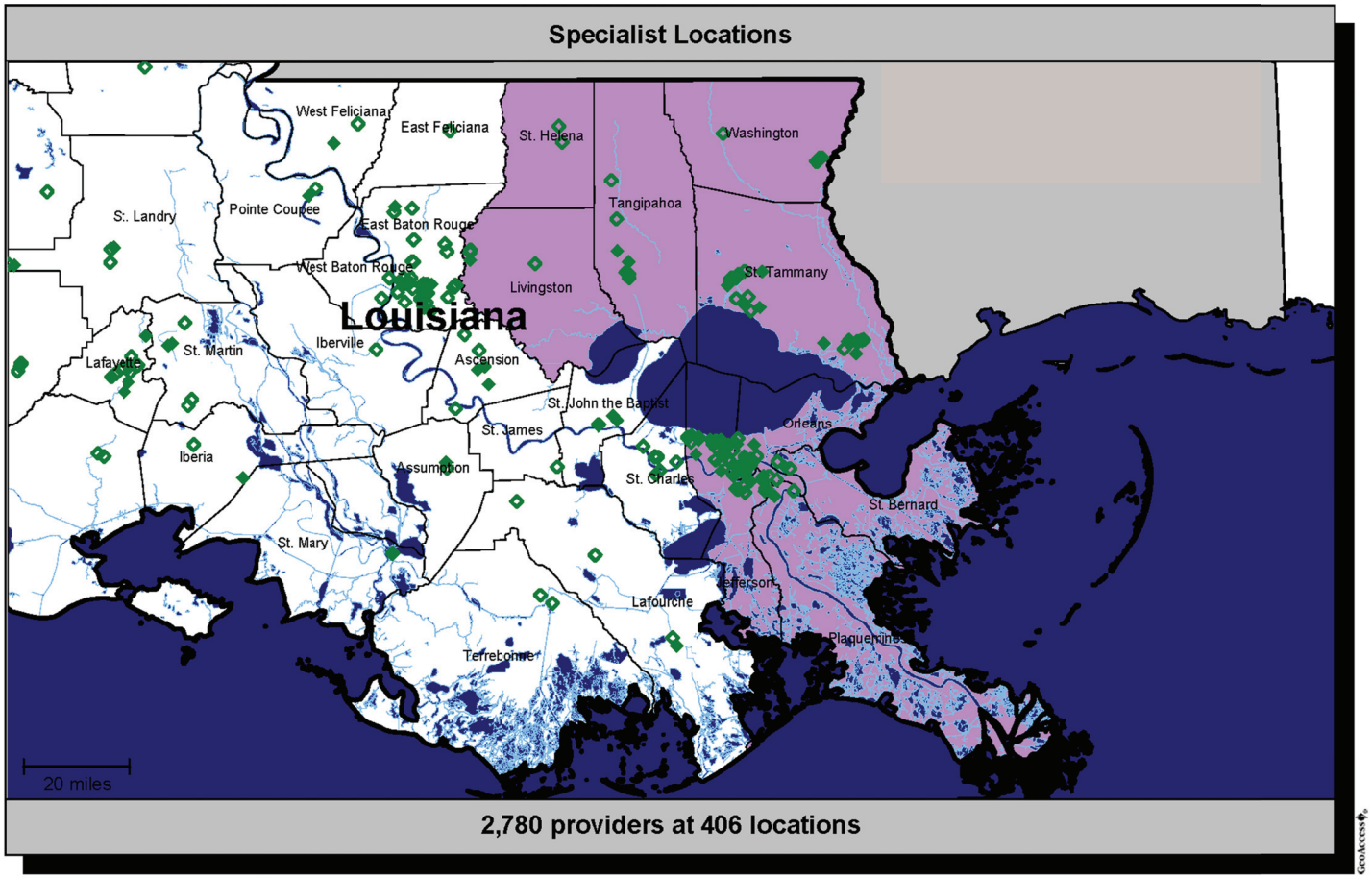
GSA "A" - Regions 1 & 9



- Single provider locations (150)
- Multiple provider locations (256)

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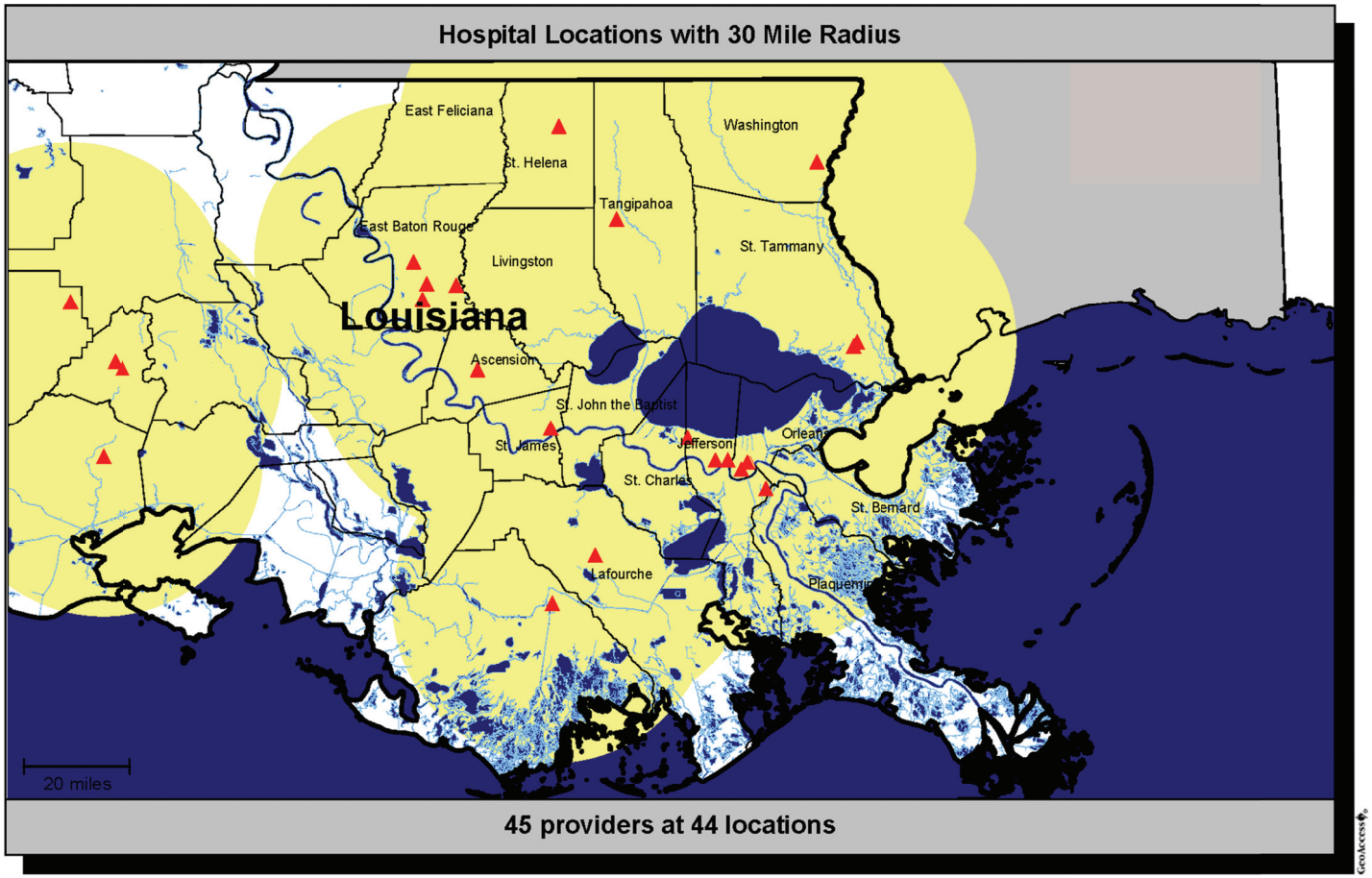
GSA "A" - Regions 1 & 9 - Rural



- Single provider locations (41)
- Multiple provider locations (3)
- Rural Parishes
- 30 mile radius

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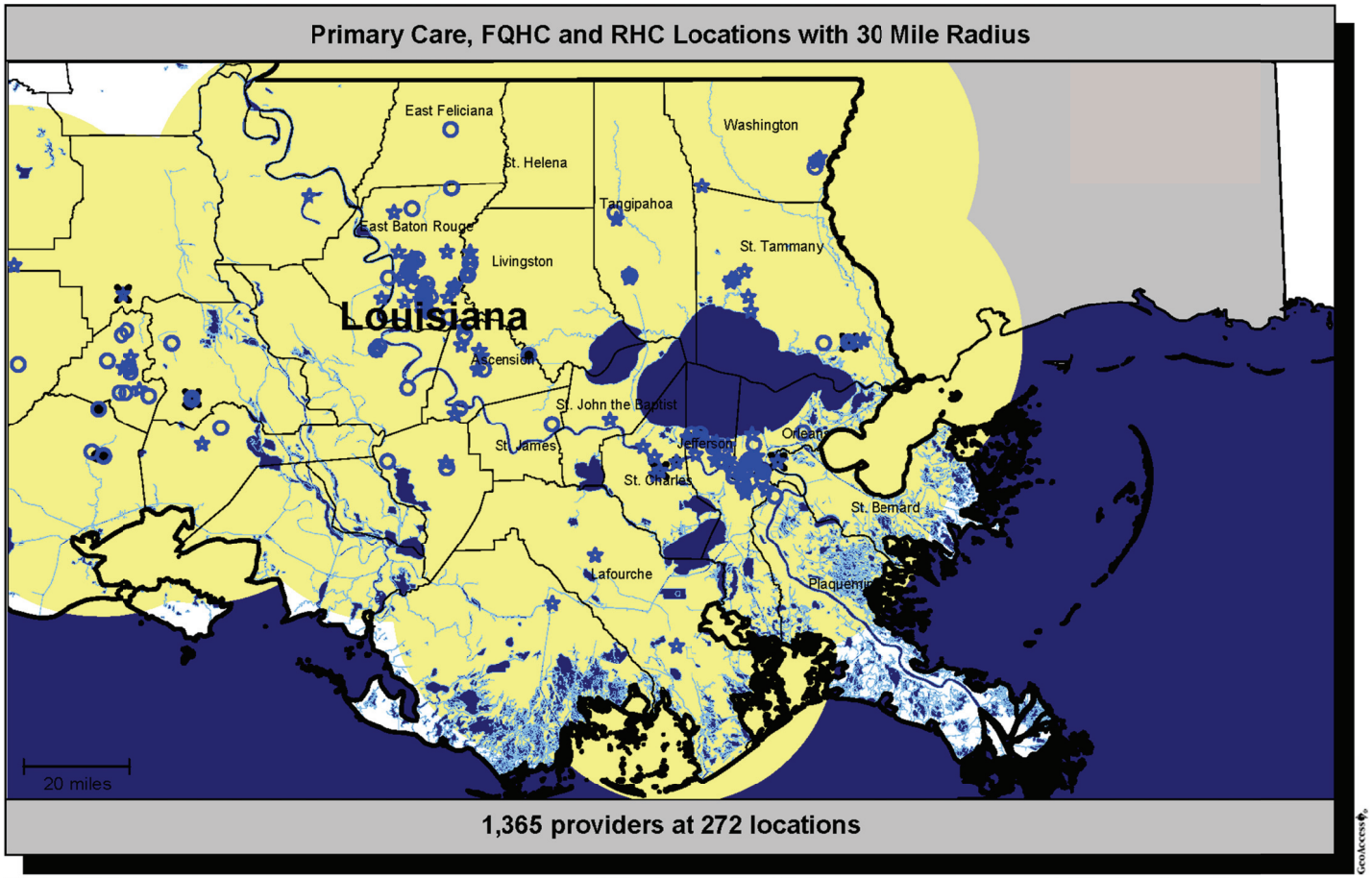
GSA "A" - Regions 1 & 9 - Rural



Single Multiple
1. Primary Care Providers (111) (156)
2. RHC/FQHC Providers (16) (5)

Service area: Rural Parishes

30 mile radius - All

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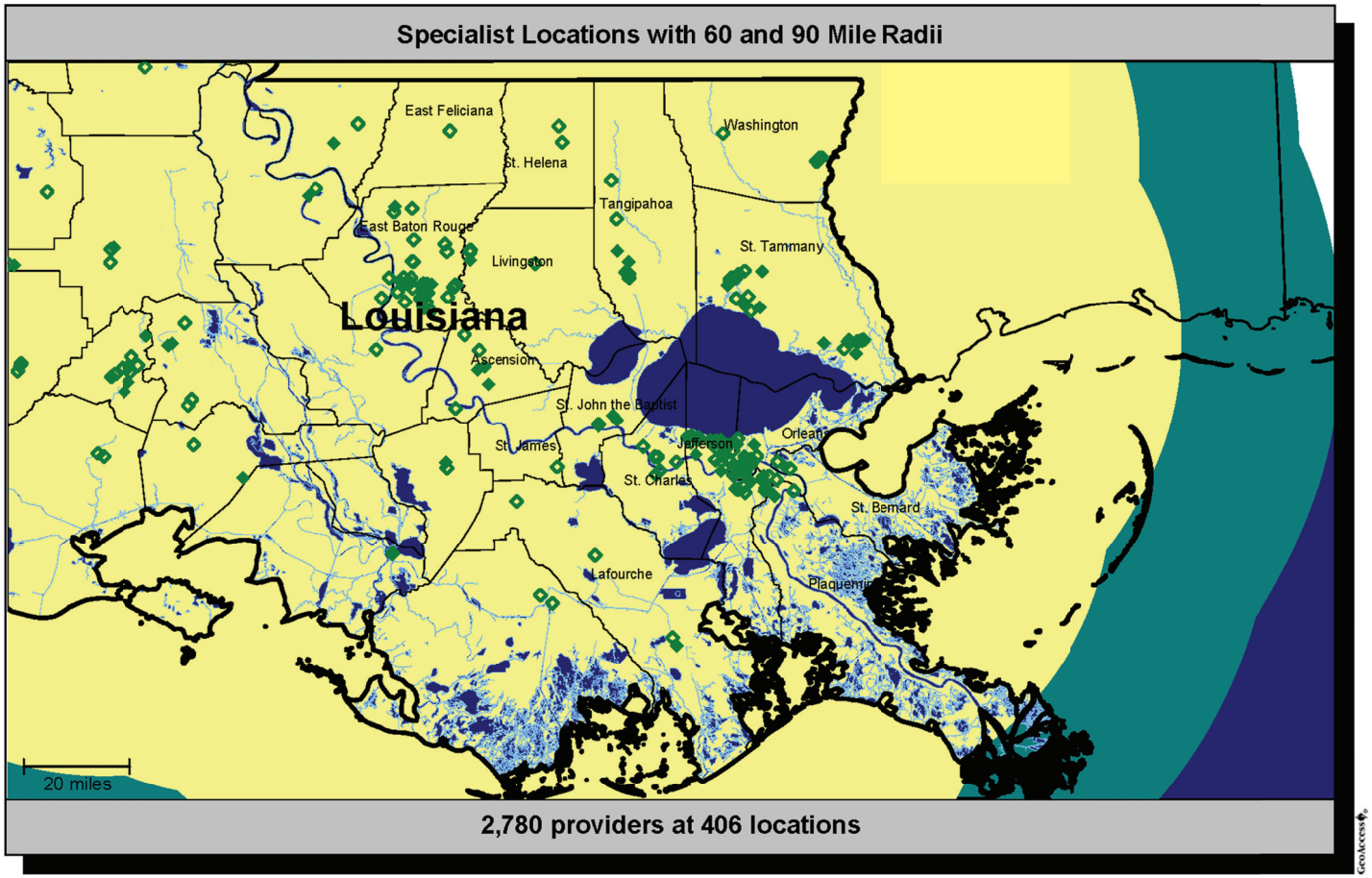
GSA "A" - Regions 1 & 9 - Rural



- Single provider locations (150)
- Multiple provider locations (256)
- Rural Parishes
- 60 mile radius
- 90 mile radius

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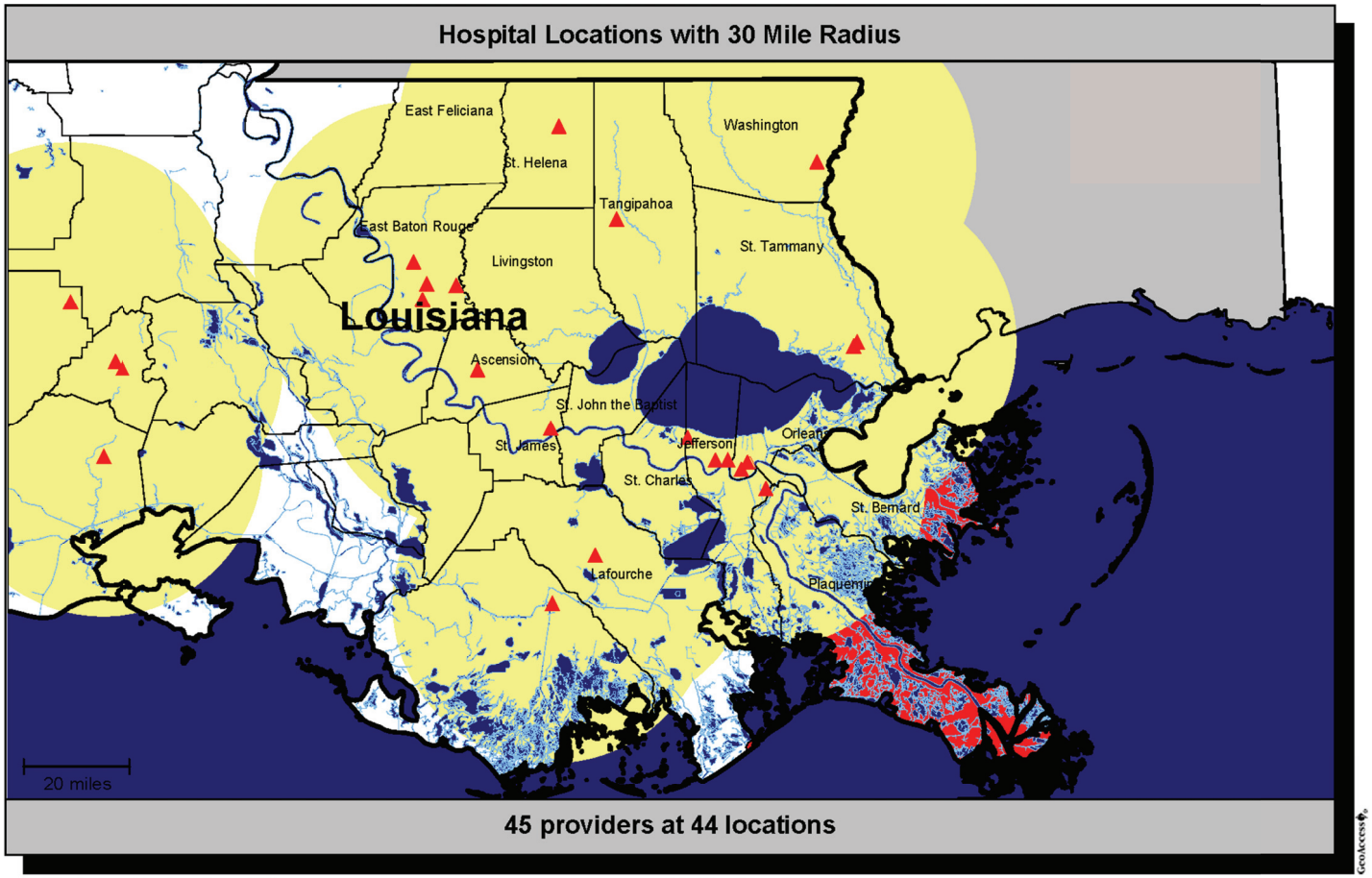
GSA "A" - Regions 1 & 9 - Urban



- Single provider locations (41)
- Multiple provider locations (3)
- Urban Parishes
- 30 mile radius

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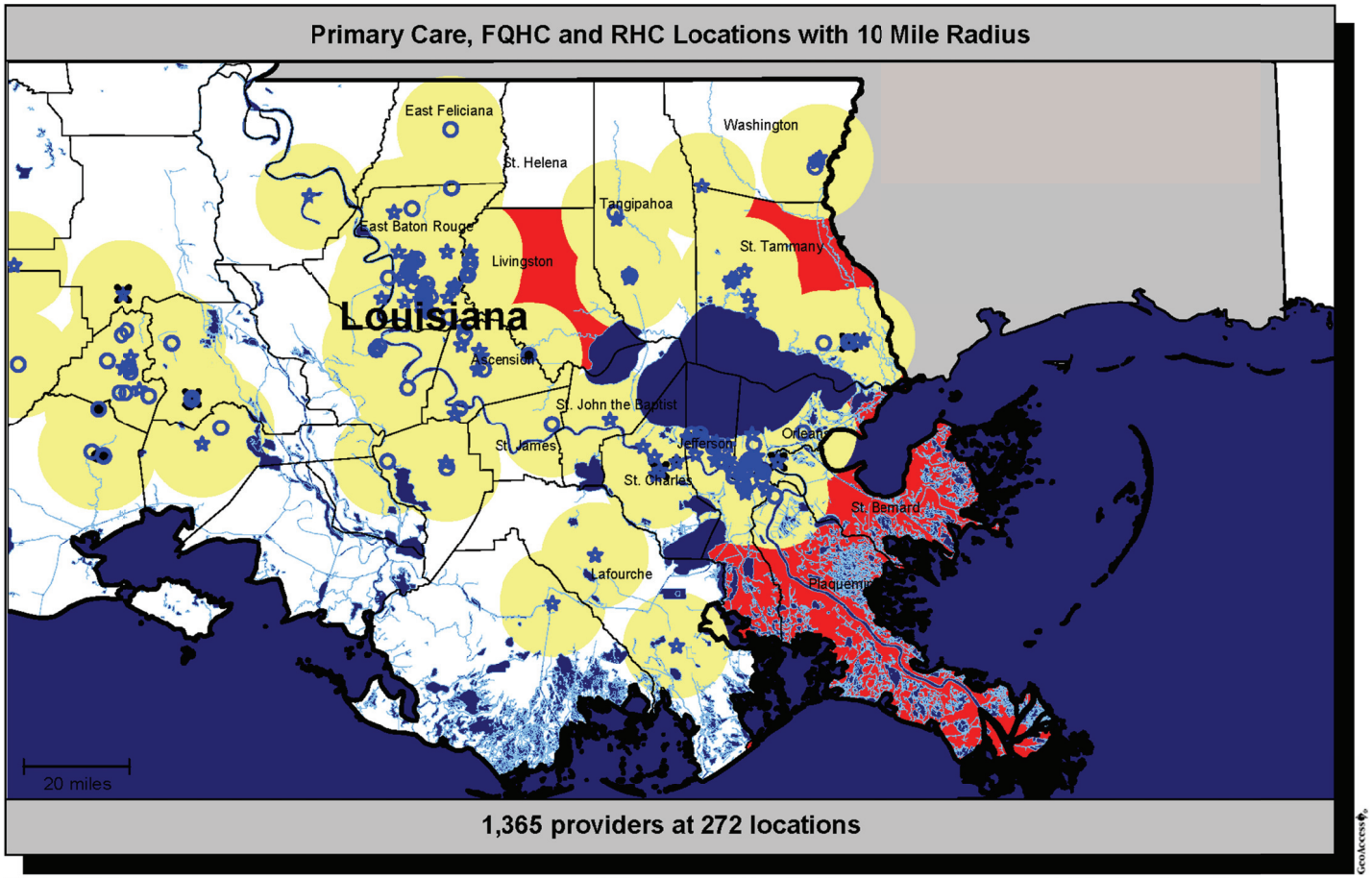
GSA "A" - Regions 1 & 9 - Urban



Single Multiple
1. Primary Care Providers (111) (156)
2. RHC/FQHC Providers (16) (5)

Service area: Urban Parishes

10 mile radius - All

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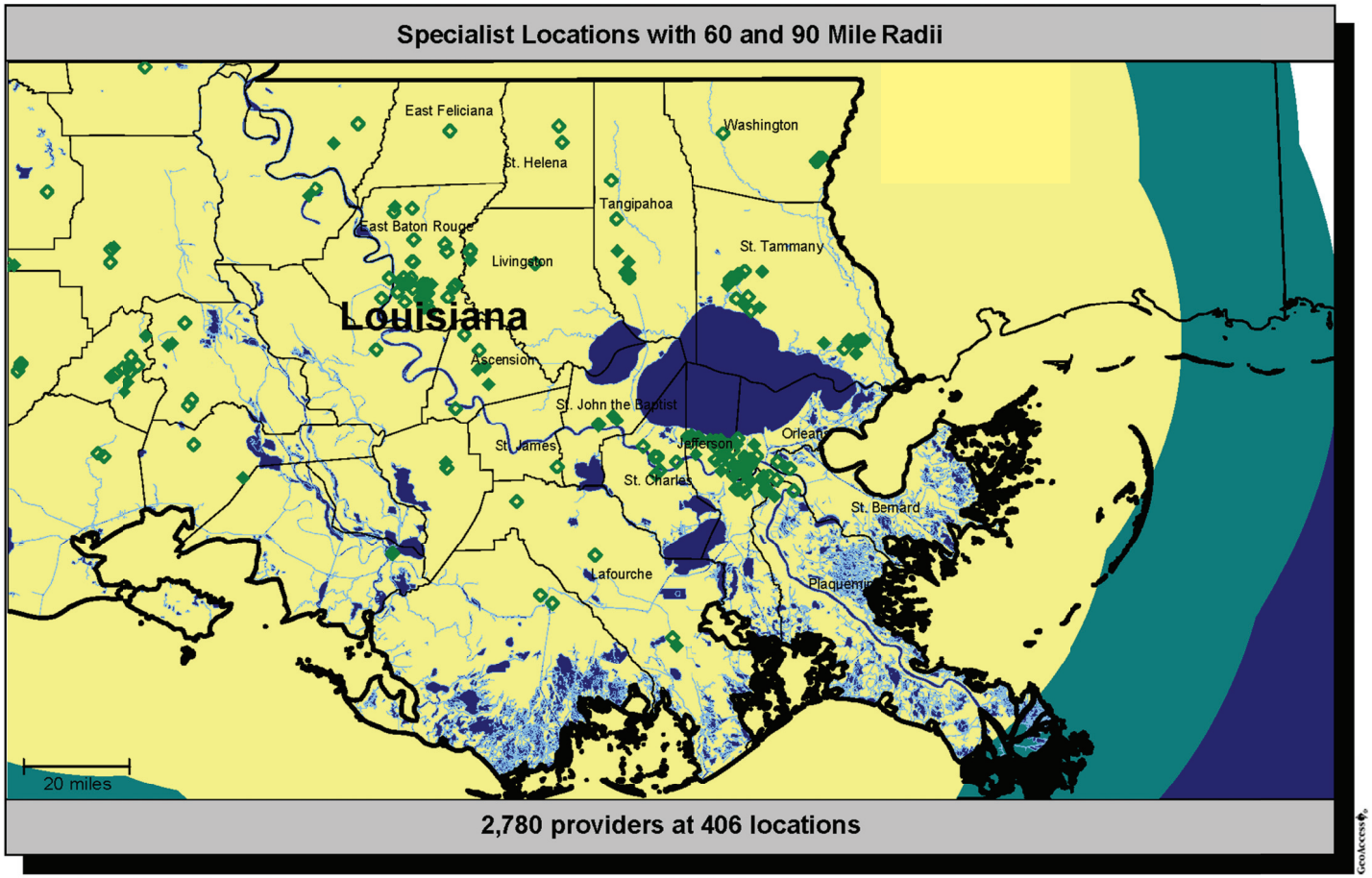
GSA "A" - Regions 1 & 9 - Urban



- Single provider locations (150)
- Multiple provider locations (256)
- Urban Parishes
- 60 mile radius
- 90 mile radius

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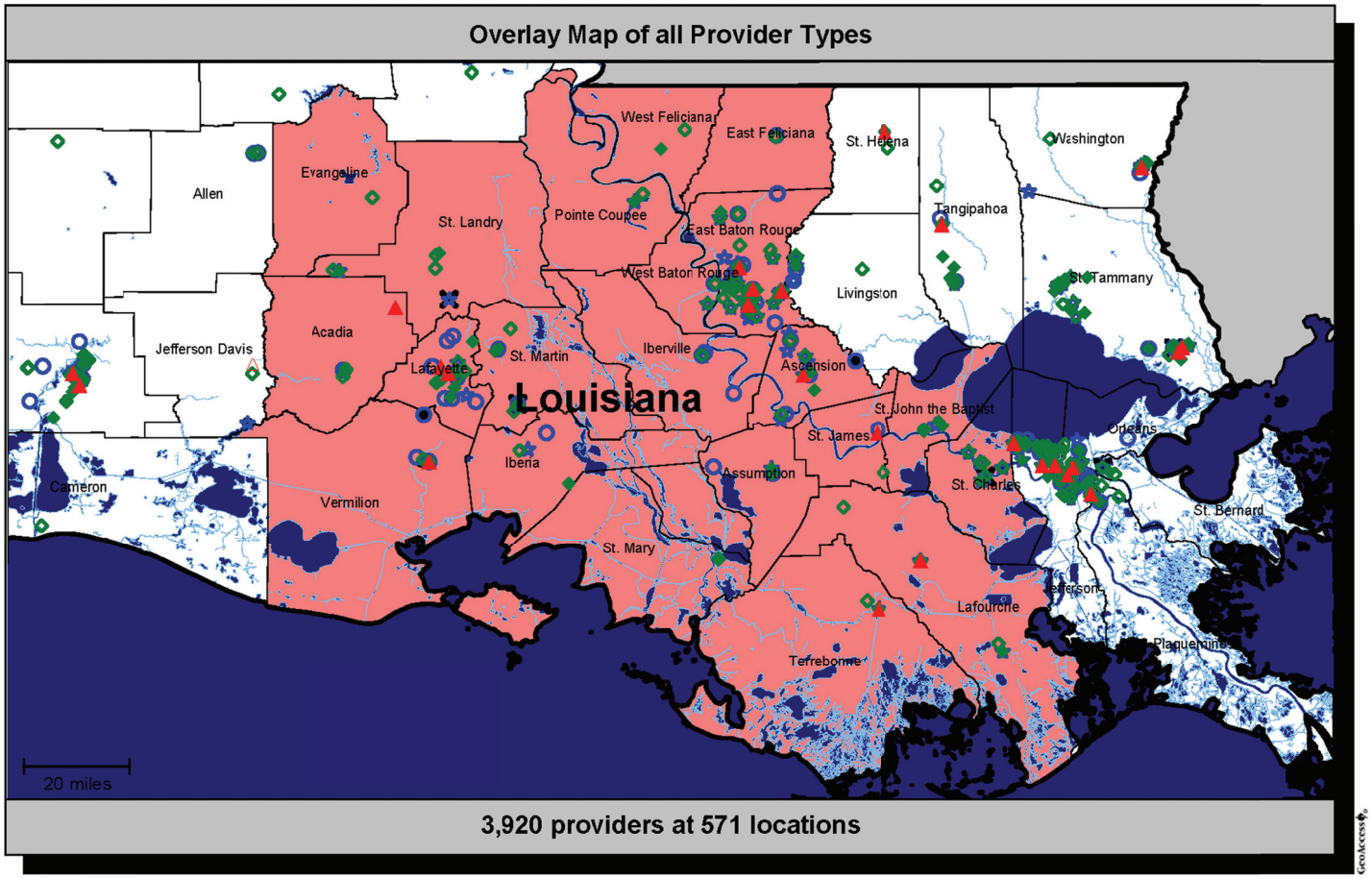
GSA "B" - Regions 2,3 & 4



Single	Multiple	
▲	△	1. Hospitals (41) (3)
●	✖	2. RHC/FQHC Providers (16) (5)
○	★	3. Primary Care Providers (111) (156)
◆	◇	4. Specialist Providers (150) (256)

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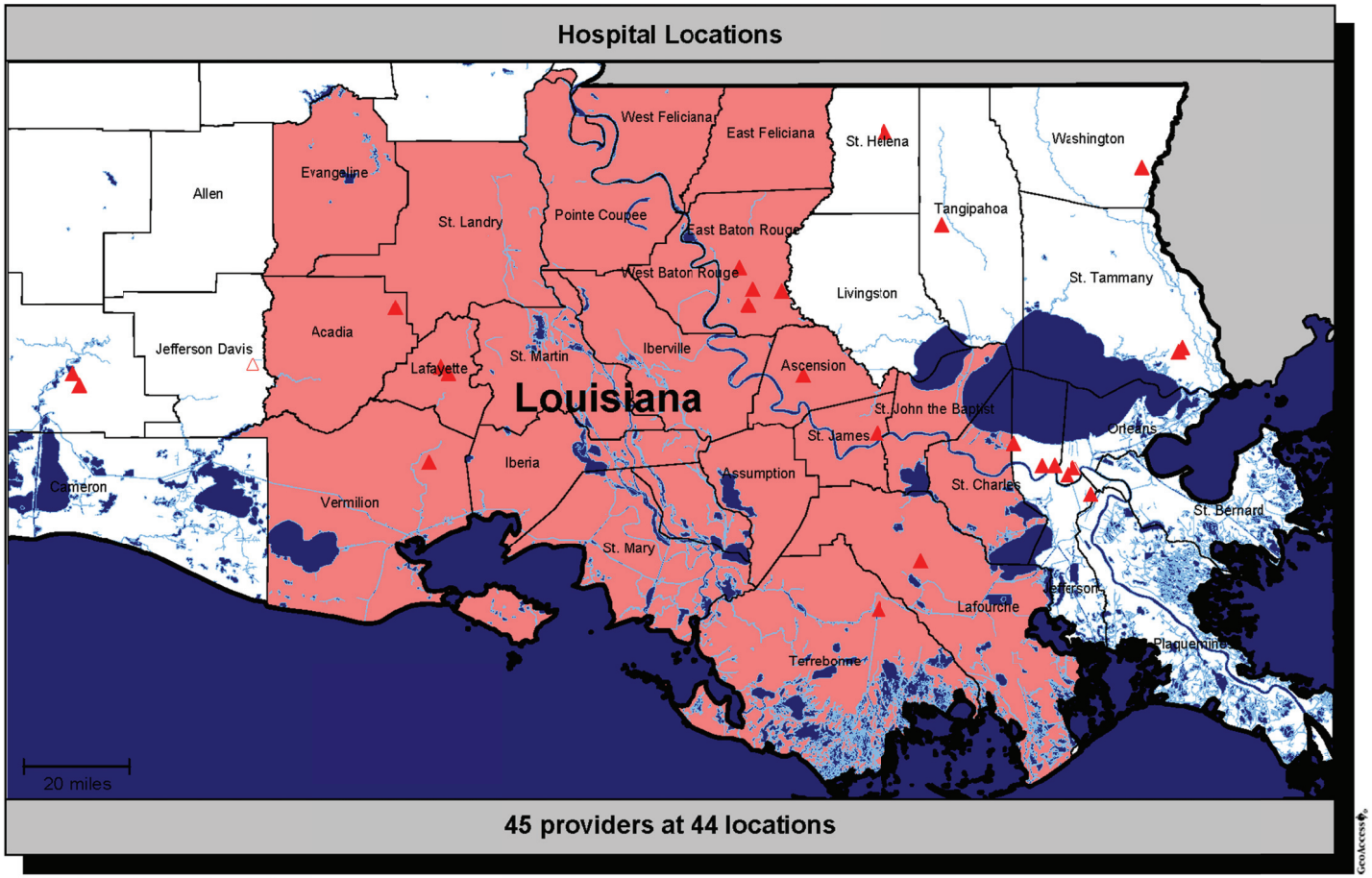
GSA "B" - Regions 2,3 & 4



▲ Single provider locations (41)
△ Multiple provider locations (3)

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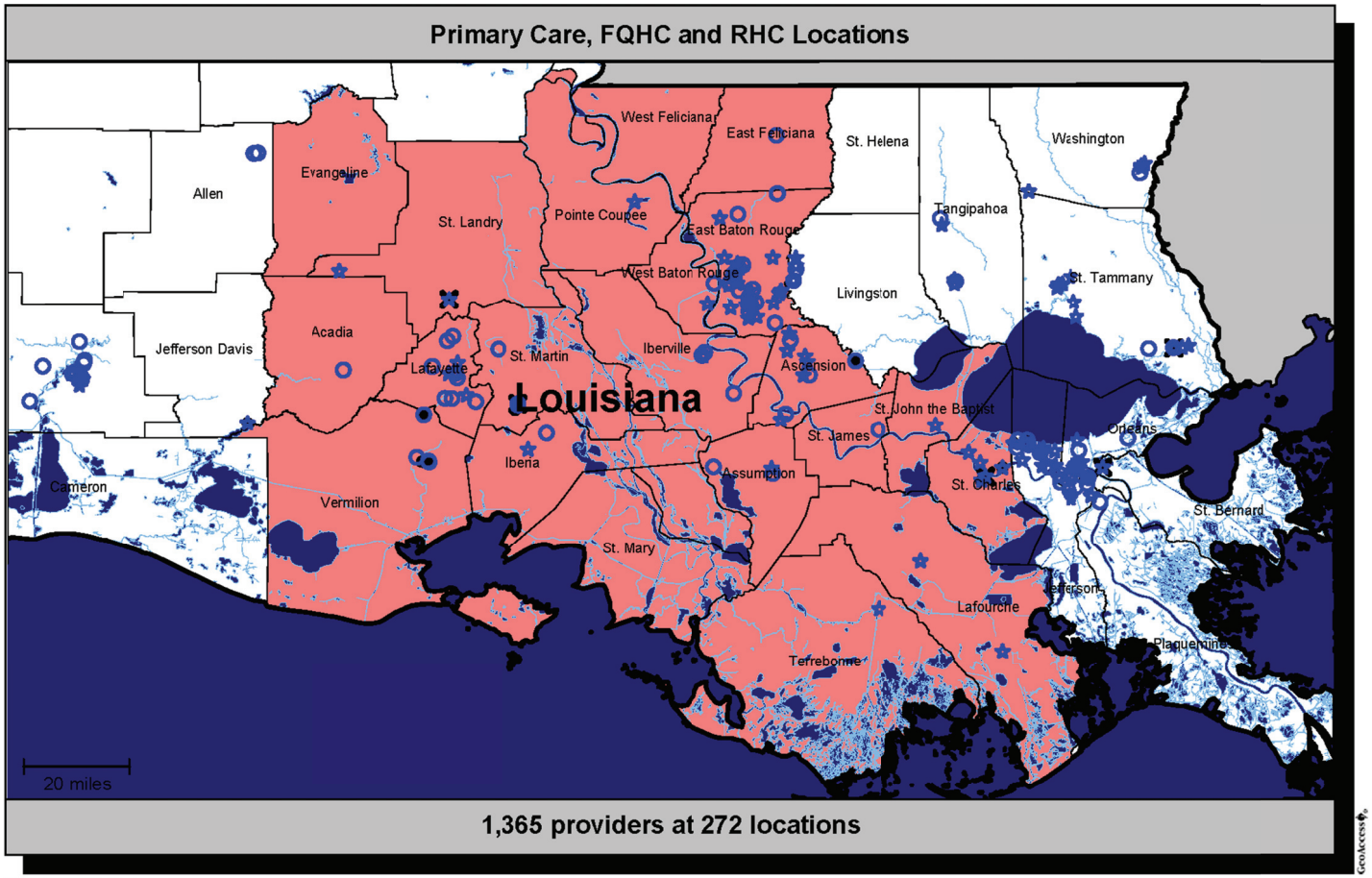
GSA "B" - Regions 2,3 & 4



Single	Multiple	
○	★	1. Primary Care Providers (111) (156)
●	✖	2. RHC/FQHC Providers (16) (5)

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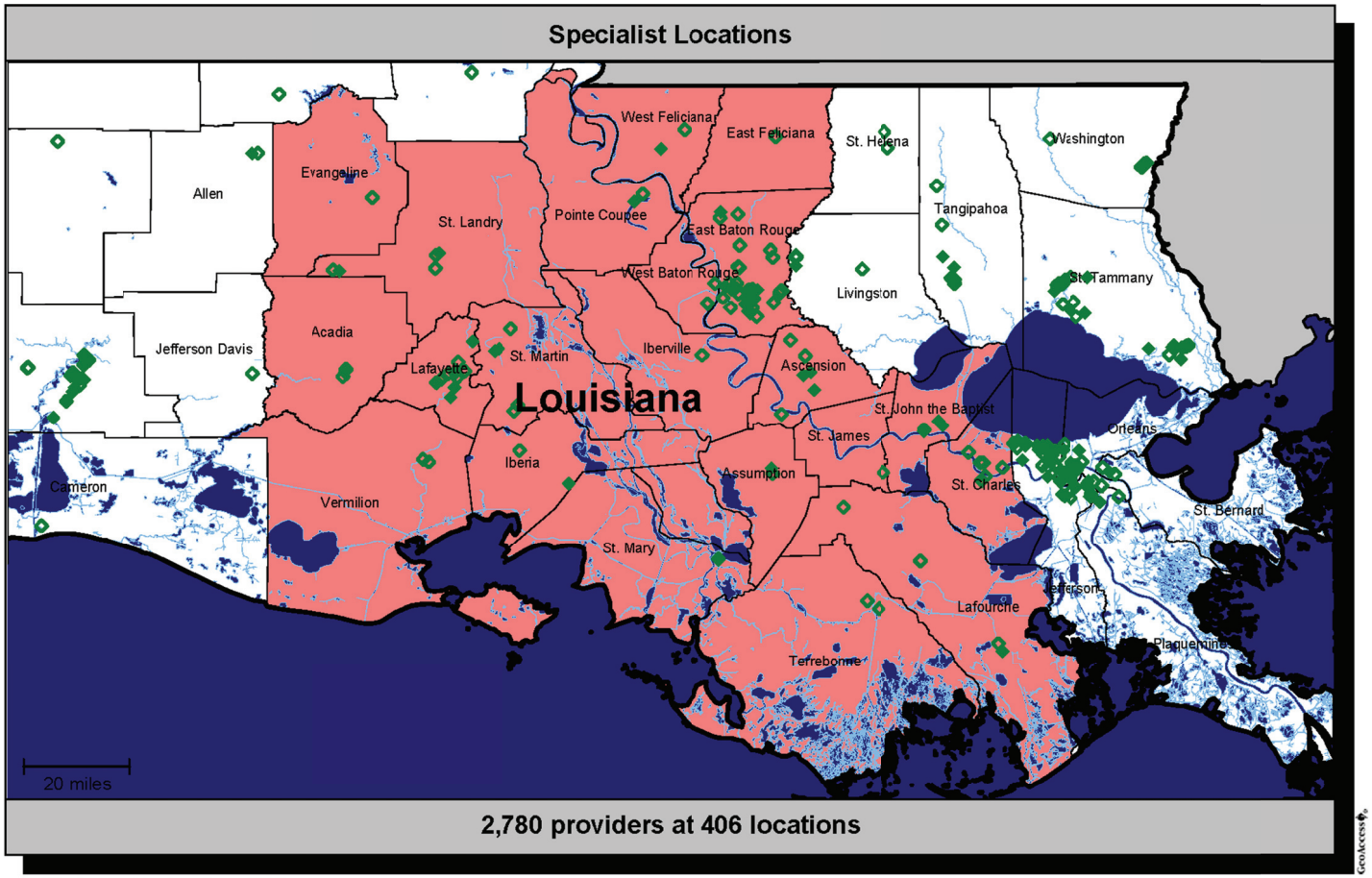
GSA "B" - Regions 2,3 & 4



- Single provider locations (150)
- Multiple provider locations (256)

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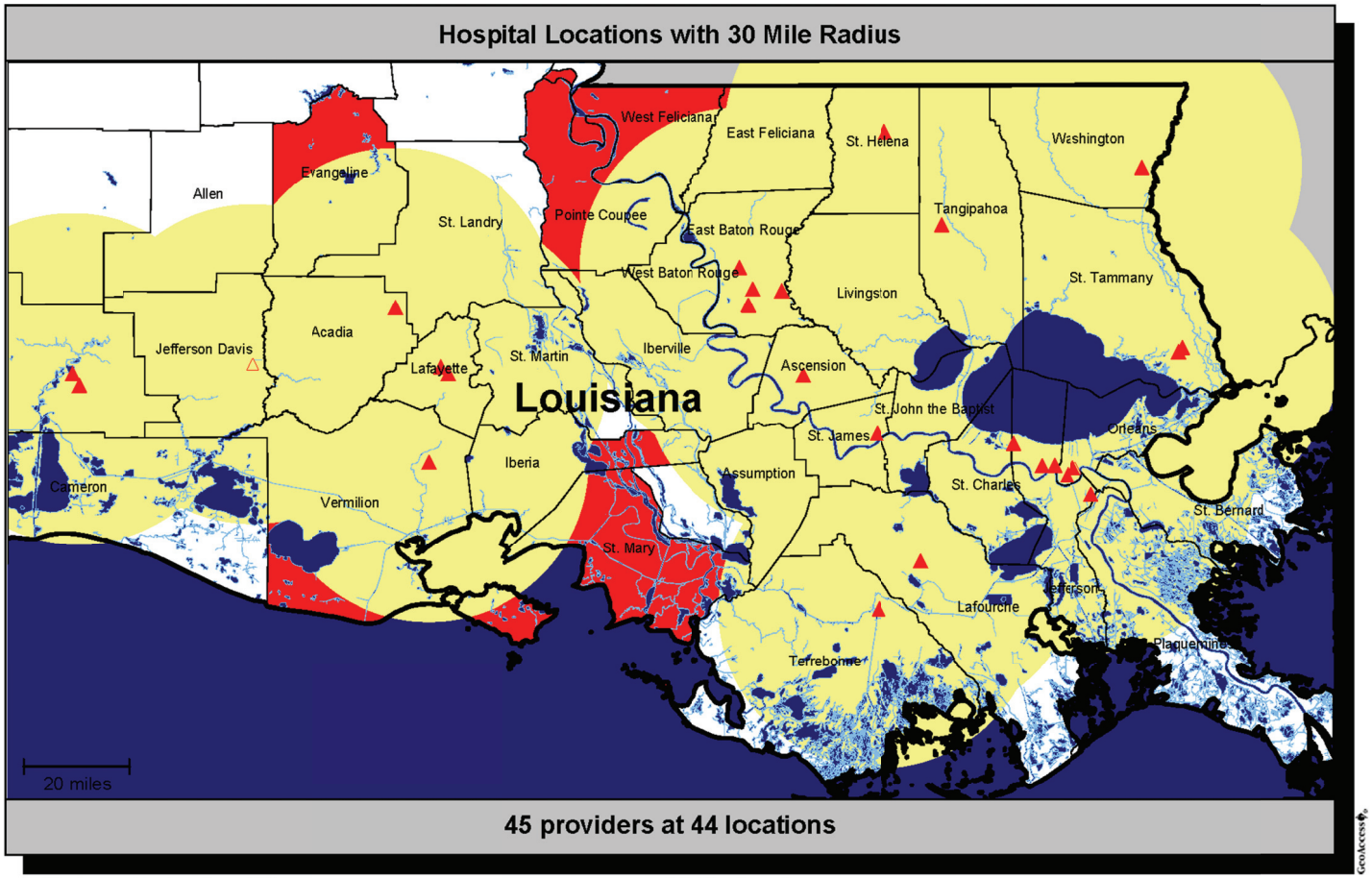
GSA "B" - Regions 2,3 & 4 - Rural



- Single provider locations (41)
- Multiple provider locations (3)
- Rural Parishes
- 30 mile radius

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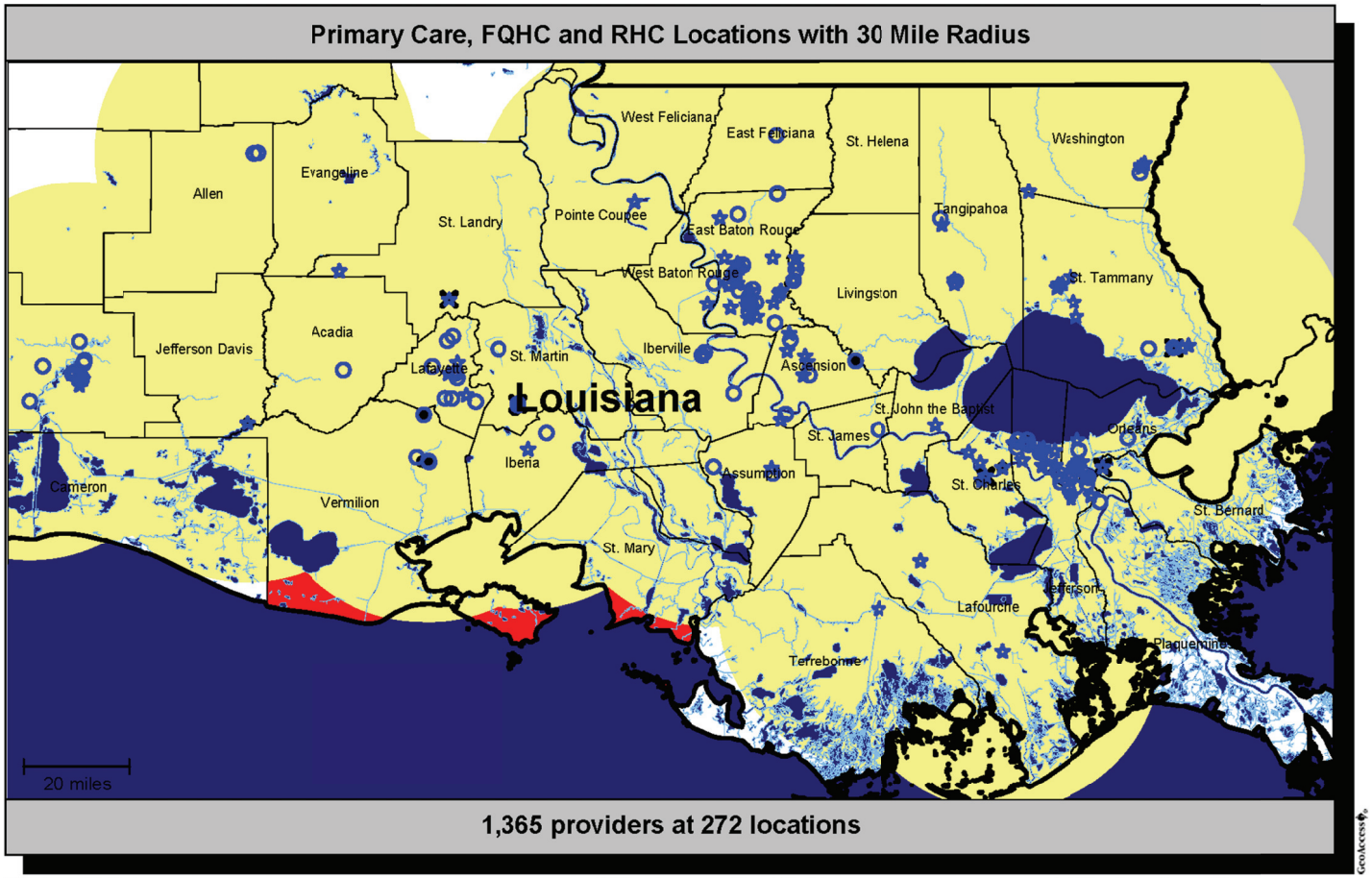
GSA "B" - Regions 2,3 & 4 - Rural



Single Multiple
1. Primary Care Providers (111) (156)
2. RHC/FQHC Providers (16) (5)

Service area: Rural Parishes

30 mile radius - All

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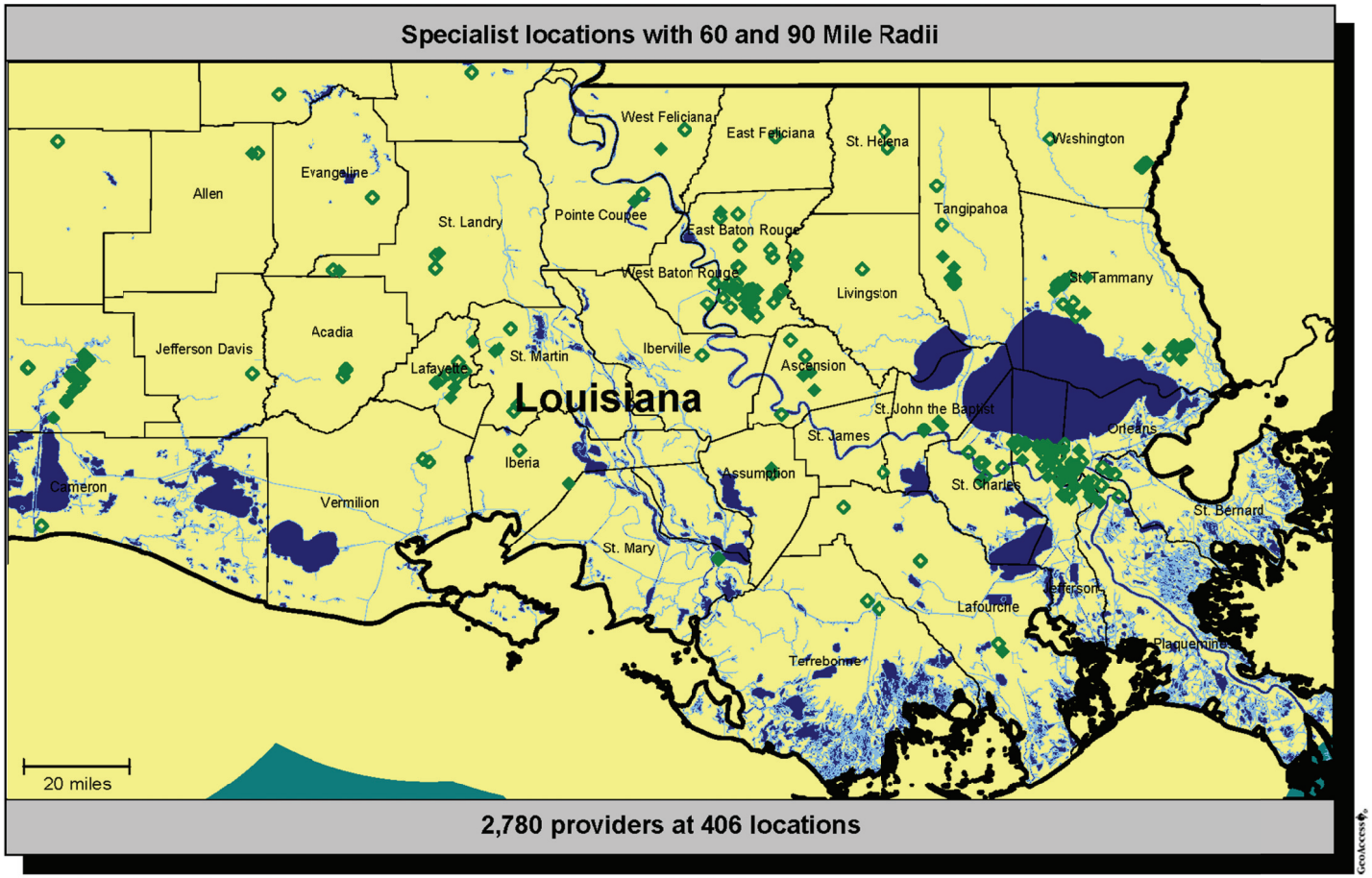
GSA "B" - Regions 2,3 & 4 - Rural



- Single provider locations (150)
- Multiple provider locations (256)
- Rural Parishes
- 60 mile radius
- 90 mile radius

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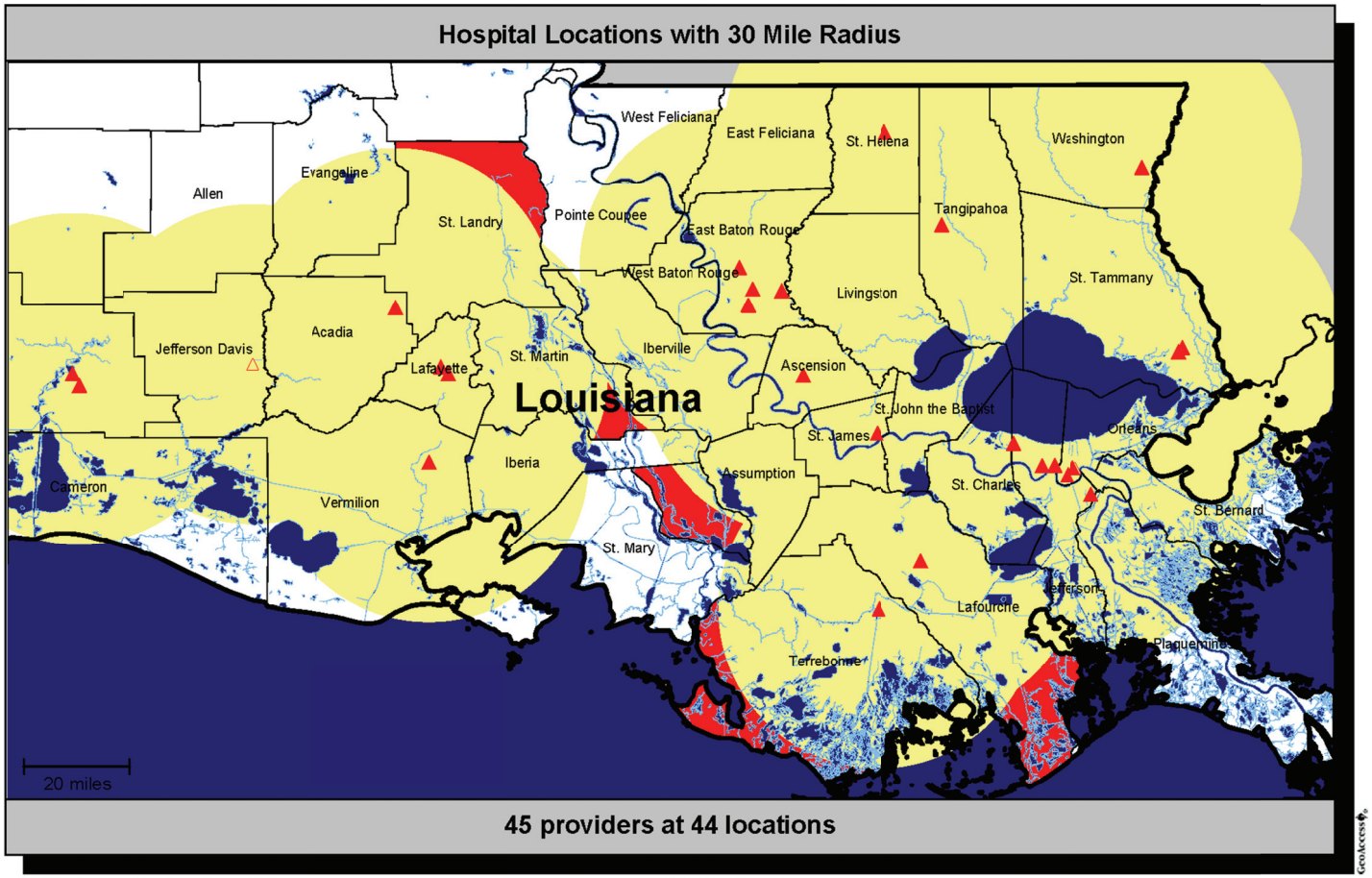
GSA "B" - Regions 2,3 & 4- Urban



- ▲ Single provider locations (41)
- △ Multiple provider locations (3)
- ■ Urban Parishes
- ▢ 30 mile radius

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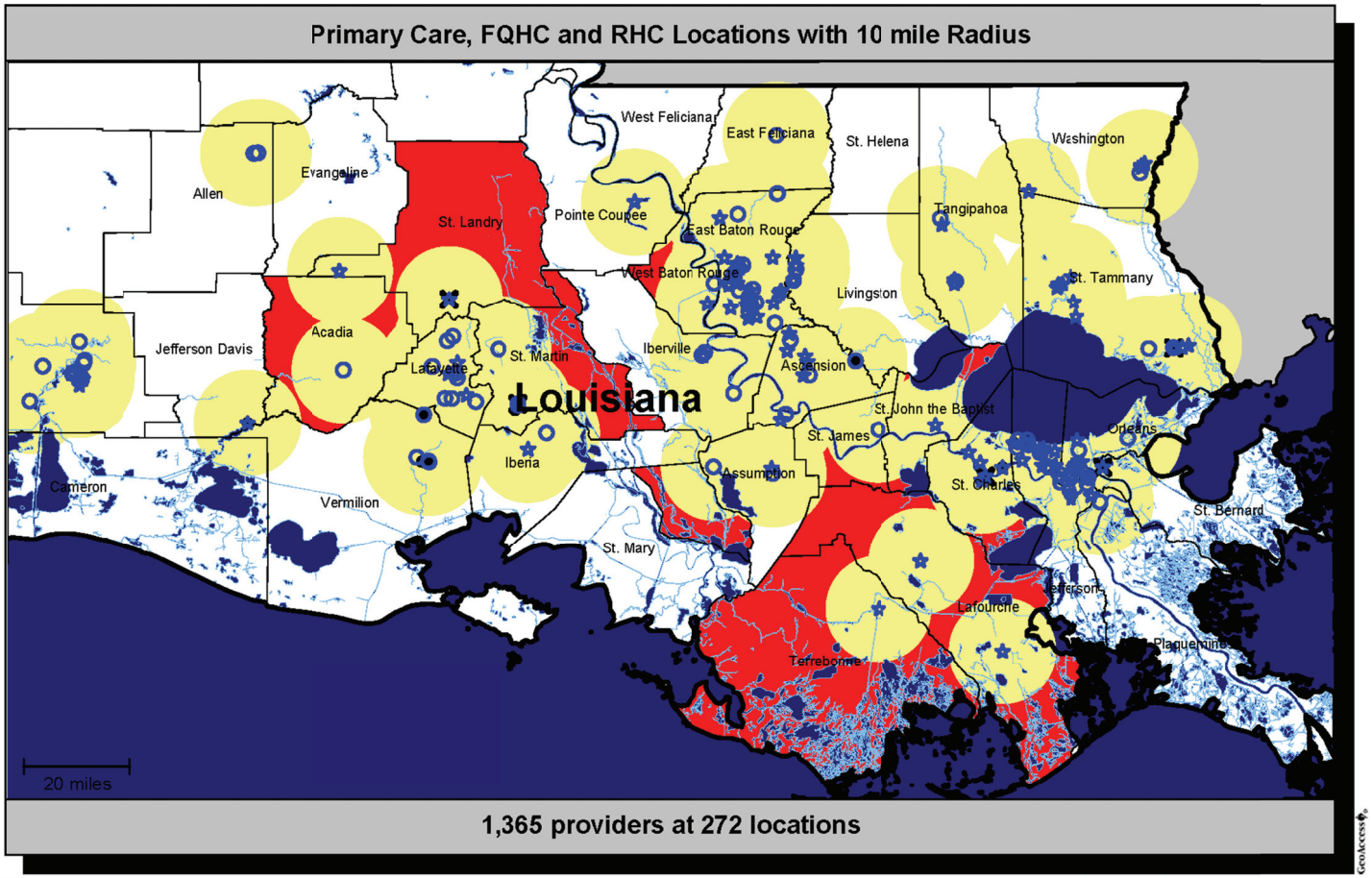
GSA "B" - Regions 2,3 & 4- Urban



Single Multiple
1. Primary Care Providers (111) (156)
2. RHC/FQHC Providers (16) (5)

Service area: Urban Parishes

10 mile radius - All

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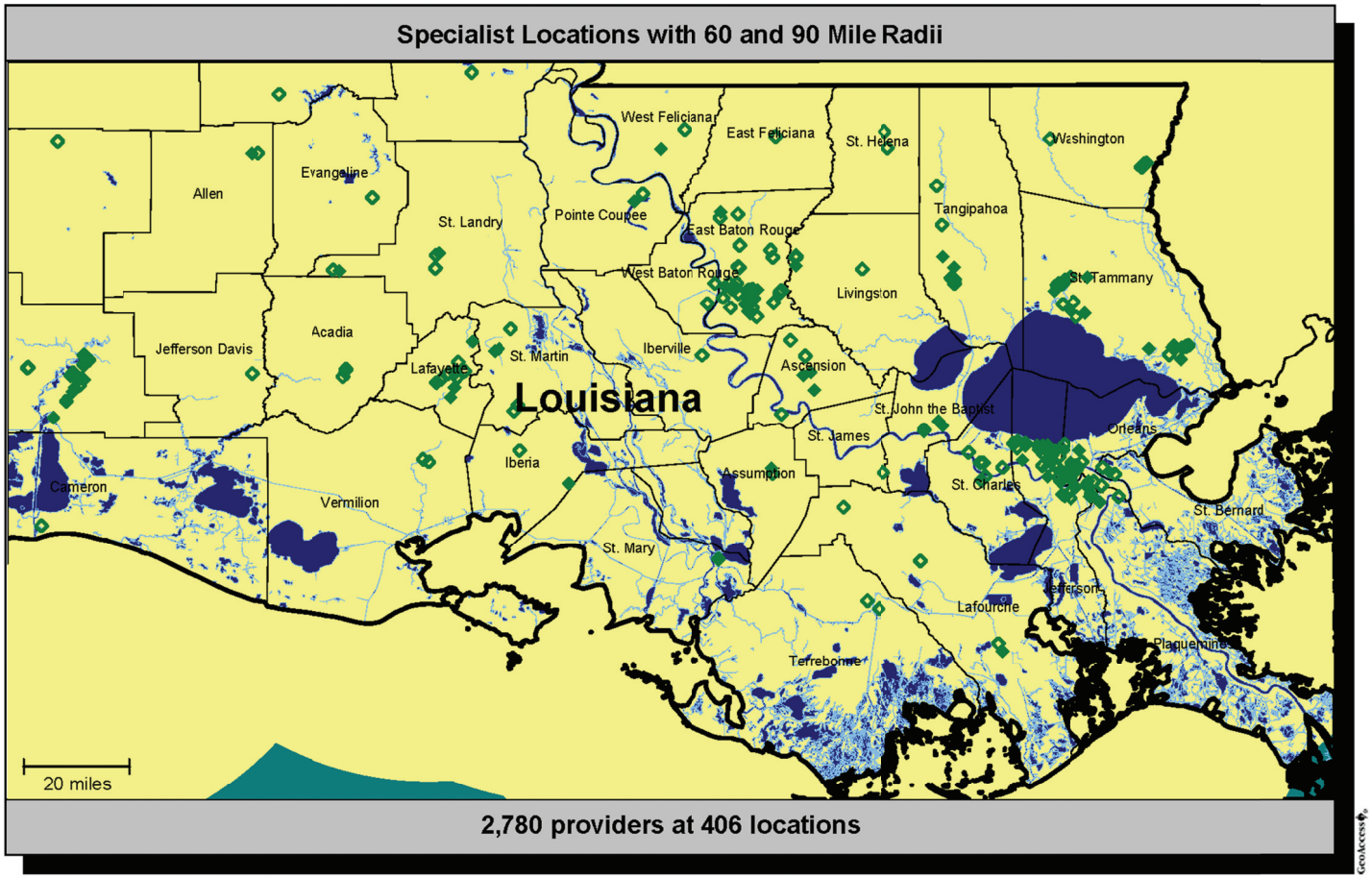
GSA "B" - Regions 2,3 & 4- Urban



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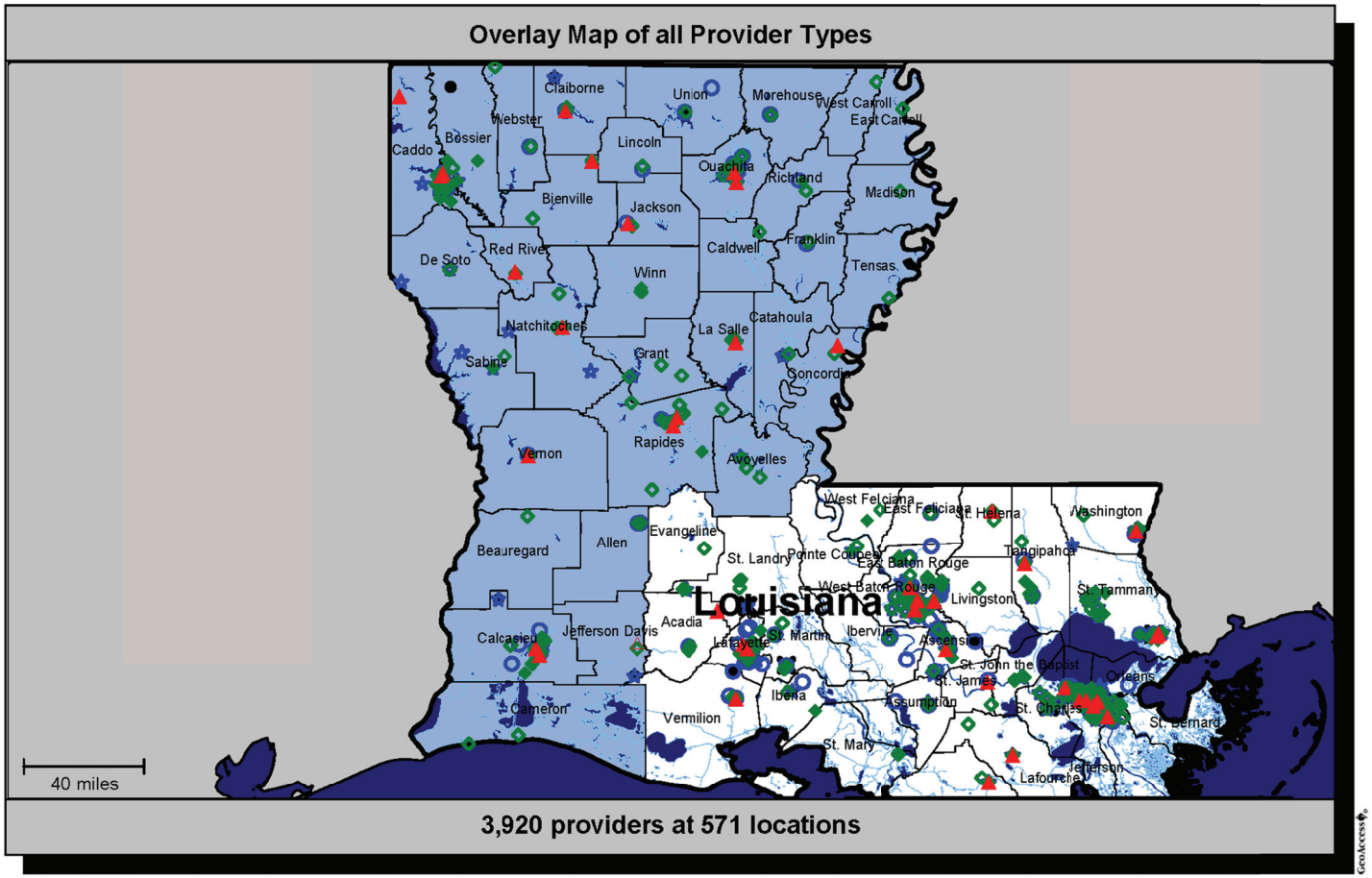
GSA "C" - Regions 5, 6, 7 & 8



Single	Multiple	
▲	△	1. Hospitals (41) (3)
●	✖	2. RHC/FQHC Providers (16) (5)
○	★	3. Primary Care Providers (111) (156)
◆	◇	4. Specialist Providers (150) (256)

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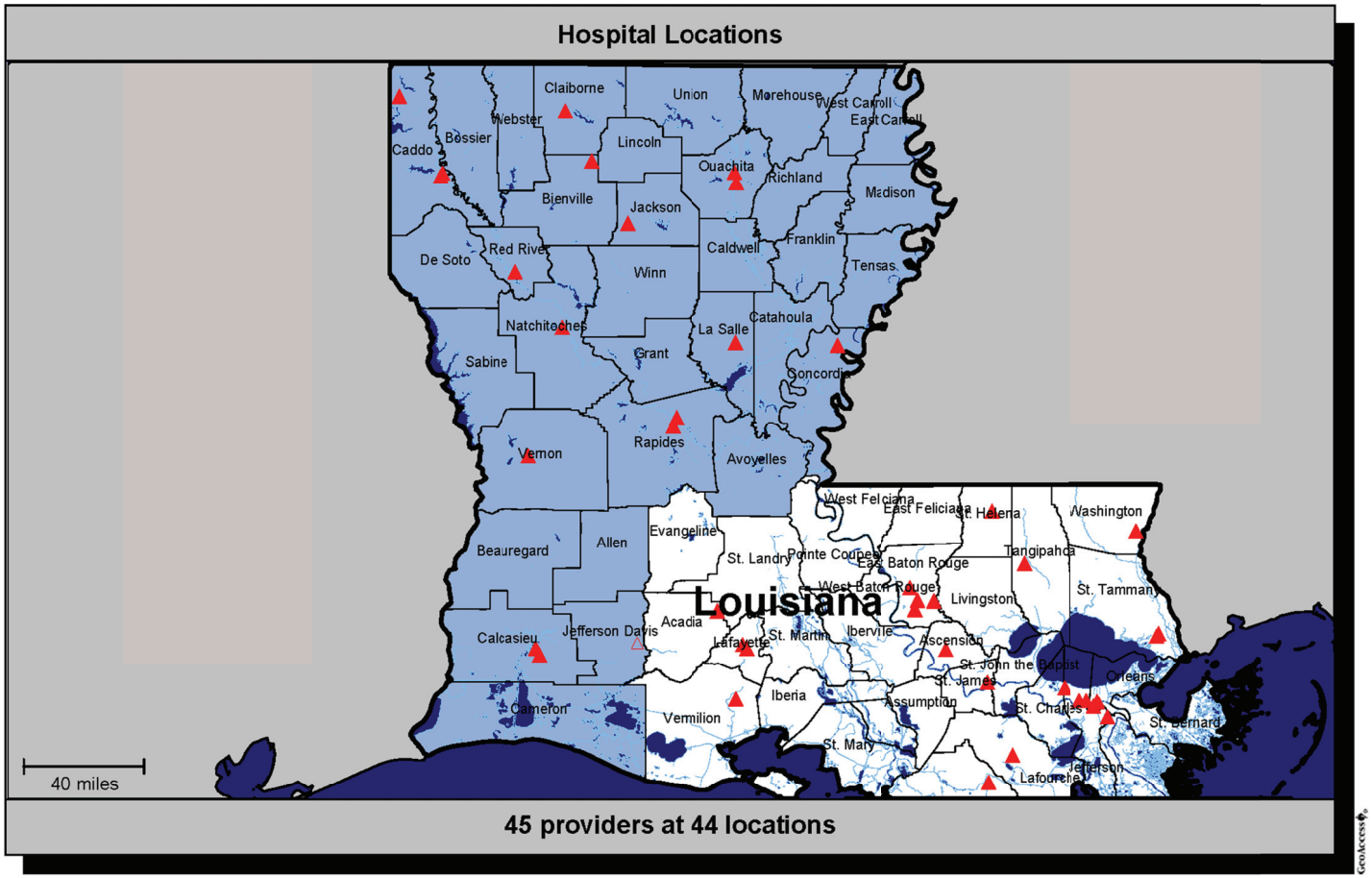
GSA "C" - Regions 5, 6, 7 & 8



▲ Single provider locations (41)
△ Multiple provider locations (3)

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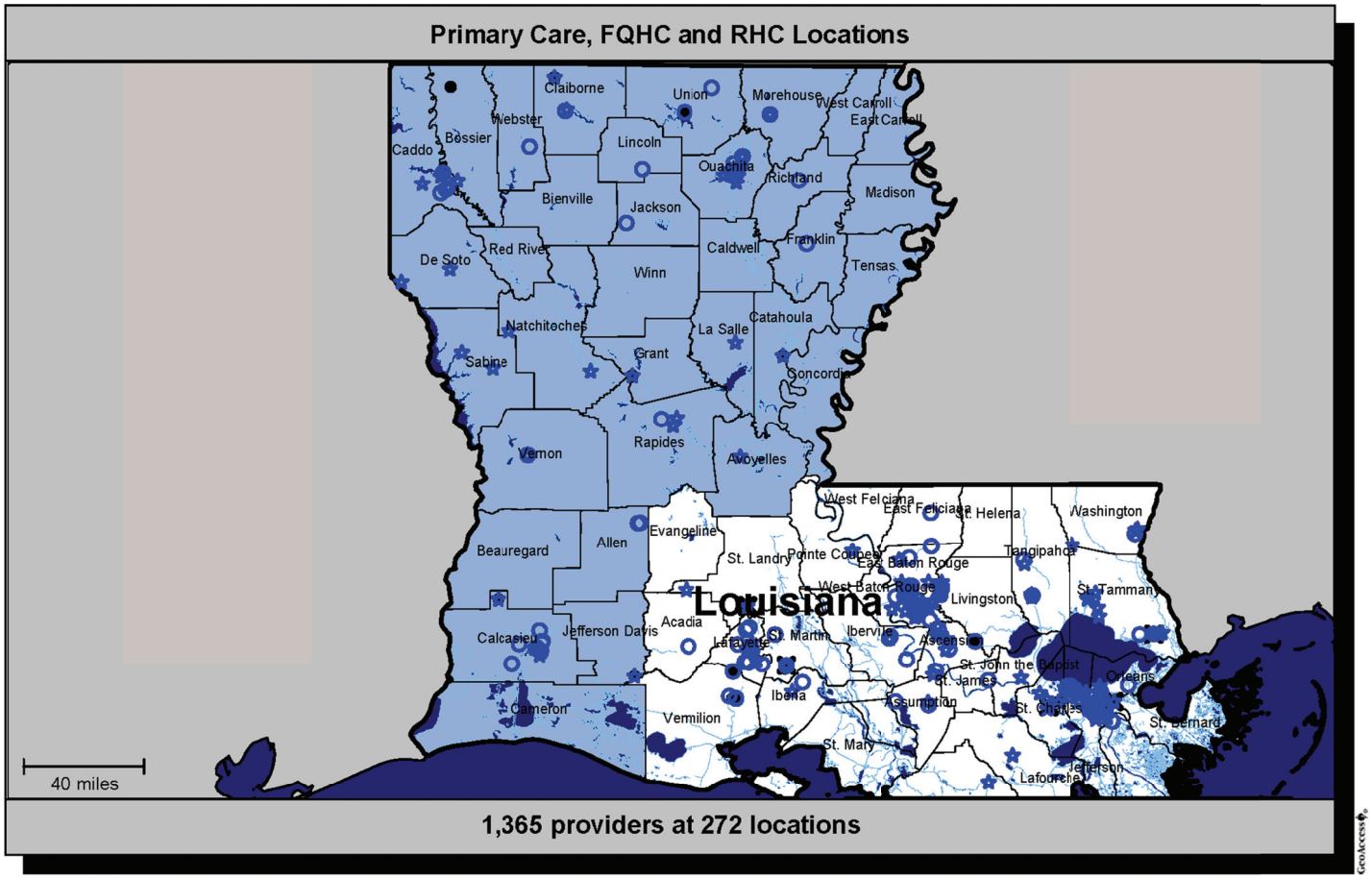
GSA "C" - Regions 5, 6, 7 & 8



Single	Multiple	
○	★	1. Primary Care Providers (111) (156)
●	✖	2. RHC/FQHC Providers (16) (5)

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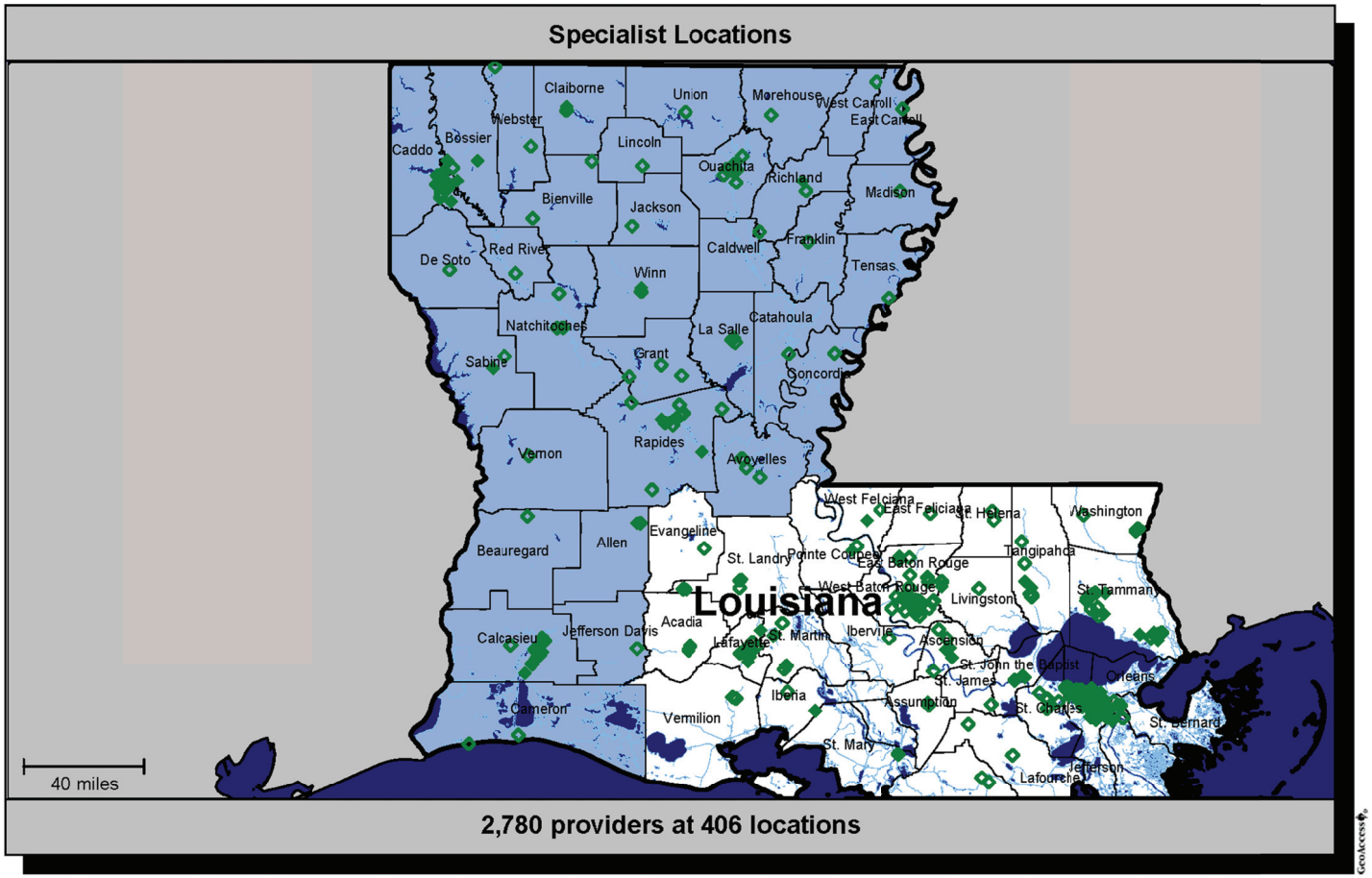
GSA "C" - Regions 5, 6, 7 & 8



- Single provider locations (150)
- Multiple provider locations (256)

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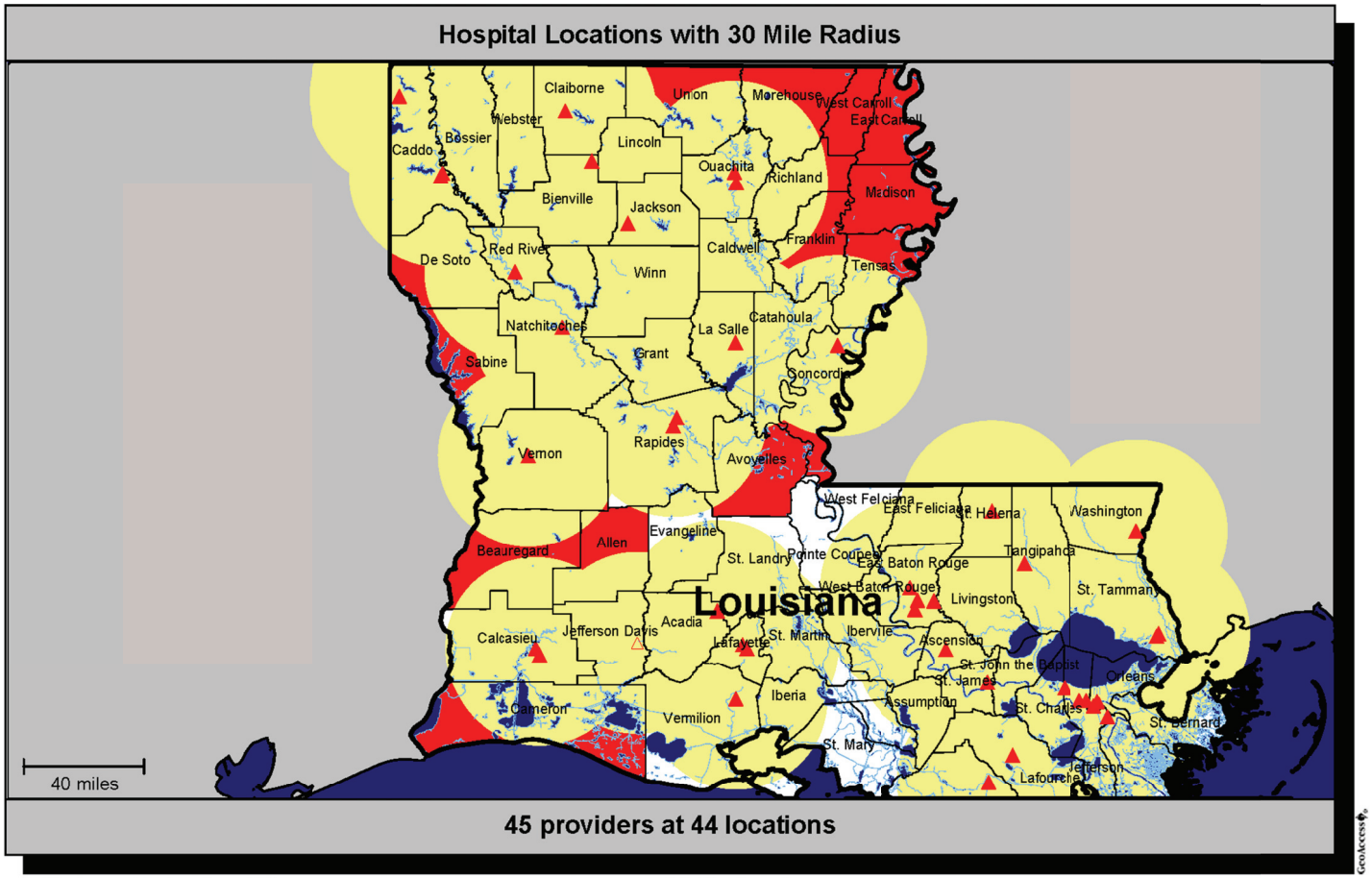
GSA "C" - Regions 5, 6, 7 & 8 - Rural



▲ Single provider locations (41)
△ Multiple provider locations (3)
■ Rural Parishes

□ 30 mile radius

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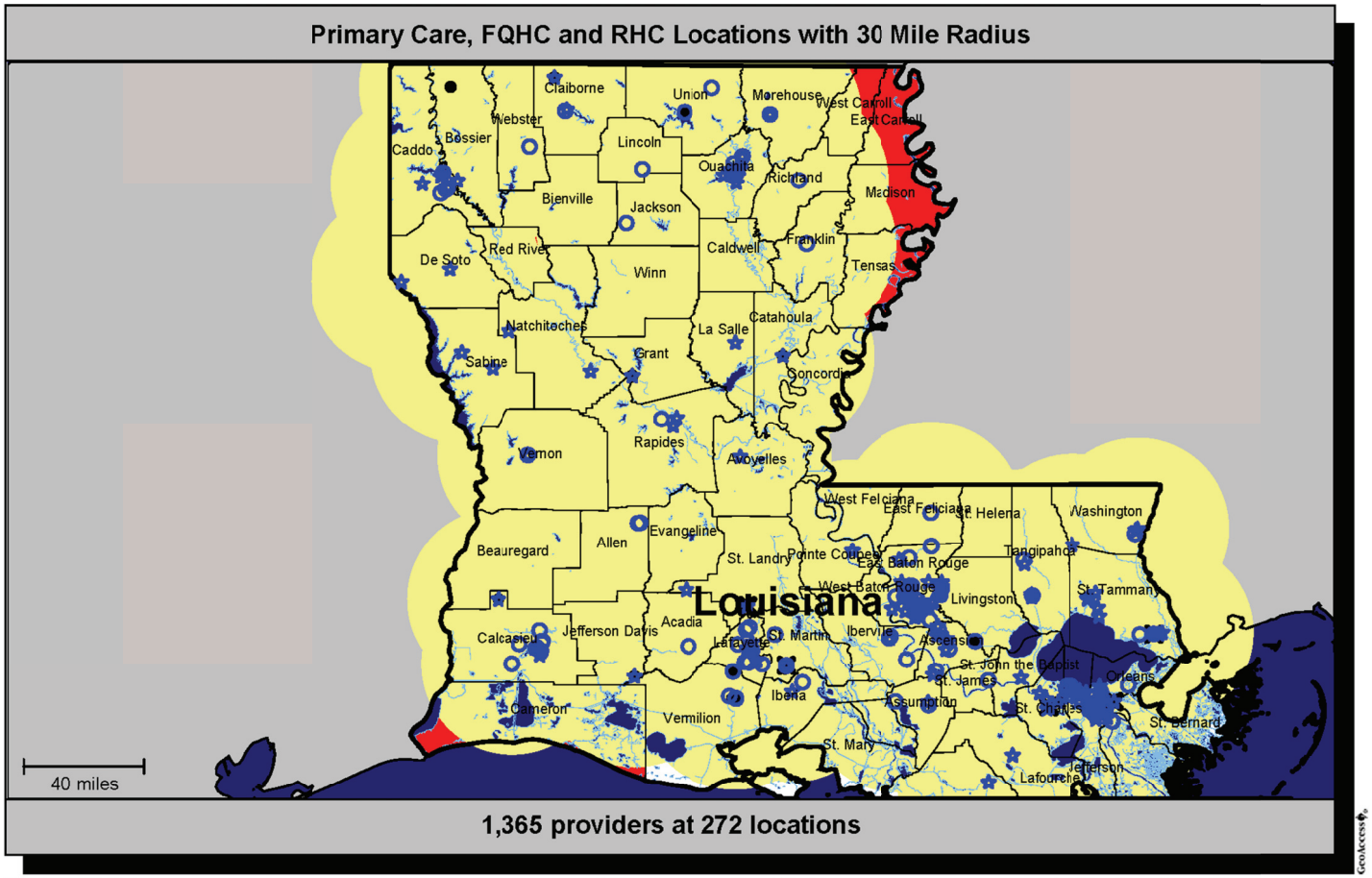
GSA "C" - Regions 5, 6, 7 & 8 - Rural



Single Multiple
1. Primary Care Providers (111) (156)
2. RHC/FQHC Providers (16) (5)

Service area: Rural Parishes

30 mile radius - All

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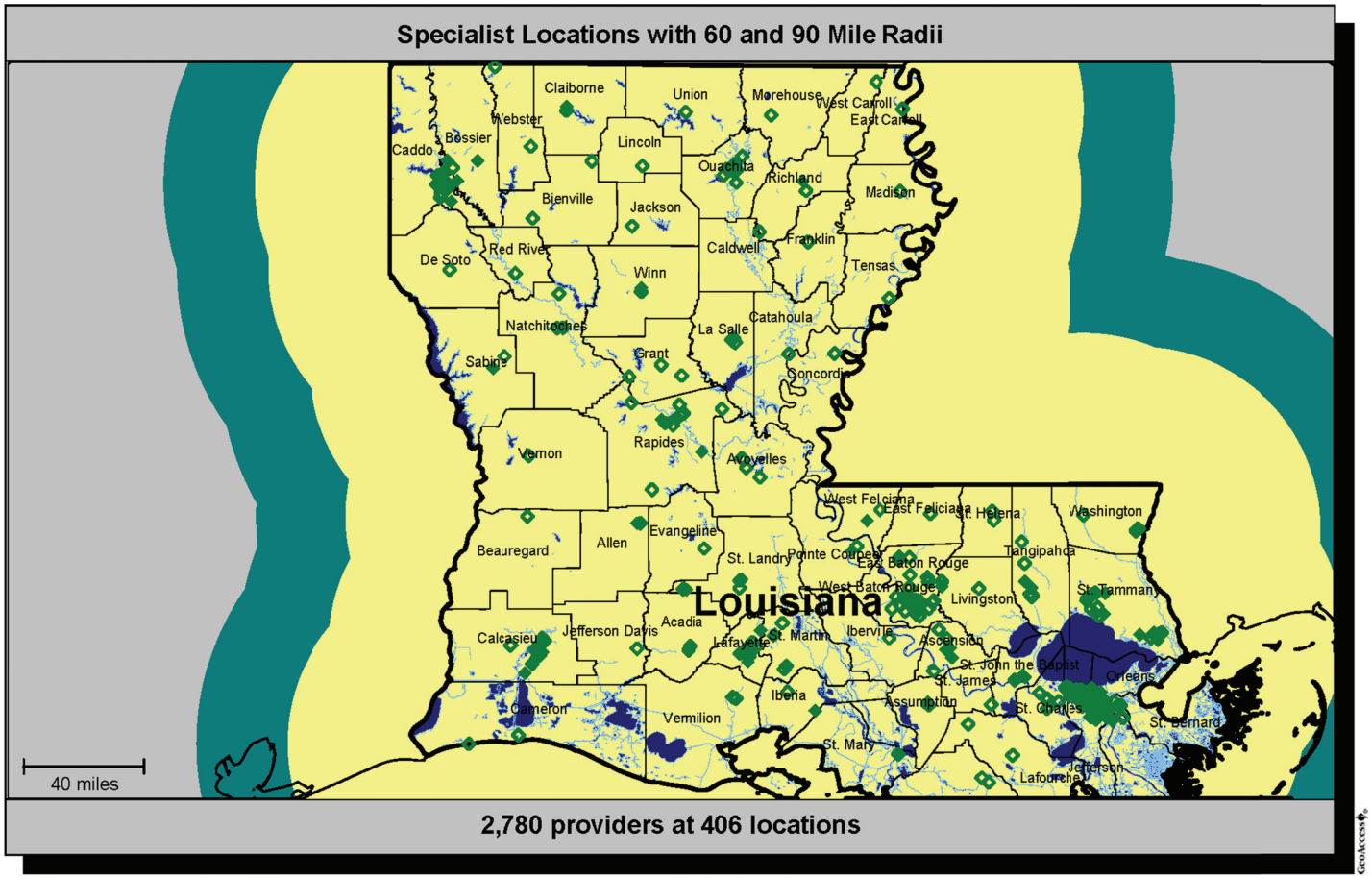
GSA "C" - Regions 5, 6, 7 & 8 - Rural



- Single provider locations (150)
- Multiple provider locations (256)
- Rural Parishes
- 60 mile radius
- 90 mile radius

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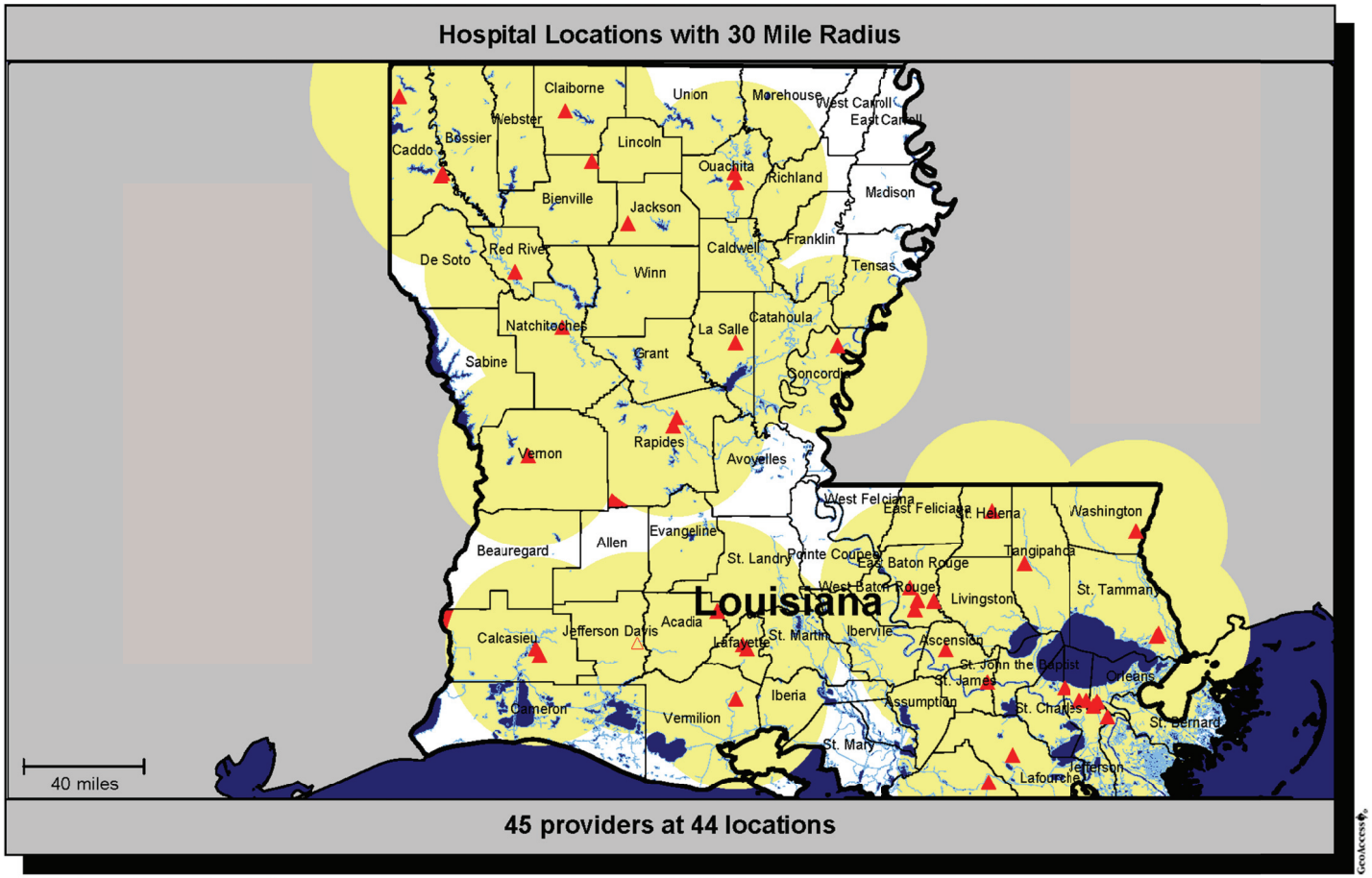
GSA "C" - Regions 5, 6, 7 & 8 - Urban



- ▲ Single provider locations (41)
- △ Multiple provider locations (3)
- ■ Urban Parishes
- ☐ 30 mile radius

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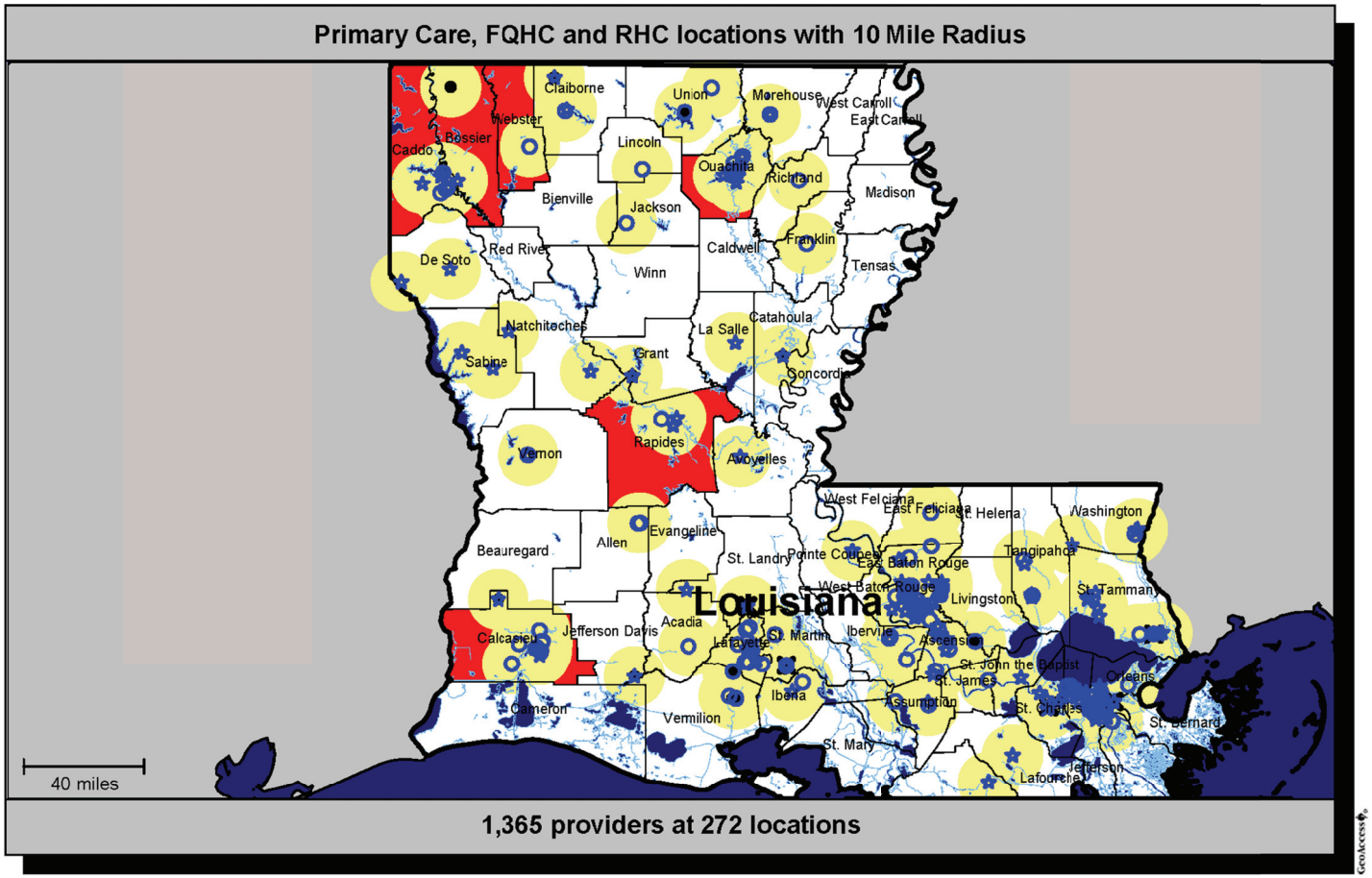
GSA "C" - Regions 5, 6, 7 & 8 - Urban



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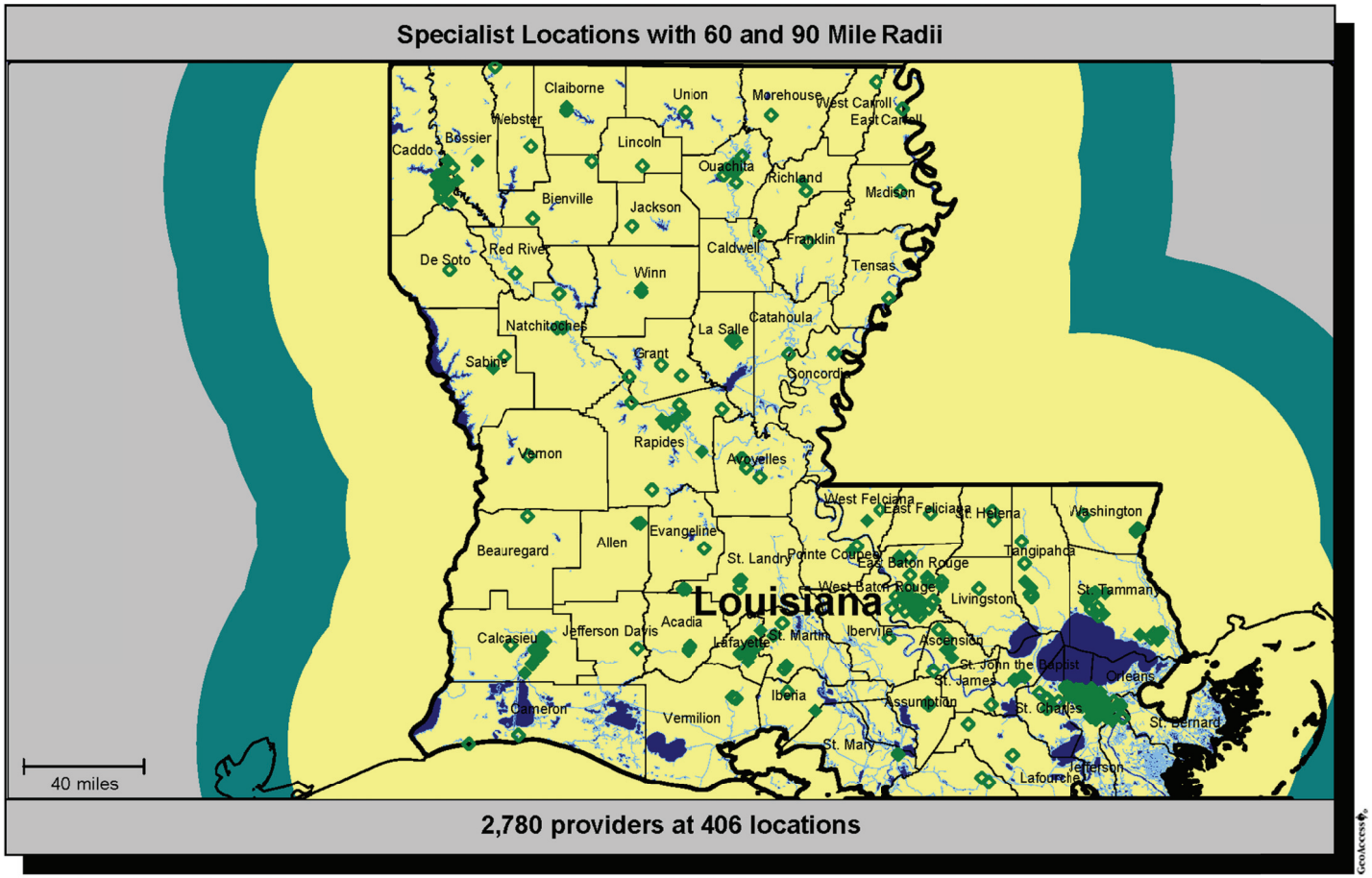
GSA "C" - Regions 5, 6, 7 & 8 - Urban



- Single provider locations (150)
- Multiple provider locations (256)
- Urban Parishes
- 60 mile radius
- 90 mile radius

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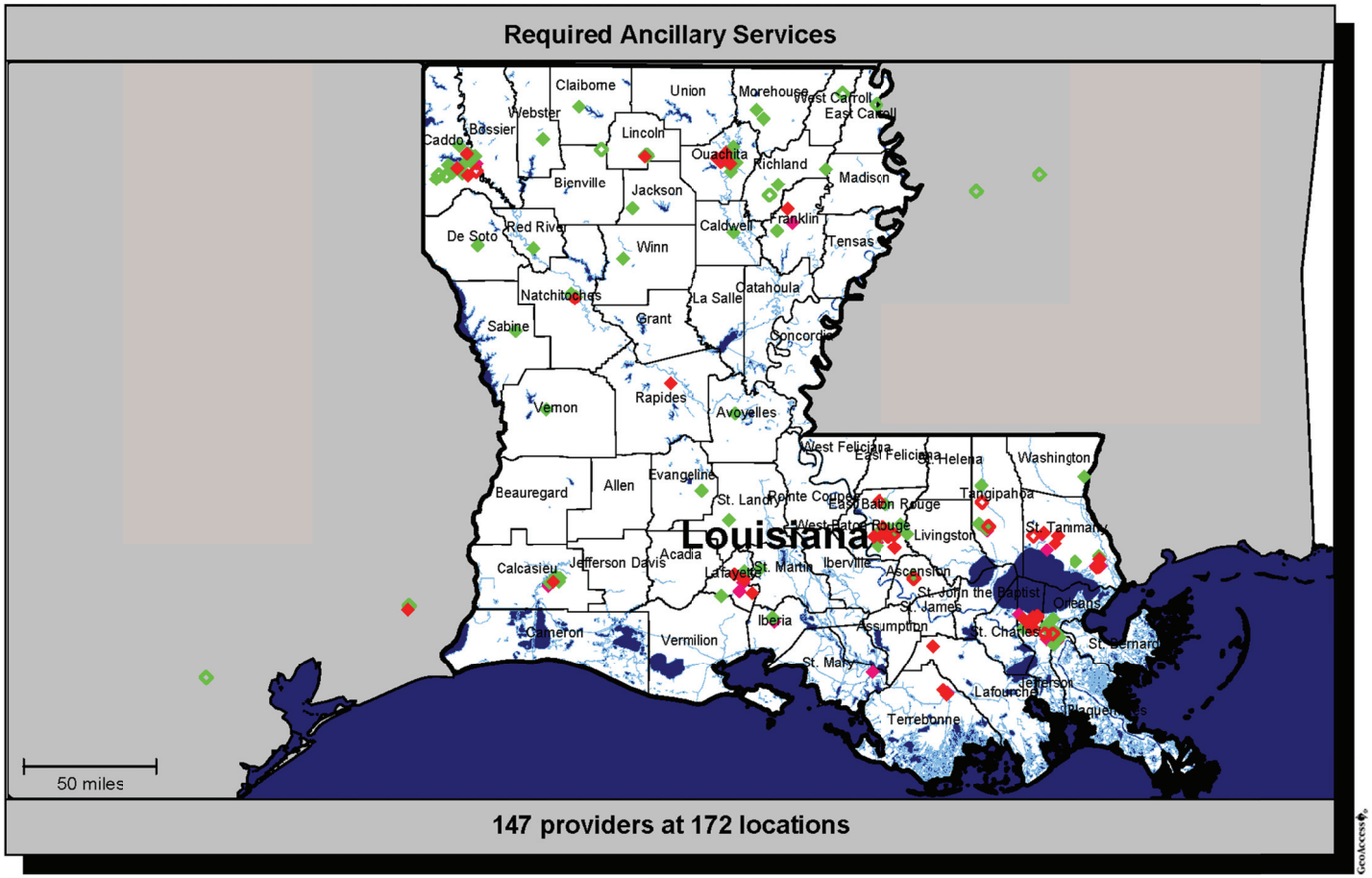
Appendix E - Ancillary Services



Single	Multiple	
◆	◇	1. Durable Medical Equipment (39) (14)
◆	◇	2. Home Health (0)
◆	◇	3. Lab/X-Ray (23)
◆	◇	4. NEMT (77) (19)

Single	Multiple	
◆	◇	5. Orthotics/Prosthetics (77) (19)

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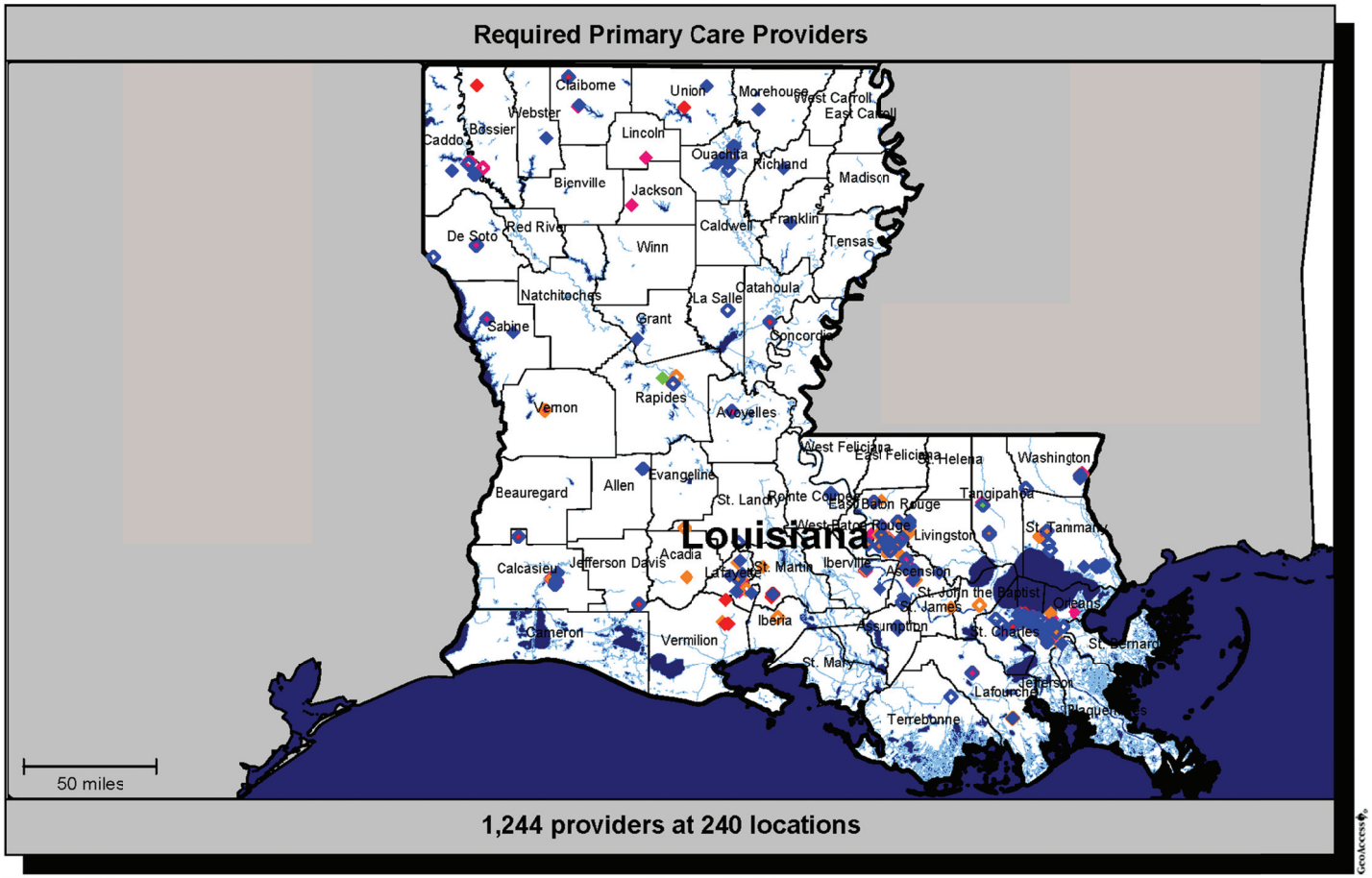
Appendix E - Primary Care Providers



Single	Multiple	
◆	◇	1. Family/General Practice (55) (76)
◆	◇	2. Internal Medicine (69) (54)
◆	◇	3. OB/GYN (7) (3)
◆	◇	4. Pediatrics (50) (55)

Single	Multiple	
◆	◇	5. RHC/FQHC (16) (5)

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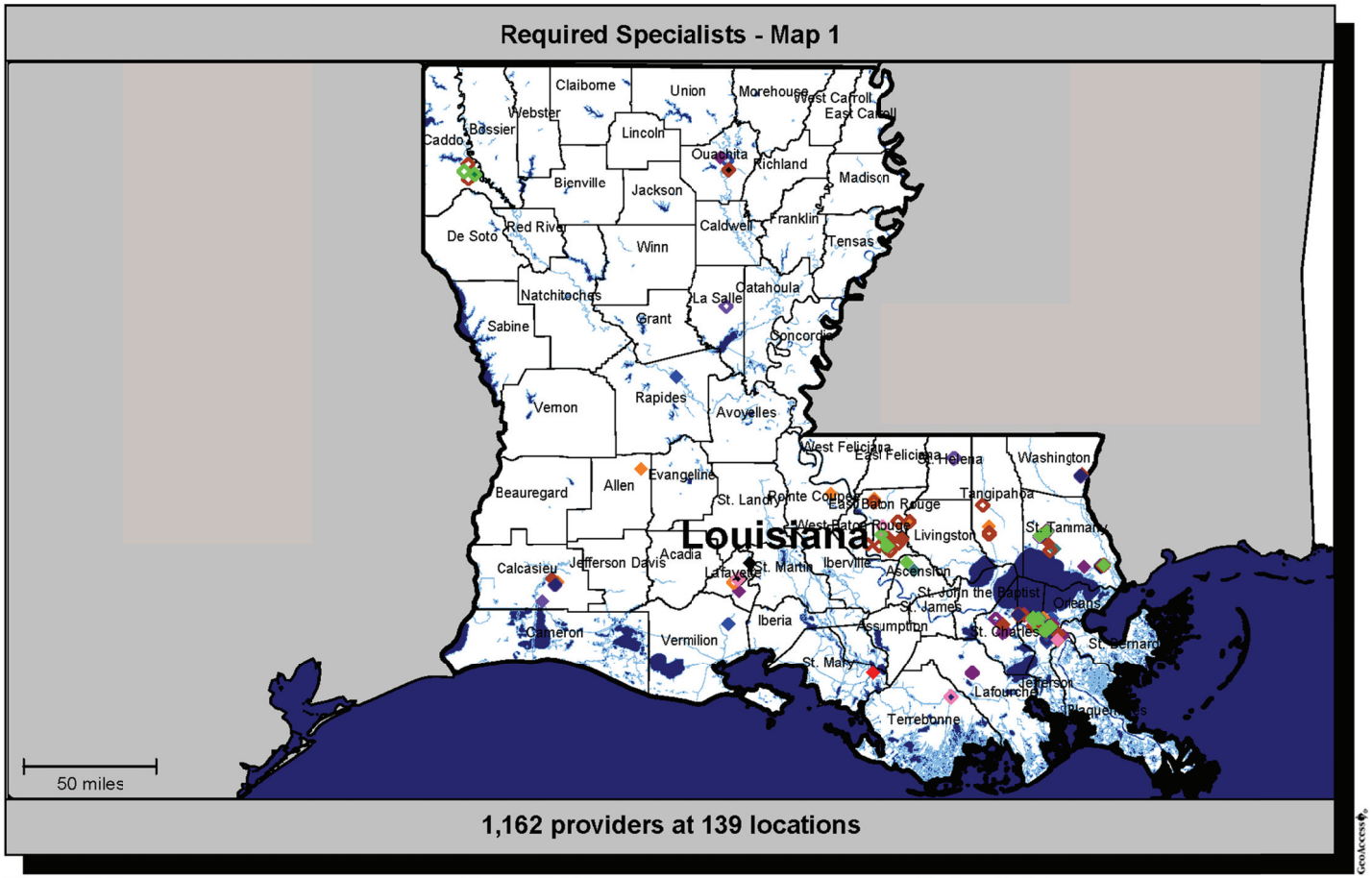
Appendix E - Specialists



Single	Multiple	
◆	◇	1. Allergy/Immunology (11) (7)
◆	◇	2. Anesthesiology (18) (21)
◆	◇	3. Audiology (1) (1)
◆	◇	4. Cardiology (18) (19)
◆	◇	5. Chiropractic (7) (1)
◆	◇	6. Dermatology (10) (6)
◆	◇	7. Emergency Medical (4) (23)
◆	◇	8. Endocrinology and Meta... (10) (7)
◆	◇	9. Gastroenterology (17) (11)
◆	◇	10. Hematology/Oncology (24) (35)
◆	◇	11. Infectious Diseases (12) (12)
◆	◇	12. Neonatology (3) (6)

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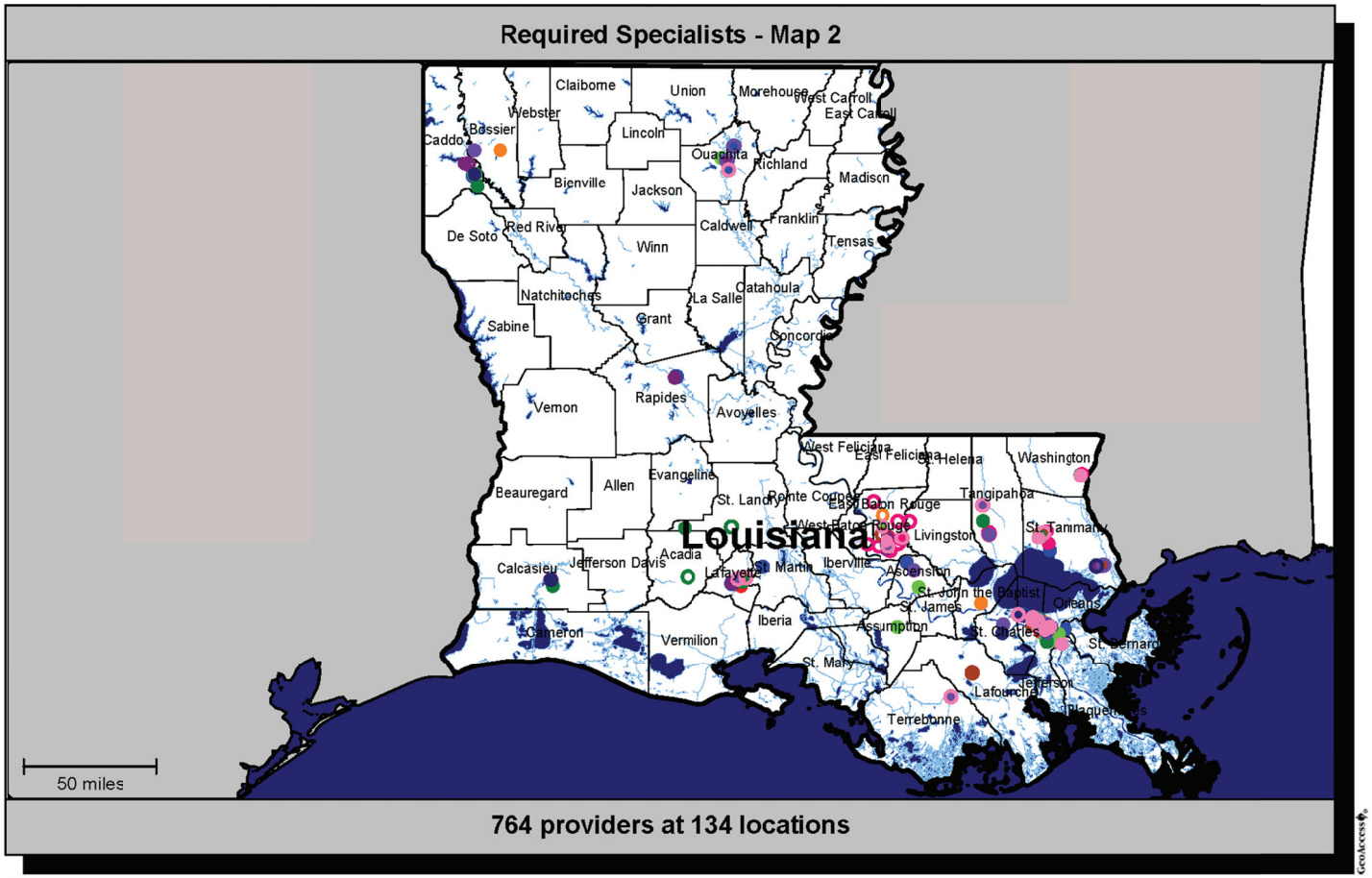
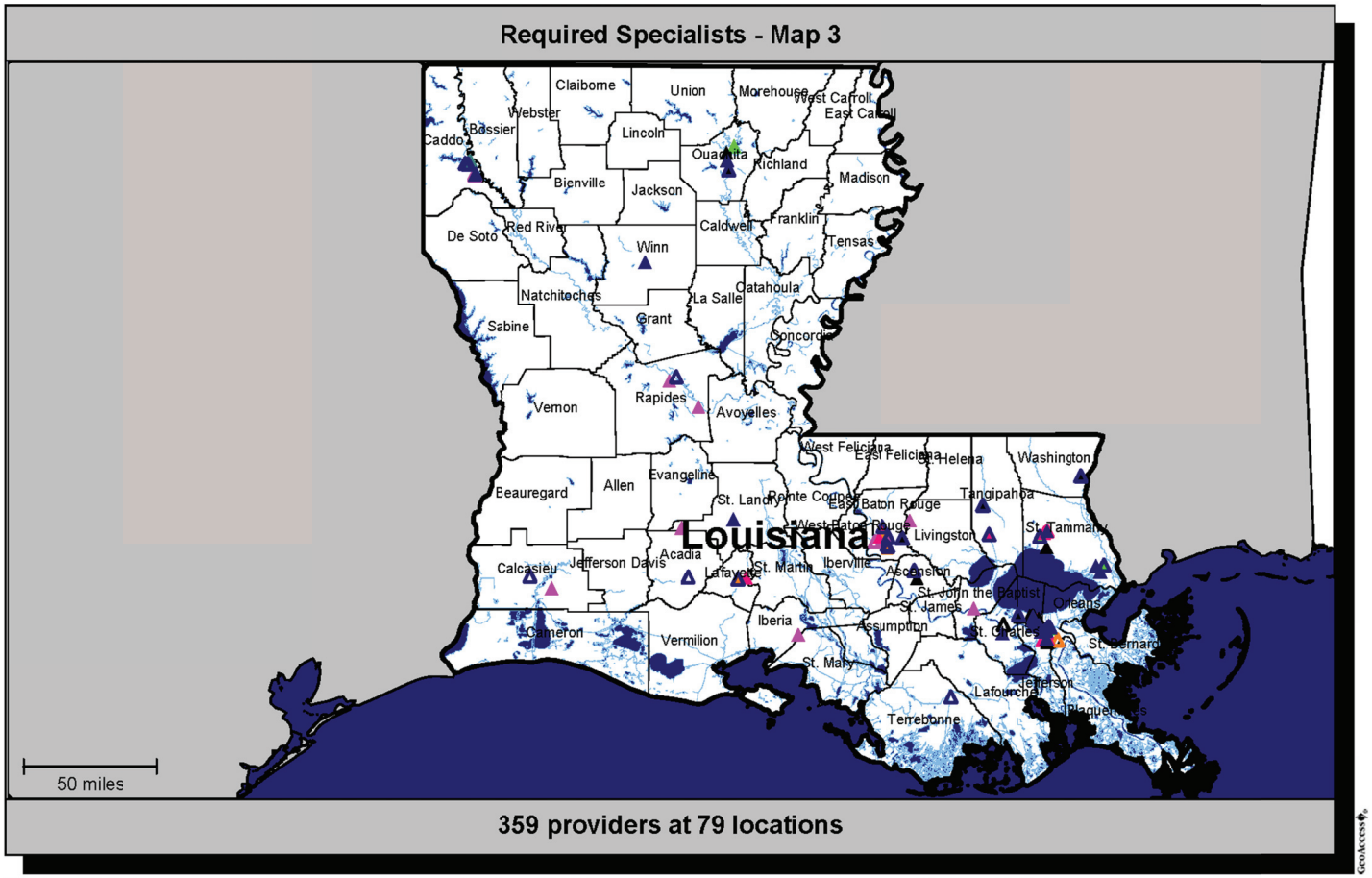
Appendix E - Specialists



Single	Multiple	
●	○	1. Nephrology (8) (14)
●	○	2. Neurology (17) (16)
●	○	3. Opthalmology (20) (18)
●	○	4. Optician/Optometry (6) (4)
●	○	5. Orthopedics (16) (29)
●	○	6. Otorhinolryngology (13) (12)
●	○	7. Pathology (12) (11)
●	○	8. Pediatrics, Cardiology (5) (5)
●	○	9. Podiatry (11) (5)
●	○	10. Pulmonary Medicine (21) (9)
●	○	11. Rhuematology (7) (6)

Appendix E - Specialists



Single	Multiple	
▲	△	1. Surgery, General (16) (26)
▲	△	2. Physical Therapy (3) (1)
▲	△	3. Speech Therapy (6) (2)
▲	△	4. Surgery, Neurological (11) (6)
▲	△	5. Surgery, Neurological (5) (5)
▲	△	6. Surgery, Pediatric (3) (2)
▲	△	7. Surgery, Plastic (14) (4)
▲	△	8. Surgery, Thoracic (11) (6)
▲	△	9. Urology (17) (13)

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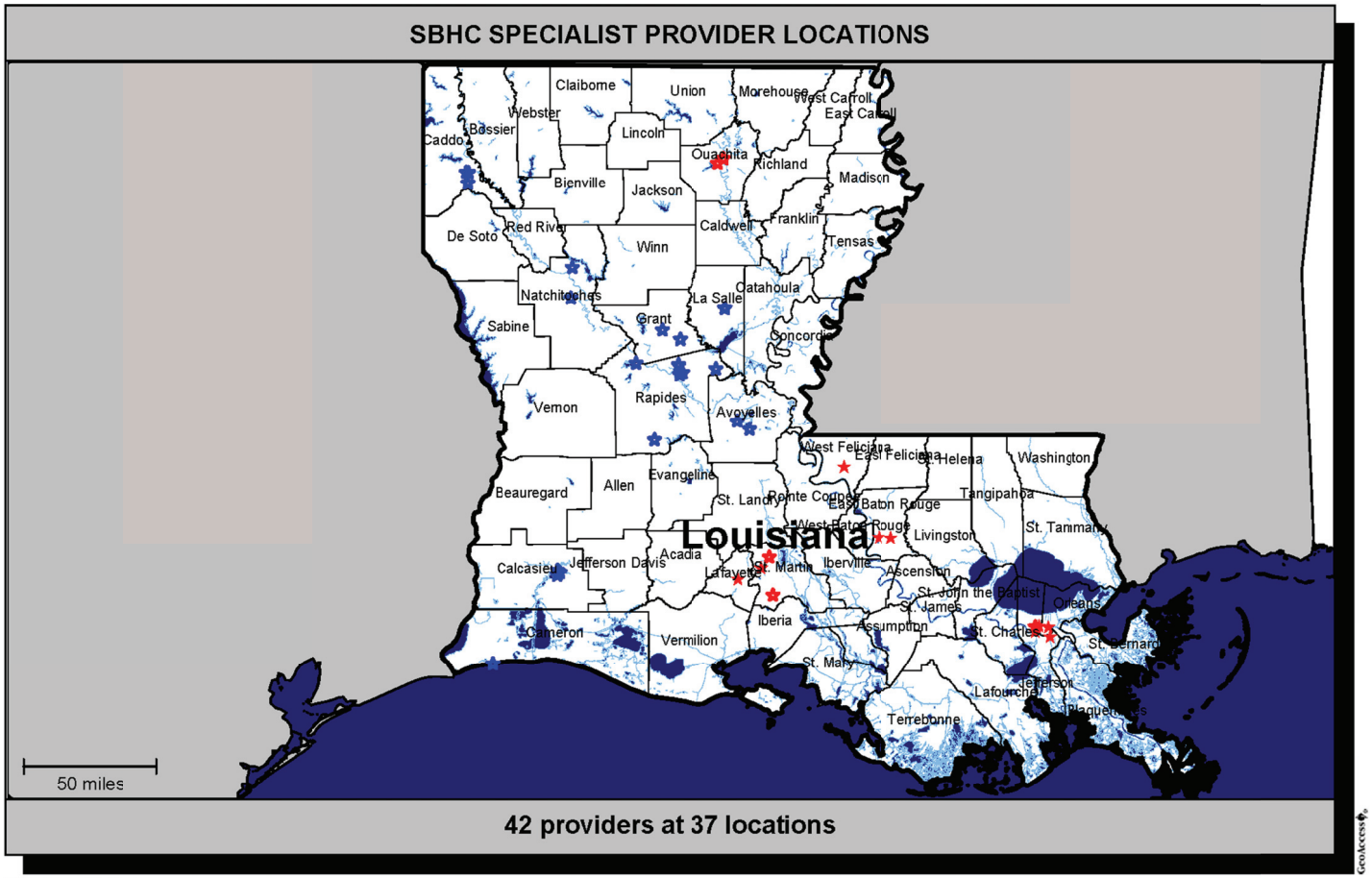
School Based Health Clinics - Specialists



Single Multiple
★ ★ 1. SBHC NURSE & MD FULL - TIME (0) (23)
★ ★ 2. SBHC NURSE & MD PART - TIME (9) (5)

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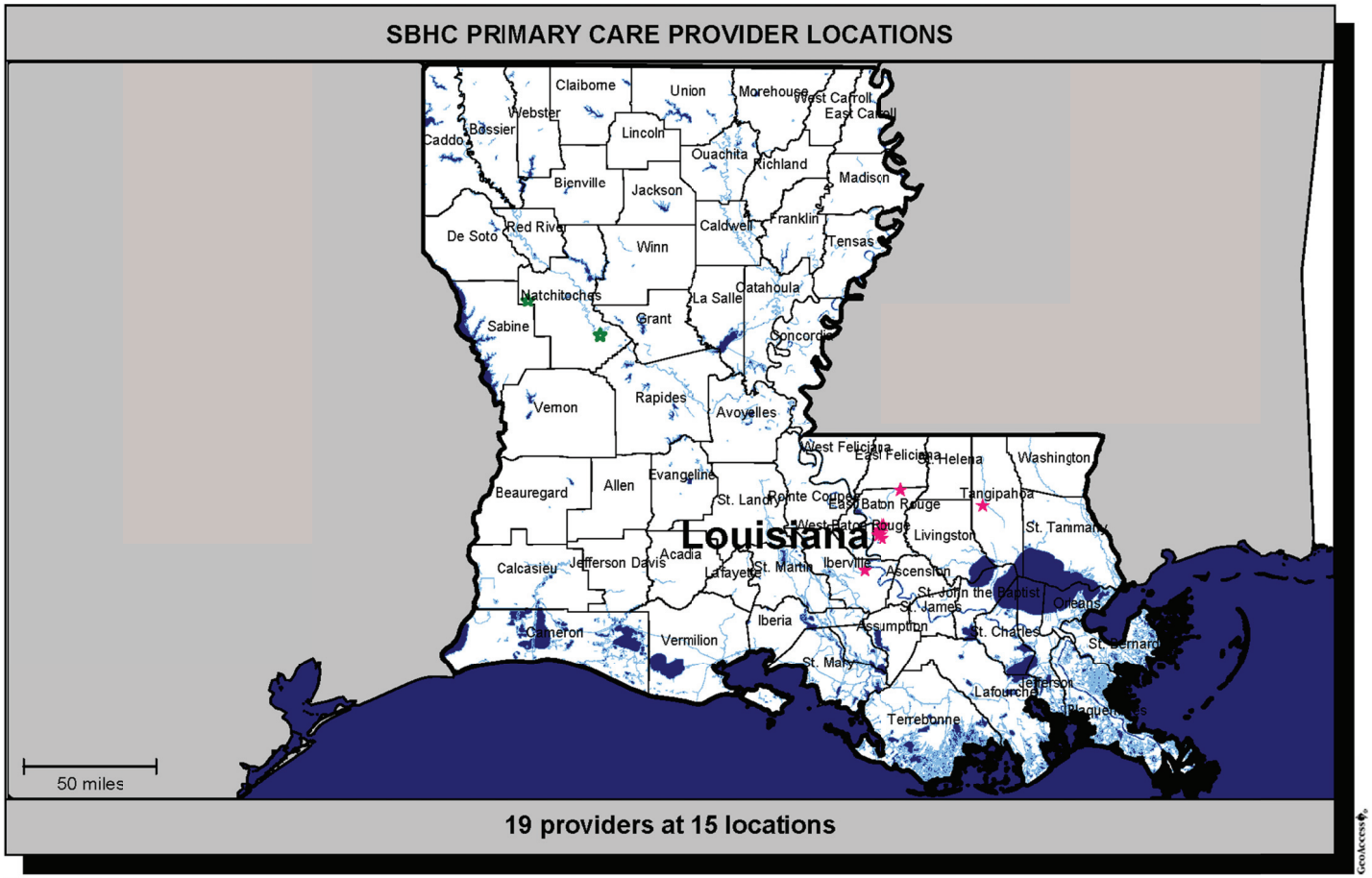
School Based Health Clinic - Primary Care Providers



Single Multiple
★ ★ 1. SBHC NURSE & MD FULL - TIME PCP (12) (1)
★ ★ 2. SBHC NURSE & MD PART - TIME PCP (0) (2)

G.2: Tertiary Care Providers

G.2 Describe how you will provide tertiary care providers including trauma centers, burn centers, children's hospital, Level III maternity care; Level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the GSA. If you do not have a full range of tertiary care providers describe how the services will be provided including transfer protocols and arrangements with out of network facilities.

AmeriHealth Mercy understands that there is often a need for highly specialized services to address severe injury and highly complex medical conditions. We want our members who suffer severe trauma or burns, or have a high risk pregnancy or a seriously ill child to know that our network is structured to give them access to such specialized services and state-of-the-art facilities and technology and to offer access to follow up treatment, such as rehabilitation, within our network. Emergency care is always covered whether provided at a participating or non-participating provider. However, we want our members to know we have a full range of tertiary services available with our network.

AmeriHealth Mercy will construct a network of tertiary care providers leveraging statewide systems as well as regional and local providers. Central to this network will be a uniquely collaborative relationship with the Louisiana State University Health System (LSU). The 11 hospitals operated by the LSU Health System include the only two current trauma centers and one of four burn centers in Louisiana. In addition, but not limited to, relationships with Woman's Hospital, Ochsner Health System and CHRISTUS Health provide a foundation for maternity and neonatal services. AmeriHealth Mercy will continue to develop relationships with other tertiary care providers to include them in the network.

In meetings facilitated by Roxane Townsend MD of LSU, AmeriHealth Mercy representatives met with Cindy Nuesslein, Vice President, Hospital Operations and Laurie Weiss, Executive Director of Children's Healthcare Network of Children's Hospital. Children's Hospital has notified AmeriHealth Mercy that it will wait to enter into contracting discussions once the decision of which CCNs will be awarded business under this RFP have been made. Similar comments have been made by a number of providers during the initial outreach process, and AmeriHealth Mercy has made a commitment to reconnect with these providers should we be chosen as a participating CCN. It is our long term goal to provide a wide range of tertiary care providers to our members across Louisiana.

Status of Tertiary Facilities
Trauma Centers
LSU Health Sciences Center Shreveport – LOI Received
LSU Interim Public Hospital – Orleans – LOI Received
Burn Centers
LSU Health Sciences Center Shreveport – LOI Received
Our Lady of Lourdes Regional Medical Center – Lafayette – LOI Received
Children's Hospital
Children's Hospital – Orleans – Notified that facility will wait to contract until after CCN awards
Level III Maternity Care
Woman's Hospital – East Baton Rouge – LOI Received
Level III (high risk) Nurseries
Children's Hospital – Orleans- Notified that facility will wait to contract until after CCN awards.
CHRISTUS Schumpert Highland – LOI received
CHRISTUS St. Frances Cabrini Hospital / CHRISTUS Dubuis Hospital-Rapides – LOI received
LSU Health Sciences Center Shreveport – LOI received
Ochsner Medical Center-Jefferson– LOI received
Ochsner Medical Center-East Baton Rouge– LOI received
St. Tammany Parish Hospital-St. Tammany – Negotiating LOI
Tulane Medical Center-Orleans – Negotiating LOI
Rehab Facilities
Sage Rehabilitation Hospital
Rehabilitation Hospital of Jennings
Ochsner Medical Center Elmwood (Rehab)
Baton Rouge Rehab Hospital
Riversouth Rehab Center
Medical Sub-Specialists
4,024 specialists included in the provider listing

Figure 1: Status of Tertiary Facilities

Out-of-Network Tertiary Care

We understand that members will occasionally need tertiary care services that are not available in the AmeriHealth Mercy network. In those cases, we will swiftly engage processes to authorize and obtain the service from an appropriate out-of-network provider. Our transfer protocols require prior authorization for medical necessity for the use of non-participating practitioners or providers.

In an emergency, members and providers can access tertiary care services from any available provider without obtaining prior authorization from AmeriHealth Mercy. Additionally, pregnant women and newborns requiring immediate transfer and care from a Level III maternity facility or Level III nursery do not require authorization prior to initiating care.

Requests for urgent or routine services from a non-participating provider are reviewed by a physician reviewer based upon the availability of the service or expertise within the AmeriHealth Mercy network, the physician reviewer's clinical expertise, the needs of the member and the definition of medical necessity. Decisions not to approve the use of a non-participating provider are communicated to the provider and member via fax or phone and result in the issuance of a written notification of action. The member, and the provider on behalf of the member, can appeal the decision. In these situations, a Care Manager will work with the member to facilitate access to available in-network tertiary care.

When services are approved to be delivered by an out-of-network provider, the authorization and contact information for the out–of-network provider is sent to Provider Network Management Department for negotiation of a single case agreement. A Care Manager will work with the member and family to facilitate transportation and any other arrangements necessary.

If we are selected as a CCN, we will follow up with several key out-of-network providers such as Natchez Regional Medical Center in Mississippi, Herman Memorial in Houston as well as the various centers of excellence for organ transplants around the country.

24-Hour Availability

To ensure needed services are available 24-hours a day, AmeriHealth Mercy will have a utilization management nurse and physician reviewer on-call 24-hours a day, seven days a week. Members or providers needing to arrange medically necessary tertiary care can call the toll-free Contact Center number or the toll-free utilization management number to reach the on-call nurse after business hours, on weekends and on holidays. The utilization management nurse will facilitate the authorization process, as needed, and arrange for a Care Manager to continue to work with the member.

G.3 Loss of Hospital or Providers

Describe how you will handle the potential loss (i.e., contract termination, closure) in a GSA of a) a hospital and b) all providers within a certain specialty.

AmeriHealth Mercy's philosophy is to maintain a diverse, quality network of providers to meet the needs of our clients and members. Maintaining a high quality network requires us to focus on ensuring we are diligent in monitoring provider relationships and status for any potential changes. When faced with a possible termination of a provider, particularly one whose loss would adversely impact care to a significant number of members, we will first and foremost take all reasonable measures to prevent such a termination. We will immediately contact the provider to ascertain the reasons for the termination notice. In our experience, a termination notice is often a legal prelude to negotiations, indicating that the provider does not intend to continue participating under current contract terms. We will also explore whether there are administrative modifications we can make to improve provider satisfaction to prevent the loss of the provider to our network. Once we are aware of the potential termination of a hospital or large group of providers, we will implement our well-defined contingency.

Provider Contract Monitoring

We believe that good communication with providers and their staff is an essential part of improving overall provider satisfaction and services for our members. The Provider Network Management Department has primary responsibility for building and maintaining provider relationships and will monitor provider contracts.

AmeriHealth Mercy provider contracts address the notice period required when a participating network provider desires to terminate their contract. When a participating provider desires to leave the AmeriHealth Mercy network, the provider must communicate the desire to do so in writing to AmeriHealth Mercy. Our provider contracts state that notice of termination should be sent to the Provider Network Management Department, and in the case of hospitals, the Legal Department must also be copied. Providers are not always compliant and may send the termination notification to one or multiple sources within the plan. All correspondence will be date stamped by whichever department receives the notice. The effective date of the Provider Contract termination will be based on the date the letter is date stamped. All departments are trained on the importance of immediately forwarding the notification to the Provider Network Management Department who will initiate the contingency process and internal processes for member notification.

Hospitals are required to provide a minimum of 120 days written notice of termination to the organization and primary care physicians and specialists are required to provide a minimum of 90 days written notice. However, under the direction of the Director of Provider Network Management, all provider contract renewals are proactively monitored and our contracts management sends internal email notifications when a notification time frame is near. Particular attention is given to hospital and large provider contracts.

At least 30 days prior to deadline for the applicable termination notice, a team is mobilized to discuss the contract renewal process and to plan for any outcome of the contract renewal process. The team is multi-disciplinary and includes: Provider Network Management (negotiators, Network Provider Representatives), Provider Communications, Government Affairs, Informatics, Medical Affairs (Case Management, Utilization Management, Rapid Response Team), Credentialing, Marketing and Retention, Informatics, Operations – Provider Maintenance, Panel Transfer, Enrollment, Call Center, Operations Reporting and others, as needed.

Geo Access maps are prepared to determine network composition and access with, and without, the provider in question. This allows the development of a recruitment plan to replace the needed provider specialty, if possible. Additionally, we take steps to ensure early identification of members with special needs. Early outreach to all affected members enables the arrangement of appropriate, quality alternative health care services and mitigates disruption to both members and the provider network. If alternative providers and practitioners cannot be located, early outreach allows AmeriHealth Mercy to arrange continuation of care with the terminating provider for as long as medically necessary, without disrupting care for the member.

In the event that AmeriHealth Mercy terminates a provider contract and the contract notification period is less than ninety (90) days, AmeriHealth Mercy will give hospitals and provider groups ninety (90) days' notice prior to a contract termination without cause. AmeriHealth Mercy also understands that contracts with single practitioners are exempt from this requirement and will follow the standard contract notice period of 90 days.

Provider Termination Contingency Activities

While we will exhaust all reasonable options to retain the provider, AmeriHealth Mercy also has detailed contingency plans to ensure a network provider termination is managed effectively and efficiently and to assure that the continuity of care for our members is not compromised.

The contingency planning process includes the following activities when a health system is terminating:

- Identify all providers and practitioners owned (employees of the health system) by the health system
- Determine community practitioners (not employed by the health system) with admitting privileges only at terminating facilities
- List community practitioners (not employed by the health system) with admitting privileges at terminating facilities and who also can admit to other hospitals in the network

- Analyze member health care access issues caused by facility and practitioner termination through a GeoAccess Survey
- Inform the state and benefits counselor and other relevant parties of the potential for a termination
- Provide DHH written notice of any material change to the provider network no later than seven business days. Notice will include the reason(s) for the proposed action
- Issue an immediate notice of a termination for cause of a provider or subcontractor that could impact network access
- Develop strategies to mitigate access to care issues, e.g., recruitment of additional providers and practitioners to fill gaps in care
- Identify members who within the past 12 months received health care services from a terminating facility or practitioner or whose primary care practitioner (PCP) is terminating
- Manage all open authorizations at a terminating provider so continuity of care arrangements can start for members in an active course of treatment
- Draft and obtain DHH's approval of member and provider notification letters and related materials
- Submit to DHH a copy of draft notification to affected members within 60 days prior to the expected implantation date of a material change in its provider network
- Draft scripts for associates who will be outreaching to and receiving calls from affected members; Scripts will also be provided to DHH
- Create a member strategy and identify and outreach to physicians to whom members will be transitioned
- Identify those members with special needs or who will have continuity of care issues for immediate outreach – especially pregnant women, members in care management programs, members with HIV/AIDS, children in foster care or in children and youth custody

A strong communication plan details steps taken to ensure that AmeriHealth Mercy is not only complying with DHH requirements, but also ensuring that we are assisting all affected members in transitioning to new providers. The following outlines the process that AmeriHealth Mercy will follow in notifying both DHH and AmeriHealth Mercy members.

DHH Notification

AmeriHealth Mercy will provide written notice to DHH no later than seven business days of our notice of any network provider contract termination that represents a material change in our provider network. Material change is defined in the RFP as:

- Any change that would cause more than five percent (5%) of members in the GSA to change the location where services are received or rendered
- A decrease in the total of individual PCPs by more than five percent (5%)
- A loss of any participating specialist which may impair or deny the members' adequate access to providers
- A loss of a hospital in an area where another CCN hospital of equal service ability is not available as required by access standards specified in this RFP
- Other adverse changes to the composition of the CCN which impair or deny the members' adequate access to providers

In addition, AmeriHealth Mercy will provide an assurance to DHH when a determination has been made that a significant change in operations has affected AmeriHealth Mercy's ability to provide adequate capacity and services. As with any material changes, AmeriHealth Mercy will request approval of the material change in the provider network as well as any accompanying provider and member communications sixty (60) days prior to the expected implementation of the change. Such a request will include information about how the provider network change will affect the delivery of covered services, and the plan for maintaining the quality of member care, if the provider network change is likely to affect

the delivery of covered services. In the event of any unexpected changes (e.g., provider illness, death, etc.), AmeriHealth Mercy will provide DHH with notice within one business day of the change.

Member Notification

All affected members will be notified in writing by AmeriHealth Mercy within 15 days prior to a provider's contract termination date. In the case of terminated primary care physicians, affected members are defined as members who have designated the terminating PCP as their primary care provider. In the case of terminating specialty physicians, utilization data will be used to identify those members who had seen the terminating specialist for specialty services during the preceding 12 months. In the case of a terminating hospital, utilization data will be used to identify those members who had seen been treated at the terminating hospital for services during the preceding 12 months.

Notification to affected members will include information regarding assistance in choosing another contracted practitioner and referral to the AmeriHealth Mercy website for a list of network providers in the member's geographic area. The member may also call AmeriHealth Mercy's Member Service Department for assistance in selecting a new PCP.

AmeriHealth Mercy has employed various types of additional notification strategies which will be used as needed to supplement the written notification to ensure members receive timely information. These strategies include phone calls, "on hold" messages, and automated and interactive phone calls. We have also initiated some "social networking" notification pilots – through texts to cell phones. One primary goal of the pilot was to assure no member would be charged for the messaging directed to their cell phones.

Special effort is made to contact members with special needs so that the health care services they receive continue without interruption. Members with special needs receive repeated phone calls and/or home visits arranged by our Rapid Response staff until our Care Connectors have successfully transitioned or arranged for continuation of their care.

Once the termination notification has been mailed, members with terminating PCPs are given at least 10 days from the letter's date to choose a new PCP. Once the time period ends, the members are automatically assigned to a new PCP through a process placing the member with a geographically accessible PCP and Members receive information on how to change the assigned PCP if they are not happy with the assignment. In most circumstances, members are able to change PCPs at any time. AmeriHealth Mercy will be a source of clinical information continuity, and we will support the member to identify a PCP where they can maintain a positive care relationship. Failure to achieve this strong patient-provider bond could lead to avoidance of preventive services and/or unnecessary use of the emergency room. AmeriHealth Mercy does, however, monitor excessive movement/doctor "hopping" by a member as a warning sign of drug seeking or other abusive behavior. We will restrict a member to a PCP if there are such indications.

G.4 Significant Traditional Providers (STPs)

G.4 The CCN is encouraged to offer to contract with Significant Traditional Providers (STPs) who meet your credentialing standards and all the requirements in the CCN's subcontract. DHH will make available on www.MakingMedicaidBetter.com a listing of STPs by provider type by GSA. Describe how you will encourage the enrollment of STPs into your network; and indicate on a copy of the listing which of the providers included in your listing of network providers (See G.3) are STPs.

We understand the importance of Significant Traditional Providers (STPs) as these safety net providers are essential to meeting the needs of the communities we serve. We have an extensive corporate history of contracting, partnering with, and valuing community based providers and would actively seek their continuous participation in our networks. The STPs have participated with the Medicaid program for years and continue to serve Medicaid recipients when many other providers decline to participate.

Currently, the Provider Network Listing represents a total of 5,432 STP provider records, which reflect the STPs, or the group practice providers that are affiliated with STPs. The strong representation of STPs in our provider file shows our on-going commitment to outreach and partnership with these key providers. We have provided a copy of the STP providers in the provider listing in G1.

AmeriHealth Mercy will build the backbone of our provider network with STPs. We have invested years into developing strong collaborative relationships with key STPs such as the LSU Health System (LSU) and Franciscan Missionaries of Our Lady Health System (FMOLHS). Our discussions with these provider systems have gone beyond preliminary contracting discussions to full engagement and co-development of medical management programs, opportunities to increase access to care, and initiatives to support the better delivery of care to other Louisiana populations such as the uninsured. Many of these discussions are covered in greater detail in the relevant care management sections of this response.

In addition to the uniquely strong relationships with LSU and FMOLHS, we have targeted to contract STPs, including CHRISTUS Louisiana and the Office of Public Health through an aggressive outreach and contracting initiative. This initiative encompasses a combination of direct mail, telephonic outreach, provider conferences and in-person visits from network development representatives. We have also had numerous discussions with members of the Louisiana Primary Care Association as well as with Dr. Joia Creir and the Louisiana Medical Association about possible relationships post award. STPs have been prioritized for in-person visits and telephonic outreach from locally hired Provider Network Management and Education Staff.

AmeriHealth Mercy's Unique Approach to Provider Collaboration: The Partnership Council

STPs will also be engaged to be an integral part of the management of the CCN through a Partnership Council. The Partnership Council will be formally organized to solicit input from key stakeholders regarding the structure and implementation of new and existing clinical policies and strategies. It is important that these stakeholder groups are geographically representative of Louisiana and reflect the communities that serve Medicaid recipients. The Partnership Council becomes a strong recruiting tool for STPs to engage in the delivery of care in a true partnership with AmeriHealth Mercy.

To convene the Partnership Council, we will reach out to different constituencies, as outlined below. These include:

- Behavioral health providers and community health advocates
- Significant traditional providers, including FQHCs, RHCs, clinics and safety net hospitals
- Providers of all types who serve the Louisiana Medicaid population, including physicians, hospitals, health departments, School-based Health Centers
- Other applicable Louisiana State, Parish or City Departments identified by DHH as Stakeholders
- Members or member representatives

Figure 2: Partnership Council

We will ask each constituent to identify suitable delegates to participate in the Partnership Council. Participation will be limited to a certain number of delegates from each major constituency, to ensure that each group is equally and fairly represented. We usually ask that delegates serve for at least one year. We do not compensate Council delegates for their time; we ask that they volunteer to contribute their opinions and expertise in the hope of achieving a better set of outcomes and achievements for the program. We plan to create a Council in each GSA to address the healthcare delivery needs of those regions and maximize participation. For example, we do not envision a provider from Monroe attending a Partnership Council meeting in Baton Rouge.

Partnership Council Functions

The primary goals of the Partnership Council are to improve the health status of members and build relationships with key Medicaid providers. The Partnership Council also contributes to the future direction of our program through collaboration around policy, training, provider education and research. The Partnership Council meets to:

- Exchange information and materials
- Discuss approaches to service delivery and models of care
- Select priority areas on which to focus collaborative efforts and communication
- Jointly design consensus guidelines, protocols, and health promotion materials when appropriate
- Discuss issues or concerns and facilitate problem-solving

The Partnership Council plays an integral role in providing input to, and collaborating with AmeriHealth Mercy regarding:

- Improving access to comprehensive and coordinated care for our members, including behavioral health, condition management and member outreach programs
- Creating better systems for identification, screening and evaluating health outcomes for members with special health needs
- Decreasing use of emergency room for primary and specialty care services
- Developing new approaches to preventive, primary, and specialty care
- Identifying methods to reduce the administrative burden on physicians
- Responding to cultural, racial and linguistic needs of our members

- Supporting dissemination and replication of "best practices"
- Strengthening data sharing capabilities, use of health information technologies, outcome evaluation, and measures for collaborative activities
- Evaluating the results of quality activities, instituting actions and overseeing follow up as appropriate
- Decreasing or eliminating non-clinical barriers for members

The Partnership Council will be instrumental in helping AmeriHealth Mercy employees to promote the components of medical home certification. By enhancing data sharing and communication between physicians and other community health providers, we will facilitate coordination of services and helping practices strengthen their medical home capabilities in preparation for certification.

AmeriHealth Mercy will also use the Partnership Council as a forum to provide technical assistance, share data and offer program development support. The Partnership Council helps to focus the collective efforts of members on high-priority health problems that affect low-income populations in the region and ensure that our constituents have a voice in determining the policies and procedures of AmeriHealth Mercy's program. We hope that the Partnership Council will continue to foster open communication, create an atmosphere where lessons learned from successes as well as failures can be shared, and opportunities will be supported to apply new learning.

Delegates to the Partnership Councils 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 and other types of Health Centers or Clinics
- Local Health Departments
- School-Based Health Centers
- Social Service agencies
- Schools of Medicine
- Local Care Management Programs
- AmeriHealth Mercy staff
- Health information technology representatives

Subcommittees or workgroups may be formed around the following:

- Medical Home Team
- Provider Engagement
- Primary care/behavioral health integration
- Health information technology
- Quality improvement

- Member outreach

The Partnership Council will report findings and recommendations to the Quality Assurance Performance Improvement Committee (QAPIC). The QAIPC, which is comprised of AmeriHealth Mercy executive staff and participating providers, is responsible for the overall effectiveness of the quality improvement program.

We believe we will begin to build a successful network delivering high quality care to our members in Louisiana through our strong relationships with STPs such as LSU and FMOLHS, our targeted and personalized outreach to STPs, and our formulation of the Partnership Councils.

We have noted in the provider listing required in G1 which providers are STPs.

G.5 Developing and Maintaining a Provider Network

G.5 Based on discussions with providers in obtaining Letters of Intent and executed subcontracts as well as other activities you have undertaken to understand the delivery system and enrollee population in the GSA(s) for which a proposal is being submitted, discuss your observations and the challenges you have identified in terms of developing and maintaining a provider network.

Provide a response tailored to each GSA of the following provider types/services:

- *Primary Care*
- *Specialty Care*
- *Prenatal Care Services*
- *Hospital, including Rural Hospital*
- *Office of Public Health*
- *Private Duty Nursing/Home Health Services;*
- *FQHC*
- *School Based Health Clinics*

Leveraging our years of relationship building efforts in Louisiana, AmeriHealth Mercy implemented a resource intensive campaign to obtain Letters of Intent and executed contracts from providers. For more than 17 years, senior leadership has been working with various providers, administrations and associations as Louisiana considered Medicaid managed care programs. While the challenges of creating a statewide network are significant, AmeriHealth Mercy is uniquely positioned to develop a comprehensive network for our members.

With providers where AmeriHealth Mercy has close relationships, such as those with FMOLHS and LSU, we have been able to hold several meetings to discuss the CCN program, educate providers on the mechanics of managed care and develop an understanding of the challenges related to the healthcare delivery system in Louisiana. These meetings have enabled AmeriHealth Mercy to move on from traditional contracting conversations to more advanced topics such as integrated care management, potential sharing of electronic data and innovative gain-sharing incentive financial arrangements.

As we moved to address a statewide network in addition to FMOLHS and LSU, there are a number of key observations and challenges that frequently arise. The most common finding has been the desire of providers to learn more about the CCN program concept. As AmeriHealth Mercy has hired a number of local staff to outreach and recruit providers, many providers have asked basic questions about the CCN program and what it means for them. Our primary role during in-office visits and presence at various provider association meetings has been one of CCN program and managed care educator. There clearly remains an opportunity to enhance the understanding and clarity about the transition of Medicaid to CCNs. To that end, in addition to provider recruitment mailings to all DHH providers statewide, our local and dedicated network development staff have been well received. Practices interested in the

Medicaid population appreciated the opportunity to have their questions and concerns addressed in person.

As we continue to advance DHH's goal of mainstreaming Medicaid patients, we have observed that many providers have no interest in accepting Medicaid patients. Several providers have mentioned the various rate cuts and poor economics of having a Medicaid patient base. Specialists, in particular, stated they often only provide access to their services in emergency and critical care environments. In addition, office-based providers have relayed the difficulties in getting the population to show up for appointments and the difficulties of managing the patients when they do arrive in the office. While we are able to explain that we have a lot of experience in outreaching to patients and improving no-show rates, many providers still refuse to take on Medicaid patients.

Late in 2010, AmeriHealth Mercy conducted a series of focus group research sessions throughout the state. One overriding theme heard from the prospective recipients was while they were very grateful to receive their Medicaid coverage, they often felt like second class citizens in accessing care. Only through close partnerships and meaningful support to providers can we bridge this gap and make members truly feel valued and cared for in the future.

Finding and communicating with providers has also been a challenge. As we reached out to providers, we often found the contact information for the provider was outdated or listed a personal residence as opposed to an operational practice. A number of our in-person visit attempts resulted in finding empty office buildings. The evidence remains that the provider community is still somewhat unsettled, and maintaining accurate and updated provider data will be a focus for AmeriHealth Mercy as we move into the next few years.

Finally, some providers have chosen to wait until the CCN awards are made before they expend time and resources into contracting with CCNs. Children's Hospital and several of the FQHCs have expressed this point of view. While we are confident these providers will choose to participate in AmeriHealth Mercy's network should we be chosen as a CCN, this wait and see strategy has been taken by a number of providers.

Recently, AmeriHealth Mercy helped to sponsor and participate at a Louisiana Medical Association meeting. A provider visited an AmeriHealth Mercy booth and asked about the Letters of Intent. She stated that she had 14 or 15 of them sitting on her desk, and she had no idea what to do with them. An AmeriHealth Mercy representative went over the basics of the CCN program and discussed the purpose of the Letters of Intent. The next day, the provider came back with a signed AmeriHealth Mercy Letter of Intent and expressed gratitude for someone finally taking the time to explain what was going on for her.

GSA "A" Specific Information – Regions 1 and 9

Region 1 contains the City of New Orleans (Orleans Parish) and three surrounding parishes—Jefferson, Saint Bernard and Plaquemines. Orleans Parish makes up approximately 46 percent of the region's population and has a higher rate of individuals who are either uninsured or on Medicaid. Region 9, often referred to as the Northshore area, has St. Tammany Parish as well as the parishes of Washington, Tangipahoa, Livingston and St. Helena.

Our network development in this GSA has leveraged committed relationships with LSU, Ochsner Health System and the physicians affiliated with Tulane University Medical Group. Below is a description for the GSA by provider type of specific observations and challenges faced in developing a CCN network.

Primary Care

In meeting with the primary care providers, we found many concerned about an added administrative burden that would require the provider to hire additional staff. We expressed that AmeriHealth Mercy would offer a streamlined approach and a provider friendly navigation tool. Many providers indicated that

AmeriHealth Mercy was the only company that had stopped by to speak with them. We committed to meeting face to face with providers and that someone would always be available to assist them.

AmeriHealth Mercy hosted a dinner meeting with the Louisiana Medical Association and the New Orleans Medical Association in February to share our mission, experience and local commitment to Louisiana. During the event, one of the key topics discussed was emergency room utilization. Several pediatric providers shared frustrations around members not leaning on them for care when they are available. This was a great opportunity for AmeriHealth Mercy to encourage them to communicate openly and work with one another for coverage after hours and to share best practices. As an example, one of the independent Pediatricians stated she was preparing a brochure for her patients to remind them of her availability (24 hour), and we discussed ways we could provide support and coordination with provider efforts.

Providing adequate coverage in Livingston, St. Tammany, St. Bernard and Plaquemines has been a challenge. As a remedy, we will look to leverage our relationship with FMOLHS. We anticipate the completion of the Our Lady of the Lake-Livingston medical complex in the summer of 2012 will provide sufficient primary care and specialty care coverage for these parishes. In the interim, we will develop an adequate network utilizing FQHCs, Rural Health Centers and other community based providers.

Specialty Care

We have strong coverage for specialty services for this GSA. Through our relationships with LSU and Oschner Health System, we have a wide variety of specialists included in the network. In Livingston, St. Tammany, St. Bernard and Plaquemines, we will also leverage the completion of the Our Lady of the Lake-Livingston medical complex in the summer of 2012 to add more specialists for this region. We continue to develop relationships with community providers and STPs throughout these parishes.

Prenatal Care Services

March of Dimes hosted a community event April 30, 2010, at which AmeriHealth Mercy participated and sponsored the event in Baton Rouge and New Orleans.

Through our relationship with LSU, we continue to support the partnership with the March of Dimes Mom and Baby Program to activate a mobile health unit to provide prenatal and post natal care to pregnant women in the community setting.

We have already partnered with several key providers, such as LSU and Ochsner, in this GSA and will continue to refine the network coverage. We have also reached out to St. Tammany Parish Hospital and several other STPs.

Hospitals

We have strong hospital coverage and have partnered with key hospital systems, such as LSU and Ochsner, along with several other independent facilities. We will continue to partnership with the remaining hospitals in the area to ensure the delivery system is supported.

While we have had a number of conversations facilitated through our relationship with LSU, Children's Hospital has notified us they do not intend to sign with any CCN until post award. They have agreed to meet with us after the RFP submission date to begin those discussions.

Office of Public Health

The Office of Public Health has signed a letter of intent with AmeriHealth Mercy. OPH had specific questions about the working relationship between AmeriHealth Mercy and OPH in other states we service. We described the collaborative relationship we have with OPH in South Carolina and reinforced our understanding of the OPH role in the rural and underserved areas of Louisiana as well as the significant role they play in the School Based Health Center program. Once OPH reviewed our information, we received a signed LOI and provider listing for statewide services.

Private Duty Nursing/Home Health Services

In meeting with ancillary providers, we found many who were unclear about how the CCN implementation would affect them; our dedicated local representatives were able to explain the concept and found home health agencies optimistic and willing to sign LOI's quite readily.

We have partnered with several regional home health companies that provide nursing, PT, OT and ST services in the home, private duty nursing and infusion therapy services across the GSA. Although their corporate location is provided in the Network Listing, they support members throughout the GSA.

Federal Qualified Health Centers

We have partnered with St. Charles Community Health Centers in GSA A and outreached to all FQHCs regarding participation. Many of the FQHCs have committed to one CCN at this time and are unwilling to participate with other CCNs until post award.

School-Based Health Clinics

School-Based Health Clinics in Tangipahoa, Jefferson and Orleans are participating with us currently. We have outreached to all of the SBHCs in this GSA and will continue to collaborate with them in order to reduce administrative/operations concerns. In addition, we are identifying SBHCs in all regions that would be interested in participating with us as PCPs.

GSA "B" Specific Information – Regions 2, 3 and 4

Region 2 represents the Capital area of Baton Rouge as well as the parishes of West Feliciana, East Feliciana, Pointe Coupee, Iberville and Ascension. Region 3 is the South Central Louisiana area featuring the parishes of Terrebonne, Lafourche, St. Charles, St. John the Baptist, St. James, St. Mary and Assumption. Region 4 is the greater Lafayette area with the parishes of Lafayette, Acadia, St. Landry, Evangeline, Vermilion, Iberia and St. Martin.

Our network development in this GSA has leveraged committed relationships with FMOLHS, LSU and Woman's Hospital. Rene Ragas, Director of Payer Relations, along with key stakeholders with FMOLHS, and Fred Cerise, MD, Executive Vice President LSUHSC, are very supportive of our partnership, and we communicate on a regular basis regarding provider implementation and needs. Below is a description for the GSA by provider type of specific observations and challenges faced in developing a CCN network.

Primary Care

We held a collaborative meeting with the Louisiana Chapter of the American Academy of Pediatrics (LAAAP), Louisiana Academy of Family Physicians (LAFP), Medicine Louisiana, American College of Obstetricians and Gynecologists (ACOG) in April. We discussed several key topics with Dr. Horace Collinsworth, Pediatrician with FMOLHS and Ragan LaBlanc, Executive Vice President, LAFP. These topics covered reimbursement claims submission and payment, Electronic Health Record platforms, medical guidelines, coordination of care and information (e.g. immunization data).

As a result of our efforts, we have been able to obtain a letter of intent from Lake Primary Care, one of the largest primary care groups caring for the Medicaid population. Almost universally, providers have appreciated the time we dedicated to meeting with them. They shared concerns and discussed solutions around the implementation and transition of the CCN Program. We communicated our support, experience and commitment to supporting primary care providers.

Even though we have put together a strong PCP network in GSA B, we will continue to outreach and partner with providers to ensure potential members have adequate access to primary care services. One of our main priorities will be to enhance the coverage in St. Landry, Terrebonne and LaFourche.

Specialty Care

We have partnered with many key providers throughout GSA B to provide specialty coverage including LSU Health Network, Ochsner and FMOL. Our approach is one of collaboration, education and support. We continue to reach out to specialists of this GSA to ensure complete access to specialty care.

In April, we also met with Berkley Durbin, Executive Director of MedicineLouisiana. We openly discussed her concerns related to the transition with regard to reimbursement, technology and local commitment to Louisiana. Although she appreciated our mission, support and information, she stated they plan to wait until post Award to encourage providers to participate with CCN Plans. Communication will continue with key associations and providers.

In June, we attended the Louisiana Quality Health Forum Spring Meeting in Baton Rouge which provided additional opportunities to share our story in Louisiana and relay our commitment to the local providers.

Prenatal Care Services

Our relationships with Woman's Hospital, Ochsner Health System and FMOL provide strong prenatal care for the recipients of this GSA. We continue to reach out to independent prenatal providers to enhance our existing network. We have received LOIs and/or contracts from Baton Rouge OB/GYN Associates, Woman's Assessment Center and Albert Cammon Wellness Center.

Through our relationships with LSU and March of Dimes, we will continue to support the expectant mothers throughout this GSA.

Hospitals

In partnering with LSU, FMOL, Woman's Hospital – Baton Rouge and Ochsner, we have established a strong network of hospitals throughout the GSA. Sherry Poss, Director of Managed Care with Woman's Hospital has agreed to participate on the Partnership Council and relevant quality committees. We continue to have open communication and collaboration with this crucial Baton Rouge hospital. Additionally, we have received LOIs from Abbeville General Hospital, Acadia St Landry Hospital, and St James Parish Hospital.

We are scheduling visits with Life Point Hospitals to include River Parishes Hospital & Teche Regional as well as Lady of the Sea to ensure we provide strong coverage throughout the Bayou region of this GSA. We will continue to develop our network of hospitals to meet the needs of potential members in this area.

Office of Public Health

The Office of Public Health has signed a letter of intent with AmeriHealth Mercy. OPH had specific questions about the working relationship between AmeriHealth Mercy and OPH in other states we service. We described the collaborative relationship we have with OPH in South Carolina and reinforced our understanding of the OPH role in the rural and underserved areas of Louisiana as well as the significant role they play in the School Based Health Center program. Once OPH reviewed our information, we received a signed LOI and provider listing for statewide services.

Private Duty Nursing/Home Health Services

In addition to our mailings, we launched a telephonic follow-up campaign to touch all the home health providers in the state. We found providers to be optimistic and very willing to work with us.

We have partnered with several regional home health companies that provide nursing, physical therapy, occupational therapy and speech therapy services. Many of these entities also provide private duty nursing and infusion therapy services across the GSA. Some of the key providers in this category that we have been able to get a letter of intent or an executed provider contract includes Chase Home Care, Synergy Home Care and Innovative Home Health. Although their corporate location is provided in the Network Listing, they support members throughout the GSA.

Federally Qualified Health Centers

We were able to secure several LOIs from the following FQHCs and RHCs: St. Charles Community Health Center, St Martin Community Health Center, Abbeville Community Health Center, Fleur-De-Lis Community Health Center and St. Martinville Maternal-Child, Maurice Community Care Clinic. We have reached out to all RHC/FQHC's of this region and found that many were unwilling to discuss signing a letter of intent or hold contract negotiations until after the awards have been made.

School-Based Health Clinics

Sherry Wilkerson, who joined our network development team from Molina, has worked closely with School Based Health Clinics statewide during her tenure with the Medicaid fiscal intermediary. She was responsible for Medicaid service operations and served for many years as the primary contact for Julia Lively, Chief Executive Officer, and Sue Catching, Chief Financial Officer at the Health Care Centers in Schools. Building on this past relationship, AmeriHealth Mercy received signed LOI's from Health Centers in Schools which represents eight SBHCs throughout the GSA. Additionally, we have LOIs from SBHCs in St. Martin and West Feliciana, East Baton Rouge and Lafayette.

We look forward to collaborating with the SBHC's of this GSA to ensure that these "front-line" providers are well supported. Discussions include assisting SBHCs in meeting the requirements to become PCPs, and using our technical resources to support their infrastructure

GSA "C" Specific Information – Regions 5, 6, 7 and 8

Region 5 covers Southwest Louisiana with Lake Charles being the largest city in Calcasieu Parish. Other parishes include Beauregard, Allen, Jefferson Davis and Cameron. Region 6 covers the largely rural Central Louisiana area with Alexandria as the largest city in the Rapides Parish. In addition, the region also includes parishes of Avoyelles, Concordia, Catahoula, La Salle, Winn, Grant and Vernon. Region 7 includes the city of Shreveport in Caddo Parish as well as the parishes of Bossier, Webster, Claiborne, Bienville, Red River, De Soto, Sabine and Natchitoches. Region 8 is the Northern Louisiana region featuring the city of Monroe in Ouachita Parish. Other parishes include Lincoln, Union, Jackson, Morehouse, West Carroll, East Carroll, Richland, Madison, Caldwell, Franklin and Tensas.

Our network development in this GSA has leveraged committed relationships with Melanie Sotak, MHSA, Administrative Director of Shared Business Services, LSU Shreveport and Dr. Hugh Mighty, Vice Chancellor at LSU Shreveport. In addition, we have also relied on our commitments from FMOLHS in the Monroe area.

AmeriHealth Mercy actively communicates and supports face-to-face meetings with key executives as well as operational leads for the key health systems and providers. For example, we have held meetings to discuss collaboration efforts with Stephen Wright, the President and CEO and Kevin Parsley, Senior Director Managed Care for Southern Region of CHRISTUS Health System. Hospital CEOs and Operational Leads affiliated with CHRISTUS actively participated in the meeting as well, including Mark Marley, CEO for Natchitoches Regional Medical Center.

Below is a description for the GSA by provider type of specific observations and challenges faced in developing a CCN network.

Primary Care

Our outreach to the GSA began with an extensive mailing campaign to ensure that all providers received our information. We then followed up with telephonic outreach to each provider included in our mailings. Finally, we dedicated field representatives to meet with providers, answer questions and gauge interest in the CCN process. Many providers requested more information about the CCN Program, and our staff answered questions or helped clarify the process. Our PCP partnerships in this area with LSU and CHRISTUS provided a foundation to our provider network. In addition, we received LOIs from Highland Clinic, Pediatrics Plus, LaSalle Family Medicine and Lake Arthur Clinic.

In our outreach efforts, many providers indicated that AmeriHealth Mercy was the only company that had taken the time to explain the CCN process. We will continue to recruit providers to ensure that we have an adequate network in all parishes in this GSA.

Specialty Care

Our collaboration with LSU and CHRISTUS Health Systems provides strong specialty care throughout GSA C. In addition, we have LOIs from Highland Clinic and, Affinity Health Group and many other individual and small group practices.

We continue to outreach to specialty providers specifically in region 5 and 6 to ensure we provide a strong network of specialists. To date, we have received LOIs from several specialty providers. A few examples include LA Cardio Vascular and Thoracic, LaSalle Family Medicine and L R Collier, MD.

Prenatal Care Services

Through our collaboration with LSU, CHRISTUS Health Systems and many independent prenatal providers, we have established access to quality prenatal care. For example, we have received LOIs or contracts for these services from Highland Clinic, LaSalle Family Medicine and P & S Surgical Hospital Clinic.

Hospitals

Our relationships with LSU, CHRISTUS Health System and a number of important small rural hospitals provide strong access to acute care and ambulatory care. We have received LOIs from several hospitals in this GSA including, but not limited to: Doctors Hospital of Deer Creek, LaSalle General Hospital, Homer Memorial Hospital, Union General Hospital, DeSoto Regional Medical Center.

We were referred to Howard Green, Associate Vice President, Quorum Health Resources, LLC by several of the rural hospital executives. We confirmed our commitment to the rural hospitals and delivery system and received LOIs for the majority of the hospitals he represents. We will continue to partner with Mr. Green to obtain the remaining LOIs and implementation needs.

Sonia Madison, AmeriHealth Mercy of Louisiana's Interim Executive Director, has a strong relationship with John Mattesino, President and CEO of Louisiana Hospital Association, that dates back to when he and Sonia worked together on the rebuilding of healthcare infrastructure post-Katrina. He is very influential with all of the hospitals in Louisiana, including the rural hospitals. Jocelyn Bayliss, AmeriHealth Mercy of Louisiana's Network Director, also has open communication with Mr. Mattesino regarding key hospitals, and he shared his appreciation for supporting rural hospitals during the Louisiana Rural Hospital Coalition conference.

Sponsoring the Louisiana Rural Hospital Coalition meeting in May was a great opportunity to present to the Coalition Members and share our commitment to the rural communities in Louisiana. We received several LOIs from rural hospitals due to our partnership and have a good relationship with Linda Welch, Executive Director.

In reaching out to some of the rural hospitals of GSA C and with the Willis Knighton Health System, we found many of these institutions waiting to commit to a particular CCN until post award. We have scheduled visits with key providers to ensure access to Beauregard, Allen, Avoyelles and the Delta parishes of GSA C. We will continue our recruitment efforts and expect to offer potential members an attractive delivery system of care.

Office of Public Health

Matthew Valliere, Interim Assistant Center Director, Office of Public Health had specific questions about the working relationship between AHMP and OPH in the other states we service. We described the collaborative relationship we have with OPH in South Carolina and reinforced our understanding of the OPH role in the rural and underserved areas of Louisiana as well as the significant role they play in the

School Based Health Center program. Upon OPH review of our information, we received a signed LOI and provider listing for statewide services.

Private Duty Nursing/Home Health Services

We have partnered with several regional home health companies that provide nursing, physical therapy, occupational therapy and speech therapy services. Specifically, we have been able to come to agreement with LaSalle Home Health, Synergy Home Care and Red River Home Health and Magnolia Home Health. Although their corporate location is provided in the Network Listing, they support members throughout the GSA.

Federally Qualified Health Centers

One of the key challenges we faced when reaching out to FQHC/RHCs was identifying those that are independent versus those affiliated with a rural hospital system. The independent Rural Health Centers and Federally Qualified Health Centers were optimistic about the CCN implementation, and many have signed LOIs and returned them to us. We continue to outreach to the remaining centers and have scheduled meetings to discuss our program. However, many of the hospital affiliated RHC's are waiting for awards to be granted before they will sign with any CCN.

We have built a strong base of independent Rural Health Clinics to support primary care. The FQHC/RHCs that have submitted LOIs include: DeSoto Regional Family Medicine, Lake Arthur Health Clinic, LaSalle Primary Health Care, North Caddo Medical Center and Union General Hospital RHC.

School-Based Health Centers

We have received a signed LOI from CHRISTUS and their 25 affiliated School-based health clinics covering nine parishes in GSA C. We have begun to develop relationships with many of the remaining school based health clinics throughout GSA C and will continue to support their efforts to provide care in the region.

G.6 Monitoring Appointment and Wait Times

G.6 Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.

AmeriHealth Mercy network providers are required to meet and treat members according to the standards for access – appointment and wait times – established by DHH and outlined in Section 7.5.

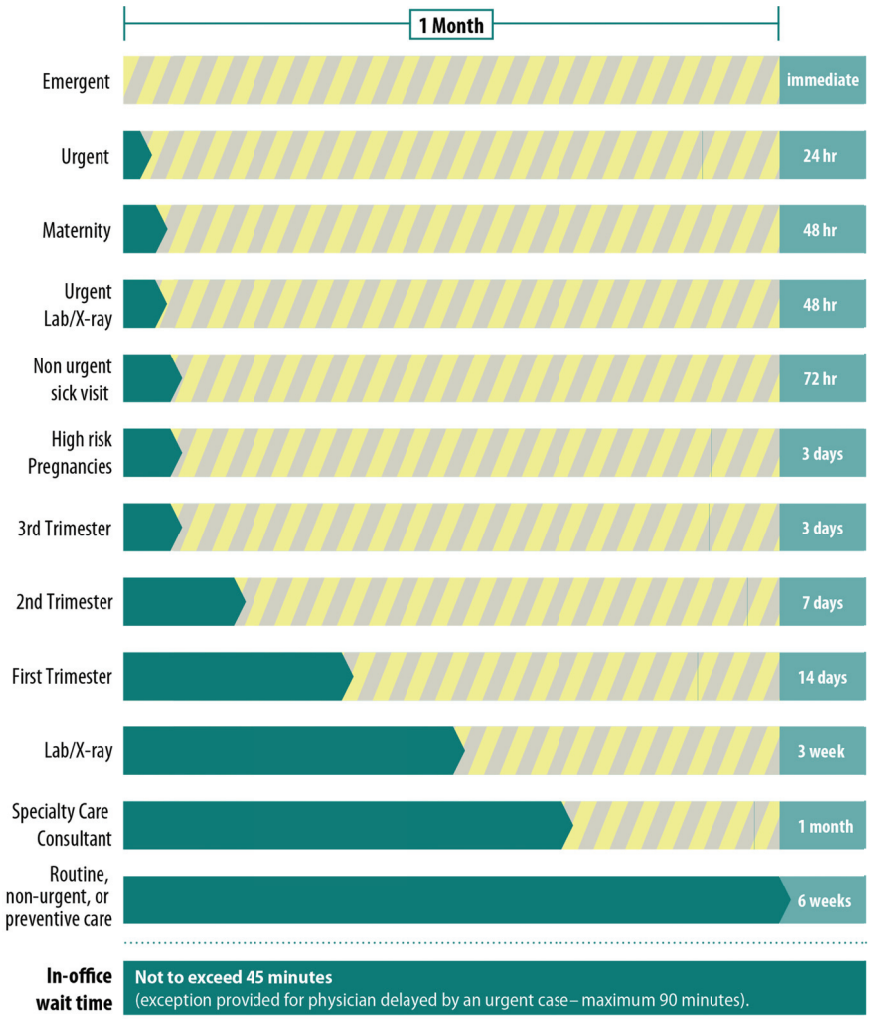


Figure 3: Provider Access Standards

AmeriHealth Mercy has a written policy and procedure which outlines our requirements and defines the process how the plan will monitor providers for their compliance with accessibility standards. The policy identifies the access standards for emergent care or emergency visits, urgent non-urgent sick care, maternity care, routine non-urgent or preventative care, specialty care consultation, laboratory and X-ray services, follow-up visits after emergency care, and after hour availability and the in-office waiting time for scheduled appointments.

Education and Communication of Standards

AmeriHealth Mercy uses several methods to educate and communicate provider accessibility standards. Our process uses standard documents such as the Provider Manual included in the provider contract and on-site visits and orientation sessions conducted in-person, with the goal of ensuring that providers have a clear understanding of expectations placed on them as an AmeriHealth Mercy network provider. Examples of different ways that AmeriHealth Mercy makes this information available to providers include, but are not limited to, the following:

- Provider Manual
- Provider Portal section of the LaCare website
- On-site orientation presentation for newly contracted/credentialed providers

- Routine provider office/site visits
- Provider workshops
- Provider newsletter

Monitoring of Standards

Once the accessibility standards have been communicated to the providers, following up to ensure that the member's experience is consistent with those standards is a critical component of assessing access to care. Compliance with the accessibility standards is monitored through a number of tracking and reporting vehicles. We track calls from members related to dissatisfaction appointment and wait times. Individual dissatisfactions are forwarded to the Provider Network Management Representative assigned to the provider for investigation and resolution. In addition aggregate data related to dissatisfaction appointment and wait times is trended to identify physician offices with repeated problems.

In addition, AmeriHealth Mercy will conduct its own assessments via "Secret Shopper surveys," and formal After Hours Access surveys and provider audits. "Secret Shopper" calls allow us to experience the response from the physician's office that our members receive. For the After Hours Access Survey, we call physician offices when the office is closed to check that members who call are able to reach a physician, if needed. We also audit provider scheduling records to determine the availability of the next appointment for preventive, routine and urgent care. During on-site visits, we assess office wait times.

Review and Analysis of Findings

Providers who are non-compliant with any of the standards are notified of our findings and educated regarding the standards. The assigned Provider Network Management Representative schedules another monitoring event, either an on-site visit to monitor office wait times, a "Secret Shopper" call to check appointment availability or an after-hours call to verify ability to reach a physician. Offices that are non-compliant during repeat monitoring are required to create and implement a corrective action plan. The Provider Network Management Representative monitors the implementation of any corrective action and reports the results to the Quality of Service Committee (QSC), a subcommittee of the Quality Assessment Performance Improvement Committee (QAPIC). Non-compliant offices are also automatically included in the sample for the next monitoring session.

Sample monitoring reports appear below:

Table 1: Sample Report – Plan Appointment Access Survey Results (2008-2010)

	2008	2009				2010			
Standard	**% Met**	**Met Standard**	**% Met**	**Did Not Meet Standard**	**% Not Met**	**Met Standard**	**% Met**	**Did Not Meet Standard**	**% Not Met**
All types of care	96%	562	97%	17	3%	632	95%	32	5%
Preventive	96%	545	97%	17	3%	636	95%	28	6%
Routine	100%	562	100%	0	0%	662	99%	2	1%
Urgent	99%	562	100%	0	0%	663	99.9%	1	.01%
Emergent	100%	562	100%	0	0%	662	99%	2	1%

Total PCP sites surveyed in 2010: 664

Table 2: Reasons Why PCP Sites Did Not Meet After-Hours Standards 2008-2010

2008			
Reason	**#Non-Compliant**	**% of Non-Compliant**	**#Study Population**
Total	**84**	**100%**	**710**
≥ 10 Rings	17	20%	2%
Answering Machine instructions to ER only	18	21%	3%
No emergency instructions on answering machine	46	55%	6%
Answering Service does not pick-up	3	4%	0%
2009			
Reason	**#Non-Compliant**	**%Non-Compliant**	**#Study Population**
Total	**44**	**100%**	**749**
≥ 10 Rings	13	30%	2%
Answering Machine instructions to ER only	5	11%	1%
No emergency instructions on answering machine	21	48%	3%
Answering Service does not pick-up	5	11%	1%
2010			
Reason	**#Non-Compliant**	**%Non-Compliant**	**#Study Population**
Total	**49**	**100%**	**891**
≥ 10 Rings	10	20%	1%
Answering Machine instructions to ER only	10	20%	1%
No emergency instructions on answering machine	18	37%	2%
Answering Service does not pick-up	11	23%	1%

Corrective Measures

Our Provider Network Management Representatives work with provider offices to help them find creative solutions and alter their processes to become compliant. We have worked with some PCPs to offer "open

hours" or walk in hours. One of our large hospital-based practices in Central Pennsylvania implemented walk-in hours from 7-9 am Monday – Thursday, giving the practice more flexibility in meeting standards for urgent appointments. We also worked with other offices that offer several "unscheduled" appointments throughout the day. One group is offering our members urgent care appointments by scheduling so that each physician has one unscheduled appointment each hour.

Results of all of our monitoring activities are combined with select CAHPS responses and phone access performance to create a global picture of Access and Availability. The Access and Availability findings are reported to the QSC for review, identification of opportunities, prioritization and planning. Final results and recommendations are reviewed by the Partnership Councils for input into planned actions and approved by the QAPIC.

Non-compliant providers are carried over on subsequent quarterly reports until final resolution of the issue has been accomplished. Site visits are conducted with non-compliant providers and, as noted, corrective action plans are developed with the provider in order to remedy non-compliance. One particular PCP office failed the After Hours Survey and subsequent monitoring two years in a row. The provider was notified in writing of the need to submit a plan to resolve the performance issue and that failure to submit a plan and comply will result in termination.

G.7 PCP Assignment Process

Describe your PCP assignment process and the measures taken to ensure that every member in your CCN is assigned a PCP in a timely manner. Include your process for permitting members with chronic conditions to select a specialist as their PCP and whether you allow specialists to be credentialed to act as PCPs.

One of the most crucial elements in being able to deliver quality efficient care to the Louisiana Medicaid population is the enhancement of the role of primary care providers. Developing a strong relationship between the patients and their respective PCP is a fundamental goal for AmeriHealth Mercy, and it starts with the assignment of the PCP. We encourage members to make a choice with regards to their PCP and have processes set up to give every opportunity for members to select their PCP. However, there are times when members either do not engage in the process or do not have a preference to their PCP assignment. AmeriHealth Mercy will then follow policies and procedures around auto-assignment of PCPs. In some cases where members have chronic conditions and/or complex cases, a specialist can serve as the member's PCP pending approval from the specialist and a review from AmeriHealth Mercy.

Assignment of Primary Care Providers

We understand that the Enrollment Broker will encourage the member to remain with their current PCP, provided the relationship with the PCP is satisfactory for the member and the PCP participates in the member's CCN. PCP choices made during the enrollment process will be transmitted to AmeriHealth Mercy through the Member File. Members are notified of their PCP selection through the Welcome Package that will include all other new member materials.

If no PCP is selected on the Member File received from the Enrollment Broker, a Customer Service Representative will:

- Contact the member, as part of the welcome process, within 10 business days of receiving the Member File from the Enrollment Broker to assist the member in making a selection of a PCP
- Explain the advantages of selecting the same primary care provider for all family members, as appropriate, and inform the member that each family member has the right to choose his/her own PCP

If the member cannot be reached or does not make a choice of PCPs, AmeriHealth Mercy will follow our auto-assignment protocols to assign a PCP to the member.

PCP Auto-Assignments

Members who do not proactively choose a PCP within 10 days of enrollment will be assigned to a PCP using a systematic PCP algorithm. Our automated process increases the likelihood that the assignment is acceptable to the member and expedites the process by assigning a PCP in the member's local community or one selected by a family member.

The process for auto-assignment is as follows:

- Each month the automated process reads members' eligibility records in our eligibility and claim system, Facets®, and identifies any members enrolled more than 10 days without a PCP assignment.
- The process first searches paid claims or health status data, including any fee-for-service data made available by the state, and assigns members to a PCP with whom the member has a historical PCP relationship.
- If no PCP is found in the data, the process searches for other family members with a PCP assignment. The Family Link cross-reference file search for all active family members who have been active within 180 days of the file processing date. The results will exclude from consideration any non-active family member records, which were disenrolled as duplicates. The process sorts the family members to look for the closest in age. This process is repeated through the active family members until a PCP selection has been made, or there are no remaining family members.
- If another family member is located with an assigned PCP, the algorithm verifies the PCP is language appropriate (to the extent known), verifies that the provider is a participating PCP without panel limitations and age/gender appropriate and makes the assignment.
- If a family relationship search is unsuccessful, the algorithm makes the assignment based on geographic proximity while ensuring the PCP is age, gender and language appropriate, has not reached the maximum physician/patient ratio and has no restrictions/limitations (e.g. pediatric only practice).

Changing PCP Assignments

In the event that members wish to change their PCP, AmeriHealth Mercy's Customer Service team will assist the member to make the selection and update the Facets system (AmeriHealth Mercy's claims processing system). AmeriHealth Mercy will permit members to change their PCP at any time during the enrollment period, or if the member was assigned a PCP within the auto-assignment process, within 90 days from the assignment. The member can request to change their PCP by either calling one of our trained Customer Service Representatives or e-mailing the request through our member portal.

In addition to member-initiated PCP assignment changes, AmeriHealth Mercy's policies and procedures provide information on options for selecting a new PCP when a current PCP is terminating from the network or when a change is necessary to address a grievance process. This situation may occur when it has been determined that a PCP is non-compliant with provider standards (i.e. quality of care) or when a PCP retires or leaves the area. AmeriHealth Mercy will also allow members to select another PCP within 10 business days of the postmark date of the termination of PCP notice to members. Member notifications will communicate information on options for selecting a new PCP and what to do if the member needs to seek emergency/urgent care during the transition phase. Once the PCP has been chosen or assigned, AmeriHealth Mercy will notify the Enrollment Broker by close of business the next business day.

Selection of a Specialist as the PCP

AmeriHealth Mercy allows vulnerable populations (for example persons with multiple disabilities, acute, or chronic conditions, as determined by AmeriHealth Mercy) to select their attending specialists as their PCP so long as the specialist is willing to perform responsibilities of a PCP.

As part of our policy, AmeriHealth Mercy designates the following types of specialty providers as a member's primary care provider:

- Pediatricians
- Family and General Practitioners
- Internists
- Obstetrician/Gynecologists
- Nurse Practitioners
- Physician Assistants
- Specialists who perform primary care functions at Federally Qualified Health Centers, Rural Health Clinics and Health Departments

However, AmeriHealth Mercy understands that many of the members in its plan will have disabling conditions, chronic illnesses, or are children with special health care requirements. A review process exists for members with special needs who are requesting specialists as their PCPs. Expedited processing of identified specialists as PCPs will be implemented as is reasonably feasible, and in accordance with our plan's credentialing policies and procedures. AmeriHealth Mercy will also always make a good faith effort to ensure that children for whom the PCP is a specialist receive all appropriate EPSDT services, including immunizations and dental services.

AmeriHealth Mercy will request a review and approval of other provider types to become PCPs as identified by members and plan representatives. These may include physicians in the following areas:

- Infectious Disease for patients with HIV/AIDS
- Internal Medicine for unique circumstances
- Endocrinology for diabetic patients
- Nephrology for dialysis patients and kidney transplant patients
- Other specialists in unique circumstances

The process to enroll other specialists as PCPs under unique circumstances may include local Medical Affairs Representatives collaborating with key specialists on a listing of their patients, and encouraging conversion of their office to a PCP. This approach in some unique situations has proven to be the best process for managing very complex members with multiple co-morbidities, requiring one specialty as their primary source of health care services.

G.8 Medical Home Recognition

G.8 Describe your plan for working with PCPs to obtain NCQA medical home recognition or JHCAO Primary Home accreditation and meeting the requirements of Section § 14.

The AmeriHealth Mercy Family of Companies appreciates the tremendous commitment and progress that the State of Louisiana has invested towards the establishment of Patient-Centered Medical Homes as the cornerstone of the re-design of the health care system. Louisiana has had a strong, long term commitment to Patient Centered Medical Homes for the poor and chronically ill– well before Health Care Reform measures added impetus to the transformation of primary care.

AmeriHealth Mercy's founding plan, Mercy Health Plan, was created as a pilot project with the Commonwealth of Pennsylvania in 1983 to create what is now known as Patient-Centered Medical Home. From AmeriHealth Mercy's corporate beginnings and in all our markets, we have been committed to providing coordinated care through our primary care providers. Through this commitment, we have supported and encouraged their efforts to monitor and track and improve the quality of the care of their patients by providing bonus programs for preventive health measures, incentives to regularly schedule appointments for high risk members, and case management services for members with intensive medical needs – with the case manager keeping a care management plan keeps all providers involved in the patients care informed. As the movement toward Patient Centered Medical Homes evolved, the AmeriHealth Mercy Family of Companies was refining technology and data capabilities. The result is we

are uniquely positioned for AmeriHealth Mercy to offer assistance to our providers in meeting the requirements for NCQA certification as a Patient Centered Medical Home.

Our response below outlines the broad scope of our plan for working with the provider community to obtain NCQA PCMH certification. We will supply a detailed implementation plan containing our methodology and timetable for promoting and facilitating Patient Centered Medical Home and JHCAO Primary Care Home accreditation in order to meet the goals of the program within 90 days of the go live date.

AmeriHealth Mercy can immediately assist our network providers in meeting the following NCQA requirements in the following ways:

Access and Communication

AmeriHealth Mercy has numerous initiatives and programs to assist providers in this area:

- Transportation assistance and coordination
- Our 24/7 Customer Service Contact Center
- Multi-cultural health information available online for members
- Handbooks in multiple languages,
- Web site in the predominant language (other than English) in the area,
- Translation and interpreter assistance

Patient Tracking and Registry Functions

AmeriHealth Mercy will assist providers with data to allow them to know our members individually, but to also collect demographic and clinical data for purposes of population management. Through NaviNet, PCPs will have a 360 degree view of their panels with access to clinical information about all their AmeriHealth Mercy members. They can access the Member Clinical Summary that shows all medical services including those from other providers and specialists that an individual member has received. The Member Clinical Summary can be printed for inclusion in the patient's chart or downloaded as a Continuity of Care Document (CCD) for integration into an electronic medical record.

A simple check of eligibility will notify a provider if that a member is missing a recommended preventive care or chronic care monitoring service. Any time a PCP accesses our system for an individual member, if there are gaps in that member's care, a message will pop up alerting the PCP to the needed service.

In addition, PCPs will be able to access this information at the panel level, allowing them to use population management techniques within their practice. This panel-level information is available as a printable report or a CSV (Comma Separated Value) file for compatibility with other electronic systems.

Care Management

AmeriHealth Mercy has an array of care management employees that support our providers in assisting members with special needs, chronic care needs and disease specific conditions. Please see Section E for a full description of our Integrated Care Management programs. PCP involvement in such programs is imperative and we communicate the following to provider about the expectations of the program:

This proactive medical care coordination program focuses on AmeriHealth Mercy members with specific health risks.

Providers who are treating members/consumers that participate in the Integrated Care Management program have the right to:

- Obtain information about AmeriHealth Mercy including its programs and services, its staff and its staff qualifications

- Be informed of how AmeriHealth Mercy coordinates its interventions and plan of care for individual members
- Know how to contact the Care Manager who is responsible for managing the case, and communicating with the practitioner's patients
- Be supported by AmeriHealth Mercy and work collaboratively in decision making with members/consumers regarding their health care
- Receive courteous and respectful treatment from AmeriHealth Mercy staff, and communicate complaints to AmeriHealth Mercy

Providers are responsible to participate in the program through:

- Providing relevant clinical information, as requested
- Taking action to follow-up on reported information
- Participating in the member/consumer plan of care

Based upon the illness and the severity of illness of the members, the provider may be contacted to refer AmeriHealth Mercy patients to us for participation in one or more of our Integrated Care Management programs. These programs are intended to be a collaborative arrangement between our Care Managers and the provider's existing treatment plans for the involved members and will in no way impede on provider autonomy to provide care to members enrolled in the following programs. Full details of each program can be found in Sections F and I.

Pediatric Preventive Health Care

AmeriHealth Mercy's Pediatric Preventive Health Care Program (PPHC) is designed to improve the health of members under age 21 by increasing adherence to Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program guidelines through the identification and coordination of preventive services. The PPHC combines scheduled written and telephonic outreach with state-of-the art informatics that provides point-of-contact notification of EPSDT needs to associates and providers.

Episodic Case Management

The Episodic Care Management (ECM) program provides coordination of services to new adult and pediatric members to the plan and existing members with short-term and/or intermittent needs who have single problem issues and/or multiple co-morbidities.

WeeCare (Maternity) Program

The Wee Care (Maternity) Program is managed by a dedicated team Care Managers and Care Connectors. WeeCare staff outreaches and engages pregnant members into the program based on internal and external assessments that level them into high and low risk categories. Care Managers coordinate care and address various issues throughout the member's pregnancy and post-partum period, including dental screenings and depression screenings.

Complex Care Management

Members identified for Complex Care Management (CCM) receive comprehensive and disease-specific assessments and reassessments, along with the development of short-term and long-term goals and an individual plan of care, created with input from the member/caregiver and the physician.

Rapid Response Team

Rapid Response (RR) is an important component of the ICM model, the Rapid Response (RR) team was developed to address the urgent needs of our members and to support our providers and their staff. The RR consists of registered nurses, social workers, and non-clinical Care Connectors.

Patient Self-Management and Support

AmeriHealth Mercy offers educational materials, reminders, and other forms of support for patient self-management programs. Examples (fully described in Section F.6) include:

- Healthy Hoops® is an innovative health education program that uses basketball as a platform to help children with asthma and their families learn about the disease and how to manage it through appropriate nutrition, medication use, and monitored exercise.
- "Lose to Win" Diabetes and Weight Management Program is a URAC award winning 12-week program that helps members with type-2 diabetes learn the importance of regular exercise, eating a balanced diet and living a healthy lifestyle.
- The Women's Health Ministry Program was created to provide health and wellness information in a faith-based environment – including churches, synagogues and mosques – thus providing women and their families with a safe, supportive setting to learn about their health and receive needed health screenings.

Performance Reporting and Improvement

AmeriHealth Mercy through our comprehensive profiling offers our providers full ability to track their performance across multiple metrics: HEDIS measures, hospitalizations, ER utilization. Our provider profiles are fully described in G.13.

AmeriHealth Mercy will provide education to our providers about how to access the data available through our Provider Portal.

For those NCQA measures that are rooted at the practice and/or not limited to those patients who are our members, we will work with a qualified consulting organization to solicit and enter into a Memorandum of Understanding. These consultants will work with our network practices to help them understand the NCQA or new JHCAO requirements and to give assistance in meeting them –including guidance around moving to Electronic Medical Records and understanding/applying for the grant programs created as part of Healthcare Reform to assist practices to acquire and use Electronic Medical Records.

Additional broad goals of our plan include:

- Validating Certification status during the site review required for PCP credentialing. At this time we can 1) confirm certification or 2) perform an assessment of interest and readiness and refer the PCP to our consultants/educators for more information and guidance on becoming a Patient Centered Medical Home.
- Assisting Practices with their Baseline Assessments and calculations
- Analyzing the network and creating focused targets to meet our goals
- Creating access to NCQA certification standards and information online
- Thoroughly training our Provider Network Management Representatives in PCMH standards and requirements so they can help the practices work on their gaps

AmeriHealth Mercy has already initiated discussions with several large Louisiana health systems (LSU, FMOLHS, Tulane and CHRISTUS) who are working toward the PCMH goals outlined by the Louisiana Healthcare Quality Forum. These organizations have had a commitment to the PCMH goals and have numerous practices that have achieved NCQA PCMH Level 1, 2 and 3 certifications.

AmeriHealth Mercy Clinical Leaders held discussions with Dr. Michael Kaiser, Associate Chief Medical Officer and Ron Horswell, PhD HSRP of LSU, to identify ways in which AmeriHealth Mercy can complement the operations in their offices as they work toward a Medical Home model and seek certification for their non-certified sites. We agreed to collaborate on the following initiatives:

- Educate LSU office staff and hospital staff on the use of the Rapid Response team to serve as an adjunct to LSU staff in reinforcing key elements of the physician's plan of care with the member after the member leaves the office or facility. AmeriHealth Mercy can assist in reinforcing medication adherence, coaching on recommended lifestyle changes and providing reminders for upcoming appointments.

- Share information on services received outside of LSU. Dr. Kaiser identified that the physician practices do not have a reliable mechanism to understand what care the member received outside of their office or health system and whether the member obtained the prescribed medications. AmeriHealth Mercy's Provider Portal delivers this important information to the LSU providers through the Member Clinical Summary, discussed above.

As we continue to refine our plan and have access to additional utilization and other data, AmeriHealth Mercy will seriously consider the following reimbursement options:

- for practices who attain Level 1, 2, or 3 certification status
- to assist smaller practices in working toward certification – an example of an option under consideration is paying the certification fee for very small practice

AmeriHealth Mercy's affiliates are developing PCMH reimbursement strategies to provide a financial incentive and reward for practices who achieve NCQA Medical Home certification. One pilot is a reimbursement strategy that includes traditional fee for service, adds a management fee per member per month, and has a discrete fee schedule to cover services not typically on a state Medicaid fee schedule for instance, telephonic consults, online consults, team conferences. As we gain experience in the Louisiana market and have feedback from pilot programs underway in other markets, we will, of course, adapt the best practices/successful strategies for implementation across the network.

G.9 Monitor Providers to Ensure Compliance with Provider Subcontracts

G.9 Describe how you will monitor providers and ensure compliance with provider subcontracts. In addition to a general description of your approach, address each of the following:

- *Compliance with cost sharing requirements;*
- *Compliance with medical record documentation standards;*
- *Compliance with conflict of interest requirements;*
- *Compliance with lobbying requirements;*
- *Compliance with disclosure requirements; and*
- *Compliance with marketing requirements.*

Monitoring Providers Summary

All provider contracts and vendor subcontracts contain provisions requiring compliance with state and federal regulatory provisions such as cost sharing, conflict of interest, medical record documentation, lobbying, marketing, and disclosure requirements. The Provider Manual contains detailed information on each of these provisions, including acceptable and prohibited provider and plan marketing practices. These requirements also will be confirmed in our online information. Requirements are included in provider orientation and regular education, training and monitoring activities.

Cost Sharing Requirements

Any applicable required cost sharing requirements are stated in the Provider Manual and applicable policy. We monitor compliance through annual reviews of payments to the provider as well as any member grievance or appeals.

Medical Record Documentation Standards

Biannual medical record reviews are performed at all PCP offices and high volume specialists. Providers found in non-compliance are re-trained and then subject to follow up audits. Failure to correct inadequate performance can result in provider termination from the network.

Conflict of Interest Requirements

The Provider Manual and provider contract require that providers self-report any material conflict of interest. Monitoring is performed through site visits, provider complaints and periodic audits. Provider

conflicts of interest can be discovered through claims audits of ancillary areas such as home care and DME providers.

Lobbying Requirements

On occasion, providers will join the plan in specific lobby efforts. In these instances, we work to ensure compliance by proactively giving providers lobbying materials including brochures, flyers and scripting. We communicate all relevant compliance issues surrounding the lobbying effort through fax, emails and face-to-face meetings. We monitor lobbying efforts through provider complaints and site visits.

Disclosure Requirements

The Provider Manual and Provider Contract require providers to comply with the disclosure requirements. Providers are required to disclose any related investment where they hold greater than or equal to 5% ownership interest. Monitoring is completed by site visits and provider complaints.

Marketing Requirements

The Provider Manual and Provider Contract require that AmeriHealth Mercy review any provider marketing materials that include the AmeriHealth Mercy or LaCare name, logos or branding. For any external marketing events such as health screenings where providers are asked to cooperate with our marketing effort, we develop the marketing materials to ensure compliance with any state or federal regulations.

There are several departments responsible for contract compliance monitoring beginning with initial credentialing site visits and the credentialing process itself which monitors contract requirements, license and debarment status.

Detailed Monitoring of Providers

Credentialing

On an ongoing basis, AmeriHealth Mercy will maintain criteria and processes to credential and re-credential MDs and DOs; DPMs; DCs; Therapeutic Optometrists (ODs); Certified Nurse Midwives (CNMs); and Certified Nurse Practitioners (CRNPs) who may contract as PCPs within the scope of their practice. Dentists and Therapeutic Optometrists are credentialed if they provide care under the medical benefit, as are the following allied health professionals: Audiologist, Chiropractor, Licensed Clinical Social Worker, Midwife Occupational Therapist, Optometrist, Speech-Languages Pathologist, Physical Therapist, and Licensed Social Worker.

Facility-type providers identified for the credentialing/re-credentialing process are the following:

- Hospitals (acute care and acute rehabilitation)
- Home Health agencies/Home Health Hospice
- Skilled Nursing facilities
- Skilled Nursing facilities providing sub-acute services
- Nursing homes
- Free standing ambulatory surgical centers

AmeriHealth Mercy's credentialing/re-credentialing criteria and standards are consistent with applicable regulatory and National Commission for Quality Assurance (NCQA) accreditation standards.

With the completed credentialing application, the provider must submit an attestation of the correctness of the information supplied regarding his/her unrestricted and current license work history, board certification (if applicable), state Medicaid number, facility accreditation (if applicable) and a copy of the current malpractice face sheet.

Upon receipt of a signed credentialing application, AmeriHealth Mercy completes primary source verification of the following:

- Education and training
- Licensure
- DEA
- Board Certification
- Malpractice History
- Medicare/Medicaid Sanctions (DHHS & OIG)
- National Practitioner Data Bank (NPDB)
- Healthcare Integrity and Protection Data Bank (HIPDB)
- Federation of State Medical Boards (FSMB)
- Hospital Privileges (Participating in the network)

An office site visit is completed for practitioners as part of the credentialing process. The office must have a score of 90% or higher in the initial site evaluation (which includes a review of handicapped accessibility and other compliance issues) and a general medical record keeping score of 85% or higher. Site visits are completed for facility-based providers if the provider does not have evidence of the most current CMS or State review, and there is a need to contract with the provider to ensure appropriate access to care for enrollees.

Once the credentialing application is deemed complete, and after completion of the office site visit and primary source verification, the credentialing file is submitted to the Credentialing Committee for approval. Once approved by the Credentialing Committee, the credentialing status is valid for three years. We routinely check Medicare and Medicaid sanctions through the Office of the Inspector General (OIG) database and receive updated from the Healthcare Integrity and Protection Database (HIPDB) after initial credentialing. Our automated license expiration monitoring (LEM) system will alert us to the expiration of practitioner licenses for any credentialed practitioner.

The re-credentialing process is identical to the initial credentialing process, except that at re-credentialing, we query the member complaint database to determine whether member complaints have been reported and review this information along with available performance monitoring results for the Provider at the time of re-credentialing.

Fraud and Abuse

We also aggressively seek out and investigate cases of potential fraud and abuse. A full description of our program integrity processes, which include detection of activities not in compliance with contract provisions, can be found in Section O.

Medical Record Review

AmeriHealth Mercy will perform compliance-focused bi-annual medical record reviews at all PCP sites as well as at high-volume specialists. If a provider scores less than 90% compliance, we discuss the results and leave a copy of the clinical guidelines with the provider. Six months later we re-audit and share the results with our Credentialing Committee. Continued non-compliance may result in the application of sanctions, up to and including termination of the provider's contract.

Provider Network Management Representatives

Our Provider Network Management Representatives conduct frequent site visits to build relationships and assist providers with issues and concerns. These visits also allow us to monitor for any visible compliance issues, such as inappropriate marketing signage and or failure to conceal protected health information behind the reception desk.

Claim Submission Audits and Referral Trending

We regularly review claim submissions and review referral patterns to identify drivers behind utilization. These activities often alert us to patterns that may indicate fraud or abuse.

In addition, AmeriHealth Mercy primary care providers are monitored against performance metrics related to their conditions of participation. We calculate and communicate the provider's score on a regular basis. The metrics include:

- Operational Requirements
  - Encounter Submission Rate
  - Utilization of Assigned Laboratory
  - Compliance with Appointment Accessibility Standards
  - Compliance with After-Hours Accessibility Standards
- Quality Requirements
  - Quality Performance (HEDIS measures)
- Resource Utilization Requirements
  - Non-Emergent ER Utilization
  - Cost Efficiency Index

Continued failure to achieve a reasonable score against these metrics after corrective action measures could lead to termination of the provider.

Ensuring Compliance with Provider Subcontracts

AmeriHealth Mercy aligns subcontractor contracts and performance with our members' needs and enforces standards of performance. Sub-contractor contracts also include a regulatory section binding the sub-contractor to comply with state and federal regulatory provisions. We plan to use subcontractors to administer transportation and vision benefits as well as enhanced benefits such as 24/7 Nurse Line services.

We will monitor the performance of our subcontractors through a formal contract-based quality oversight program and through ongoing day-to-day oversight and monitoring performed by AmeriHealth Mercy staff dedicated to this function. All subcontracts have performance measures built in which are monitored through monthly reports which are also presented to the Quality Assessment Performance Improvement Committee (QAPIC), In addition, annual onsite audits are conducted for all subcontractors where regulatory compliance and performance is reviewed.

Prior to executing an agreement with a subcontractor, AmeriHealth Mercy will perform a pre-contracting assessment of the subcontractor to ensure it is prepared to perform the subcontracted duties in accordance with our contract, standards of care and service as well as applicable Louisiana Department of Health, Insurance Department, and National Committee for Quality Assurance (NCQA) standards.

This assessment will include a readiness review and evaluation of written documents submitted by the subcontractor. We score the subcontractor on its level of compliance with applicable standards. If necessary, we require a written corrective action plan for the subcontractor to address areas of non-compliance. The outcome of the assessment is reviewed by the QAPIC, which votes to either approve or reject the plan to subcontract the services to the organization.

Our QAPIC is responsible for oversight and monitoring of subcontractor performance. Identified quality subcommittees routinely review and monitor required monthly and ad-hoc reports prepared by subcontractors based on AmeriHealth Mercy performance indicators. A sample subcontractor report appears below.

Table 3:Sample Subcontractor Report

CLAIMS PAYMENT (PAID DATE)							
2011	Reporting Frequency	Performance Goal	JAN	FEB	MAR	APR	MAY
30 days	M	90%	100%	100%	100%	100%	100%
45 days	M	100%	100%	100%	100%	100%	100%
90 days	M	100%	100%	100%	100%	100%	100%
Claims Paid	M	N/A	26,316	30,164	34,478	34,786	36,485
Service Lines	M	N/A	94,962	112,775	126,738	129,127	134,501
# Adjusted	M	N/A	176	6,353	104	237	551
Accuracy	M	97%	99.81%	94.37%	99.92%	99.82%	99.59%
TELEPHONE SERVICE FACTORS							
2011	Reporting Frequency	Performance Goal	JAN	FEB	MAR	APR	MAY
Membership	M	N/A	303,731	309,957	311,004	314,246	316,408
Call volume	M	N/A	1038	944	1,209	1,123	1,159
Calls per 1000 Mbrs			3.4	3.0	3.9	3.6	3.7
ASA (seconds)	M	30 seconds	:21	:18	:18	:14	:14
Service level	M	85%	81.0%	86.0%	85.0%	94.0%	91.0%
Abandonment Rate	M	5%	0.3%	0.3%	0.2%	0.1%	0.1%
UTILIZATION MANAGEMENT							
2011	Reporting Frequency	Performance Goal	JAN	FEB	MAR	APR	MAY
Membership	M	N/A	303,731	309,957	311,004	314,246	316,408
Number of Authorizations	M	N/A	13,106	13,311	17,177	16,298	15,639
Denial Rate - Med. Necessity	M	N/A	15.40%	13.54%	12.49%	12.39%	11.64%
Denial Rate - Benefit/Admin.			8.11%	7.39%	6.99%	9.73%	7.91%
Average TAT	M	2	2.0	2.0	2.0	2.0	2.0
Number of Appeals	M	N/A	0	0	0	0	0
Inter-Rater Reliability	Annual	80%					
MEMBER SATISFACTION INDICATORS							
2011	Reporting Frequency	Performance Goal	JAN	FEB	MAR	APR	MAY
Membership	M	N/A	303,731	309,957	311,004	314,246	316,408
# dissatisfaction CSFs	M	N/A	26	18	19	12	16
Quality of Care	M	N/A	2	0	2	1	2
Quality of Service	M	N/A	12	13	9	8	9
Access	M	N/A	1	1	4	0	4
Administrative	M	N/A	11	4	4	3	1
Avg TAT for CSFs	M	15 days	8.1	8	7.5	7.90	8.5

PROVIDER SATISFACTION INDICATORS							
2011	Reporting Frequency	Performance Goal	JAN	FEB	MAR	APR	MAY
Provider Complaints	M	N/A	16	20	14	18	39
Provider Complaints TAT	M	30 days	3.75	8	18	24.0	5

CREDENTIALING							
2011	Reporting Frequency		JAN	FEB	MAR	APR	MAY
Number of Providers	M		519	522	526	521	533
Percentage of Providers accepting new patients	M		91.50%	98.80%	99%	99%	99%
Newly Credentialed Practitioners Profiles	M		10	8	8	3	14
Recredentialed in 36 months (#)	M		13	11	7	3	12
Recredentialed in 36 months (%)	M		100%	100%	100%	100%	100%
1. Terminations(for cause) (#)	M		0	1	0	2	1
2. Terminations (for cause) (%)	M		0%	100%	0%	100%	100%
3. Terminations for failure to recredential timely (#)	M		1	2	3	5	5
4. Terminations for failure to recredential timely (%)	M		100%	100%	100%	100%	100%
Total Terminations (#) Sum of 1 and 3	M		1	3	3	7	6
NCE (non-credentialing events) Reported to KMHP #	M		0	0	0	0	0
Routine Terminations(not for cause)	M		4	0	1	4	0
Data Changes/Updates	M		0	0	0	0	0
Requests for Exception to Credentialing Criteria	M		0	0	0	0	0

ONGOING MONITORING OF SANCTIONS – SANCTIONS FOUND							
2011	Reporting Frequency		JAN	FEB	MAR	APR	MAY
PA State Licensing Board Report	M		0	0	0	0	0
OIG Report-Medicare/Medicaid	M		0	0	0	0	0
KMHP/IBC notified of any matches	M		0	0	0	0	0

These subcommittees also review the results of our comprehensive annual audit of each subcontractor that includes staff going on-site at the subcontractor location to observe operations. The annual audit includes in-depth file reviews against AmeriHealth Mercy's standards. For instance, one audit topic will be to ensure that any cost sharing imposed on Medicaid members is in accordance with Federal and State requirements. In addition to advance DHH's goal of mainstreaming, patients must be provided services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical of behavioral disability, except where medically indicated. Member grievance and appeals will be a source data to evaluate these topics as well as the on-site observations.

The results of the annual audit and recommendations for any necessary corrective action, along with the target completion date(s), will be presented to our quality committees. Based on the committee's decision, the subcontractor is approved or disapproved for continued operation. If a corrective action plan is imposed, the results of the corrective action and subsequent monitoring are brought back to the committee. All subcontractor agreements will contain provisions permitting us to terminate the agreement for non-performance of contract requirements and/or the inability of the subcontractor to meet established performance standards.

We will proactively work with all subcontractors to identify and remedy any performance issues on an ongoing basis. Our Contact Center will have direct phone numbers linking them to the subcontractor call centers. Our dedicated subcontractor oversight staff can escalate issues within the subcontractor's organization to ensure a quick and appropriate response. As needed, larger inter-organization workgroups will be created to address complex issues.

In addition to provisions regarding termination for failure to meet performance standards, many of our current subcontractor agreements contain financial penalties for failure to meet various operational standards, such as the average speed of answer in a provider call center. If the subcontractor is unable or unwilling to implement necessary corrective action within a predetermined period of time, the QAPIC may recommend that legal remedies be sought.

AmeriHealth Mercy will provide immediate written notice to providers if they are terminated for cause. We shall simultaneously notify DHH to assure they are notified within seven calendar days of the termination.

G.10 Handling Provider Non-Compliance

G.10 Provide an example from your previous experience of how you have handled provider noncompliance with contract requirements.

At AmeriHealth Mercy, once we have identified a provider is non-compliant with a contract requirement, we work aggressively and collaboratively to bring the provider back into compliance. As stated in the Provider Education and Training section, providers who were found to be non-compliant are reported on the QM Report listing a tracking number, summary description of the issues and any follow-up or actions planned/taken by AmeriHealth Mercy. The non-compliant providers are carried over on subsequent quarterly reports until final resolution of the issue has been accomplished. Site visits will be conducted with non-compliant providers and, as noted, corrective action plans are developed with the provider in order to remedy non-compliance.

Two examples are provided where we handled provider noncompliance with contract requirements. In the first case, the provider was not in compliance with access to care standards. Through an After Hours phone survey, we identified a provider office that did not offer an option for patients to contact them when the office was closed. A site visit was held with the office and the required compliance standards discussed. The office verbalized understanding of their contractual requirements and requested assistance with back-up coverage. We were able to share existing processes that other offices utilize and the non-

compliant provider implemented one of the suggestions. A follow-up after-hours call verified the office became compliant with the access standards.

In another recent case, a pediatric practice had been out of compliance with a preventive care-scheduling requirement. According to the contract, a patient must to be seen within one month after a request for an appointment is made, and as this provider had not met this requirement, they were on a Corrective Action Plan. The provider network staff followed up with the practice, and the provider indicated that in May they had hired a pediatric nurse practitioner to address the situation. At our suggestion, they also added a hospitalist position to allow the practice providers to remain in the office and increase their practice hours by 8 hours per week per provider. This in effect gave them another full time provider and brought them back into compliance.

In many cases, the providers are willing to become compliant once they are notified where they have not met the requirements. Both of our examples demonstrated the philosophy to support the provider practices with not only the appropriate information, but also supplying the offices with other best practices from around the country to help their operations run more smoothly.

G.11 Initial Provider Education and Training

G.11 Describe in detail how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers.

Provider education about billing requirements will be a top priority as AmeriHealth Mercy prepares for the commencement of business operations. AmeriHealth Mercy understands that there is some trepidation in the marketplace around what the move to managed care means to the provider community. While providers may have experience with commercial managed care, they do not know what to expect with Medicaid. We also know there are concerns about a surge in demand for services once enrollees received their member cards.

We will first share with our providers that we are a mission driven organization committed to serving the Medicaid population. We know that assuring access to the appropriate level of healthcare at the right time will improve the quality of care for Louisiana citizens.

AmeriHealth Mercy is poised to begin working with our contacts at key systems, including Chris Vidrine of LSU, Kevin Guidry of FMOLHS and Les Tomkins of CHRISTUS immediately after the award is announced to finalize provider contracts and begin the provider orientation process.

The most basic concern of the provider community is "will I get paid" timely and without undue hurdles. AmeriHealth Mercy plans to address this concern in several ways. Orientation visits occur within 30 days of placing a newly contracted provider or provider group, and continuously, upon request. In addition, Provider Network Management staff are assigned to providers as a resource should there be additional questions after orientation.

Billing information is available to providers in multiple formats – it is included in the Provider Manual which also covers referral and prior authorization requirements (which can impact claims payment). A 44- page "Detailed Claims Filing Instructions" booklet is included on line that has sample claim forms, field requirements and common reasons for rejection. Hard copies can also be made available to the provider. Other topics included in the online provider reference include: Timely Filing EDI Questions and Answers, Eligibility Verification Guide, Electronic Fund Transfer Instructions, and other instructions and billing guidance notifications or coding requirements (for example, NCCI edits). This information is reviewed in depth with new providers and all information available for Providers through the web site is reviewed and updated on a regular basis.

Once AmeriHealth Mercy commences operations, we will continue to post new claims filing advice and information on the website. We will also include information on corporate Claims Payment policies and

DHH and Louisiana State regulations online so our providers have information about the many subjects that impact how their claims are processed. Education and Training on numerous additional topics will be presented to providers as we approach the start date. Key educational components included in the standard provider orientation include:

- AmeriHealth Mercy Family of Companies overview
- CCN program basics
- Physician requirements and programs
- Member eligibility
- Confidentiality requirements
- Marketing requirements –acceptable and prohibited practices.
- Lobbying requirements
- Benefit coverage
- Referrals and authorizations
- Claims
- Claims Dispute Process (sec 17.5.2.1)
- Provider Contact Center (24/7 access) services
- NaviNet Provider Portal use and instructions
- Quality, Credentialing and Utilization Management
- Integrated Care Management
- Provider Rights and Responsibilities
- Member Rights and Responsibilities
- Provider Complaint System
- Grievances and Appeals
- Regulatory Provisions

AmeriHealth Mercy's Indiana affiliate plan, Hoosier Alliance, assists its member providers by offering training workshops that teach Best Practice management programs, patient outreach strategies and other assistance. Each participating provider can learn and share their knowledge and experience of Best Practice implementation with others in the network.

Providers will be directed to our website to allow them to become familiar with the broad range of educational topics we cover. Providers are free at any time to contact their assigned Provider Network Management Representative for education, follow up questions and concerns.

We will also host seminars in the local community for additional provider education. We structure the seminars in a variety of ways to address the needs of different provider community audiences. We host practitioner seminars focused on concerns of physicians and healthcare service providers, office manager seminars which typically focus on administrative and claims issues, and hospital system orientation sessions where we invite employees at the health system practices to attend sessions to cover orientation subjects. Education related to billing requirements occurs during orientation visits, routine site visits and Provider Workshops held by the Provider Claims Educator which will be held within the communities of providers for their convenience. We will offer assistance with establishment of electronic claim submission and/or electronic funds transfer as needed. We also review the Health Plan's Claim Editing system and how to easily review claims status and correct claims when necessary.

We have recently added the capability to offer direct claim entry. Provider WebConnect is a direct claim entry function through the clearinghouse Emdeon. This valuable service will assist practices in reducing costs while improving overall office workflow. This tool enables the practice to manually enter CMS-1500 claims data that will be electronically submitted to AmeriHealth Mercy. This is a free tool for practices who may not be financially able to purchase a practice management system.

In addition to addressing the "will I get paid" concerns, AmeriHealth Mercy will actively address general concerns about changes associated with the introduction of managed care. Most importantly, we will

have active strategies to assist the provider community in dealing with an anticipated surge in people seeking healthcare services and office appointments.

Once AmeriHealth Mercy has access to prior utilization data, we can "triage" and stage the member appointment seeking. Initial efforts will be based on 1) the utilization data and 2) confirmation of member official enrollment or 3) responses to the health assessment questions that raise concerns. AmeriHealth Mercy staff will reach out to those with known medical needs to make sure they are scheduled as soon as possible after "go live."

We will reach out to providers concerned about an appointment surge, but also worried about "no shows" to share some successful past strategies:

- Care Manager works with those with special needs or complex conditions to schedule necessary appointments.
- Block scheduling days – we ask providers to reserve a half a day or full day. Our community outreach staff call and schedule their panel members.
- Three way calls – we link a member with a provider office and the transportation provider to assure the member has a means to get to their appointment.

We will reach out to Significant Traditional Providers who have been providing services to this population all along to identify additional outreach opportunities.

G.12 Ongoing Provider Education and Training

G. 12 Describe how you will educate and train providers that join your network after program implementation. Identify the key requirements that will be addressed.

AmeriHealth Mercy will utilize numerous venues for provider education and training in order to offer all providers and their office staffs the ability to quickly obtain the information needed for administrative tasks as well as coordination of clinical care, specifically preventive health care requirements, programs related to patients with chronic diseases, children with special healthcare needs and patients with high utilization of specific services such as emergency care and medication usage.

As noted in our response to G11 above, provider orientation visits occur within 30 days of placing a newly contracted provider, or provider group, on active status. All sections of the Provider Manual are discussed during the orientation (see components below). In addition, contact and billing information is provided, assistance with EDI Payer information occurs and electronic access to systems and processes is reviewed.

Provider training occurs on an ongoing basis as deemed necessary by AmeriHealth Mercy or DHH in order to ensure compliance with standards and the contract. The need for provider training is identified by:

- DHH updates
- Federal and State mandates
- Patient Centered Medical Home
- HIPAA Compliance
- Privacy, Transactions & Code Sets,
- Electronic Data Security
- Provider input
- Survey results
- Provider Claims Educator identified trends/issues

Training occurs through routine site visits, Provider Workshops, letters to specific providers, updates to the Provider Manual and provider web site, provider newsletters or other mailings. AmeriHealth Mercy will utilize electronic communication venues so information is readily available to all providers.

For example, our Indiana affiliate offered training workshops that taught Best Practices management programs, patient outreach strategies and other assistance. Each participating provider could learn and share their knowledge and experience of Best Practice implementation with others in the network. Combined with the profiling reports (discussed in G.13), and the Best Practices program, the providers could identify new opportunities for improving patient care. The Brinks Family Practice utilized the information and tailored a plan to serve their Indiana Medicaid members. By implementing these patient-focused changes, Brinks Family Practice witnessed significant improvement in many areas:

With a new emphasis on preventive care, the practice was showing positive results within six months. According to nurse practitioner Amy Spurling, "We are finding that patients we didn't see unless they had an acute problem are becoming more interested in being healthy. It gives us the chance to help them understand how active they need to be in their own levels of health."

- More parents scheduled and kept appointments for well-child care visits.
- More women received sufficient prenatal and postpartum care.
- Additional cases of diabetes were identified and management of individual cases improved.

In addition to the key topics covered in our standard orientation, AmeriHealth Mercy offers educational programs on numerous topics. In some cases, completion of the courses allows our providers to gain CME credits. Topics include:

- Cultural Competency Training
- Health Literacy
- Domestic Violence Intervention Training
- Child Abuse Prevention
- Tobacco Cessation

Finally, every Provider will be assigned a Provider Network Management Representative who will be available to answer questions and arrange to link the provider with internal subject matter experts, such as the Provider Claims Educator, should there be additional questions or issues that arise.

G.13 Quality of Care Profile Reporting

G.13 Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled.

- *Submit sample quality profile reports used by you, or proposed for future use (identify which).*
- *Describe the rationale for selecting the performance measures presented in the sample profile reports.*
- *Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.*

AmeriHealth Mercy has access to a long history of using data and metrics to assess the quality and performance of our provider networks. Our PerformPLUS profiling and reporting model supports AmeriHealth Mercy's efforts in providing network providers with actionable and benchmark data to improve the quality of care delivered to our members. We combine local provider expertise through participation in the Partnership Council with our nationwide experience in developing performance measures for PCPs, specialists and hospitals.

Monthly, quarterly and annual reporting provides key information to providers on their relative performance to peers.

PerformPLUS

PerformPLUS is a model that provides the methodology for profiling and reporting the performance of provider practices. The model promotes key quality-related metrics or indicators. Developed by AmeriHealth Mercy, PerformPLUS provides a balanced scorecard of accountable care quality and cost concepts characterized by key performance metrics on which physician incentives are based. Peer and trend-based performance metrics are aligned to promote efficient use of resources and to mitigate unnecessary or redundant care. The PerformPLUS model will give AmeriHealth Mercy the ability to monitor and discuss utilization performance with selected specialist practices.

Performance metrics include:

- Inpatient admissions
- Emergency room utilization
- Quality reporting measures*
- Potentially preventable readmission rates*
- Ambulatory care sensitive conditions*

* relative to the practitioner's specialty

In AmeriHealth Mercy's Pennsylvania plan, PCPs receive bonuses based on the quality of care they give their patients. Top-tier providers are segmented within each respective category and supplemental bonus opportunities are available for statistically significant achievement relative to the top-tier baseline.

Using PerformPlus to evaluate and reward specialty providers is a recent development that is being well received by both oncology and cardiology providers. Since its inception in March of this year, seven oncology groups and the affiliate's largest Cardiology provider have formally agreed to participate in the program. Peer and trend-based monetary performance metrics are aligned within the model to promote efficient use of resources and to mitigate unnecessary or redundant care. Although it is too early to determine the actual return on investment derived from medical trend improvement, conservative estimates suggest notable savings by assuming only a modest improvement to the median percentile target for each respective provider. For example, the largest cardiology provider is on track to receive an incentive payment of approximately $80,000 with corresponding medical savings attributable to favorable trend improvement of over $1M.

A large cardiology provider is on track to receive an incentive payment of approximately $80,000 with corresponding medical savings attributable to favorable trend improvement of over $1M.

We select quality measures in consultation with the PCPs and specialists through our Partnership Council. We also review position papers from National Medical Academies and Associations when setting performance measures. In the states we serve, the state Medicaid agencies have chosen HEDIS/CAHPS or other measures that are germane to locally prevalent conditions and health issues. This reflects their consideration of what measures would do the most to improve the quality of health for their population, We have the flexibility to address state-specific requirements for different quality measures that suit their populations as Louisiana DHH does in Appendix J.

Once these measures are defined, AmeriHealth Mercy will collect and mine the appropriate data to analyze trends, develop and implement quality improvement activities, monitor the impact of medical management programs, and compare performance to established goals or benchmarks. Our monitoring programs will cover all aspects of health care services, including focus on:

- Individual member findings (such as Gaps in Care)
- Member Disease State level (such as diabetes care protocols)
- Physician provider rates (PCP/Specialist profile components)
- Hospital provider rates (facility profile components)

- Prescription drug metrics (such as medication adherence profiles)

We will also analyze and report on aggregate data compiled from specific occurrences in quality of care, member complaints, provider complaints, and appeals data that help to identify trends in performance and opportunities for improvement. Aggregated data examined includes member dissatisfaction reports, provider dissatisfaction reports, primary care provider change requests, and reasons for voluntary disenrollment.

We combine these numerous sources of data into comprehensive profiles. We will then compile comprehensive provider profiles for PCPs, selected high volume specialists, and acute care hospitals as tools to allow AmeriHealth Mercy and our providers to assess the quality and cost-effectiveness of care delivered to our members. Ad hoc reports will also be produced to evaluate specific areas of concern. The Provider profiles are created using industry-validated algorithms and sophisticated analysis of claim data. Results are risk adjusted to account for variations in the patient acuity mix. Comparisons are made to the provider's peer group.

In the discussions below, specific metrics, methodologies, frequency of reporting and sample reports are provided for PCPs, specialists and hospitals.

Reporting and Profiling for PCPs

Selected demographic, utilization, and quality measures will be reported quarterly for all PCP practice sites with more than 75 members on their panels. These PCP profiles compare each practice to its peers (pediatrics to pediatrics, internists to internists, family practitioner to family practitioner), and include a risk-adjusted analysis of actual versus expected utilization for the assigned members. The reports are shared with each PCP practice and utilization outliers receive written education regarding potential process changes that should be considered to address issues. Selected providers receive visits from Provider Network Management, Medical Management and Informatics staff.

Our analyses of these performance indicators have consistently provided tangible results and have provided opportunities for intervention and education. The comparison against peers encourages the providers to work to improve their scores. We will also supply providers with Care Gap reports to assist them in meeting HEDIS measures.

HEDIS-based quality measures (and criteria) are an integral part of profiling PCP performance. Examples of current HEDIS measures are:

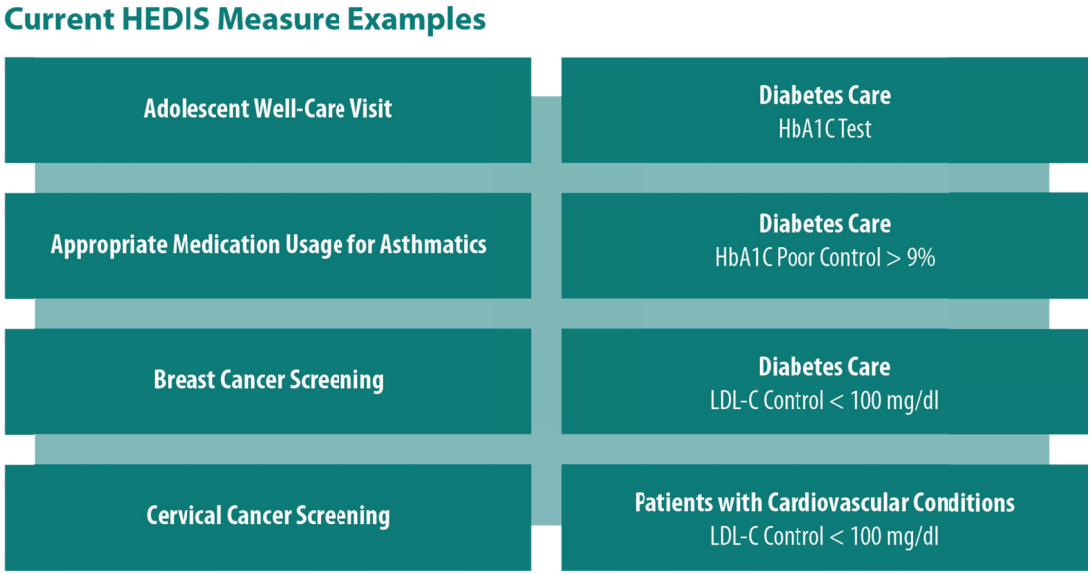


Figure 4: HEDIS measures

In addition, La Care will add all Louisiana HEDIS measures as outlined in Appendix J and create targets based on DHH expectations and baselines.

Results will be calculated for each of the above Quality Performance Measures for each practice, and then aggregated for a total score for all HEDIS measures. Overall practice scores will be calculated as the ratio of members who received the above services as evidenced by claim and/or encounter information (numerator) to those members in the practice's panel who were eligible to receive these services based upon the above definitions (denominator). This score will then be compared to the score for all practices of the same specialty type to determine the practice percentile ranking.

Practices will also receive a Severity of Illness Score with the intent of identifying practices that are treating higher risk panels than their peers. This is calculated through evaluation all the claims/encounters submitted by the practice and risk-adjust this information using the "Chronic Illness & Disability Payment System" (CDPS) methodology developed by the University of California at San Diego. The risk-adjusted practice score will be compared to the score for all practices of the same specialty type to determine the practice percentile ranking.

Each practice's overall Medical Cost Management is evaluated and scored. We will risk-adjust this information using the "Chronic Illness & Disability Payment System" (CDPS) methodology developed by the University of California at San Diego.

We will also score the ER Utilization patterns of panel members in the practice. ER utilization is compared from two perspectives: Total ER utilization and Non-Emergent ER utilization and ranked against peer performance for a percentile ranking.

All of the above measures and rankings will be combined in an overall report card for the practice which is shared regularly with the practice. Our Provider Network Management Representatives will be trained on measures and methodology and help PCPs use the data to improve their performance. These metrics will be a central part of our provider incentive programs at AmeriHealth Mercy. We will work with our Partnership Councils to finalize and define the quality metrics and targets used.

Some of the above measures will also be used as part of our overall compliance/conditions for participation measures discussed in G.9. As noted previously, measures for analyzing base performance include operational compliance requirements, quality and efficiency metrics. Metrics can be changed/amended to meet the needs of the local marketplace.

Practice Name: ABC Family Practice
Provider ID/Specialty 123456, Family Practice / General Practice
Average Panel Count 222
Peer Average Panel Count 352

Quality Performance

This box contains the practice quality performance related to the eight HEDIS measures. It contains your practice score for each measure. It also contains your overall practice score for all eight HEDIS measures rolled-up and your percentile ranking when compared to your peer practices. If the percentile ranking is eligible for an incentive payment, and information is also included. A more detailed breakout of these services is available from your Provider Account Executive upon request.

	Practice Score	Percentile Ranking	PMPM bonus
Adolescent Well-Care Visit	17%		N/A
Breast Cancer Screening	32%		N/A
Cervical Cancer Screening	30%		N/A
HbA1C Test for Diabetics	62%		N/A
HbA1C Poor Control (>9%) for Diabetics	N/A		N/A
LDL-C Control (<100 mg/dl) for Diabetics	N/A		N/A
LDL-C Control (<100 mg/dl) for Patients with Cardiovascular Conditions	N/A		N/A
Use of Appropriate Medications for People with Asthma	100%		N/A
Overall Ranking	33%	<5th	$0.00

Figure 5: PCP Profile Sample

Reporting and Profiling for Specialists

Specialist profiles will look at average age, visits per member, inpatient admissions per member, distribution of diagnoses, and adherence to recommended medication guidelines (if we receive necessary pharmacy data). Utilization metrics on cost per episode were compared to expected utilization. Specialist profiles are based on episodes of care and actual versus expected costs and utilization, for each service category in line with that of the particular specialty. For example, for orthopedists we report X-rays among other services and for cardiologists we report EKGs and other related services. These reports are used to identify high-quality/high-efficiency providers. In other markets, we recently created more sophisticated specialty profiles for cardiology, oncology and women's health providers in our network. These are being prepared as part of pay for performance model programs within the specific specialty. For example, the Cardiology Program includes 9 industry standard quality performance metrics specific to Cardiology. These are based upon AMA/Physician Quality Reporting Initiative measures. The quality component contains performance metrics based upon the following PQRI/AMA measures;

- 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

There are cost management performance criteria for inpatient and emergency service utilization. Efficiency is measured by effective management of potentially preventable readmissions and ambulatory care sensitive conditions.

Table 4: Sample Cardiology Quality Profile Report

Measure	55th Percentile	75th Percentile	95th Percentile	2011 Actual Performance
ACEI/ARB Therapy (CAD)	68%	75%	90%	90%
Antiplatelet Therapy	55%	56%	68%	80%
Event Cholesterol Test	76%	82%	92%	85%
LDL Lowering Drug Therapy	27%	29%	36%	60%
Lipid Test	73%	80%	92%	82%
ACEI/ARB Therapy (HF)	60%	71%	91%	80%
Beta Blocker Therapy (HF)	54%	59%	65%	80%
LVF Assessment	25%	33%	54%	70%
Warfarin Therapy	60%	66%	73%	80%
Average/Total	55%	61%	73%	79%

Reporting and Profiling for Hospital Profiles

Monthly Inpatient Utilization Profiles will be prepared for the top 25 highest volume admitting hospitals based on authorization, claims, and appeal data for the prior 12-month period. Facility utilization, admission diagnoses, length of stay and approval history is trended against past performance. Admission diagnoses mix, length of stay by diagnosis and cost per stay will be compared to the network average.

The Hospital Performance team (UM, Care Management, Provider Network Management, Service Operations) will use these profiles to identify trends and changes in the facility's performance. The profiles will also be shared with the hospital during routine Joint Operating Committee meetings which we will establish with our AmeriHealth Mercy hospital providers.

Monthly Summary of Healthcare Activity (SHA) Reports will be generated to monitor cost and utilization levels across 85 service categories and at plan, hospital and member group levels. Contractual remedies, recoveries, fraud and abuse investigations, and quality of care investigations have been initiated based upon aberrations noted on the SHA reports.

Summary Hospital Performance Report

Contract Type: DRG

MEMORIAL HOSPITAL OF YORK

DRG	Admissions	Cost/Admit	# Days	Alos	Plan Alos
Maternity	85	$3,605.29	295	3.47	4.02
NEONATES WITH OTHER SIGNIFICANT PROBLEMS	22	$1,167.12	52	2.36	2.42
FULL TERM NEONATE WITH MAJOR PROBLEMS	6	$1,979.69	15	2.50	5.66
PREMATURITY W/O MAJOR PROBLEMS	5	$1,557.16	11	2.20	4.79
SIMPLE PNEUMONIA & PLEURISY AGE > 17 WITH C.	4	$5,524.60	13	3.25	4.67
MAJOR JOINT REPLACEMENT OR REATTACHMENT	4	$10,968.31	12	3.00	3.82
OTHER ANTEPARTUM DIAGNOSES WITH MEDICAL	3	$2,029.57	5	1.67	3.28
BRONCHITIS & ASTHMA AGE 0-17	3	$2,049.21	8	2.67	2.37
ESOPHAGITIS,GASTROENT. & MISC DIGEST. DIS. A	2	$1,822.33	6	3.00	3.08
ESOPHAGITIS,GASTROENT. & MISC DIGEST. DIS. A	2	$3,499.34	3	1.50	3.75
ESOPHAGITIS,GASTROENT. & MISC DIGEST. DIS. A	2	$2,540.71	8	4.00	3.21
ENDOCRINE DISORDERS W/O C.C.	2	$2,570.59	8	4.00	2.29
Circulatory Disorders exc AMI, w/Cardio Cath & Comple	2	$5,363.48	10	5.00	5.96
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	2	$5,137.37	6	3.00	3.73
CELLULITIS AGE >17 WITH C.C.	2	$4,366.51	6	3.00	3.76

MEDecision: Med/Surg & SNF Admissions

Month-Year	Gross Admits	Net of Medicare	Gross Days	Gross ALOS	Rloc Days	Rloc Rate	Denied Days	Denial Rate	Denied Admits	Denied Admits Rate	Admin Denials	Inpatient to Observations	Inpatient to Obs. Rate
12/2009	6	6	12	2.00	0.00	0.00%	0	0.00%	0	0.00%	0		
1/2010	13	13	31	2.38	0.00	0.00%	0	0.00%	0	0.00%	0		
2/2010	21	21	54	2.57	0.00	0.00%	0	0.00%	0	0.00%	0		
3/2010	14	14	43	3.07	0.00	0.00%	0	0.00%	0	0.00%	0		
4/2010	23	23	67	2.91	0.00	0.00%	8	11.94%	2	8.70%	0	1	4.35%
5/2010	16	16	43	2.69	0.00	0.00%	6	13.95%	1	6.25%	0		
6/2010	15	15	52	3.47	0.00	0.00%	6	11.54%	1	6.67%	0		
7/2010	19	19	59	3.11	0.00	0.00%	4	6.78%	2	10.53%	0	1	5.26%
8/2010	12	12	27	2.25	0.00	0.00%	0	0.00%	0	0.00%	0		
9/2010	14	14	41	2.93	0.00	0.00%	1	2.44%	1	7.14%	0		
10/2010	14	14	26	1.86	0.00	0.00%	1	3.85%	1	7.14%	0	1	7.14%
11/2010	11	11	33	3.00	0.00	0.00%	1	3.03%	1	9.09%	0	1	9.09%
Totals:	178	178	488	2.74	0	0.00%	27	5.53%	9	5.06%	0	4	2.25%

MEDecision: Appeals

Resolved Month	# Cases Resolved	% Upheld	# Upheld	% Overturned	# Overturned	% Modified	# Modified
	0	0.00%	0	0.00%	0	0.00%	0
Totals:	0	0.00%	0	0.00%	0	0.00%	0

Figure 6: Hospital Performance Chart

Ad Hoc Facility Drill-down Analyses will be produced based on patterns noticed in the above-named facility reports. As an example of how this would work, in an affiliate plan, we conducted a breakdown of inpatient approval statistics by DRG subtype for a hospital system with relatively high denial rates. The analysis showed that chest pain, abdominal pain, and overdose categories generated most of the denials. This allowed for targeted discussions about hospital staff practice patterns.

We have recently added Prevention Quality Indicators such as Ambulatory Care Sensitive Conditions (ACSC) and Potentially Preventable Admissions (PPA) / Potentially Preventable Readmissions to our profiling capability. They are reliable indicators of good outpatient care (that) can potentially prevent the need for hospitalization and therefore, potential indicators of quality in hospital care.

G.14 Provider Inquiries and Complaints

G.14 Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.

Quickly responding to providers' inquiries and complaints is key to enabling the providers to better serve the Medicaid recipients. AmeriHealth Mercy has implemented several processes to address inquiries timely and effectively. Providers can access information, ask questions, request investigation of a problem or potential issue through a variety of venues. Our goal is to answer questions immediately and accurately to resolve problems before they become formal grievances or appeals. Once these inquiries and requests for information are submitted by providers, we monitor progress and final resolution in a tracking database managed by the Provider Network Management Department.

Provider Access Points to Make Inquiries, Complaints and Requests for Information

Providers have access to information and can make inquiries through the following means:

- Navinet Provider Portal
- LaCare website
- Provider Call 24/7 Contact Center
- Provider Claims Educator
- Provider Network Management Staff

AmeriHealth Mercy uses NaviNet as its provider portal. NaviNet is the largest provider portal with over 700,000 providers nationally. As a multi-payer portal (including Aetna, United Healthcare, and numerous Blue plans) it allows the provider to log in once and access information from multiple plans. AmeriHealth Mercy offers access to all the standard transactions through NaviNet including eligibility and benefits, claim status and referral submission and update, as well as links to provider manuals, forms and other important administrative information.

In addition to Navinet, the LaCare web site will maintain a Provider Center where information for providers is supplied and consistently updated. Available information includes topics such as:

- Services
- E-Lert (e-mail) Registration
- Provider Credentialing
- Resources
- Clinical Practice Guidelines
- Emdeon Provider WebConnect
- EPSDT
- iExchange
- Member Rights and Responsibilities
- NPI
- Patient Centered Medical Home
- Provider Portal
- Provider Directory
- Provider Forms
- Provider Manual
- Provider Orientation
- Provider Reference Guide
- Provider Training and Education
- Billing
- Billing Information
- Electronic Funds Transfer
- EDI Questions and Answers
- Eligibility Verification Guide
- Member Co-pay Schedule
- Quality Care Compensation Program
- Communications
- Contact Account Executive
- Electronic Health Records
- Fast Facts
- Flu/H1N1 Information
- HIPAA
- MA Bulletins and RA Alerts
- Provider Letters
- Provider Newsletters
- Initiatives
- Cultural Competency
- Domestic Violence
- Intensive Care Coordination Programs

Providers can also access our 24/7 Provider Service Contact Center to make telephonic inquiries regarding eligibility, routine billing questions, and requests for documents. Our Contact Center employees will also have the ability to research and resolve certain claims payment issues over the phone. Provider calls will be acknowledged within 3 business days of receipt and resolution of the call will be communicated back to the provider within 30 business days of receipt. Provider Service Representatives

are trained to escalate complaints or issues that are of a significant nature to ensure expeditious resolution. If the call is not resolved within the 30 business days of receipt, AmeriHealth Mercy will document why the call has not yet been resolved. AmeriHealth Mercy will ensure that all provider calls will be resolved within 90 days, as required.

All calls will be documented via an online tracking application that will allow users to capture information such as provider data, identification of the issue and issue resolution that are related to the call. This application will allow routing of issues between departments as needed, tracking of issues to ensure adherence to established turnaround times based on service level agreements, and reporting of call activity and trends.

The Provider Claims Educator will be a resource for claims issues and questions and our Provider Network Representatives will be charged with developing and maintaining a relationship with their assigned providers and are a resource for them when they have concerns. We consider a provider complaint or concern a "provider dispute" and we will have policies and procedures and timelines which will govern provider dispute resolution.

In our experience, reimbursement issues are most often brought to the attention of the Provider Network Representative staff. Staff will be supported internally by the Provider Network Operations (PNO) unit. This unit will be responsible for 1) assuring that provisions of the provider contract are accurately transmitted to the configuration department and 2) assuring all contracts are tested and paying as expected prior to going "live" in the system and 3) researching and resolving provider issues or Claims disputes brought to the organization through the Provider Network Management Representatives or other Departments. These issues tend to be non-routine in nature. The Provider Network Management Representatives will submit provider issues through an online tracking database; each submission is assigned a tracking number. The Provider Network Operations Unit staff research the issue brought to determine the root cause and action required for resolution. For example, a claim payment dispute can be provider error, claims processing error, a clinical edit/correct coding issue, or a system configuration/system set-up issue. We will include in our policies for DHH review, a process for referring a provider directly to DHH/MMIS for complaints about AmeriHealth Mercy or its subcontractor.

Once the root cause of the problem is researched and the course of action required for resolution is determined, the Provider Network Operations Unit will coordinate and track all activity related to resolution of the submitted issue. Activities required for resolution vary, but may include creation of a work order to modify system configuration, a request with specific instructions for reprocessing of a claim or claim project, a request to modify existing processes or rules utilized by operational areas, or education of internal staff or providers regarding plan policy, process or contractual arrangements.

Monitoring and Tracking Provider Inquiries and Communications

All activity, communication and documentation associated with an issue will be managed through the Provider Network Operations (PNO) tracking database. This database will allow all documentation, research activity, communication and subsequent actions to be maintained in a central location, accessible to all internal departments that are needed in order to resolve a provider issue. For example, a claims reprocessing project is not considered complete until a summary spreadsheet is sent to the provider showing the reason for the claims issue, what claims were reprocessed, and the total payment to the provider. The tracking database will also be utilized to generate internal reports to assist in monitoring issue resolution activity in order to ensure that issues are resolved within established timeframes as well as spot any issue trends.

Both the Contact Center and the PNO unit document and track all issues brought by providers. In tracking and trending, if there is a bottleneck or need for an immediate decision to resolve the issue, the

PNO staff will escalate the issue to the person with the authority to make the decision necessary to resolve the issue.

The PNO tracking database will allow the Provider Network Management Representatives to see where an issue is in the issue resolution life cycle which they can then share with the provider. The provider will receive a response from their Provider Network Management Representative once the issue is resolved and all activities related to the issue are complete.

If the provider is not satisfied with the resolution proposed, the provider may proceed through the Provider Complaint Systems as required by Section 10.6 of the Louisiana CCN-P RFP to initiate a second level dispute within a defined time and is invited to present his case in person if he/she so desires. The appointment is arranged through that Provider Network Management Representative who schedule meeting with the provider and relevant staff.

Provider concerns or complaints related to a medical necessity decision will be handled through the Grievance System. We will have processes and procedures for immediately forwarding appeals to the Medical Affairs Grievance and Appeals unit.

G.15 Non Emergency Medical Transportation Services

Describe in detail your proposed approach to providing non-emergency medical transportation (NEMT) services, including, at a minimum:

- *What administrative functions, if any, you will subcontract to another entity;*
- *How you will determine the appropriate mode of transportation (other than fixed route) for a member;*
- *Your proposed approach to covering fixed route transportation;*
- *How you will ensure that pick-up and delivery standards are met by NEMT providers, including training, monitoring, and sanctions;*
- *How you will ensure that vehicles (initially and on an ongoing basis) meet vehicle standards, including inspections and other monitoring;*
- *Your approach to initial and ongoing driver training;*
- *How you will ensure that drivers meet initial and ongoing driver standards;*
- *How your call center will comply with the requirements specific to NEMT calls; and*
- *Your NEMT quality assurance program (excluding vehicle inspections).*

Administrative Functions Subcontracted to Another Entity

AmeriHealth Mercy will contract with an experienced non-emergency medical transportation (NEMT) vendor that can evaluate member capabilities and coordinate transportation resources to ensure that every member is placed on the least costly, most appropriate mode of transportation available.

For non-emergency medical transportation services, the following administrative functions will be subcontracted to our vendor:

- Customer Service
- Credentialing
- Contracting

Performance standards will be developed and monitored in accordance with AmeriHealth Mercy's policies and procedures on subcontracting with providers for covered services.

Determining Appropriate Mode of Transportation: Fixed versus Non-Fixed

AmeriHealth Mercy members will always be placed on the most appropriate, cost-effective mode of transportation by leveraging a level of need assessment process. This assessment is an efficient, effective process for reviewing and documenting the medical necessity of requested modes of transportation.

Public transportation, if available, is generally the first choice for the appropriate level of care. However, public transportation is not always available. Even in cities like New Orleans, public transportation ridership is declining significantly—which will likely reduce resources.

However, if public transportation is available in the particular GSA, all members requesting a higher mode of transportation than public transit will be required to undergo a level of need assessment. If an elevated level of service is required, the contracted vendor will assign paratransit services as appropriate, followed by ambulatory sedan/van (curb-to-curb, then door-to-door) or wheelchair transportation (curb-to-curb, then door-to-door). Door-to-door services will only be assigned following thorough assessment resulting in certification documenting that the member has physical, sensory, mental, developmental, or cognitive disability that requires this level of service for the member's safety. AmeriHealth Mercy and its subcontractor will also authorize stretcher and non-emergency ambulance when the member's needs dictate these modes, and coordinate exceptional transportation services such as air travel, lodging, meals, and transportation for visitation purposes when a member must travel a great distance for treatment.

The foremost concern is member safety at all times. AmeriHealth Mercy and its subcontractor will collaborate directly with the medical community to ensure that the most appropriate mode of transportation is scheduled. Please see below to further understand the assessment process to ensure that the least costly, most appropriate mode of transportation is assigned to a member

Public transit (fixed and deviated route)

As fixed route is the most cost-effective mode of transportation, this will always be the first mode of choice. The vendor will determine immediately if the member's pickup and drop-off location are within ½ mile from a fixed route stop. The vendor will not assign transportation to a member provider if the trip distance is less than ½ mile, unless the member cannot travel the distance independently.

Mileage reimbursement

If a member is ambulatory and has access to a personal vehicle owned by the member or a family member/friend, AmeriHealth Mercy will approve mileage reimbursement as an appropriate mode. The member must then complete and return a trip log requesting reimbursement. The vendor will process these reimbursement requests.

ADA paratransit services

If a member is certified for ADA services, the vendor will arrange transportation directly with the ADA provider and arrange for the appropriate reimbursement, either via token/pass or direct reimbursement to the ADA provider.

Special needs requiring higher modes

If a healthcare provider submits an assessment which indicates the need for a higher mode of transportation due to a qualifying medical reason, such as the member is physically or mentally disabled to the degree that accessing public transit could result in a health or personal risk, the vendor will authorize the most appropriate form of transportation based on the physical and cognitive abilities of the member. This mode will most commonly consist of demand response transportation services, but may occasionally include air travel. The following rules will be used when making such determinations:

- A member who is ambulatory or can transfer out of their mobility device without assistance and has no cognitive disabilities receives shared van/sedan/taxi transportation with curb-to-curb service depending on availability.
- A member who is ambulatory or can transfer out of their mobility device with assistance and has severe cognitive disabilities receives shared van/sedan transportation with door-to-door services.
- A member who is in a mobility device, does not require assistance, but cannot transfer into a vehicle and has no cognitive disabilities is assigned curb-to-curb wheelchair transportation.

- A member who is in a mobility device, is not able to transfer, and has cognitive limitations receives door-to-door wheelchair transportation.
- A member who must remain in a supine (lying down) position due to a medical condition receives stretcher van services.
- A member who is supine and needs medical assistance such as intravenous line administration during transport receives non-emergency ambulance services.
- Exceptional transportation requests: Requests for air ambulance, commercial air, commercial bus, commercial train, meals and lodging, etc., are handled individually through transport completion by specialized vendor resources.

Proposed Approach to Covering Fixed Route Transportation

As fixed route is the most cost-effective mode of transportation, this will always be the first mode of choice. To determine the appropriateness of fixed-route public transit services for members, a number of factors are considered through vendor procedures during the reservation process. Unless the member has already been designated as ineligible for public transportation, the vendor will ask a series of questions during the reservations process to guide the member to mass transit such as:

- Is transit service running between the pick-up and drop-off locations?
- Is the service reasonably timely? Service may involve transfers, but the wait for transfers must be reasonably brief. Also, the recipient must not be delivered to the healthcare facility too early, nor be required to wait for too long after the appointment.
- Does the member have any medical condition that prevents him/her from riding on public transit vehicles or accessing public transit stops?
- Is the member able to understand common signs and directions?
- If either the pick-up or drop-off location is too far from a transit stop for walking, would it be cost effective to provide a short ride to the closest transit stop?
- Will the treatment the member will receive mean they can utilize mass transit on the initial trip to the appointment, but need a vehicle to pick them up for the return trip because they may be too weak (chemotherapy, radiation, dialysis, etc.)?

Once the vendor has determined the most cost effective and medically appropriate means of transportation is via fixed route transportation, the vendor will work to provide the member fixed route travel training. As part of the training, the vendor will ascertain whether the member's medical appointment is a one-off event or a reoccurring medical appointment. This travel frequency along with the timing of the appointment will determine how the vendor will cover fixed route travel expenses for the member. For example, if the travel appointment is scheduled far enough into the future, the vendor will arrange to courier travel remuneration—bus passes or tokens, for example-- to the member. If the timing of the medical appointment does not allow for courier service, the vendor will work with the member to provide reimbursement for fixed route travel expenses. If the medical appointment(s) is re-occurring, the vendor may elect to provide the member with a monthly pass.

Ensuring Pick-up and Delivery Standards are Met by NEMT Providers

AmeriHealth Mercy, through a transportation management vendor, will monitor transportation provider on-time performance through a 100 percent trip reconciliation process. Providers must record their pick-up and-drop off times and submit driver logs to the vendor for payment authorization. Vendor staff carefully reviews the trip logs to identify any inconsistencies, and document inconsistencies to track provider performance.

AmeriHealth Mercy and its vendor will hold the contracted transportation providers to high standards, expecting at minimum a 90 percent on-time performance threshold. If at any time a transportation

provider is delayed, the member is contacted and kept informed of the issue. Also, if needed, an alternate transportation provider will be utilized.

Quality Service Coordinators closely monitor the overall complaint percentage and the number and nature of complaints concerning transportation providers. Where warranted, transportation providers are placed under corrective action plans (CAPs). CAPs are reviewed for performance improvement. If noticeable actions have not been taken and performance has not improved, other measures may be taken, such as reducing transportation provider's available capacity in the system, closing them to new trips until compliance has been met, or termination from the network.

Ensuring that Vehicles Meet Vehicle Standards

AmeriHealth Mercy will require the vendor to have policies to conduct vehicle inspections of all provider vehicles that will service the contract prior to its execution, annually, and periodically throughout the year. All procedures call for complete vehicle inspections for all transportation providers to verify that vehicles meet the requirements and transportation provider guidelines, and to ensure that member safety and comfort features are in good working order (i.e., brakes, tire tread, signals, horn, seat belts, air conditioning/heating, etc.). If any vehicle is found to be substandard, AmeriHealth Mercy has the right to submit a request for the vehicle to be repaired, to be removed from service until repaired, or to be permanently removed from service depending on the severity of the issue.

All vehicles undergo the stringent credentialing process. Required information for credentialed vehicles includes:

- Regular maintenance documentation
- Safety inspection documentation for each vehicle
- Accident/incident report
- Current insurance card
- Vehicle registration
- Safety equipment

It is the transportation provider's responsibility to maintain all vehicle records. The provider must keep vehicle credentialing information up-to-date with the AmeriHealth Mercy vendor.

Initial and Ongoing Driver Training

AmeriHealth Mercy will require various training activities for drivers to ensure they are able to respond appropriately to specific NEMT related issues. Adequate driver training is a critical component to ensuring member satisfaction and safety. To ensure drivers receive this necessary training, AmeriHealth Mercy will require transportation providers to submit proof of completed training, along with proof that training was obtained from a reputable source, for each of their drivers. The driver training program, includes:

- Basic first aid and defensive driving
- Overview of passenger assistance techniques, including sensitivity training; proper loading, unloading, and mobility device securement procedures; and emergency procedures
- Techniques for diffusing tense situations
- HIPAA guidelines and requirements
- Orientation on client and NEMT procedures
- Tips on working with NEMT and the processes
- Receiving trip assignments
- Calling in member no-shows
- Recording pick-up and drop-off information appropriately
- Billing and trip reconciliation

- Collecting pick-up and drop-off information, including member signatures

Upon training completion, the transportation provider must upload information pertaining to the specific training received, driver's signature, and date of completion. All required training must be completed within 90 days of the driver's hire date, and providers are required to develop and maintain an annual Driver In-Service Schedule to ensure ongoing training of drivers.

Ensuring Drivers Meet Initial and Ongoing Driver Standards

Throughout the life of each provider's subcontract, the transportation provider and the provider network management department maintain all driver information. All drivers are re-credentialed annually.

Required information for credentialed drivers includes:

- Copy of current Driver's License
- Defensive Driver Training documentation
- Basic first aid training documentation
- Emergency Procedures training documentation
- Passenger Assistance training documentation
- Annual driver In-Service training documentation
- Wheelchair Securement training documentation (if applicable)
- Drug Free Workplace Policy (signed by driver)
- State Driver History Check (reviewed on an annual basis), typically referred to as DMV, DRV, or MVR reports
- National Criminal Background Checks (reviewed on an annual basis)
- Driver Performance Evaluation and Review (when applicable)

Provider Network Management staff works with each transportation provider to ensure the provider maintains and submits all current credentialing records. All credentials must be reviewed despite being notified of the pending expiration the transportation provider does not update the credential, a member of the Network Management department will contact the provider. If a credential expires for any driver, that driver will not be allowed to transport any member until the credential is updated in the database.

Call Center Compliance with Requirements for NEMT Calls

Hours of call center operation

To ensure optimum service, members will have 24/7/365 access to the transportation call center. By calling the dedicated toll-free telephone line, members or their representatives will have the ability to schedule transportation services. In addition to maintaining sufficient, appropriate staffing to handle calls during regular business hours at the call center, the vendor will also maintain capable staff to take in after-hours calls, weekend, holiday, and back-up support will be provided as needed.

Training call center staff

The call center's number one priority will be to provide professional, prompt, and courteous customer service to all members and their representatives. To ensure this high quality level of service, a comprehensive training program will educate call center staff to treat all callers with dignity, respect, and confidentiality. With the programs consisting of the following topics, we can ensure that all incoming calls for NEMT services will be handled in a timely, responsive, and courteous manner:

- Background on the NEMT industry and Medicaid
- Scheduling services in compliance with state regulations
- Cisco system and other call center equipment
- Management System
- Confidentiality, including HIPAA safeguards and compliance

- Cultural diversity, sensitivity, and CLAS standards
- Using the Language Line and TTY/TDD services
- Customer service soft skills, phone etiquette, and professionalism, especially when working with members with special needs or managing difficult behavior
- Active listening, documentation, and restating trip details before concluding the call
- State requirements and protocols, and vendor policies and procedures through the relevant training manuals

Monitoring call center staff

Vendor management will be responsible for monitoring call center staff for proper performance and duty execution, and will be on the call floor to answer any questions or solve any problems call center staff may have. In addition, AmeriHealth Mercy will audit performance through a live and recorded call monitoring review process to assess:

- Timeliness of answering and completing calls
- Accuracy of information acquired during intake
- Call center staff professionalism, sensitivity, courtesy, and responsiveness to the member's needs
- Accuracy of trip scheduling

Meeting Limited English Proficiency (LEP) Needs

The vendor will provide call center staff with the training necessary to handle culturally diverse, limited English proficiency (LEP) populations with sensitivity and active listening. In addition, to abiding by Culturally and Linguistically Appropriate Services (CLAS) standards; hire bilingual employees; and utilize a certified language line service for all languages not spoken by the call center staff.

CLAS Standards Govern Cultural Sensitivity

To ensure all members receive high quality service, the vendor will take an additional step in providing high quality service to LEP individuals by educating the staff on cultural competency. The U.S. Department of Health and Human Services Office of Minority Health has issued standards for CLAS to improve access to healthcare services, while promoting sensitivity and communication styles that respect cultural diversity. In general, CLAS standards address:

- Training
- Initial and ongoing organizational self-assessments
- Management accountability/oversight mechanisms to provide culturally and linguistically appropriate services

Hiring Bilingual Employees to Meet LEP Needs

The vendor will seek to hire bilingual call center staff to improve communication with LEP members. To meet the varying language needs of members in this service area, the vendor will hire call center staff with language skills in all the required languages as specified by DHH.

Using Language Line Services to Additional LEP Needs

To meet the needs of LEP individuals, we will utilize a certified language line service with interpreters to accommodate more than 140 languages.

TTY/TDD Services for the Hearing and Speech Impaired

In addition to meeting LEP needs, the vendor also will have the capabilities to meet the needs of other populations who experience communication barriers. As well as process calls for hearing or speech impaired members through TTY (teletype) and TDD (Telecommunication Device for the Deaf) services. By using these services, we can effectively ensure that all populations, regardless of their specific needs, will not experience communication barriers with the vendor.

NEMT Quality Assurance Program

In providing NEMT to members, the goal is to achieve high performance standards and to deliver quality NEMT services. To ensure this goal is met, AmeriHealth Mercy will require the vendor to develop a comprehensive quality management program. AmeriHealth Mercy will develop and/or customize performance measurements for Louisiana during the first year and beyond as needed.

The quality management program will feature performance metrics and thresholds to evaluate compliance with relevant standards and AmeriHealth Mercy protocols. The vendor shall collect data from the various operational departments and then compare the data to established goals and thresholds. Then, the vendor's quality management committee receives and trends each threshold, or predetermined level of performance.

Vendor Quality Management Committee

The Vendor's Quality Management Committee is central to the quality assurance efforts. The quality management committee will meet quarterly to evaluate reports with the goal of operational excellence and quality assurance for all NEMT services. It serves as an advisory committee and is responsible for:

- Recommending policy decisions
- Analyzing and evaluating the results of quality management activities
- Ensuring the integrity of the vendor's quality management program through planning, designing, implementing, reviewing, and approving corrective actions
- Ensuring follow-up to quality improvement initiatives

URAC Accreditation Shows Quality Commitment

As a demonstration of the commitment to ensuring high quality service, AmeriHealth Mercy will require that the vendor has pursued and received URAC (Utilization Review Accreditation Committee) Core Standard accreditation. The URAC accreditation process reviews the operations of a company to ensure that the company meets established national standards and promotes quality improvement. The accreditation covers a broad range of healthcare industries. The following URAC criteria address areas of interest to the requirements of this RFP involving infrastructure and human resources:

- Organizational Structure
- Policies and Procedures
- Regulatory Compliance
- Inter-Departmental Coordination
- Oversight of Delegated Functions
- Marketing and Sales Communications
- Business Relationships
- Information Management
- Quality Improvement/Management
- Staff Qualifications
- Staff Management

Section H - Utilization Management

AmeriHealth Mercy's Utilization Management (UM) program is a comprehensive, systematic, and ongoing effort that is based on more than 25 years of experience coordinating care for our diverse membership. Our UM program employs nationally recognized guidelines, regular and ongoing evaluations, and a thorough employee training program to ensure that members receive quality, medically necessary care. AmeriHealth Mercy will use this proven UM program as a foundation to ensure that Louisiana's residents receive the most sound and effective care available.

H.1: Ensuring Appropriate Denial of Services

H.1 Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.

AmeriHealth Mercy will use its more than 25 years of experience in Medicaid managed care to ensure that utilization management (UM) decisions in Louisiana are not arbitrarily made. We do this by employing four distinct strategies. The first strategy assures that we base all decisions on well-established standards that consider all relevant clinical information. The second strategy makes sure that the utilization management team is well-trained on all the standards. Third, we periodically audit the decisions to assure accuracy. And lastly, we provide a process for providers to appeal decisions.

As part of our first strategy, we will base all UM decisions on objective and evidenced-based criteria. To assure that all decisions are made appropriately, AmeriHealth Mercy employees will have its Quality Assessment and Performance Improvement Committee (QAPIC) and DHH approve the following criteria for use in making utilization management decisions:

- InterQual Adult ISD (Intensity of Service, Severity of Illness & Discharge Screens) Criteria
- InterQual Pediatric ISD (Intensity of Service, Severity of Illness & Discharge Screens) Criteria
- InterQual Outpatient Therapy Criteria
- InterQual Home Care Criteria
- InterQual Outpatient Procedures Criteria
- InterQual DME Criteria
- Louisiana Medicaid Services Manual

AmeriHealth Mercy will review and approve InterQual criteria annually – and more often when indicated – before it is used as part of the UM process. The QAPIC, which consists of actively practicing practitioners, will be responsible for this annual review and approval as part of AmeriHealth Mercy's Quality Assessment and Performance Improvement Program. Practitioners that serve on this committee will provide input in the development and revision of these criteria.

Before we apply these criteria, Utilization Management (UM) employees will request all necessary clinical information from the ordering practitioner and/or servicing provider to render a determination. We do not want to burden the provider, so we ask for only the information necessary to determine if the request meets the criteria specified above. For example, if the DME criteria states that a particular piece of equipment is appropriate if five requirements are met, we request information on those five requirements. While applying the UM criteria, all employees will consider the individual circumstances of the member as well as the characteristics of the local health delivery system.

For example, member considerations may include age, co-morbidities, complications, progress of treatment, psychosocial situation, or home environment.

Local delivery system considerations may include:

- Availability of subacute care facilities or home care in plan service area for post discharge support
- Plan benefits for subacute care facilities or home care where needed

- Ability of local hospitals to provide all recommended services within the estimated length of stay

When the information provided does not meet the elements of the UM guidelines based on any of the above considerations, a physician or designated licensed clinical professional will review and render the decision. Practitioners/providers are invited to discuss a determination to deny or limit coverage with a Physician Reviewer through AmeriHealth Mercy's reconsideration (peer-to-peer) process. The flowchart below summarizes the decision making process.

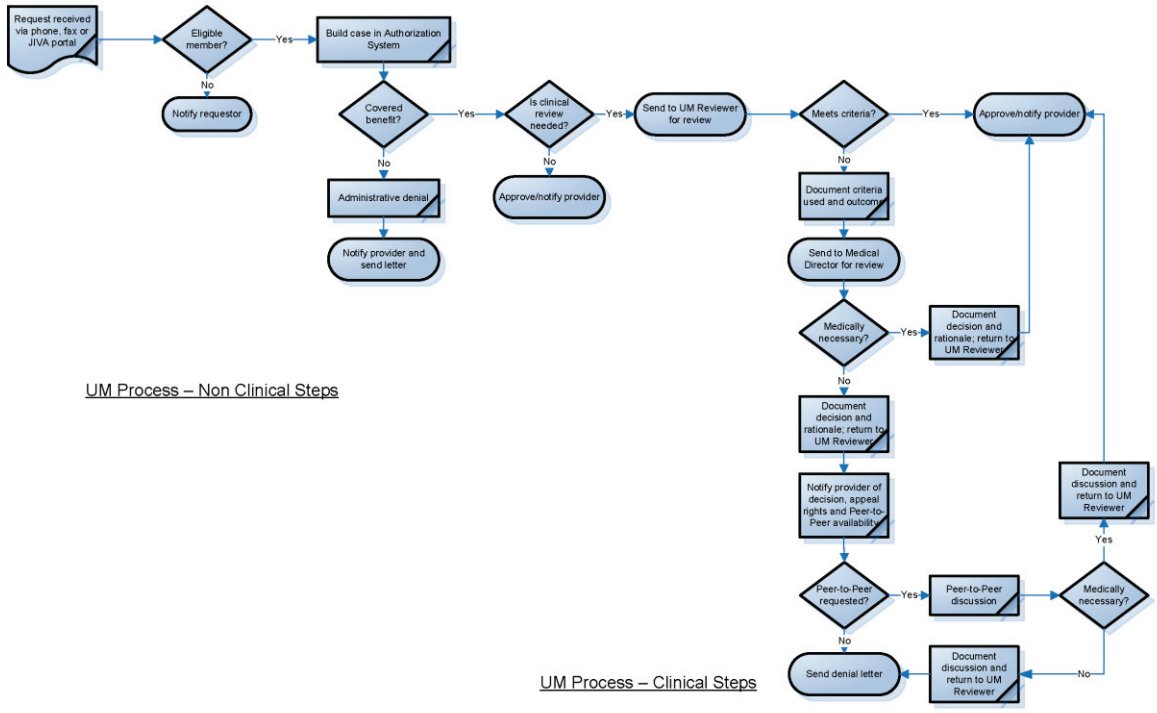


Figure 1: Utilization Management Denial Workflow

The second strategy is to make sure that our UM team is well- trained and performs services consistent with our policies and procedures. AmeriHealth Mercy's Louisiana-based and licensed Medical Director will be responsible for the development, implementation, and medical interpretation of medical policies; planning; and the administration of the Utilization Management department.

We will base all decisions solely on appropriateness of care and service, and the existence of coverage. The Utilization Management team will provide services consistent with written policies and procedures to ensure that criteria are applied appropriately and consistently. The policies restrict adverse decision making regarding medical necessity to clinical professionals who possess an active, unrestricted license and have the appropriate education, training, or professional experience in medical or clinical practice.

AmeriHealth Mercy does not provide any financial incentives or rewards to encourage decisions that result in underutilization, denial, limits or discontinuation of medically necessary covered services. If a medically necessary denial decision is appealed, a physician in the same or similar specialty as the care being requested will review the request.

Criteria utilized by AmeriHealth Mercy will be available upon request to all AmeriHealth Mercy participating practitioners, providers and members. We educate practitioners and providers on available review criteria and methods to obtain clinical criteria in our Provider Manual, information posted on the AmeriHealth Mercy provider website and written UM determination letters. Upon provider request, plan personnel may fax, mail or read criteria over the phone.

In order to ensure appropriate and consistent application of criteria, AmeriHealth Mercy will implement its third strategy, which measures the accuracy of its decisions. UM employees (including physicians) undergo Inter-rater reliability testing on a regular basis to evaluate consistency in applying criteria. UM employees are also subject to periodic quality audits of case files. We develop action plans to address any identified variances. We communicate performance results and action plan results to employees via individual sessions, team meetings and department communications. These results are also reported to the QAPIC.

Lastly, if providers disagree with the decision, a member or provider may appeal the process. The appeal process is described in Section N.

H.2: UM Guidelines Development Process

H.2 If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.

AmeriHealth Mercy will use the nationally-recognized InterQual guidelines for its Utilization Management program. We will review these criteria for approval at least annually – or more often if needed – during our Quality Assessment and Performance Improvement Committee (QAPIC) meeting, which includes external physicians as members with voting privileges.

As needed, AmeriHealth Mercy will develop internal criteria to supplement InterQual. We use the following information sources during the development process:

- Results of the Hayes Incorporated (Hayes, Inc.) technology assessment report
- Information from appropriate government regulatory bodies, such as the Food and Drug Administration (FDA) or the Department of Health and Hospitals (DHH)
- Published scientific evidence
- Publicly available reference information (including web/online resources)
- Information from a board-certified consultant(s) familiar with the specialty or technology area under review

Following the internal review, will review the proposed criteria with the Partnership Councils for additional input. The final criteria are reviewed and approved by the QAPIC.

H.3: Utilization Management Staff

H.3 Regarding your utilization management (UM) staff:

- *Provide a detailed description of the training you provide your UM staff;*
- *Describe any differences between your UM phone line and your provider services line;*
- *If your UM Phone line will handle both Louisiana CCN and non-Louisiana CCN calls,*
  - *explain how you will track CCN calls separately; and*
  - *how you will ensure that applicable DHH timeframes for prior authorization decisions are met.*

AmeriHealth Mercy's training and orientation programs for its Utilization Management (UM) team will be based on the proven programs utilized by AmeriHealth Mercy. The programs are designed to help the UM employees understand the delivery of health-related services to Medicaid recipients, as well as the implementation of utilization management policies and procedures.

Additionally, AmeriHealth Mercy recognizes the vital nature of ongoing training for its employees and will implement various training methods to ensure the expansion of their knowledge, skills, and job satisfaction.

New Hire Orientation

New hire orientation provides the platform to introduce new employees to the culture of AmeriHealth Mercy, with a focus on its history, vision, and mission. New hire orientation for AmeriHealth Mercy's employees will outline business operations, performance standards, and appropriate conduct, while defining expectations. The orientation includes the following items:

- AmeriHealth Mercy's mission, values and organizational structure
- AmeriHealth Mercy's policies and requirements of the programs
- Louisiana and applicable federal regulatory requirements and accrediting body standards
- AmeriHealth Mercy operational procedures including documentation standards and style guide
- Department policies and procedures
- Performance standards and reporting requirements
- HIPAA privacy/security as well as general corporate confidentiality requirements
- AmeriHealth Mercy compliance program
- Diversity
- Cultural competency/culturally and linguistically appropriate services (CLAS)
- AmeriHealth Mercy information systems
- Clinical policy and benefit administration policy (as appropriate to the position)
- False Claims Act detection and reporting obligations

In addition to the new hire orientation described above, new employee training is provided in each department. New employees are educated and trained on job duties by the department manager and program trainer. This enables each employee to receive a focused training from the individual who is responsible for evaluating his or her job performance. The department leader will educate new employees on department policies, procedures, and position-specific responsibilities and expectations. Department orientation may include shadowing a colleague for a specified period of time, cross training, or other on-the-job training as appropriate. The length of orientation varies depending on the nature of the job and the competencies demonstrated by the new employees. For example, orientation for a Utilization Management Technician can last eight to ten weeks, while training for an Appeal Review Nurse will last more than three months.

Specific Training for Utilization Management Staff

All Utilization Management employees will complete a comprehensive competency-based orientation program and receive ongoing training on critical aspects of the program, processes and associated timelines. New employee orientation consists of an 8- to 12-week program combining classroom and hands-on training. Topics addressed in a classroom setting include customer service skills, confidentiality and HIPAA provisions, program integration, benefit availability, medical necessity criteria, documentation requirements, and notification policies. Utilization review skills are taught using scenarios that mimic the coverage needs of the Louisiana Medicaid population and focus on commonly encountered requests. Basic system navigation and documentation is taught in the classroom.

In the initial phase of the program, certified InterQual trainers from AmeriHealth Mercy affiliates will conduct InterQual training for employees. As the program matures, select employees will undergo InterQual Trainer certification.

UM employees initially shadow and observe their preceptor, and gradually progress to performing the job functions and tasks while under observation. Dual headsets are used, allowing the employee to hear all conversations during the shadow period, and allowing the preceptor to hear both sides of the call as roles are reversed. Once an employee reaches proficiency, he/she will transition to working independently with the preceptor on standby.

UM employees can also reference online desktop policies and procedures, training manuals and written workflows, and are free to call department trainers, supervisors, and their preceptor with questions. Medical Directors can also respond to UM employees' questions and provide reinforcement of the learning process.

After two to three weeks, new employees are paired with a preceptor to review cases side-by-side with an experienced employee in a similar role. AmeriHealth Mercy will leverage its relationship with its affiliates to enhance training for new employees. Select Utilization Management employees will train side-by-side with nurses and technicians from AmeriHealth Mercy's affiliate plans. These employees will serve as resources and preceptors to the initial team hired for the program. In addition, AmeriHealth Mercy affiliates will supply resource staff from the South Carolina and Pennsylvania programs for the first few weeks of Louisiana implementation.

During the orientation process, the responsible department director or manager will assess the new employee's needs and comprehension to determine if additional orientation is needed. AmeriHealth Mercy utilizes a competency-based orientation plan to assess the performance of an employee to identify areas where additional education, training, or resources should be devoted on an individual basis. Each employee is given an opportunity to evaluate the training they received and offer suggestions for future improvements.

AmeriHealth Mercy employees evaluate the orientation process annually to identify possible improvements and enhancements. This helps to ensure that AmeriHealth Mercy offers an orientation program that meets the needs of the organization while maintaining the satisfaction of employees.

Table 1: Orientation Plan for New Utilization Management Employee

Topic	Method	Competencies
Learning about the Company		
Mission, Vision and Core Values	Instructor-led discussion with reflective written exercise (Core Module)	▪ Paraphrase or quote Mission and Vision ▪ List eight competencies and give example of how each relates to role
Learning about the Department		
AmeriHealth Mercy UM Organizational Chart	Self-study exercise with written exercise (Core Module); Organization chart on Intranet	▪ Identify senior corporate and Medical Management team ▪ Identify and describe purpose of sub-groups in Utilization Management (UM)
Program Description	Self-study with written exercise (Core Module); Program Description on Intranet	▪ Understand the concept, goals, programs and activities of UM ▪ Explain connection of personal role to Program Description

Topic	Method	Competencies
Learning about Your Role		
Job Description	Discussion with Supervisor/Manager – review description and performance expectations	▪ Describe main job responsibilities and metrics used to measure performance ▪ Understand purpose of auditing in overseeing, measuring and improving performance ▪ Describe responsibilities consistent with training/education, licensure, certification and State Practice Act ▪ Explain State/Federal Requirements specific to Job Function
Role-specific Work Flows	Discussion with Supervisor/Manager or UM Preceptor	▪ Locate and identify role-specific work flows ▪ Understand impact of role in completing work flows ▪ Explain impact of poorly executed work flow on members and co-workers
Goal Planning and Professional Development	Discussion with Supervisor/Manager - review corporate/ departmental goals on Intranet; review individual goal planner; resources for professional development	▪ Locate corporate, company and departmental goals on Intranet ▪ List at least three company goals related to role ▪ List at least three departmental goals ▪ Understand personal goals and explain how they relate to departmental and corporate goals ▪ Understand the performance review process ▪ Identify at least three sources for professional development
Policies and procedures	Self-paced; review policies and procedures on Intranet	▪ Understand and identify job-related policies and procedures; including all relevant UM P&Ps, HIPAA P&Ps, and Medical Management P&Ps ▪ Locate policies on Intranet ▪ Know regulations for timeframes of UM activities
Grievance and Appeals process	Policy and procedure review with Supervisor/Manager or UM Preceptor	▪ Describe grievance and appeals process in terms of member rights and role-specific activities
Quality of Care/ Service Concerns	Policy and procedure review with QM Nurse	▪ Describe events that trigger Quality of Care/Service concern processes ▪ Explain processes from start to finish
Auditing criteria	Discussion with auditor; review of criteria and auditing policy and procedure	▪ Explain purpose of auditing ▪ Reinforce understanding of auditing in overseeing, measuring and improving performance ▪ Identify and understand criteria measured in audits

Topic	Method	Competencies
Accreditation Standards	Self-paced; read copy of accreditation standards related to role	▪ List accreditation organizations ▪ Explain components of accreditation standards related to role ▪ Locate resources for reviewing standards and results of accreditation process
AmeriHealth Mercy Code of Conduct	Web-based module with Code of Conduct forms	▪ Understand personal responsibilities for complying with rules and the consequences for non-compliance ▪ Know the policies and procedures that guide professional conduct ▪ Understand how Fraud and Abuse is defined and what actions to take when discovered ▪ Understand how professional ethics are governed and what P&Ps guide ethical decision-making
Cultural Competency	Web-based module with on-line assessment	▪ Describe purpose of Culturally and Linguistically Appropriate Services (CLAS) and how standards are followed in the company ▪ Explain how race and culture affect members' medical decision-making and health care behaviors ▪ Describe role-specific responsibilities regarding cultural competency
Your Tools		
Medical Management Information System	Instructor-led training with practice exercises in system training environment using role-based scenarios	▪ Use search and navigation features ▪ View all cases, open and closed ▪ Start a new case and select data elements (e.g., Treatment Setting, bed type, etc.) appropriately ▪ Check member eligibility ▪ Approve, pend, deny a case ▪ Perform denial notification with appeal rights ▪ Perform member and provider data reconciliation ▪ Choose the correct diagnosis using the drop down and the Autocoder ▪ Add detail lines ▪ Add procedures ▪ For denials, select the correct denial letter ▪ Select appropriate template/tool to create proper documentation ▪ Use the Route To function appropriately ▪ Use the Next Review Date appropriately ▪ Close cases correctly ▪ Access and document using correct UM template or tool

Topic	Method	Competencies
Medical Management Information System (cont'd)		▪ Use triggers for appropriate case referral and follow-up actions ▪ Use the Quality Management Indicators
▪ InterQual Criteria Sets: ▪ InterQual Adult ISD (Intensity of Service, Severity of Illness & Discharge Screens) Criteria ▪ InterQual Pediatric ISD (Intensity of Service, Severity of Illness & Discharge Screens) Criteria ▪ InterQual Outpatient Therapy Criteria ▪ InterQual Home Care Criteria ▪ InterQual Outpatient Procedures Criteria ▪ InterQual DME Criteria ▪ AmeriHealth Mercy Clinical Indicators – ESI	▪ InterQual Certified Instructor-led training with practice exercises in system training environment using role-based scenarios ▪ Louisiana Medicaid Manuals available for Providers, Hospitals, Home Health Care, Durable Medical Equipment, Ambulance, Transportation, EPSDT and Family Support Services	▪ Demonstrate ability to apply criteria to case studies ▪ Create InterQual reviews ▪ Obtain an IRR test score of > or = to 90%
Phone System	Instruction and set-up with UM Preceptor	▪ Use correct scripting for voicemail ▪ Know functions of phone system related to role
Language Interpreter Services; TTD	Instructor-led training with practice	▪ Reinforce Culturally and Linguistically Appropriate Services (CLAS) knowledge related to language interpreter services and TTY ▪ Understand when and how to use language interpreter services and TTY.
Introduction to the State Program		
Louisiana DHH Overview	Self-study (Core Module) with on-line assessment	▪ Locate Louisiana DHH website ▪ Describe eligibility rules and benefits provided by program
DHH Policy and Procedure Manual	Self-study (Core Module) with on-line assessment	▪ Locate manual ▪ Relate DHH policies and procedures to

Topic	Method	Competencies
		corporate policies and procedures
DHH Contract	Self-study (Core Module) with on-line assessment	▪ Understand contract and reporting elements that are related to role activities ▪ Explain consequences of not fulfilling contract requirements

Ongoing Training Programs

AmeriHealth Mercy will promote ongoing training programs covering topics such as the Louisiana CCN, customer service skills, accrediting agency standards, regulatory requirements, and other topics pertinent and necessary to maintain professional competencies. While training begins with the orientation process, employees at all levels will undergo training throughout their employment with AmeriHealth Mercy. The goals of AmeriHealth Mercy's training programs are consistency, compliance, cross training, skill advancement, and capitalizing on strengths while minimizing weaknesses. Ongoing training is a critical component of employee productivity and satisfaction, leading to improved retention. Enabling employees to expand their skill set fosters a creative and energetic approach to performing job responsibilities. We consider our ongoing training programs to be an innovative corporate approach that is focused on each individual employee.

Examples of ongoing training include:

- Corporate presentations through our Learning and Organizational Development department (outlined below)
- Off-site staff training seminars
- Professional conferences, seminars, and/or continuing education courses
- Peer-delivered care management presentations
- Web-based learning modules

Additional training methods for Utilization Management staff include:

- Individual coaching
- In-services
- Case rounds

A log of all corporate seminars and conferences attended is kept on file in the Human Resources department. Documentation on department-specific training sessions (e.g., Clinical Updates) is kept on file with the responsible AmeriHealth Mercy manager.

Learning and Organizational Effectiveness

AmeriHealth Mercy's Corporate Learning and Organizational Effectiveness (L&OE) department is a one-stop learning service for the organization's training needs. L&OE focuses on employee performance improvement by providing services that help develop the organization's people, processes, and business. Alongside our extensive functional job training we provide supervisor, management and leadership, and core competency development for individual contributors. These curricula provide the learning framework for our Talent Management Pipeline Program.

Learning & Organizational Effectiveness — *Your Performance Improvement Center*

The goal of the Learning & Organizational Effectiveness program is to provide effective, business-specific learning opportunities that strike a balance between our corporate strategy and the needs of our nation-wide business partners, specifically, Learning & Organizational Effectiveness:

- Creates and maintains our strategic direction as a learning organization

- Delivers customized programs to support our Medicaid Managed Care, Care Management Programs, Medicare Managed Care, Pharmacy Benefits Management and Behavioral Health businesses
- Provides solutions that support individual, team and organizational competency needs
- Manages the organization's performance management process and recognition programs
- Implements and oversees learning curriculums that support our corporate vision, strategy, mission and goals

Educational programs are delivered using a variety of methods to accommodate varied learning styles and to reach users in multiple locations. Delivery methods include instructor-led classroom training, computer-based training and video conference training. Robust tools track attendance and manage assessment and reporting data. Testing, feedback and other structured processes are applied to continuously improve training curricula and methodologies.

The range of programs available through Learning & Organizational Development includes:

- Team building
- Customer service
- Software skills (e.g., MS Access, MS Excel)
- Personal development
- State and federal government required training
- Basic work skills including writing, time management and conflict management
- Creative thinking and innovation workshops
- Civil treatment series
- Change management
- Performance management
- Leadership and influence workshops
- Effective communication
- Diversity

Off-Site Staff Training and Seminars

AmeriHealth Mercy offers each professional employee the opportunity to attend at least one conference, seminar, or continuing education course annually. Employees are able to choose educational opportunities that will contribute to growth in the professional competencies required for his/her individual position. As appropriate, participants are expected to disseminate information that they received during their training sessions. The information may be presented at a staff meeting or via email, depending on the nature and relevance of the information to other employees.

Web-Based Learning Opportunities

Web-based learning modules are becoming increasingly valuable in employee training. Web-based courses cater to many different learning styles, which employees appreciate. Additionally, Web-based courses are available at any time, offer thorough coverage of a topic, and provide knowledge testing upon conclusion. Courses are technologically advanced and easy to operate and understand. AmeriHealth Mercy will license Captivate, a software tool that allows us to create custom Web-based educational modules.

Inter-rater Reliability

In addition, Utilization Management staff involved in the application of medical necessity criteria will participate in an Inter-Rater Reliability (IRR) process twice per year. This process will involve reviewing blinded actual case examples to check that staff are selecting the appropriate criteria and are either approving or pending the cases to a physician reviewer for approval if criteria appear to have not been met. Physician reviewers also participate in an IRR process twice per year. The IRR process helps to identify if clarification or recommendations for modifying criteria is needed, or if additional individual or group training is indicated. Action plans are developed to address identified variances. Performance

results and action plan results are communicated to staff via individual sessions, team meetings and department communications and reported to the Quality Assurance and Performance Improvement Committee (QAPIC).

Individual Coaching

Utilization Management cases, including information collection, criteria application, documentation, timeliness and notification, are audited on an ongoing basis. Monthly, a supervisor will review the results with the individual employee responsible for the case and evaluate aggregate trends. Each employee receives coaching based on the individual results. Training initiatives are developed to address common opportunities for improvement.

Case Rounds

On a weekly basis, nurses, social workers, physicians and care coordinators meet to review complex cases. This forum serves a dual purpose. It is a problem-solving session to develop creative solutions to complex management issues, as well as an educational forum to share information, resources and example-based education.

In-Services

Utilization management staff members also attend in-service sessions on topics ranging from clinical updates to network utilization management capabilities and new operational policies. Whenever possible, outside representatives with knowledge of the program or topic are brought in to provide the education. In-services are scheduled several times a month. Employees are required to attend all mandatory topics, such as criteria updates and changes to operational policies, and a percentage of other offerings. In-service records are reviewed quarterly as part of the employee's development plan.

Differences between the UM Phone line and the Provider Services Line

The main difference between the UM phone line and the Provider Service phone line is the role-specific training provided to employees. Employees servicing the UM phone line are trained in prior authorization and integrated care management programs. Employees servicing the Provider Service phone line are trained to investigate and resolve claim payment issues; update provider demographics and explain payment policies.

To fulfill their different roles, UM and Provider Service staff have access to different information sets in our systems. UM staff can access clinical detail related to the member's authorization, care management assessment, care plan and care coordination notes. Provider Service employees have access to the services authorized and notes related to claim payment, but are unable to see clinical detail or notes.

UM employees will also have access to member's Care Gaps, which are not visible to Provider Service staff. For example, a UM employee who receives a call from a provider requesting coverage for a power wheelchair can verify in claim history whether the member has received the item in the past; review the member's benefit summary to verify that the time is covered; and explain to the provider the information needed to complete the medical necessity review using the online resources and workflows. In addition, our online system will alert the UM employee that a member has missed recommended services, known as a Care Gap. Using this alert, the employee can remind the provider that the member is overdue for an annual adolescent well care visit.

The UM call centers use the same Contact Center technology as our Provider and Customer Service departments. Calls are answered by a live AmeriHealth Mercy representative within 30 seconds. Both UM phone staff and Provider Service phone staff can use a warm transfer to move a call belonging to another team without requiring the caller to redial or restate the reason for the call. For example, if a Care Manager is talking with a member and learns that the member is having difficulty scheduling an appointment with a PCP, the Care Manager can transfer the member to a Customer Service Representative for assistance.

Both teams are also trained on the use of interpreter services and TTD equipment, to assist callers with limited English proficiency or who are vision- or hearing-impaired. In addition, both the UM phone line and the Provider Service phone line are answered by a representative 24-hours a day, seven days a week. Calls received after business hours, on weekends and holidays are answered by our Off-Hours team. The Off-Hours team will contact the on-call UM nurse for any urgent issues. A Medical Director is also on-call to address any medical necessity determination requests.

Care Coordination for out of state travel

H is a 3 year old member with a complicated medical history including diagnosis of tracheomalacia, chronic lung disease, and gastroesophageal reflux disease (GERD). With a history of multiple surgical procedures including a Nissen fundoplication to relieve her GERD, placement of a tracheostomy for airway maintenance and suctioning, and gastrostomy tube placement for enteral feedings and medication administration, H also required humidified air and supplemental oxygen at night or during periods of acute illness. H also needed her oxygen levels monitored through the use of a pulse oximeter intermittently throughout the day and continuously overnight when sleeping to ensure that she was properly oxygenated.

Our Care Manager received a call from H's mother shortly before a family trip to Florida. The mother was inquiring about the need to have back up equipment available for H while traveling along with extra supplies such as suction catheters. The Care Manager immediately began coordinating to ensure that H had sufficient supplies and equipment to travel safely with her family including the supplemental oxygen for nighttime use. H's mother was instructed on contingency plans should a need for additional supplies arise while in Florida such as how to receive assistance locating a Florida based provider of Durable Medical Equipment (DME) including catheter supplies. Two days before the trip, H's mother called again concerned that in addition to having supplemental oxygen available for usage at night during the trip, "H's" physician had prescribed for her to have oxygen available in-flight. The mother had called the airline and found there are restrictions on the types of oxygen concentrators approved for use in-flight, and unfortunately H's regular DME provider did not have the approved equipment.

Our Care Manager collaborated with a colleague with extensive knowledge of DME and DME providers to find the type of oxygen concentrator approved for in-flight usage on such short notice. Additionally, our Care Manager outreached to the physician specialist and obtained additional information regarding his travel protocols for "H" and recognized that other supplies were going to be needed in the event that H's tracheostomy tube was displaced during travel and needed to be replaced (to prevent her stoma from closing). Our Care Manager, through a series of phone calls with the physician and outreach to DME providers, was able to ensure that all items were ready and available in time for departure and arrange for a DME provider to make a home visit to educate "H's" mother on the use of the new oxygen equipment.

Despite the short notice given, the Care Manager was able to work with the DME providers to accommodate the fact that the trip would include flying into one Florida city, driving to another and flying home from there. The preparation included switching DME providers so the specialized oxygen equipment would be available for travel for the duration of the trip while ensuring no gap occurred in the provision of DME supplies and equipment before leaving or upon returning home when it was necessary to switch back to the original DME provider. Our Care Manager worked with H's mother to keep her informed along the way and intervened during times when the mother did not follow through with DME providers as needed.

After returning home, the mother notified our Care Manager the family had enjoyed a great trip, had all of the needed equipment and supplies, and H remained healthy the whole time.

AmeriHealth Mercy-Specific Monitoring and Reporting

We will create dedicated phone queues for our AmeriHealth Mercy business, accessed through dedicated toll-free numbers. This set up will allow us to monitor and report AmeriHealth Mercy phone volume and performance separately, even in peak periods when we may have additional staff assigned to ensure

performance levels are met. Through our Automatic Call Distribution (ACD) system, we will be able to report AmeriHealth Mercy-specific average speed of answer, abandonment and service level.

Similarly, our JIVA Care Management Platform contains identifiers at the member level. JIVA reports separate performance data for each line of business. This functionality enables us to provide LaCare-specific monitoring and reporting of prior authorization decision timeliness.

H.4: Utilization Data

H.4 Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system. Individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the CCN medical director or other qualified and trained professional.

Collection, Analysis and Reporting of Utilization Data

AmeriHealth Mercy will employ the robust reporting infrastructure to collect, analyze and report utilization data on Louisiana members. Data is collected from multiple sources, including eligibility records, claim transactions, authorization records and supplemental files, such as historical claim data, pharmacy claim data, immunization registries and lab results. Data on members, providers, authorizations, and medical claims is loaded from our transactional systems, Facets and JIVA, to our data warehouse. The data warehouse is refreshed or updated on a weekly and monthly basis depending on the data source and the frequency with which it is received. Supplemental data files are loaded as often as they are received.

The Informatics Department will extract the data for reporting purposes from the data warehouse or the source system, depending on the level of granularity and data elements needed. The data will be extracted and reported using any combination of the following tools or applications: Microsoft Access, BI query, SAS, SQL, Crystal Reports, Business Objects, and Excel.

Various types of reports can be generated by the Informatics Department for Utilization Management. Some are operational such as the Daily Inpatient Census or Weekly Case Load reports, while others are more trend-oriented and performance-based. Some of the reports that Utilization Management uses are:

Summary of Healthcare Activity (SHA) Reports

The Summary of Healthcare Activity (SHA) report is based on claims data and shows cost and utilization for each service category and compares the results of a current period to a corresponding prior period. Services are trended by year and by quarter. The report details utilization by unit cost, and utilization of units, allowing the reader to see whether a change in PMPM for a service category was due to changes in utilization, unit cost or both. In addition to total plan and category of aid, the report can be run and viewed by disease population, selected providers or hospitals, selected members or geography.

The SHA report has enabled successful interventions relating to cost trends. For example, by using the SHA report, our Kentucky affiliate saw their per member per month (PMPM) cost for durable medical equipment (DME) increase 10.5 percent, or nearly $200,000, from 2008 to 2009. Our research showed that the increase was driven predominately by an increase in unit cost. Closer examination allowed us to determine that this was driven by a shift from wheelchair rentals to purchases primarily from one non-participating provider. To address the issue we contracted with the provider, thereby changing its status to a participating provider that requires prior authorization for wheelchairs, whereas non-participating providers were not required to seek prior-authorization. As a result, we saw DME costs decrease 8.3 percent, or $2.51 PMPM, through September 2010.

Inpatient and Outpatient Authorization Reports

These reports compare inpatient and outpatient services that were authorized and requested, and from the current period to the corresponding prior period both on a monthly and year-to-date basis. In addition to serving as a harbinger of claims,, they allow the UM area to review the current services performance versus projected and historical results. The reports can also alert UM of a pending or developing increase in certain conditions such as influenza, heat-related conditions, and pregnancies.

Using inpatient and outpatient authorization results, we monitor for unusual changes between specific periods of time. For example, in our Indiana plan, authorization data showed that outpatient medical authorizations increased 85 percent and obstetrics authorizations increased 430 percent in a month when compared with the corresponding month of the prior year. We investigated and learned that a large network provider had become non-participating, requiring the practice to seek prior-authorization for services whereas before authorization was not required. The change in that provider's status contributed substantially to the increase in authorizations. The increase was adequately explained and no intervention was required at the time.

Another example how we used these reports occurred in our South Carolina plan. We discovered a seven-fold increase in the rate of obstetrics authorizations from January through May 2010 to January through May 2011. Research revealed that maternity authorizations had been entered in our authorization system using service code 99201 (office visit for new patients). Rather than reflecting an increase in utilization, the increase was attributed to a new process for entering data for this service. No intervention was necessary, though monitoring of the data continues.

Member and Provider Demographics Reports

These reports provide demographic information on members and providers, such as county of residence, age, race, ethnicity, gender, and category of aid. AmeriHealth Mercy will use information about the demographic profile of its membership and practitioner network to identify potential unmet needs, and assess the network's ability to deliver culturally appropriate care to members. They provide population trends and indicate areas of growth or contraction.

For example, these reports enabled our Southeastern Pennsylvania plan to successfully intervene and improve care to a growing number of Vietnamese population. An analysis of 2007 – 2010 membership language data revealed a significant increase in Vietnamese- speaking members. A workgroup was established and identified the zip codes in which the Vietnamese-speaking members lived. The vast majority (95 percent) had addresses in Philadelphia County. A review of Philadelphia County census data confirmed that the increase in Vietnamese-speaking membership mirrored the county trend. The work group next identified the location of Vietnamese-speaking PCPs in the county.

The group developed and distributed a "Fast Facts (Vietnamese Health Beliefs)" document to all PCPs in the zip codes with Vietnamese-speaking members to assist the offices in understanding the health beliefs and practices of that population. The workgroup is currently developing a survey that will be sent to the Vietnamese members later this year to assess access to care and availability and quality of translation services.

KEYSTONE MERCY
A Program of Keystone First and Mercy Health Plan

Coverage by KeystoneFIRST

FAST FACTS *Important Information for our Providers*

Keystone Mercy's Vietnamese population is growing.
We would like to provide some suggestions for providing care for those of Vietnamese culture

- **Show respect for the patient's health beliefs and practices.** Vietnamese patients sometimes use both Western and Asian medicine concurrently. Patients may be reluctant to tell their providers about their use of Asian medicine. Gather information about the specific beliefs and practices of the patient being served. The Vietnamese regard the Provider's knowledge, inquiry, and non-judgmental acceptance of their beliefs and practices as being a part of effective patient-provider communication.
- **Offer a trained medical interpreter for Limited English Proficient patients.** Patients may prefer the use of a trained interpreter rather than using a family member to interpret personal medical information.
- **Encourage patients to ask questions.** Vietnamese patients greatly respect educated individuals, particularly physicians. Fear of appearing less educated in the eyes of a person of higher status may prevent some Vietnamese patients from asking questions.
- **Patients may exhibit confusion over how to obtain urgent care in the U.S.** They may be accustomed to the walk-in system in Vietnam and may require education about the Pennsylvania healthcare system.
- **Be aware of the patient's personal situation and direct him or her to social support services as needed.**
- **Provide prompt communication about test results.** Vietnamese patients are uncomfortable with invasive laboratory or diagnostic tests and may lose faith in their Provider if results are not communicated immediately.
- **Provide translated health education materials and instructions about prescribed medication.** An explanation about how to participate in their care is appreciated.

Resources

- **Language Services Associates (LSA)** for an opportunity to contract for language services at Keystone Mercy corporate rates: www.keystonemercy.com for details
- **Medline Plus** is an excellent source of translated patient education: http://www.nlm.nih.gov/medlineplus/languages/vietnamese.html
- **Ethno Med** for translated materials http://ethnomed.org/patient-education/vietnamese

Figure 2: Sample Provider Education Material

HEDIS Reports

Certainly, we will use our HEDIS results to fulfill our state or accreditation requirements. Just as importantly, the HEDIS results are utilized to monitor the quality, access and availability of care and to identify health care disparities. Our plans look at selected services on a summary and member-level for opportunities to identify and remove any barriers to preventive and recommended services. HEDIS enables us to compare our results to local competitors as well as to national benchmarks. Outliers are identified and actions plans are developed to address outliers as needed.

Over- and under-utilization is monitored annually by comparing the results of select HEDIS measures with national HEDIS Medicaid benchmarks (90th percentile and 10th percentile for upper and lower thresholds, respectively). Measures are selected based on their demographic, clinical, and practical relevance to the member population. All AmeriHealth Mercy plans routinely monitor myringotomy, tonsillectomy, dilation and curettage, and abdominal hysterectomy, because of the services can be of concern to women and children, both of which are present in high numbers in our respective state Medicaid populations.

HEDIS reports support successful interventions in a variety of ways. We recently used these reports relating to the overutilization for ER services. Over-utilization of ER services can be an indication of access barriers to PCP utilization, inadequate outpatient management, a member's unawareness of his/her PCP or an inadequate supply of PCPs. We also review inpatient utilization reports because inappropriate and unnecessary hospitalizations place members at risk for medical errors. The majority of inpatient admissions arise from an ER visit. High inpatient utilization can indicate under-utilization of outpatient

services, or inadequate outpatient management. Low inpatient utilization can indicate barriers to admission.

Based on annual and ongoing analysis of the utilization of these and other services, our Pennsylvania affiliate successfully implemented initiatives to address over utilization of ER services. We formed an interdisciplinary ER strategy workgroup to review ER utilization trends, evaluate root cause and propose initiatives to address barriers, knowledge deficits and behavior. Over the past three cycles, the plan has been able to close the gap between the ER visit rate and the upper HEDIS benchmark, thus reducing the risks identified above for our members. Results for HEDIS 2011 (calendar year 2010) show a 6.1 percent decrease in ER visits/1000 from the HEDIS 2010 result. Benchmark data for this period will not be available until the fall.

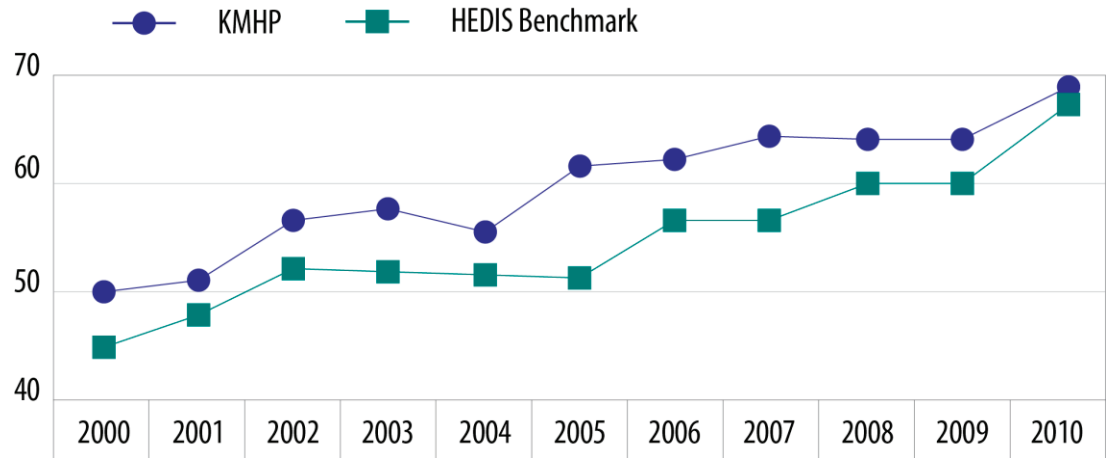


Figure 3: HEDIS ER Visit Rates

In addition, we have seen a significant downward trend on both requested admissions (consisting mostly of emergent admissions) and medically necessary admissions.

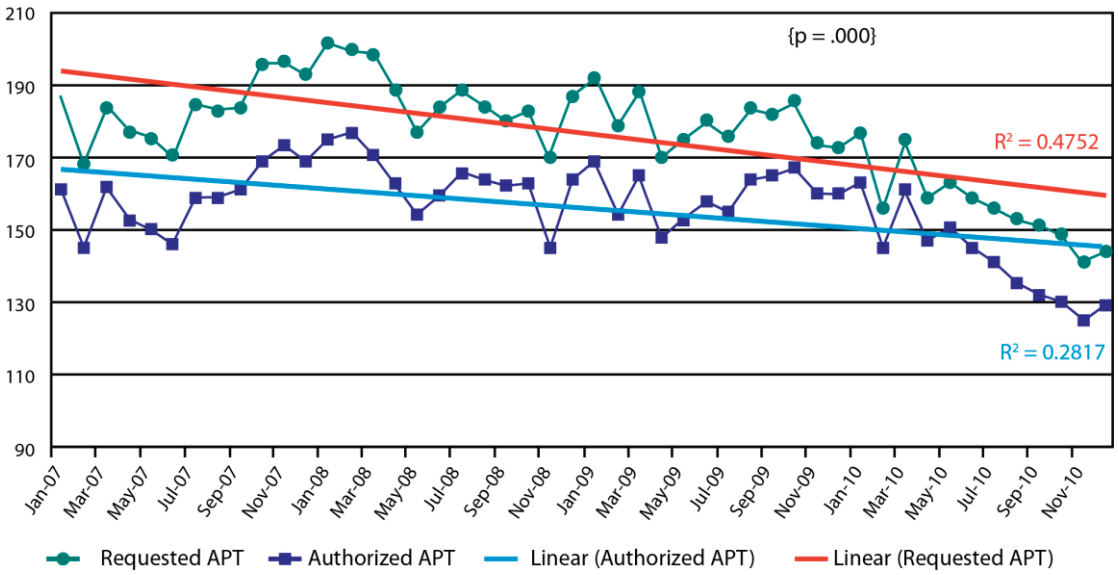


Figure 4: Requested and Authorized Admissions/1000

The initiatives to reduce emergency room visits include:

- Stratified ER outreach to members using ER services that include:
  - A mailing to members with three ER visits in 90 days
  - An outreach to members with four to six ER visits in 90 days
  - Case manager intervention for members with four or more ER visits in 30 days
- Discharge outreach program included:
  - A telephone survey that is focused on the following elements:
    - Did the member feel ready for discharge?
    - Did the member understand the discharge instructions?
    - Did the member set up a follow-up PCP appointment?
    - Did the member receive all medications and services set forth in the discharge plan?
    - Does the member have a condition for which they feel they needed help?
    - Does the member feel that they will need to return to the hospital within the next 30 days?

If the member's response indicated assistance is necessary, the call is transferred to the Rapid Response/Care Connector department for further evaluation and assistance.

Acute care transition (ACT) program include:

- Onsite Care Manager to assist the member to transition back into the community from the inpatient and emergency room setting by:
- Setting up follow up appointments
- Removing barriers that may lead to a return visit to the ER or readmission
- Reviewing their personal health record
- Reviewing and reconciling medications, discharge instructions and care gaps with the patient
- Assessing the patient's knowledge of their condition and red flags
- Emphasizing and facilitating follow-up with the PCP
- Supplying hospitalization information to PCP
- Coordinating services with Rapid Response
- Monthly medication adherence letters for members who had missed refills or had been late in refilling their asthma, diabetes and/or heart failure medications

We are cognizant of the challenges faced in Louisiana related to emergency room usage, and will design specific interventions to address inappropriate emergency room use for Louisiana's Medicaid members.

Care Gap Reports

Care Gaps occur when members do not receive (or there is no documentation that they have received) recommended services based on evidence-based clinical practice guidelines. Like other AmeriHealth Mercy affiliates, LaCare will analyze claim data against evidence-based algorithms monthly to identify gaps in care. Care gap algorithms exist for a full range of preventive services and chronic disease states.

Care Gap reports, in the form of system alerts, will be available to employees performing utilization management, quality management, care management and member service activities. Employees will see a system flag when the member's ID number is entered.

Providers also receive Care Gap reports, both as alerts during an eligibility check, and as full panel reports through the Provider Portal. When the member's ID number is entered in the portal, a pop-up alert appears notifying the provider that a Care Gap exists. When the provider clicks on the alert, a member-level report appears identifying both missing and overdue services, Care Gaps, and up-to-date services. The provider can also access a report of all Care Gaps for his assigned members, either as a printable document or a CSV file that can be incorporated into other systems. More information on the scope of care gap algorithms and Care Gap functionality can be found in Section E.

Preventive Quality Indicators (PQIs)

Using software developed by the Agency for Healthcare Research and Quality (AHRQ), this report on selected conditions produces rates of inpatient admissions that might have been avoided if appropriate ambulatory care had been provided. These reports are trended over time and can be produced by plan, hospital, PCP practice, and by member. We also indicate which members with high PQI rates are in case management. Those members that may not be in case management are then contacted for engagement and assessment. We also work with individual hospitals and review their PQIs in hopes of successfully modifying the hospital's performance.

PerformPlus

A model for profiling and reporting the performance of network providers, PerformPlus includes key UM-related metrics or indicators. PerformPlus provides a balanced scorecard of accountable care quality and cost concepts characterized by key performance metrics on which physician incentives are based. Peer- and trend-based performance metrics are aligned to promote efficient use of resources and to mitigate unnecessary or redundant care. The PerformPlus model creates the ability to monitor and discuss utilization performance with selected specialist practices.

Performance metrics include:

- Inpatient admissions
- Emergency room utilization
- Quality reporting measures*
- Potentially preventable readmission rates*
- Ambulatory care sensitive conditions*

In a few of our plans, primary care providers receive bonuses based on the quality of care they give their patients. Top-tier providers are segmented within each respective category and supplemental bonus opportunities are available for statistically significant achievement relative to the top-tier baseline.

Using PerformPlus to evaluate and reward specialty providers is a recent development that is being well received by both oncology and cardiology providers. Since its inception in March of this year, seven oncology groups and the affiliate's largest cardiology provider have formally agreed to participate in the program. Although it is too early to determine the actual return on investment derived from medical trend improvement, conservative estimates suggest notable savings by assuming only a modest improvement to the median percentile target for each respective provider. For example, for the largest cardiology provider, assuming the year-one actual performance results in improvement to the median target in each category, the incentive payment will be approximately $80,000 with corresponding medical savings attributable to favorable trend improvement of more than $1 million.

AmeriHealth Mercy will implement the data collection and reporting elements of PerformPlus for primary care and one or two specialties. Once baseline information is gathered, AmeriHealth Mercy will evaluate the implementation of related provider incentives. Additional detail and examples of PerformPlus reports can be found in Section G.

Dealing with Variances

AmeriHealth Mercy will actively monitor variances in utilization to identify under-, over- or mis-utilization. The results of utilization monitoring reports are reviewed by the respective management team. We monitor performance, analyze cost, utilization and outcome data, compare our results to benchmarks and prioritize areas for program changes and initiatives. The 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.

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* *Relative to the practitioner's specialty.*

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

As part of the planning process, we will form a workgroup consisting of representation from stakeholders, our analytic team and subject matter experts. The workgroup conducts additional analysis to identify the drivers of the variance. Where appropriate, the analysis and findings are presented to the Provider Council for additional input and feedback.

The findings and recommendations are reviewed by the AmeriHealth Mercy management team and the Quality Assessment and Performance Improvement Committee (QAPIC). Part of our quality infrastructure, more information on QAPIC can be found in Section J. Monitoring and reporting activities continue to evaluate the impact of any changes on the identified area.

Our Indiana plan identified a significant variance in an elevated C-section rate of 29.9 percent in their population using data from the SHA report(described above). This result was higher than the Healthy People 2020 baseline of 26.5 percent. In conjunction with Healthy People 2020's target of a 10 percent reduction, the affiliate set a target of 25 percent for C-sections. The affiliate used the authorization reports to identify C-section rates for all physicians, groups and hospitals. Using a cross-functional team of medical management, provider network, quality, and informatics employees, the affiliate obtained input from participating obstetricians and developed a program to identify inappropriate C-sections, and then discuss the cases with physicians and hospitals. This program is ongoing and has led to a far better understanding of the dynamics that result in variations in C-section rates. We are addressing this both as a clinical and a quality issue. Outcome data for the first period of the initiative will be available later this year.

Individuals Making Medical Necessity Determinations

Requests for benefit coverage or Medical Necessity determinations are made through employees supervised by a Registered Nurse. Decisions to approve coverage for care may be made by Utilization Management employees when they fall within AmeriHealth Mercy's written guidelines.

Any request that is not addressed by, or does not meet, AmeriHealth Mercy's guidelines is referred to the Physician Reviewer for a decision. Medical Necessity decisions made by a Physician Reviewer or designated licensed clinical professional are based on DHH's definition of Medical Necessity, in conjunction with the member's benefits, medical expertise, applicable criteria, and/or published peer-review literature. At the discretion of the Physician Reviewer, input to the decision may be obtained from participating board-certified physicians from an appropriate specialty. The Physician Reviewer or designated licensed clinical professional makes the final decision.

Any decision to deny, limit coverage for an admission, service, procedure or extension of stay based on Medical Necessity, or authorize in an amount, duration or scope that is less than requested, is made by a Physician Reviewer or other appropriate designated licensed clinical professional under the clinical direction of the Physician Reviewer. The name and license indicator (MD, DO, PhD, etc) of the Physician Reviewer or licensed clinical professional making the adverse determination is included in the written determination letter (Notice of Action).

We will base all decisions solely on appropriateness of care and service, and the existence of coverage. The Utilization Management team will provide services consistent with written policies and procedures to ensure that criteria are applied appropriately and consistently. Our policies restrict adverse decision making regarding medical necessity to clinical professionals who possess an active, unrestricted license and have the appropriate education, training, or professional experience in medical or clinical practice. AmeriHealth Mercy Physician Reviewers and licensed clinical professionals making medical necessity determinations will attest that adverse determination will not be made for a medical procedure or service

outside of the scope of the individual's expertise, as required in Section 8.1.18 of the Louisiana CCN-P RFP.

AmeriHealth Mercy does not provide any financial incentives or rewards to encourage decisions that result in underutilization, denial, limits or discontinuation of medically necessary covered services. The medical necessity criteria utilized by AmeriHealth Mercy will be available upon request to all AmeriHealth Mercy participating practitioners, providers and members. We educate practitioners and providers on available review criteria and methods to obtain clinical criteria in our Provider Manual, information posted on the AmeriHealth Mercy provider website and included in the written determination letter (Notice of Action).

Section I – EPSDT

Good health starts as a newborn. Our Pediatric Preventive Health Care Program (PPHC) is designed to improve the health of members from birth to age 21 by increasing adherence to Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program guidelines through the identification of growth and development needs and the coordination of appropriate healthcare services. The PPHC program combines scheduled written and telephonic outreach with state-of-the art informatics that provide point-of-contact notification of EPSDT needs to providers and AmeriHealth Mercy employees. We partner with providers and community programs to ensure members have access to required services and use creative outreach strategies to assist members and their parents/guardians to use the services.

In order to ensure that children receive good care, providers must deliver and document all state-required EPSDT services. AmeriHealth Mercy works with providers through new provider orientation and ongoing education to ensure that they are kept up-to-date with requirements for the delivery and documentation of all EPSDT services.

AmeriHealth Mercy's proven PPHC program incorporates best practices from successful affiliate programs in other states. AmeriHealth Mercy's program will focus on:

- Identifying members who need EPSDT screening, immunization and other preventive services
- Outreach to parents/guardians about upcoming and missed preventive services
- Outreach to PCPs about members who have missed EPSDT services
- Providing electronic data and alerts allowing providers to identify members who have missed or will soon be due for EPSDT services
- Coordination of services for members identified as having a health care need through EPSDT screening
- Coordinating services between Louisiana's programs and LaCare's covered services

The PPHC program operates under the direction of the Medical Director and the Maternal Child Health/EPSDT Coordinator who will be a Louisiana-licensed registered nurse located in the Baton Rouge office.

I.1: EPSDT System

I.1 Describe your system for tracking each member's screening, diagnosis, and treatment including, at minimum, the components of the system, the key features of each component, the use of technology, and the data sources for populating the system.

AmeriHealth Mercy will use an integrated EPSDT tracking system that links individual member eligibility, provider-submitted encounter data and supplemental data sets to identify and record the immunization and screening status of EPSDT-eligible members. Data obtained through analysis of claims and supplemental file loads will run against algorithms that analyze the services due, missed and received based on the member's age. The results will be loaded monthly into the AmeriHealth Mercy data repository that feeds the Provider Portal, Member Portal and internal care management system.

Provider Portal: Providers performing an eligibility check on a member through the Provider Portal will receive an alert for any services – or "Care Gap" - that are missing or overdue. The provider can also access and print an EPSDT Clinical Summary that contains a log of all EPSDT screens and services performed by date. This allows the provider to adjust schedules for members who need care according to the catch-up schedule. The Member Clinical Summary can be printed or downloaded as a Continuity of Care Document (CCD) for electronic integration into an electronic medical record.

Providers can also pull reports on the EPSDT status of their entire panel – and print or download the information in a MS Excel or CSV file format. More information on our Provider Portal care management capabilities can be found in Section E.

Member Portal: Members can access this same information through the secure Member Portal. They can print the EPSDT Clinical Summary for their records or to take with them to the physician's office. (A sample EPSDT Clinical Summary is provided below.)

AmeriHealth MERCY
A Program of AmeriHealth First and Mercy Health Plan

EPSDT Clinical Summary
Date of Report: 06/11/2011

Member Information
Name: Marianne Jones
Address: 234 Main St
City/St/Zip: Easton, PA 18045
Phone: (610) 123-4567
DOB: 9/3/2005 Gender: Female
Member ID: 98765430

PCP Information
Provider Name: David Yucha
Address1:456 Steel Rd.
City/St/Zip: Easton, PA 18045
Phone: (610) 456-7890

Chronic Conditions

Asthma

Gaps in Care

Condition	Service	Status	Last Service	Next Service	Rule
Preventive Health Screens	Inactivated Poliovirus	Due Soon	10/07/2006		Four by age 7

EPSDT Screening Services (within past 24 months)

Date	Service
09/15/2010	99393 – Periodic comprehensive preventive medicine ages 5-11
09/22/2009	99383 – Periodic comprehensive preventive medicine ages 1-4
09/22/2009	99173 – Vision Screening

Hepatitis B (at birth plus 2 doses*)

Date	Immunization	Age (mos)
10/06/2005	90744 – Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule)	1
10/07/2006	90744 – Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule)	13

Rotavirus (2 doses*)

Date	Immunization	Age (mos)
11/05/2005	90680 – Rotavirus vaccine, pentavalent, 3 dose schedule, live for oral use	2
01/06/2006	90680 – Rotavirus vaccine, pentavalent, 3 dose schedule, live for oral use	4

Diptheria, Tetanus, Pertussis (4 doses*)

Date	Immunization	Age (mos)
11/05/2005	90700 – Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP),	2
01/06/2006	90700 – Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP),	4
03/08/2006	90700 – Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP),	6
10/07/2006	90700 – Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP),	13

***Haemophilus influenzae* type b (4 doses*)**

Date	Immunization	Age (mos)
11/05/2005	90645 – Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose	2
01/06/2006	90645 – Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose	4
03/08/2006	90645 – Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose	6
10/07/2006	90645 – Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose	13

* Please refer to the CDC/AAP/AAFP Recommended Immunization Schedule for specific timing and catch-up recommendations

Data Source: The data in this EPSDT 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 1: EPSDT Clinical Summary

AmeriHealth Mercy's Care Management System: AmeriHealth Mercy employees will receives alerts when accessing a member's information in the care management system and in the member service call screens notifying them of gaps in care for a particular member. This will allow AmeriHealth Mercy employees to address and assist with coordination of missing and overdue services for members who contact AmeriHealth Mercy for other reasons. For example, if a member calls the Member Service Contact Center to ask a question about a benefit, the Customer Service Representative will see on his/her computer screen that the member is missing a recommended EPSDT service. Before the end of the call, the Customer Service Representative will address the Care Gap using a pre-approved script and/or transfer the member to the Rapid Response Team for assistance.

In addition, AmeriHealth Mercy employees will have the ability to access a "family link" in the system, allowing them to view missing services on other family members under the Medicaid grant. This lets the employee remind and assist the member to coordinate care for other household members at the same time. Using this approach of "Making Every Member Contact Count" allows us to capitalize on each contact we have with our members. Care Management, Utilization Management and Rapid Response members will also have access to the EPSDT Clinical Summary for use in their interactions with the member/caregiver and treating providers.

Data Sources: AmeriHealth Mercy will utilize several data sources to populate its EPSDT tracking system. Eligibility, claims and encounter data from the Facets system will serve as the base for the data set, using date of birth to drive the algorithms on services due. Facets data will be supplemented by data obtained from participating providers and the Louisiana Immunization Network for Kids Statewide (LINKS). We have spoken with Quan Le, the LINKS Program Manager. Mr. Le has agreed to work with us on a data exchange agreement to allow us to include LINKS data in our EPSDT tracking system.

In addition, the Care Gap process used to alert providers to missing and overdue services includes a mechanism for the provider to update the Care Gap Worksheet and fax it back to AmeriHealth Mercy. Data collected in this mechanism is entered into an administrative database which is used to supplement the information in the main data repository.

I.2: Member Education and Outreach for EPSDT

I.2 Describe your approach to member education and outreach regarding EPSDT including the use of the tracking system described in I.1 above and any innovative/non-traditional mechanisms. Include:

- *How you will conduct member education and outreach regarding EPSDT including any innovative/non-traditional methods that go beyond the standard methods:*
- *How you will work with members to improve compliance with the periodicity schedule, including how you will motivate parents/members and what steps you will take to identify and reach out to members (or their parents) who have missed screening appointments (highlighting any innovative/non-traditional approached); and*
- *How you will design and monitor your education outreach program to ensure compliance with the RFP.*

Member Education and Outreach

AmeriHealth Mercy will implement a comprehensive program to educate members and caregivers on the screening and immunization recommendations outlined in the Louisiana periodicity charts and Department of Health and Hospitals' (DHH) KIDMED Manual. The program is designed using outreach strategies that have been successful in Medicaid programs served by our affiliates in other states. The goal of these activities is to educate, support and encourage members to become informed, responsible and active participants in their own health care and well-being. The core components of our outreach program are described below:

Reminder Calls – According to the Centers for Disease Control and Prevention (CDC) the timing and spacing of vaccine doses are two of the most important issues in the appropriate use of vaccines. To ensure optimal results from each immunization, AmeriHealth Mercy will proactively identify eligible members less than 24 months of age for priority outreach to coordinate the multiple immunizations and screenings needed for children in this age group. AmeriHealth Mercy's Care Connectors will make routine EPSDT phone calls to the parents/guardians of these children to remind them of EPSDT immunizations and screenings that are due in the next month and assist them to make an appointment with the child's PCP/Medical Home. During the phone call, the Care Connector will review the EPSDT information for other members of the household and provide reminders and facilitate services for those children as well.

Birthday Cards – Another educational tool that will be used is birthday cards. Birthday cards will be mailed on an annual basis to the parent/guardian of members age one and older to wish the child a "Happy Birthday" and educate the parent/guardian on EPSDT services that are needed in conjunction with the birthday. In addition, each birthday card will contain information on age-appropriate developmental milestones and safety tips, as well as important resource agencies and telephone numbers. An immunization card will be sent with each birthday card to assist the parent or guardian to keep track of all immunizations that have been given. The content of the birthday cards will be reviewed annually for accuracy.

Figure 2: EPSDT Birthday Card (front)
Sent to parents/guardians who have children ages three to four years old

Here are some tips from Keystone Mercy Health Plan to help you have a healthy year.

First Step – What you need to do...

Make sure you take your child to the doctor for all of his or her appointments.
This is an important step to keeping your child healthy.

Screenings – What the doctor will check for...

During this age, when you take your child to the doctor, the doctor will check:

- Height, weight and growth development
- Hearing and eye sight
- Lead levels in the blood
- Your child's teeth

Shots – To keep your child healthy...

Shots, or immunizations, are needed as your child grows to keep him or her healthy.
Be sure to talk to your doctor about which shots your child needs now.

What's Happening – A general idea of what your child should be doing...

Your child at age 3:

- Understands the idea of "mine" and "yours"
- Plays make-believe
- Walks up and down stairs, using one foot per step
- Turns pages in a book one at a time
- Holds a pencil in the writing position

Your child at age 4:

- Can dress and undress
- Is becoming more independent
- Understands the idea of counting
- Can tell a story
- Can hop and stand on one foot for up to 5 seconds

Be sure to talk to your doctor about how your child is growing and what he/she is doing at home.
Make sure you talk about any concerns you have.

Safety – Tips to keep your child safe...

- When your child is playing outside, make sure an adult is watching him or her.
- Make sure your child is wearing a helmet when riding a tricycle or bike. It is the law in Pennsylvania.
- Talk about safety around streets and traffic. Make sure your child knows not to run or ride a bike into the street.
- Do not smoke or let others smoke around your child. Children in a smoke-free home have fewer colds and infections.
- PA state law says to use a car seat at all times until your child is age 4. Children ages 4 up to age 8 must use a booster seat.
- Never leave your child alone in the car, not even for a moment.
- Keep medicines, cleaning products and other harmful products in childproof containers and out of reach.
- Check the temperature of your water. Keep water temperature in your sinks and bathtubs at or under 110 – 115 degrees.
- Do not leave your child alone in or around water.
- Ask your doctor about testing for lead poisoning. Lead can be found in paint, dirt, painted toys and toy jewelry.

What else can I do as a parent?

Make sure you take your child to the doctor every year for his or her well check-up and to the dentist every 6 months. This is an important step to keeping your child healthy.

Figure 3: EPSDT birthday card (inside)

Member Portal – AmeriHealth Mercy's Member Portal will allow parents/guardians to establish a user ID and password for secure access to completed and missing/overdue EPSDT services. The parent/guardian can print the summary as a reminder to bring to the PCP office at the next appointment. The portal will also provide members with an email alert one month before the next EPSDT service is due.

Provider Portal – AmeriHealth Mercy's Provider Portal will generate an alert for children missing EPSDT services at the time eligibility is checked. The alert will identify the missing/overdue service and can be printed for inclusion with the child's chart at the time of the PCP visit. The provider will also be able to access a complete record of EPSDT services by viewing, printing or downloading the EPSDT Clinical Summary through the portal. Panel reports are also available for PCPs, identifying assigned members who are missing, due, or up-to-date with EPSDT services.

Community Events – Like our affiliates in other states, LaCare will be a strong supporter of the community. LaCare will routinely include information and educational sessions on EPSDT services and immunizations at community events. LaCare is also working with the School Districts on a way to expand the ability of School-Based Health Centers to provide primary care services, such as EPSDT screening and immunizations.

Children in Foster Care – We are well versed with the challenges surrounding connecting children in foster care to receive timely well-child and EPSDT care. To assist the guardians of children in Foster Care, AmeriHealth Mercy will work with the Department of Children & Family Services to provide member-specific information on children in a foster care placement that the agency can provide to the foster parent. The EPSDT Clinical Summary will contain currently available information on EPSDT screenings and immunizations the member received and identify those that are due soon. AmeriHealth Mercy will also provide a brochure describing services available for children and the toll free number for the Rapid Response team. Foster parents will be encouraged to contact the Rapid Response team for assistance coordinating needed EPSDT or other care.

Publications and Messaging – In addition to the outreach described above, AmeriHealth Mercy will include information on the importance of EPSDT screening and immunizations and mechanisms to access care in new member materials, Member and provider handbooks, newsletters, website articles and on-hold messaging. We believe it is important to continually reinforce the critical nature of early preventive care, and understand the importance of repetition in the learning process.

School-Based Health Centers

We know from discussions with executive staff from several School-Based Health Centers (SBHCs) that the SBHCs recently lost funding from the Office of Public Health. Currently, the SBHCs are reimbursed for EPSDT (KIDMED) screenings and immunizations. However, the remaining services that they are required to provide are reimbursed at a lower rate than the physician fee schedule. In addition, many administrative burdens exist for the clinical staff. The funding loss, coupled with their current reimbursement rates, put many centers in danger of closing.

We are currently discussing with the SBHCs about having the centers participate as primary care providers. This will allow them to receive the current monthly management fee per recipient per month in addition to being eligible for any pay per performance related to quality measurements. It will also allow them to be reimbursed based on the physician fee schedule. We initially targeted SBHCs that are solely supported by their applicable School Board and not affiliated with a hospital or Rural Health Center/Federally Qualified Health Center (RHC/FQHC).

- Health Care Centers in Schools operates 11 SBHCs and manages the school nurse program for East Baton Rouge Parish and Recovery School District public schools. In the 2009-2010 school year they completed 106,464 encounters with children and their families and immunized 13,000 students. In addition, they provide mental health services, dental services and risk assessments; services currently not reimbursable to a SBHC in the current delivery system. Sue Catching, CFO and Julia Lively, CEO, of Health Care Center Schools, both expressed their desire to serve as primary care providers and already have the support of the parish school board. They indicated that the current delivery system did not allow for their "nontraditional" model to participate in that capacity. Their existing infrastructure will easily support their participation with AmeriHealth Mercy as a PCP/Medical Home.

- Family Service Center, the SBHC operated by West Feliciana Parish School Board has one site that serves all of the students of West Feliciana parish. Children are transported to and from the site, which serves children from six weeks to 21 years of age. Transportation in this rural parish can be difficult for its families. Bridget Plauche, Family Service Center Supervisor, at West Feliciana Parish, was hopeful that by participating in this capacity children who may otherwise go untreated would receive care.
- St. Martin Parish School Board, Lafayette Parish School Board and Vernon Parish School Board all expressed a desire to participate as primary care providers, and were looking forward to discussing this with their respective superintendents. Information on the fifty SBHCs who have signed a letter of intent with AmeriHealth Mercy can be found in Section G.

Innovation

AmeriHealth Mercy is committed to establishing relationships to give us access to non-traditional mechanisms for member education and outreach. We recognize that programs, like the school-based health center collaboration, discussed above, will enable us to effectively connect more members to services. In our other markets, AmeriHealth Mercy has developed several initiatives to enhance EPSDT performance. A few examples are outlined below:

Finger stick lead screening – We contract with Medtox, a laboratory that provides finger stick lead level screening kits to provider offices. The kits allow the PCP/Medical Home provider to collect the lead screen blood sample in the office, avoiding the need for the parent/guardian to make a separate laboratory appointment and sparing the child a venipuncture. Providers and Members are pleased with the convenience.

Zoomobility – Several of our affiliates host a "Zoo" day for children. Rapid Response care connectors work with the parents/guardians to arrange transportation and confirm attendance. Children attending are able to have various services, such as dental, vision and hearing screenings as well as finger stick lead level testing.

Figure 4: Zoo Day

Movie Tickets – Another affiliate provided movie tickets as an incentive for adolescents to get an annual well visit. The tickets were given to high-volume pediatric providers, who handed them out to the adolescent at the time of the well-care visit. Plan employees worked with the provider to notify assigned members in the target age range and their parents/guardians of the incentive plan.

Pharmaceutical Collaboration - Our Philadelphia affiliate is currently collaborating with Wyeth Pharmaceuticals to perform outreach through an automated reminder to parents/guardians of children 8- to 17-months old who have not received the pneumococcal vaccine series. Parents/guardians receive

reminders via postcards. The Rapid Response team works with the parent/guardian to coordinate the office visit and transportation, if needed.

In addition to working with AmeriHealth Mercy community representatives and providers to design similar programs for members, we will implement a member-incentive program designed to reward the member and parent/guardian for completing a well-child 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.

Comcast® Internet Essentials – AmeriHealth Mercy is a registered partner in the Comcast Internet Essentials program. Designed in conjunction with the Federal Communications Commission, Internet Essentials targets the three largest drivers of the digital divide, cost, digital literacy and relevance. Comcast's Internet Essentials program provides discounted broadband internet service and the option for a low-cost computer purchase to families with children receiving free school lunches through the National School Lunch Program (NSLP). As part of the package, enrollees receive access to online, print and classroom digital literacy training. In addition to reducing barriers to improved school performance and allowing parents to become more engaged with their children's education, Internet Essentials opens the household to more active participation in their healthcare through online education and access to self-management tools.

As a community partner, AmeriHealth Mercy will, with DHH's approval, include information on the services and application process for Internet Essentials in our member materials and community events. In addition, we are in discussions with Bret Perkins, Vice President of External and Government Affairs for Comcast, about partnering with Comcast on health literacy initiatives to complement their digital literacy curriculum.

The Comcast service area in Louisiana covers a large portion of GSA 3, including parishes with some of the highest participation in the National School Lunch program.

Table 1: Comcast Service Area

Comcast Service Location	Parish	Region	GAS/Phase	Percent of Parish Children Enrolled in Public Schools eligible for Free Lunch
Belcher Village	Caddo	7	3	57%
Caddo Parish	Caddo	7	3	57%
De Soto Parish	De Soto	7	3	57%
Gilliam Village	Caddo	7	3	57%
Greenwood Town	Caddo	7	3	57%
Hosston Village	Caddo	7	3	57%
Lafourche Parish	Lafourche	3	2	50%
Monroe City (LA)	Quachita	8	3	54%
Richwood Town	Quachita	8	3	54%
Shreveport City	Caddo	7	3	57%
St. John the Baptist Parish	St. John the Baptist	3	2	78%
Stonewall Town	De Soto	7	3	57%
Terrebonne Parish	Terrebonne	3	2	51%
West Monroe City	Quachita	8	3	54%

Improving Compliance and Motivation

Educational materials and reminders, alone, are often not enough to motivate members to take action. AmeriHealth Mercy's approach to EPSDT performance employs two key strategies, a "concierge touch" and convenience.

The "concierge touch" is provided through the Rapid Response team and will be a core focus of AmeriHealth Mercy services. Our Rapid Response team is the central point for all outreach campaigns. Rapid Response care connectors are trained to listen and address a wide variety of member concerns. This enables the care connector to veer from the purpose of an outreach contact – such as a call to a mother of an eleven year old boy about the need to schedule an appointment for Tetanus, Diphtheria, Pertussis, and Meningococcus vaccinations, along with a well-child check-up, vision and hearing screen – to instead assist the mother with obtaining utility payment assistance. We understand that the mother's focus is on finding a way to keep the electricity on to power fans in the July heat, making a physician appointment for a child who is not sick a lower priority. By dealing with the mother's immediate need, the care connector not only eliminates a distraction to making the physician appointment, but earns the mother's trust, making her more likely to follow through with the child's care.

AmeriHealth Mercy will work with providers, community partners and internal employees to make obtaining EPSDT care as easy and convenient as possible for members and providers. We are confident that our partnership with the SBHCs will provide a convenient avenue for parents/guardians to get EPSDT services for their school-age children. As PCPs/Medical Homes, the centers will also be able to provide care for other children in the household, to further increase the convenience for parents/guardians.

We will also include EPSDT screening services at community events, providing parents/guardians with a fun venue as motivation for bringing their children. Typically, arrangements can be made to hold hearing, vision and dental screenings, as well as BMI measurement at the event. AmeriHealth Mercy also contracts with agencies to provide finger stick lead screenings at community events. Information on screening results is forwarded to the PCP/Medical Home after the event, so that any needed follow-up care can be coordinated.

In addition, the Rapid Response team works with parents/guardians to identify barriers to well care appointments and devise solutions. Rapid Response care connectors assist with transportation needs; advocate with PCP offices for convenient appointment times; and provide reminders of upcoming appointments. During an appointment reminder call, the care connector will probe for any unidentified issues, such as needing child care for other siblings during the appointment. The care connector works with the parent/guardian to identify a responsible adult to watch the siblings or make arrangements with the office to permit the other children to attend the appointment.

Missed Service Strategy

For members identified as having missed recommended services, AmeriHealth Mercy will use a multi-layer approach.

"Make Every Member Contact Count" – As discussed above, information on missing EPSDT services will be displayed through AmeriHealth Mercy's Care Gap interfaces. Care Gaps are integrated with the Provider Portal and internal information systems. This integration provides an alert to a provider or AmeriHealth Mercy employee who enters the member's ID number in the system. These alerts enable providers and AmeriHealth Mercy staff to address gaps in services related to EPSDT during every member encounter. Our family link functionality provides a quick link to this same information for family members who are also members. This same information is also available to members through the secure Member Portal.

Outreach Calls – AmeriHealth Mercy will analyze claims and related EPSDT data to identify the following populations for outreach calls:

- Pediatric members with missed or overdue services
- Members between ages three months and one year with no claims for physician services

Outreach is coordinated through the Rapid Response team using a combination of in-person and automated calls to remind the parent/guardian about missed or overdue services. Calls occur at different times of the day and evening.

Rapid Response employees review the family link and identify several members in one household that may be "late" or have missed immunizations and/or screenings. The Rapid Response team coordinates an appointment and assists with coordinating transportation issues. Clinical issues are referred to the Rapid Response care manager for intervention.

Coordinating Missing Services

CD is a 26 year old pregnant woman with three children who was contacted by a Care Connector to address several EPSDT-related Care Gaps for the children. CD related to the Care Connector that she often had difficulty keeping track of appointments and what services were due. She sees a Rheumatologist every 2-3 weeks for arthritis, one child has Attention Deficit Hyperactivity Disorder and is partially blind in one eye, and two children have Asthma & Eczema. In addition to tending to these medical issues, CD is the sole parent for the children and has a demanding work schedule.

The Care Connector reinforced the importance of EPSDT services. Using our Family Link functionality, the Care Connector was able to see the Care Gaps for all of "CD's" children. This allowed the Care Connector to arrange services for all three children. The Care Connector assisted CD to make the appointments and coordinated transportation for her. The Care Connector created a reminder flag in the system so that she could call and remind CD of the upcoming appointment and verify that no additional barriers had arisen. Since the Care Connector's involvement, CD has not missed a primary care visit appointment for one of her children.

Contact Alternatives – Members who cannot be reached via phone are sought out by contacting area schools (for school-age children); reviewing unrelated claim activity for the child or family members and contacting those providers for contact information; and inquiries to parish health units. In high density areas, AmeriHealth Mercy will employ community outreach teams who will physically check the address of record and surrounding neighbors to see if the family can be located. These teams have been successful in our Philadelphia plan, working specifically in the West Philadelphia and Walnut Street neighborhoods.

Design and Monitoring

AmeriHealth Mercy will customize the established programs from its affiliates to ensure that education and outreach programs are compliant with the requirements stated in the Louisiana CCN-P RFP. Specifically, we will base our reporting and Care Gap algorithms on the current Louisiana periodicity charts (and Advisory committee on Immunization Practices [ACIP] guidelines) and DHH's KIDMED manual. We will incorporate information from these sources into our EPSDT educational material and post links to the source documents on the Provider Portal as a reference. Additionally, we will enforce the

use of the Vaccine for Children (VFC) Program by our providers to ensure that unnecessary costs are not incurred. We currently mandate VFC use in all of AmeriHealth Mercy's affiliates.

In addition, we have signed a Letter of Intent (LOI) with the Louisiana Office of Public Health (OPH) for the provision of personal health services such as immunizations within the parish health units. The Louisiana Office of Public Health plays a critical role in serving the rural and medically underserved areas of the state through its Bureau of Primary Care and Rural Health. We look forward to collaboratively working with the bureau in providing operational support to RHC/FQHC's and small rural hospitals.

Provider Profiling – As described more fully in Section G of this proposal, LaCare's PerformPlus program will produce PCP profiles, detailing PCP performance on select measures. AmeriHealth Mercy will include select EPSDT-related measures in the performance report, along with a risk-adjusted comparison to the PCP's peers. Finally, AmeriHealth Mercy will evaluate the inclusion of low-performing EPSDT measures in a provider incentive program. AmeriHealth Mercy's affiliates have been successful driving performance on adolescent well care visits using a combination of Care Gap reporting, provider incentives and member movie tickets. In the year incentives were in use, the affiliate's performance on the HEDIS Adolescent Well Care measure rose from the 50th to the 90th National Medicaid Percentile.

The table below is from AmeriHealth Mercy's plan, located in Philadelphia.

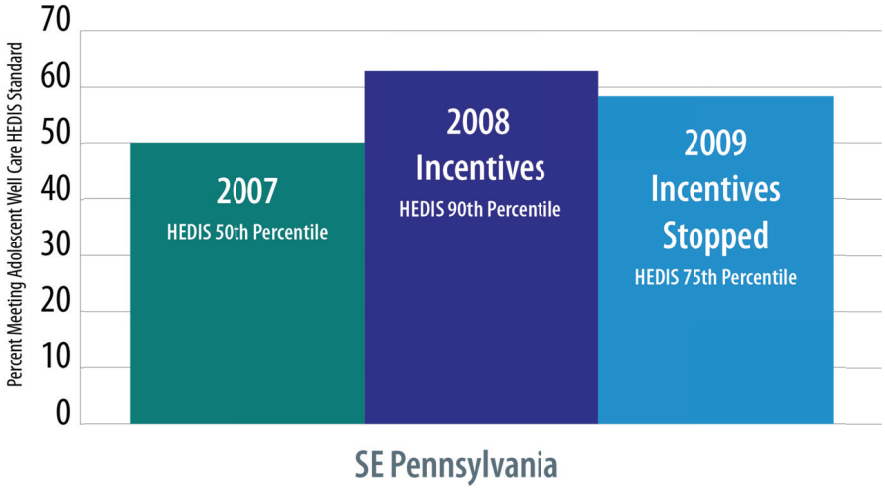

Figure 5: – Improved Adolescent Well Care (AWC) table

AmeriHealth Mercy is well versed with EPSDT reporting requirements including the requirements associated with the federally mandated CMS 416 report. We successfully submit the CMS 416 report in four other states. In addition, we are prepared to report the required EPSDT, well child, blood lead screening and preventive services outlined in Section 6.5.5 of the CCN-P Request for Proposals.

I.3: Ensuring Provider Compliance with EPSDT Requirements

I.3 Describe your approach to ensuring that providers deliver and document all required components of EPSDT screening.

AmeriHealth Mercy will use a combination of repetitive education, performance evaluation and coaching to ensure that providers deliver and document all of the components of EPSDT screening.

New Provider Orientation – Orientation sessions for new practitioners will include information regarding the provision of EPSDT screenings and vaccination, associated coding and billing processes and the use of the Vaccines For Children (VFC) program. Orientation information will reinforce the fact that EPSDT services do not require a referral or authorization. Additional emphasis will be placed on the

importance of providing and documenting the required components of a full and complete EPSDT screening. A KIDMED Periodicity schedule will be included as part of the orientation material for PCPs.

Ongoing Education - Provider Network Management Representatives routinely include educational material and emphasis on EPSDT compliance in their ongoing visits with provider offices. As part of these routine educational interactions, the representatives will re-educate providers and their staff on the components and documentation elements comprising EPSDT services for the different age levels. LaCare will maintain the current KIDMED Periodicity Schedule and the DHH Medicaid Dental Periodicity Schedule on its provider web site as a reference. Newsletter articles will highlight the importance of EPSDT completeness and documentation.

Medical Record Audits – As part of our Medical Record Review process, AmeriHealth Mercy will audit primary care medical records for documentation of EPSDT services. AmeriHealth Mercy will customize an EPSDT medical record audit form developed by our Indiana plan and seek input and feedback on the form through the Partnership Council. Audit results will be shared with the practitioners and office manager at the close of the audit and aggregated to identify trends and network educational opportunities. The Provider Network Management Department, in collaboration with the Quality area, will design network-level education an initiatives to improve documentation compliance.

Below, please find a sample EPSDT medical record audit form that has been used with AmeriHealth Mercy's plan located in Indiana. As noted above, a similar form will be developed for LaCare with input and feedback from the Partnership Council.

Physician(s): _____ **Record 1**

Reviewer: _____ **Patient Name:** _____ **DOB** _____

		Met	Not Met	N/A
1	**Office Notes**			
1a.	SOAP Notes			
1b.	EPSDT Age Specific Forms			
2	**HEDIS Well-Child Exam Criteria**			
2a.	Unclothed Physical Exam			
2b.	Health and Developmental History			
	Mental Development			
	Physical Development			
2c.	Health Education/Anticipatory Guidance			
3	**Appropriate Frequency of Well-Child Exams**			
3a.	Well Child 0-15 Months			
3b.	Number of W15 Visits Completed			
3c.	Well Child 3-6 Years			
3d.	Adolescent Well Child			
4	**Immunizations**			
4a.	CIS (2-year immunizations required met)			
4b.	All Immunizations Up-to-Date			
4c.	Adolescent Immunizations Completed			
5	**EPSDT Program Criteria** (The criteria listed below are additional to the HEDIS requirements)			
5a.	Nutritional Assessment			
5b.	Developmental Assessment			

5c.	Vision observation at each exam and referral to an optometrist or ophthalmologist when warranted			
5d.	Hearing observation at each exam, objective testing with audiometer at 4 yrs old, administered or referred			
5e.	Dental observation at each exam; direct referral to a dentist at 24 months old (dental referrals may be made as early as 12 months old when indicated)			
5f.	Laboratory tests, including lead level assessment appropriate for age and risk factors			
	Totals per medical record			

Figure 6: – Sample EPSDT Medical Record Audit Form

Care Gap Dissemination – Select EPSDT components, including lead screening and immunizations, appear as Care Gaps in the member's record. As discussed above, these Care Gaps are available to providers as alerts during an eligibility check, as part of the EPSDT Clinical Summary and on panel-level reports. Care Gaps alert providers to EPSDT components that are incomplete for a given member.

I.4: Ensuring Identified Needs Are Met

1.4 Describe how you will ensure that needs identified in a screening are met with timely and appropriate services.

Rapid Response – AmeriHealth Mercy's Rapid Response team is the cornerstone of its strategy to ensure that needs identified during an EPSDT screenings are addressed timely, with the appropriate services. During orientation and ongoing provider education, providers and their office staff will be instructed on the function of the Rapid Response team as a one-stop shop to assist them in coordinating needed care for members. Providers calling the toll-free number will speak directly with a Rapid Response care connector or care manager who will collect information on the screening result and facilitate needed care. The care connector can assist in identifying network providers or services; work with the parent/guardian to make the necessary appointments; and provide ongoing monitoring to ensure appointments are kept and any other identified care is arranged.

The care connector will also facilitate any utilization management processes that are needed for the requested care, including medical necessity review of covered services or requests to have services from a non-participating provider. Most important, the care connector will transition the child's case to a Pediatric care manager for ongoing interventions, monitoring and follow-up. Rapid Response services allow providers to facilitate timely follow-up care to address needs identified during EPSDT screenings.

Proactive Outreach - AmeriHealth Mercy will proactively act on information that states follow-up care is needed. As an example, our Pennsylvania plan partners with the city and county Departments of Health to do follow-up, education and service coordination for children with elevated lead levels. The Department of Health forwards the results to the plan. Care connectors contact the parent/guardian, review lead education materials and assist the parent/guardian with connections to local resources to remediate any environmental issues, such as lead plumbing or wall paint.

AmeriHealth Mercy also seeks out children who were seen in the emergency room for a dental issue. The care connector assists the parent/guardian with locating a dentist and making an appointment for follow-up dental care. Similar programs will be designed and implemented for the Louisiana population.

Case Study

TW is a 4-year old boy with a history of slow weight gain who was diagnosed with lead toxicity. The Care Manager contacted TW's mother in response to a lab result showing a blood lead level (BLL) greater than 10 mcg/dl. TW's

mother reported that his highest BLL (prior to becoming our member) was 51 mcg/dl. The family had recently moved from the lead-contaminated home and TW had completed his oral chelation therapy. One month later his BLL had decreased to 15 mcg/dl, but the next month it increased to 25 mcg/dl. The 7 year old sibling was tested and had a level of 0 mcg/dl.

The Care Manager worked with the TW's mother weekly, then monthly, and finally every other month to address the TW's needs. She collaborated with the county and state health departments to obtain a home environmental assessment of the family's new apartment. The Care Manager educated TW's mother on dietary guidelines, resources for transportation, and the importance of adhering to TW's treatment plan and follow up appointments. The Care Manager worked with TW's mother to identify possible sources of continued lead exposure - at friends' homes from the old neighborhood, or possibly a grandparent's home. Months later, they learned that the home environment assessment results were negative for lead sources. Eventually, working with the Primary Care Physician, the high protein level of the dietary supplement TW was taking was identified as possibly slowing his excretion of the lead in his system. The Care Manager researched diet changes to maximize dairy products and green vegetables. She worked with TW's mother to implement the new diet, despite TW's dislike of milk.

The Care Manager used many vehicles to stay in touch with TW's mother despite the phone being disconnected several times. She worked through the TW's PCP office to leave messages and monitored appointment adherence and lab results through the care management information system. With each contact, the Care Manager provided reinforcement and encouragement to TW's mother for her diligence in keeping TW's appointments and meeting his dietary needs. After two years, TW's lead level decreased to 9 mcg/dl and he was changed to an every 6-month blood draw schedule.