

1. RFP Purpose and Background

Please explain how you propose to execute Section 1 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience. To the extent that a more detailed description of your qualifications and relevant experience for this section is described in more detail later in your proposal, a brief summary will suffice.

Overview

AmeriHealth Caritas Iowa is committed to delivering high quality healthcare services for the members of Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (hawk-i) programs. By providing unparalleled access, focusing on seamless care coordination, and leveraging the strength and success of current Iowa Department of Human Services (DHS) initiatives, we will drive quality outcomes for the Medicaid and CHIP populations.

As discussed in our Executive Summary and Bidder's Background response, AmeriHealth Caritas Family of Companies (AmeriHealth Caritas) has 30 years of experience across 16 states and the District of Columbia in serving Medicaid populations and has the expertise and infrastructure in place to address Iowa's needs. Our market-leading capabilities in coordinating care and providing quality outcomes across populations (e.g., TANF, CHIP, ID/DD) and services (e.g., physical health, behavioral health, pharmacy, social supports) can address Iowa's goals: improving quality and access, achieving greater accountability for outcomes and creating a more predictable and sustainable Medicaid budget.

AmeriHealth Caritas Iowa fully understands the terms outlined in the Scope of Work (SOW) and will meet or exceed all requirements outlined. Furthermore, we share the goals outlined in the SOW, and our commitment to Iowa and its members will always be our top priority. We are committed to working with the State of Iowa to transform care delivery as the State transitions to managed care while emphasizing member choice, access, safety, independence and responsibility.

AmeriHealth Caritas Iowa will comply with all needs stated within this section, including areas not specifically addressed in the questions below.

- AmeriHealth Caritas, with 30 years of experience, is highly qualified to meet or exceed the needs of Iowa's Medicaid managed care program.
- AmeriHealth Caritas Iowa will be a partner with the DHS in implementing a program that meets the State's and Members' needs.

1.4 General Contractor Responsibilities

1. Indicate your ability to comply with all Federal and State Laws and Regulations that may affect this Contract.

AmeriHealth Caritas Iowa is dedicated to the highest standards of integrity and conducting business in an ethical and legal manner. Our Compliance Plan (the Program) will be implemented to assure we meet our legal and contractual requirements in Iowa. The Program promotes compliance with federal and state laws

and regulations, fosters ethical conduct within the Company, and provides guidance to our employees, managers, senior executives, directors and contractors.

As part of the Program, AmeriHealth Caritas Family of Companies has adopted the Code of Ethics and Conduct (the “Code”), which will be adopted by AmeriHealth Caritas Iowa. The Code is a guide to acceptable and appropriate business conduct by the Company’s associates and contractors. All associates and contractors are expected to comply with the Code by respecting the principles and observing the rules of conduct described within the Code.

In addition, the Program describes our comprehensive plan for the prevention, detection and reporting of FWA. This includes the activities performed and procedures implemented by key departments throughout the organization. If violations of the Program or the Code occur, the plan will investigate the matter, take disciplinary action, if necessary, and implement corrective measures to prevent future violations.

We have established a clear expectation of compliance with the Code, policies, DHS requirements and applicable laws, to reinforce the role of individual associates, suppliers, subcontractors, vendors, contracts and agents in maintaining an ethical and compliant workplace.

Scope

The Program and Code applies to all officers, directors, managers and associates, as well as suppliers, vendors, contractors, and agents who support the Medicaid business unit. The AmeriHealth Caritas Iowa Program is developed in accordance with 42 CFR 438.608, 42 CFR 455, Section 12 of the SOW and all relevant state and federal laws, regulations, policies, procedures and guidance, including CMS Guidelines for Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit. AmeriHealth Caritas Iowa coordinates any and all program integrity efforts with IME personnel, DHS personnel and Iowa’s Medicaid Fraud Control Unit (MFCU), located within the Iowa Department of Inspections and Appeals.

Purpose

The purpose of The Program is to ensure accountability and provide policies, procedures and standards to maintain compliance with federal and state requirements. The Program and Code activities support the following seven (7) key elements that facilitate the prevention, detection, reporting and corrective action for suspected cases of FWA in the administration and delivery of services under the state Medicaid Contract, as outlined in the following sections:

- Written standards, policies and procedures.
- Medicaid compliance officer and Compliance Committee.
- Effective training and education.
- Effective lines of communication/reporting mechanisms.
- Enforcement and disciplinary guidelines.
- Auditing and monitoring.
- Response to identified issues.

Components of the Compliance Plan

1. Written standards of conduct, policies and procedures

Policies and procedures

AmeriHealth Caritas Iowa maintains policies and procedures for the Compliance, Privacy and Program Integrity Programs. These policies and procedures ensure that all officers, directors, managers and associates know and understand what is required to ensure that AmeriHealth Caritas Iowa observes and maintains high standards of ethical conduct in its business and operational practices. Such policies and procedures include, but are not limited to:

- The Code of Ethics and Conduct.
- Implementation, operation, and communication of the Compliance Program.
- Procedures for detecting and preventing FWA.
- The AmeriHealth Caritas Iowa Employee Handbook, which contains specific discussions of the federal and state false claims, right of associates to be protected as whistleblowers and guidelines regarding HIPAA compliance.

As needed, AmeriHealth Caritas Iowa will develop new or revise policies in response to audit findings or new or revised regulations.

The AmeriHealth Caritas Iowa compliance officer, along with the Program Integrity department, will assist in the review and/or development of departmental policies and procedures, as needed.

2. Compliance Oversight

Governing authority: compliance officer

AmeriHealth Caritas Iowa will designate a Medicaid compliance officer to serve as the coordinator of all compliance activities and who will be accountable to the AmeriHealth Caritas Iowa market president and may report any findings to the Board of AmeriHealth Caritas Iowa. The AmeriHealth Caritas Iowa compliance officer's responsibilities will include, but are not be limited to, the following:

- Development, implementation, operation and monitoring of the Program.
- Develop and obtain approval of an Annual Iowa Compliance & Privacy Work Plan.
- Ensuring that reports of noncompliance and suspected FWA are promptly and thoroughly investigated.
- Reporting quarterly, or more frequently as necessary, to the Compliance Committee on the effectiveness of the Program. Reports shall include payment integrity (cost avoidance and recoveries); SIU provider case identification, planning, action plans, and investigation summaries; compliance/privacy intakes; and other reports, as necessary to support the Program.
- Ensuring quarterly reporting to the Board of Directors of AmeriHealth Caritas Iowa. .
- Participate in Corporate Compliance Committees.
- Reporting to the Compliance Committee and governing body on the status of compliance training.
- Implementation, distribution and compliance with policies and procedures as outlined in the Compliance Program.

- Development and implementation of training programs to ensure that AmeriHealth Caritas Iowa's officers, directors, managers, associates and other individuals are knowledgeable of the Compliance Program; its written Code of Conduct, related policies, and procedures; and the applicable statutory, regulatory and other requirements.
- Development and implementation of methods and programs that encourage managers and associates to report suspected fraud and other misconduct without fear of retaliation.
- Maintaining the compliance reporting mechanism and closely coordinating with the SIU, Internal Audit Department and other departments responsible for monitoring and auditing, where applicable.
- Responding to reports of potential instances of noncompliance and FWA, including the coordination of internal and external investigations and the development of appropriate corrective or disciplinary actions, if necessary. Participate as appropriate in the design and coordination of internal investigations (e.g., responding to reports of problems or suspected violations) and execute any resulting corrective action (e.g., making necessary improvements to policies and practices and taking appropriate disciplinary action).
- Ensuring that the Department of Health and Human Services Office of Inspector General (DHHS OIG), General Services Administration (GSA), and any state exclusion lists as required by DHS have been checked with respect to all associates, officers, directors and managers, as well as first-tier, downstream and related entities.
- Coordinating with the Human Resources department and/or appropriate operational areas to ensure that appropriate action is taken when excluded individuals or entities are identified.
- Identification and prevention of payment of claims submitted by providers who have been excluded.
- Maintaining documentation for each report of noncompliance, potential FWA received through any of the reporting methods (i.e., hotline, mail, in-person) which describe the initial report of noncompliance, the investigation, the results of the investigation and all corrective and/or disciplinary action(s) taken as a result of the investigation, as well as the respective dates when each of these events and/or actions occurred and the names and contact information for the person(s) who took and documented these actions.
- The development and implementation of corrective action plans.
- Coordination of potential fraud investigations/referrals with DHS Office of the Inspector General (or equivalent), the state Medicaid Program Integrity Unit and the Medicaid Fraud Control Unit.

Compliance Committee

To assist the AmeriHealth Caritas Iowa compliance officer with his or her duties, AmeriHealth Caritas Iowa will establish a Compliance Committee that reviews compliance, privacy and FWA issues. The Committee will be comprised of senior management and has a primary objective to oversee the development and implementation of an effective and efficient compliance program that meets and exceeds our regulatory and contractual obligations. The duties and responsibilities of the Compliance Committee include, but are not limited to, the following:

- Meet at least quarterly with representatives from necessary operational and other departments
- Review reports and recommendations of the compliance officer regarding compliance activities and makes recommendations regarding future compliance priorities and resources.

- In conjunction with the AmeriHealth Caritas Iowa compliance officer, provide input into the Annual Compliance & Privacy Work Plan.
- Set goals, monitor the progress of compliance and review major compliance issues identified by committee members.
- Engage in oversight activities related to correction of compliance risks and identification of areas for associate training and education.

3. Education and training

AmeriHealth Caritas Iowa's training systems will include education and guidance on our ethics and legal compliance policies, the Code of Conduct, FWA issues and procedures, and the reporting and investigation of compliance issues. This includes the use of a confidential toll-free telephone line for all associates, contractors and consultants. AmeriHealth Caritas Iowa has a policy concerning disciplinary action for noncompliance with the Code of Conduct.

AmeriHealth Caritas Iowa associates, including managers, directors and the Board of Directors who are involved with the administration or delivery of the Medicaid program, complete new hire training within 30 days of beginning date of employment in the following areas:

- Code of Ethics and Conduct.
- Privacy and Security, Health Insurance Portability and Accountability Act.
- FWA.
- Procedures for timely consistent exchange of information and collaboration with DHS.
- State-specific training on FWA and Whistleblower Protection.

As a condition of continued employment, every associate undergoes annual training on the Code of Ethics and Conduct. All associates are required upon hire, and annually thereafter, to complete False Claims Act (FCA) training, which highlights state and federal FCA requirements; the Deficit Reduction Act (DRA), the Fraud Enforcement and Recovery Act (FERA), the Affordable Care Act (ACA) and the Dodd-Frank Act. Through this course, associates are educated on the FCA and its pertinence to fraud and abuse in Medicaid programs. They are alerted to specific provisions for whistleblower protections and are provided with resources to help them remain compliant with federal and state FCA laws.

As with other AmeriHealth Caritas plans, AmeriHealth Caritas Iowa will provide additional training to its employees via quarterly associate education sessions and quarterly compliance newsletters. Topics vary from compliance and ethics to FWA reporting to DHS contract requirements.

4. Communication and systems

AmeriHealth Caritas Iowa is committed to encouraging open lines of communication for asking compliance questions and raising compliance concerns between the AmeriHealth Caritas Iowa Compliance Officer, associates, senior managers, Board of Directors and contractors, including all subcontracted entities.

Internal reporting mechanisms

Any associate or contractor may make an inquiry or report of unethical activity, activity inconsistent with the Code, corporate policies or law or noncompliance with other program requirements. The Program supports effective lines of communication by reporting through available resources, including managers, senior management, AmeriHealth Caritas Iowa compliance officer and the organization's toll-free hotline.

The hotline is available to associates, contractors and members to report a suspected violation of the Program, the Code, a law or regulation or any AmeriHealth policy. The Compliance Hotline (1-800-575-0417) is available 24 hours a day, seven (7) days a week. We also have established a FWA hotline (1-866-833-9718) that is available to associates and contractors 24 hours a day, seven (7) days a week. Potential compliance issues may be used for anonymous and confidential reporting.

All associates and contractors are required to report known or suspected noncompliance and, as necessary, assist in the resolution of identified issues. Failure to report suspected violations, misconduct or noncompliance violates the Code and the expectations of all associates. Failure to report is grounds for associate and contractor disciplinary action, including termination. AmeriHealth Caritas Iowa expressly prohibits retaliation for good faith reports as part of its non-retaliation policy. Reports of noncompliance can be made anonymously. To the extent possible, AmeriHealth Caritas Iowa will take reasonable precautions to maintain the confidentiality of those who report compliance concerns. We also encourage reporting of potential FWA through the Provider and Member Handbooks.

5. Auditing and Monitoring

The AmeriHealth Caritas Iowa Compliance Department, in conjunction with Internal Audit Department supports the organization by engaging in compliance audits pursuant to an approved auditing and monitoring plan. The purpose of the auditing and monitoring activities is to ensure the business and associated contracted entities are meeting expectations and the requirements of state and federal regulations.

Contract compliance

AmeriHealth Caritas Iowa will conduct contract compliance monitoring reviews and document results of compliance with all DHS Contract requirements. We will complete assessments and implement any necessary remedies to meet contractual requirements. The AmeriHealth Caritas Iowa compliance officer will ensure the creation of an accurate and up-to-date contract monitoring tool. This tool will be updated with new or changed contract requirements resulting from the annual contract language negotiation process, or as needed.

Monitoring of Iowa regulations

The AmeriHealth Caritas Iowa compliance officer will oversee monitoring of regulatory notices and changes in federal regulations and ensure compliance with new regulations/requirements. The contract monitoring tool will be updated accordingly to ensure adherence to state and federal regulations.

Privacy inspections

The AmeriHealth Caritas Iowa compliance officer will perform quarterly HIPAA inspections of associates' work areas and public spaces. Reports will be submitted in a timely fashion to outline the results of all completed inspections. The HIPAA inspection process will also be completed for the AmeriHealth Caritas Family of Companies' Philadelphia campus, as well as the AmeriHealth Caritas Iowa local office.

6. Enforcement

Disciplinary policies and procedures

AmeriHealth Caritas Iowa establishes clear expectations of compliance with the Code of Ethics and Conduct. The Code of Ethics and Conduct, employee handbook and various other documents require associates, supplier, vendors and contractors to identify non-compliance and unethical behavior.

Disciplinary guidelines are provided to associates in the Code of Ethics and Conduct and other guidelines, including but not limited to the Disciplinary Action for Noncompliance with the Company's Standards of Conduct, Progressive Disciplinary and the Sanctions for Violating HIPAA Privacy and Security policies. This information is also available to all associates on the AmeriHealth intranet site.

Violations may be grounds for termination or other disciplinary action, depending on the circumstances of each violation as determined by the Human Resources Department in consultation with the AmeriHealth Caritas Iowa Compliance Officer or designee.

7. Response and Prevention

Investigations

Investigations of any compliance related matter include interviews, review of source documents, review of regulatory requirements, the Code and policies and procedures, and responses to requests for information from individuals or organizations who may possess relevant information. Our investigators document investigations with various information, including but not limited to:

- The source of the investigation.
- The investigation results and findings.
- Recommendations for remedial action where appropriate.
- Communications to affected parties.
- Final resolution of the matter.

The AmeriHealth Caritas Iowa compliance officer and Program Integrity departments document issues and results of investigation and report to Management and Committee, as needed.

Response to investigations

In the event that an investigation identifies FWA, misconduct, violation of applicable laws or regulations, or noncompliance with Medicaid program requirements, AmeriHealth Caritas Iowa will take prompt appropriate action, including but not limited to, the following:

- For associates, when warranting an investigation, the Compliance Officer consults with the Human Resources department to determine appropriate action in accordance with the Code and other applicable policies and procedures.
- For contractors, when warranting an investigation, AmeriHealth Caritas Iowa management will identify appropriate disciplinary or corrective action in accordance with the contractor's contract, up to and including termination of the contract.
- Corrective action plans (CAPs) are developed based on investigative findings and are designed to correct underlying problems that resulted in program violations and prevent future program violations or misconduct. Depending on the circumstances, CAPs may involve repayment of overpayments, disciplinary action or other remediation in response to the violation. Each CAP is tailored to address issues identified in the investigation, provide structure and timeframes for completion, and is monitored and tracked to ensure that the corrective action is fully implemented in a timely manner.
- Training and education to prevent recurrence of program violations or misconduct may include training and education of associates and contractors. Such training and education may be provided as needed to individuals, groups, business areas or contractors.

- The Compliance Department and affected business areas will conduct monitoring and auditing activities to ensure effective resolution of issues identified during an investigation. The annual audit plan may be revised to incorporate additional audit activities determined to be necessary as a result of the investigations.
- Voluntary self-reporting and referrals to law enforcement, governmental authorities and/or DHS will be enforced, as appropriate. AmeriHealth Caritas Iowa will report instances of potential FWA, misconduct and/or noncompliance related to the Medicaid program. As investigations warrant, AmeriHealth Caritas Iowa will partner with state and federal law enforcement, regulatory agencies and other insurance companies, as appropriate. In addition, at the conclusion of an investigation related to the Medicaid program, if AmeriHealth Caritas Iowa determines that potential fraud or misconduct by entities not affiliated with the company has occurred, the matter will be promptly referred to the DHS or the appropriate government agency.

8. Summarize how you are qualified to provide the services listed in Section 1.4.2.

AmeriHealth Caritas Iowa is highly qualified to provide the services listed throughout the RFP. For additional information on our history and qualifications, please see our Transmittal Letter / Executive Summary and elements of Tab 4, Bidder's Background.

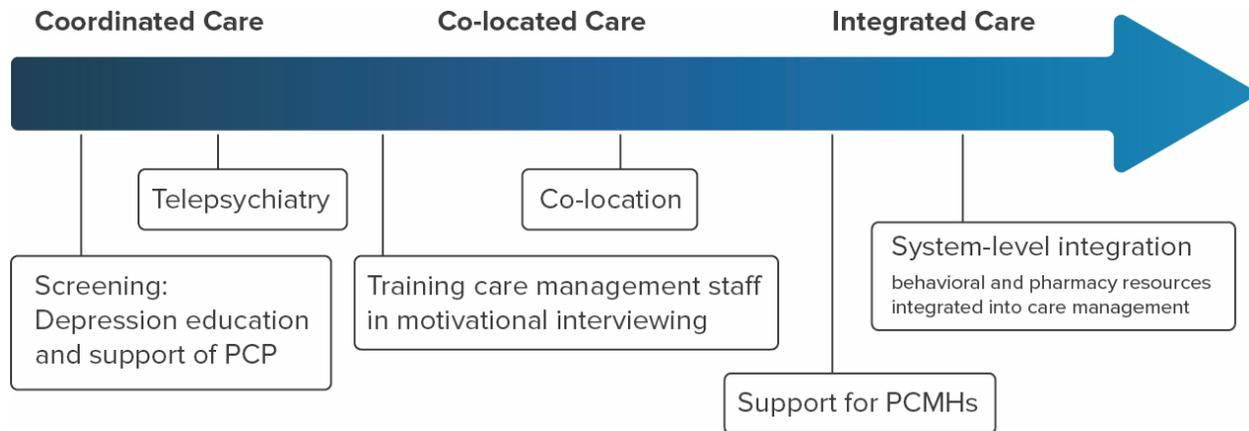
To address the specific elements listed in Section 1.4.2, we believe we have the qualifications in place to meet and exceed the State's needs:

1.4.2.1 Work with existing and additional provider networks and stakeholders to successfully meet the needs of members with a wide range of physical, social, functional, behavioral and LTSS needs.

AmeriHealth Caritas Iowa will partner with all of Iowa's stakeholders, healthcare providers, advocacy groups and other community partners in the State to ensure our members receive high quality, efficient physical, social, functional, behavioral and LTSS services and care. We have developed collaborative relationships with providers in all of the other markets we operate and we actively recruit providers and community stakeholders to participate in our plan quality committees, advisory groups, and other plan activities. We are taking the same inclusive approach in Iowa, where we will offer a full array of programs designed to complement and enhance services delivered by Iowa providers and community organizations. We are also recruiting a broad and inclusive network in Iowa.

AmeriHealth Caritas' Integrated Healthcare Management (IHM) solution is specifically designed to enable a system of care approach to care coordination. It uses a population-based health management approach that blends traditional case management and disease management with a holistic solution that fully integrates physical health, behavioral health and social/environmental aspects of the member's care into one individualized care plan with a 360° view of the member. As part of the IHM solution, AmeriHealth Caritas has embraced the collaborative care approach.

AmeriHealth Caritas is leading the way in developing innovative solutions in coordinated and integrated care delivery. We apply our strategy across a variety of healthcare settings, supporting care delivery with initiatives that span the continuum from coordinated care services and co-location of Behavioral Health providers in primary care settings to full system-level integration of Physical Health, Behavioral Health, pharmacy, and community outreach services.



We understand that the most effective delivery of care occurs when Members can receive the care they need in the most appropriate and comfortable setting available. For that reason, we promote the delivery of Behavioral Healthcare at Physical Health locations and delivery of Physical Healthcare in Behavioral Health settings. Our initiatives include:

- Providing education and support to empower primary care Providers (PCPs) in identifying and treating low-level Behavioral Health conditions;
- Providing tele-psychiatry services at participating PCP offices;
- Supporting co-location of Behavioral Health Providers in primary care settings by contracting with federally qualified health centers (FQHCs) offering this service and, where possible, providing support to change regulations prohibiting payment for Behavioral Health and Physical Health services on the same day;
- Implementing principles from the collaborative care model, in which PCPs, care managers, and Behavioral Health Providers work together to provide patient care and follow up; and
- Sharing Information to support collaborative care, so that a PCP is alerted to behavioral medications prescribed for Members to facilitate appropriate monitoring.

AmeriHealth Caritas also has more than 30 years of experience working in the community and partnering with community organizations to engage our members where they are. We partner with community agencies and advocacy organizations to organize events and programs in each of the states where we operate. We routinely organize health fairs, health screenings and other member engagement events at local community sites like the YMCA, where it is common to have between 100 and 200 members in attendance. At these events, our members receive health screenings, diabetic eye screenings, mammograms, nutrition counseling and fitness information. We also engage our members through church-sponsored activities and at local stores where they shop. In Philadelphia, we have a long-standing relationship with ShopRite grocery stores where members can receive gift cards if they undergo health screenings.

“Tammy” is a 38-year old woman with heart failure, coronary artery disease, high blood pressure, hyperlipidemia, 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. Tammy 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. Tammy is easily overwhelmed. She recently stopped smoking. Tammy 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 Tammy, slowly helping her through her fears. On several occasions, Tammy 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 Tammy’s warfarin (anticoagulant) medication.

The next goal the Care Manager worked on with Tammy was going to the primary physician’s office. The Care Manager contacted the office and explained Tammy’s fears and potential for anxiety attacks along with ways the office employees could assist to make the visit less threatening for Tammy. The Care Manager asked the office to keep Tammy in less populated areas of the office, having her wait in an examination room, instead of the waiting room. Arrangements were made for Tammy to have the first appointment of the day, to minimize the number of other patients who would be in the office.

Tammy successfully completed the visit, her first in years. Next, Tammy and the Care Manager are working on a visit to the specialist.

“Samantha” 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. Her mother has a history of substance abuse and was not very supportive in previous plans of care.

Samantha was hospitalized three times in the previous year for sleep apnea complicated by her obesity. During her multiple hospitalizations, Samantha increasingly demonstrated signs of depression and suicidal thoughts. Identified for Care Management, a Care Manager at our affiliated Pennsylvania plan began working with Samantha’s mother, PCP and behavioral health provider.

Interdisciplinary meetings with the behavioral health provider revealed that Samantha 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 Samantha 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.

Samantha 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. Samantha returned to school in a traditional setting and has not had any further hospitalizations for sleep apnea or depression.

1.4.2.2 Manage all statewide physical, LTSS and behavioral health services for Iowa residents who meet the eligibility requirements defined in this RFP.

AmeriHealth Caritas Iowa is committed to managing all statewide physical, LTSS and behavioral health services for Iowa residents who meet the eligibility requirements defined in this RFP via our experienced medical management team. Our Integrated Healthcare Model is designed to provide person-centered care, with a focus on ensuring care and services are delivered in the least-restrictive setting, at a level that meets the member's needs. We will bring our considerable experience managing behavioral health services and in-home care for the most at-risk members to Iowa.

Through Keystone First, AmeriHealth Caritas Iowa's affiliate in Pennsylvania, AmeriHealth Caritas also has extensive experience coordinating long term services and supports. At Keystone First, the Pediatric Shift Care Unit provides support and assistance to medically fragile members less than 21 years of age with complicated healthcare needs, including ventilator dependence. Many of these members would otherwise be institutionalized and all these members receive extensive skilled nursing and other in-home support services.

Keystone First coordinates services for significantly more of these members than any of our competitors in Pennsylvania, because of our extensive, inclusive relationships with specialty care providers, including Children's Hospital of Philadelphia. AmeriHealth Caritas has over 1,500 pediatric members for whom we have successfully coordinated in-home support services. Our 30 years of experience providing this level of in-home care allows these high-complexity members to remain at home with their families.

"Mark" is 20 years old, having been diagnosed with Spinal Muscular Atrophy at 6 months of age. His parents were told that he would not live past the age of two. He became a member of AmeriHealth Caritas Iowa's Pennsylvania affiliate, Keystone First, at age 3 and has received in-home skilled nursing and support services for over 17 years. Mark is not able to walk. He is fed through a gastrostomy tube, incontinent of bowel and bladder, and only able to move his head slightly from side to side and the tips of his fingers. He can see, hear and speak. He relies on others for all of his care. Mark requires Bi-Pap assistance for breathing at night and frequent oral suctioning. His respiratory status has declined over the years. Mark attends school accompanied by a nurse.

Through the comprehensive in-home service plan coordinated by the Keystone First care manager, Mark's parents are able to work, get adequate sleep, care for Mark's younger sister, and keep their son at home with his family.

"Ruby" is 12 years old, and dependent on a ventilator to breathe due to her restrictive lung disease. She also has complex partial epilepsy, encephalopathy, chronic respiratory failure, Freeman Sheldon Syndrome, hypotonia, arthrogyrosis, dysphasia, gastro-esophageal reflux disease, chronic urinary tract infections, and a neurogenic bladder. She has been a member of AmeriHealth Caritas Iowa's Pennsylvania affiliate, Keystone First, since she was a 4 months old. Ruby has a tracheostomy and is fed through a gastrostomy tube. She is not able to walk or speak and is incontinent of bowel and bladder.

Through the comprehensive in-home service plan coordinated by the Keystone First care manager, Ruby's is able to remain in her home with her parents and two brothers. Ruby's dad works full time and her mother works part time. Ruby attends school accompanied by a nurse.

1.4.2.3 Operate in a manner that results in eligible individuals receiving services that are timely and effective in reducing problems and symptoms and how proposed operations will maximize member functioning and quality of life.

The Care Management team is available to assist members to obtain the right preventive/routine care needed to maximize function and quality of life. This includes both routine care and broader services. Preventive needs of the member are identified through our health risk assessment as well as multiple sources of ongoing data analysis and contact points. Identified members are contacted via outreach for coordination of care. The following represents several of our many programs to maximize member functioning and quality of life.

Aided by cutting-edge Theranos technology, we are taking an historic step in transforming how Medicaid members are able to engage in timely, meaningful discussions with their healthcare provider about their overall health and wellness and comprehensive care plans. Theranos is a CLIA-certified laboratory that offers services for a complete range of tests from common blood screening panels to specialized testing across all specimen types. They are working to shape the future of laboratory testing and the way health information is collected, analyzed and communicated in a way that is affordable and available to every person. Our partnership with Theranos is aligned with our mission and deep roots of helping people access the care and services they need to live healthier lives. It is consistent with our commitment to offer solutions to assist our clinical partners and advocates in caring for our members. It supports our forward-thinking approaches to developing innovative, evidence-based and customizable solutions for our members and communities, and empowering our members to fully engage in their healthcare.

The innovative B.E.S.T. (Breathe Easy Start Today) program focuses on increasing medication adherence for our asthmatic members. It focuses on getting asthmatic members timely services – at the time of a routine appointment- that are effective in preventing acute exacerbations, resulting in an improved functional status and quality of life. Asthmatic members don't always fill their control and rescue inhalers when they feel well. This program makes sure they have those medicines on hand, when needed. Participating physicians dispense asthma medications and products (inhalers, spacers, masks and medications) directly from their offices. This service is billable through a contracted pharmacy vendor who provides the medications. This alliance eliminates the risk of our members not filling their prescription at a retail pharmacy. Moreover, the physician's office staff is trained to teach children and parents how to use the inhaler, spacer and mask. The patients then demonstrate to the nurse or technician that they understand what's required of them before leaving the doctor's office.

Another example of how we ensure that eligible individuals receive services in a timely and effective manner is the alignment of our Care Connectors (community health workers) with high-volume physician practices as a part of our team-based community care management program. The Care Connector meets the member in the office at a scheduled visit and acts as an extension of the practice to follow up after the member leaves the physician's office, ensuring that the member fills recommended prescriptions, understands instructions on how to take medication and follows through on other recommended changes. The Care Connector also identifies additional community services that may be available for the member and facilitates access for the member and family.

After two unsuccessful attempts to contact “Pam,” a 42-year-old woman with diabetes who had two inpatient admissions in a 30-day window, the care manager sent a Community Outreach Solutions (COS) care connector to track Pam down. Talking to neighbors, the care connector discovered that Pam had moved. The care connector was able to establish contact with her at her new residence and connect Pam with her care manager.

Pam still had not seen her PCP after being discharged, and reported that she was having difficulty getting an appointment. The care manager made a three-way call, linking the member and the physician office to schedule an appointment for three days away. After verifying that the Pam had transportation available, the Care Manager talked with Pam about the need to have an eye examination due to her diabetes and gave Pam contact information for community resources, including a discount voucher, to help her obtain glasses. The care manager verified that Pam had the diabetic supplies and medication she needed and understood how to test her blood sugar and take her medication.

Despite the fact that Pam declined further assistance, the care manager verified that Pam attended the PCP appointment and reinforced the care manager’s availability to help in the future if additional needs arose.

1.4.2.4 Establish a comprehensive, accessible provider network that offers a choice of providers in all areas of the state.

In Iowa, AmeriHealth Caritas’ goal will be to establish a robust and inclusive provider network that is better than our competitors. AmeriHealth Caritas takes great pride in offering broad specialty network capacity in each of our existing markets. The Provider Network team works closely with PCPs to assess what specialists they refer to on a routine basis. We approach those specialists first for contracting. In Iowa, we know that some specialty representation is very low, so we will pursue a strategy that also employs cross-border providers and telemedicine capabilities as necessary. The Provider Network team will continue to add specialists as well as ancillary providers, (DME, Home Health, Ambulances, SNFs, etc.) even after the minimum number of providers has been attained to make the network as accessible as possible to the members. Through this all-inclusive approach, we have been able to build robust networks that provide access to care for all of our members. As an example, in Southeast Pennsylvania, we have 48 hospitals in our network compared to 32 hospitals in the network of our largest competitor. In addition, we have approximately 1,400 OB/Gyns, 5,000 specialists and 4,100 PCPs compared to 700 OB/Gyns, 2,000 specialists and 2,700 PCPs in our competitor’s network. In Nebraska, AmeriHealth Caritas Iowa’s affiliate, Arbor Health Plan has 331 OB/Gyns in 91 locations, 7,552 specialists in 1,526 locations, 1,788 PCPs in 389 locations and 131 Hospital facilities. Nebraska and Iowa have very similar rural counties and underserved populations. We have been successful in Nebraska meeting with our providers regularly and developing relationships that help to strengthen our partnerships. We are able to address clinical and business issues proactively and successfully. This has led to a network of providers that is available and capable of caring for all of our membership in Nebraska.

In Medicaid, narrow network models do not work. Our business model is to offer our members an extensive choice of providers who are convenient and accessible. With an extensive network, wait times for appointments are lower; thus, the member is able to see their provider as quickly as possible to receive the appropriate care for their problems and illnesses. Timely access also reduces emergency room utilization and encourages thorough follow-up since they are seeing their PCP or specialist. The open model is also successful because we work with the providers to align quality incentives in their contracts. We have demonstrated the ability to contract with providers our competition avoids through collaboration with our providers that ensures high quality cost-effective services are delivered. Our contracts are

negotiated based on trust and transparency and tailored to ensure both parties are comfortable with the arrangement. Although we have over 40% of our members that are included in at least one of our value based programs, each program is different. Each program is tailored to the specific need of the State in which we operate and the individual value-based partner. Our programs are comprehensive in nature and offer a menu of program choices, thereby adding value to our relationship of all network providers, ranging from a small, independent rural provider to a large integrated delivery system.

To enhance access to care and network choice, AmeriHealth Caritas Iowa will build a telemedicine program, in collaboration with our provider network, to meet the unique needs of Iowa members. We support the use of telemedicine to improve access to care for rural populations and will work to support and enhance current telemedicine offerings in Iowa. The availability of specialties such as hematology/oncology, endocrinology, cardiology, infectious disease, hepatology, pulmonology, gastroenterology, nephrology and rheumatology via telemedicine will allow rural patients to receive specialized healthcare and in many cases continue to be cared for in their own communities. As in other states, we will contract with Iowa specialty providers to deliver these services.

1.4.2.5 Offer a coordinated array of services to eligible individuals.

The following represent a few of the many services we will offer to eligible members:

- **Integrated Healthcare Management** – Our array of integrated healthcare management programs is designed to provide care management assistance at the level necessary to meet the member’s needs. Program elements include Rapid Response assistance to address urgent needs, structured outreach using phone and text to connect members to needed care and services, and individual care management for members with the highest levels of need. Targeted programs provide education and monitoring for members with cardiac disease, chronic obstructive pulmonary disease, asthma, HIV/AIDS, obesity and depression. These programs will help members better understand their condition and take positive action to improve their health.
- **Care for your Children** – Our Pediatric Preventive Care program uses a combination of monitoring and outreach to assist members under the age of 21 to get recommended screening, wellness checks and immunizations. These efforts help prevent early childhood diseases and illnesses, and educate members on the importance of ongoing healthcare. They also provide a mechanism for early identification of problems that may have long-term negative consequences for the child’s health or development if not addressed early.
- **Bright Start (maternity management)** – Our Bright Start program focuses on assisting pregnant women to obtain recommended prenatal care, deliver a healthy full-term infant and receive recommended postpartum care. To supplement the outreach and ongoing coaching from our trained Bright Start staff, we offer members access to a mobile application that provides gestational age-specific education, prompts them about recommended prenatal care appointments and steps and keeps them in touch with the changes their body is experiencing.

1.4.2.6 Improve the quality of care provided to members.

AmeriHealth Caritas has decades of experience improving the quality of care provided to its members. All AmeriHealth Caritas health plans undergo NCOA accreditation, with multiple plans achieving commendable results. AmeriHealth Caritas Iowa will incorporate a number of programs to ensure the quality of care provided to members includes:

- **Let Us Know** – The Let Us Know program is a partnership between AmeriHealth Caritas Iowa and the provider community to collaborate in the engagement and management of members. Providers are

encouraged to “let us know” when they have a member in their office who has needs beyond what the office can address (such as housing or utility assistance) or who needs additional follow-up after the visit to ensure that treatment recommendations are implemented. Staff from our Rapid Response team connects with the member to assist with identified needs and follow-up activities, thus extending the provider’s reach into the community.

- **Care Gaps** – Our Care Gap program identifies members who are missing recommended services and it provides actionable information to providers and the care management team. Providers receive an alert on the screen when they enter the ID number of a member who has a care gap, allowing providers to address the gap while the member is in the office. Primary Care sites can also pull and filter reports of members on their panel who are missing or due soon for recommended services. This same information appears as an alert on the member’s record in our population health management system and in the member service call system, allowing AmeriHealth Caritas Iowa staff interacting with the member to educate the member on the needed service and arrange an appointment. Care Gap information is also used to generate text message health and prescription refill reminders for our members.

1.4.2.7 Improve outcomes across the healthcare delivery system.

Leveraging the processes we use in other markets, our programs will proactively monitor healthcare delivery and identify opportunities for improvement across the healthcare delivery system. Specific examples of our success are described throughout the response and include reductions in emergency room utilization and C-section rates; improvements in immunization rates, diabetic management and asthma care; and reductions in residential placements for children in need of specialized care. Through our value-based contracting efforts, we partner with providers to drive improvements in outcomes through aligned incentives, payment transparency and robust information sharing.

1.4.2.8 Ensure the delivery of services to members that are readily accessible and provided in the least restrictive environment likely to result in the desired outcomes.

In addition to offering a robust provider network, AmeriHealth Caritas Iowa will actively assist members in need of services through our 24/7 call center and the focused assistance of our Integrated Healthcare Management team. For members in need of complex care coordination or services not readily available in the AmeriHealth Caritas Iowa network, the AmeriHealth Caritas Iowa care manager will work directly with the provider network team to secure an appropriate provider.

AmeriHealth Caritas Iowa will leverage the experience gained by AmeriHealth Caritas to ensure services are provided in the least restrictive environment. AmeriHealth Caritas plans currently coordinate extensive in-home care for over a thousand medically frail or developmentally delayed children. Additionally, through our work in New Jersey, we successfully reduced the number of children needing residential placement by improving the delivery of in-home support and services. We are actively bringing that same focus to our Medicare Medicaid Program demonstrations in South Carolina and Michigan, as we will in Iowa as well.

We believe that every individual has the right to quality healthcare and services and to benefit from healthcare innovation and technology, regardless of socio-economic status. Collaborating with our state, business and community partners, we work to bridge gaps in healthcare access, innovation and technology for our members. One example of how AmeriHealth Caritas partners with like-minded and innovative organizations to make quality healthcare and services accessible and affordable to every person, is our strategic partnership with Theranos, a nationally recognized, CLIA-certified laboratory that offers services for a complete range of tests from common blood screening panels to specialized testing across all specimen types.

The process for utilizing Theranos services is consistent with what Providers and patients are accustomed to today, with improvements to enhance the ease of each step, and they have partnered with a leading retail pharmacy to place collection sites within retail stores, bringing access to Theranos' laboratory services through this nationwide pharmacy footprint. We want to make it easier for our members to get the information they need, when they need it, to make important healthcare decisions and develop comprehensive care plans. Theranos allows for easy access and is open early mornings, late evenings, weekends, and holidays to fit everyone's schedule. Theranos' partnership with a national pharmacy chain means that Theranos is well-positioned to meet geo-access requirements in a given state. It also means that there is added convenience for our members who may need to pick up a prescription or other personal needs.

1.4.2.9 Provide all covered benefits and administrative functions as required in the RFP.

AmeriHealth Caritas Iowa will provide all covered benefits and administrative functions as required in the RFP. In addition, AmeriHealth Caritas Iowa will provide value-added services that promote health and well-being, such as gym memberships, nutritional counseling, tobacco cessation and weight management programs.

1.4.2.10 Operate in a manner that promotes efficiency in the service delivery system while offering the highest quality services.

AmeriHealth Caritas Iowa will operate in a manner that promotes efficiency in the service delivery system while offering the highest quality services. We will provide and assist our members to access the most cost-effective and efficient care to live healthier lives.

As an example, members with asthma represent a disproportionate share of emergency room visits. We will educate not only our asthmatic members but also members of the household regarding the importance of using the asthma controller medicine every day. As part of our program, we contact members to remind them to refill their asthma medicine and if we identify that a member is non-compliant and had an ER visit, we outreach to the member and provide assistance. We build trust with our members by showing we care for them.

1.4.2.11 Coordinate, integrate and be accountable for all services proposed.

AmeriHealth Caritas Iowa is committed to coordinating, integrating and being accountable for all services proposed. AmeriHealth Caritas Iowa and the Iowa Department of Human Services have a shared vision to improve care quality and access for members and achieve greater accountability for outcomes through the coordination and integration of all services proposed.

AmeriHealth Caritas has been improving the lives of Medicaid members for 30 years across 16 states and the District of Columbia. Our mission is to help the poor and underserved get care, stay well and build healthy communities.

At AmeriHealth Caritas, we understand the special needs of at-risk populations and are uniquely positioned to build and deliver programs to address those needs. Our person-centered, data-driven approach has proven effective again and again in enriching lives and improving health outcomes.

AmeriHealth Caritas Iowa will provide a fully integrated suite of products and services that meet the needs of Iowa Medicaid members, while also reducing the administrative burden for the state and lowering the costs for care management and delivery. This combination of high quality, highly accessible integrated and coordinated healthcare, measurable improvements in outcomes and increased cost-effectiveness makes AmeriHealth Caritas Iowa the right partner for the Iowa Medicaid Modernization.

2. Administrative Requirements

Please explain how you propose to execute Section 2 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Overview

AmeriHealth Caritas Family of Companies (AmeriHealth Caritas) is focused first and foremost on our members. As such, we ensure that our administrative requirements are all complete, efficient, transparent and accurate so we can focus on what matters most. We will go above and beyond to limit administrative burdens for any of our partners, whether it be the Iowa Department of Human Services (DHS), providers or our members.

AmeriHealth Caritas Iowa ensures that our administrative requirements are all complete, efficient, transparent, and accurate so we can focus on what matters most — the member.

We are familiar with all the administrative processes listed in the section and have completed the requirements without incident in other states. AmeriHealth Caritas Iowa attests that we can and will comply with all elements stated within this section.

2.1 Licensure/Accreditation

1. Indicate if you are currently licensed as an HMO in the State of Iowa. If you are not currently licensed, describe your plan to achieve licensure.

AmeriHealth Caritas Iowa submitted its application for an HMO certificate of authority to the Iowa Insurance Division on May 1. We will work closely with the Iowa Insurance Division in order to secure our HMO license expeditiously. We are working with a local law firm in Des Moines to assist us in shepherding the HMO license application through the review and approval process, and we anticipate receiving our license prior to the contract effective date.

2. Indicate whether you are currently a qualified health plan (QHP) issuer certified by the Iowa Healthcare Exchange.

As we are a new entrant to the Iowa health insurance market, AmeriHealth Caritas Iowa has not had the opportunity to become certified by the Iowa Healthcare Exchange as a qualified health plan (QHP) issuer. However, we share DHS' goal of facilitating continuity of care for members who move between Medicaid and premium tax credit eligibility. As the Iowa High Quality Healthcare Initiative would be the first line of business in Iowa for AmeriHealth Caritas, we will explore our options for becoming a QHP upon being selected for contract.

3. Indicate whether you are currently accredited by the NCQA. If you are not currently accredited, describe your plan to achieve accreditation.

AmeriHealth Caritas Iowa will apply for interim accreditation within the first 12 months of plan operation. Once we achieve interim accreditation, we will undergo a full accreditation review, named a "First Review"

by the National Committee for Quality Assurance (NCQA). Our recently launched health plans in Louisiana, District of Columbia and Nebraska have pursued this strategy. All three received interim accreditation and will undergo a “First” accreditation review during 2015.

Many of our other affiliate plans are already NCQA accredited and have received NCQA distinctions. AmeriHealth Caritas’ enterprise-wide philosophy is to pursue accreditation of our managed care plans at the earliest opportunity. Please see below for more details.

Overview of NCQA Accreditation and Distinctions across AmeriHealth Caritas Family of Companies

We have included a summary of the current NCQA accreditations for AmeriHealth Caritas’ affiliates and subsidiaries.

Health Plan	Effective Date	Current Accreditation Status (based on last rescore)
AmeriHealth Caritas Pennsylvania	August 2013 to August 2016	Commendable
AmeriHealth Caritas Louisiana	April 2013 to June 2015, Interim	Interim
Keystone First	August 2013 to August 2016	Commendable
Select Health of South Carolina	October 2013 to October 2016	Commendable
MDwise, Inc.* Parent company, MDwise, holds the accreditation and completes single admission on behalf of all subsidiaries (Hoosier Alliance).	December 2012 to December 2015, earned Accreditation	Commendable
Arbor Health Plan	March 2014	Interim
AmeriHealth District of Columbia, Inc.	July 2014	Interim

* MDwise Hoosier Alliance is accredited through MDwise, Inc. as one of several MDwise, Inc. delivery systems.

Exhibit 2.1-A: Current NCQA Accreditation Status

None of the AmeriHealth Caritas affiliated plans have had accreditation revoked or suspended.

NCQA Multicultural Health Care Distinction

AmeriHealth Caritas’ plans continue to lead the industry in the delivery of culturally appropriate care and services in diverse populations. In 2015, Select Health of South Carolina, Keystone First and AmeriHealth Caritas Pennsylvania renewed or are in the process of renewing their Multicultural Health Care Distinction status from NCQA.

Each of the three plans was recognized by NCQA as “early adopters” of Multicultural Health Care Distinction standards in 2010. In 2011, the three plans were among the first six health plans in the country to receive this prestigious accolade. With renewal, the plans are three of only eight Medicaid plans in the

country to hold this distinction, which is valid through May 2015. Select Health of South Carolina is the only plan in South Carolina that has earned the recognition.

NCQA awards the distinction to organizations that meet or exceed its rigorous requirements for multicultural health care in the following areas:

- Collection of race/ethnicity and language data.
- Provision of language assistance.
- Cultural responsiveness.
- Quality improvement of Culturally and Linguistically Appropriate Services (CLAS).
- Reduction of health care disparities.



2.2 Subcontracts

1. Summarize your proposed subcontracts, including any with parent companies, and key work to be delegated under the subcontracted relationship.

AmeriHealth Caritas Iowa will subcontract for management administrative, clinical, payment integrity and pharmacy benefit management services.

Management Administrative Services

AmeriHealth Caritas Iowa will subcontract for management and administrative services with its affiliate AmeriHealth Caritas Services, LLC. Key work will be delegated from various departments, including the Call Center, Claims Services, Corporate Services (e.g., Compliance, Finance, Human Resources, Legal, Information Solutions and Marketing), Operations and Corporate Medical Management

Clinical subcontracts

We will subcontract for the administration of comprehensive medical surgical eye care (including routine vision and eyewear), non-emergent medical transportation (NEMT) and 24/7 Nurse Call Line. Key work that will be delegated to the eye care subcontractor and the NEMT subcontractor includes, but is not limited to: provider contracting, credentialing and re-credentialing, claims processing and related financial services, and utilization management. We do not expect to delegate member services or complaints and grievances. There are no services delegated to the 24/7 Nurse Call Line; instead, the 24/7 Nurse Call Line is deployed as a triage service for members and a means by which they can get health information. We have tentatively identified the entities listed below as the subcontractors who will provide these services.

Subcontract #1, SironaHealth — Telephonic nurse triage services

Key work to be delegated: Answer general health questions and evaluate current symptoms the caller (or eligible family member) is experiencing. Provide guidance on the appropriate course of action.

Subcontract #2, Access2Care or MTM — Non-Emergency Medical Transportation (NEMT)

Key work to be delegated: Provider contracting, credentialing and re-credentialing, claims processing and related financial services, and utilization management.

Subcontract #3, Avesis — Comprehensive eye medical surgical administration

Key work to be delegated: Provider contracting, credentialing and re-credentialing, claims processing and related financial services, and utilization management.

Payment Integrity Subcontracts

AmeriHealth Caritas Iowa payment integrity services subcontractors will include: Health Management Systems (HMS) and Discovery Health Partners (DHP).

- HMS will complete several pieces of our payment integrity work, including:
 - Retrospective data mining — Review of claim data post-adjudication to identify and recover overpayments made to providers.
 - Third party liability (TPL) — Supply AmeriHealth Caritas Iowa with records of members who have other insurance.
 - Medical/Rx recoveries — Retrospective identification of TPL overpayments and recovery from carriers for claims paid in error.
 - Complex medical record review — Prospective and retrospective review of medical records to identify and recover overpayments made to providers.

DHP will serve as a subrogation vendor and perform a retrospective review of claims to identify and recover cases arising from accident, injury, slip and fall, worker's compensation, etc.

Subcontract #4 — HMS

Key work to be delegated: HMS will perform retrospective data mining, complex medical record reviews, TPL data share, and carrier and provider billing for TPL recoveries.

Subcontract #5 — Discovery Health Partners

Key work to be delegated: Full subrogation services from identification of cases, tracking and monitoring through recovery.

Pharmacy Benefits Management (PBM)

As affiliate companies within AmeriHealth Caritas, both AmeriHealth Caritas Iowa and PerformRxSM are wholly owned by the same parent company. PerformRx was created as an operating division of AmeriHealth Caritas in 1999 to furnish pharmacy benefits management (PBM) services to our Pennsylvania Medicaid managed care plan affiliates, and it has grown to provide comprehensive PBM services within and outside the family of companies. PerformRx provides PBM services to all of the Medicaid managed care plans within AmeriHealth Caritas where pharmacy is not managed by the state, to our Medicare plans (dual eligible special needs plans (D-SNPs) and integrated dual eligible Medicare-Medicaid demonstration plans (MMPs)) and to other non-affiliated government-sponsored and commercial health plans across the country.

AmeriHealth Caritas Iowa will subcontract PBM services to PerformRx to continue the partnership that has positively impacted members' well-being. Key work that will be delegated includes but is not limited to member and provider pharmacy contact center, drug therapy management, clinical programs, formulary management, rebate management, pharmacy claims processing, prior authorization, compliance oversight and pharmacy network management.

2. Indicate if any of the subcontracts are expected to be worth at least five percent (5%) of capitation payments under this contract.

We do not expect that any of the subcontracts will be worth at least five percent of capitation payments under this contract.

3. Describe the metrics used to evaluate prospective subcontractors’ abilities to perform delegated activities prior to delegation.

We make a concerted effort to utilize subcontractors commonly used by our affiliates to facilitate provider simplification. Using common subcontractors increases our leverage and ability to hold the subcontractor to strict standards. As part of the contract finalization process, we will conduct an onsite audit of the subcontractor’s records and operations using comprehensive assessment tools that combine NCQA health plan accreditation standards, industry performance levels and Iowa-specific requirements. The scope of the audit is determined by the functions we are delegating, but typically includes a review of credentialing files, policies and procedures, relevant workflows, and claim payment and encounter processing, as applicable. The results of the audit are compiled and presented to management and the relevant quality committees. Satisfactory performance on the pre-delegation assessment is a condition of our delegation to the subcontractor. If a subcontractor does not meet our requirements, we will either select a different subcontractor, or educate the subcontractor and implement an action plan.

All contracts are supported by a written contract that includes a detailed delegation agreement. Our delegation agreements reflect NCQA requirements. Our contracts include language that allows us to place subcontractors on a corrective action plan. If a subcontractor’s performance does not improve, our contracts allow us to terminate the subcontractor for cause. Our contracts require subcontractors to comply with 42 CFR 434.6 and incorporate by reference the applicable terms and conditions of the Contract, as well as any other relevant state regulations.

Management and Administrative Services

Subcontractors are held accountable to meet all necessary state contract requirements and metrics within each state contract. AmeriHealth Caritas evaluated AmeriHealth Caritas Services based on adherence to the state requirements, meeting defined service-level standards and their performance with the different plans. Examples of contractual metrics are time-to-pay metrics for claims, speed-of-answer for call centers and timeliness metrics related to utilization management.

Clinical subcontracts

As part of the evaluation for a clinical subcontractor, we typically perform a document review of the following items: Utilization Management (UM):		
Program description (current year)	Program evaluation (prior year)	Committee charter
Meeting calendar	Committee meeting minutes (July through December, previous year)	Current job descriptions
Governing body and organizational chart	Medical criteria	Staff training
Licensure of physician reviewers	Policies and procedures	Delegated audit tool
Appeals policy and procedures	Process to assess inter-rater reliability	

As part of the evaluation for a clinical subcontractor, we typically perform a document review of the following items: Utilization Management (UM):

Quality Management (QM):		
Program description (current year)	Program evaluation (prior year)	Committee charter
Meeting calendar	Committee meeting minutes (July through December, previous year)	Current job descriptions
Governing body and organizational chart	Current work plan	Studies used to measure scope of QM activities
Completed QM audit tool	Policies and procedures	Member safety activities
Provider satisfaction survey template	Member satisfaction survey template	
Operations:		
Customer service/call center policies and procedures	Completed enrollee services call center audit tool	HIPAA policies
Disaster recovery plan (current year)	Business continuity plan (current year)	Compliance program (current year)
Ongoing monitoring exclusion policy for employees	Fraud waste and abuse policies/documented process	Compliance training program
Compliance training log	Medical records confidentiality policy	Medical record documentation standards
Appropriate accreditation or state licensure	Complaints/grievance policies and procedures	Completed grievance audit tool
Claims policies and procedures		
Care Coordination and Provider Network:		
Completed credentialing tools	Credentialing policies	Credentialing policies for internal reviewers
Care coordination policies and procedures	Completed care coordination audit tool	

Our typical clinical auditing tools include:

NCQA credentialing audit tool	NCQA quality improvement (QI) delegation audit tool	NCQA UM delegation audit tool
State-specific call center delegation audit tool	State-specific claims delegation audit tool	State-specific credentialing audit tool
State-specific UM delegation audit tool		

As part of the pre-delegation evaluation of NEMT subcontractors, we review documents including, but not limited to:

Transportation Provider Network:		
Provider contracts	Provider on-site visits	Provider survey
Operations:		
Customer service center reporting	Call center service disruption	Computer hardware and software
Electronic records management and destruction.	Disaster recovery (DR).	Data integrity.
Encounter transmissions.	Software development lifecycle	Policy and procedural change notifications to clients
Encounter transmissions		
Quality Management:		
Management of grievances and appeals	QM program annual review	
Utilization Management:		
Pre-service and concurrent review	Medical necessity	UM oversight by medical director
Compliance:		
Fraud, waste and abuse prevention and investigation	HIPAA training	Quality performance – call monitoring process and evaluation
Breach notification of unsecured PHI, HIPAA and/or HITECH	Americans with Disabilities Act (ADA)/Americans with Disabilities Act Amendments Act (ADAAA) compliance	Compliance and ethics overview
Compliance and ethics education training and outreach program	Risk assessment and reduction	Drug and alcohol testing results documentation
Destruction of protected health information (PHI)	Documentation retention	Sanction check search process
Pandemic preparedness	Review plan	

We also review records for call center, drivers and vehicles. A score of 95 percent or more is required to satisfy this review.

For clinical and NEMT subcontractors, metrics that we typically audit include, but are not limited to:

Functions	Standards
Claims processing	
Claims financial accuracy.	≥ 99%
Claims procedural accuracy.	≥ 99%

Functions	Standards
Clean claims paid within 30 business days of receipt.	≥ 99%
Clean claims paid within 30 business days of receipt.	≥ 99%
Rejected claims returned to provider with reason code within 15 calendar days of receipt of claim.	≥ 99%
Interest paid at 12 percent per annum, calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30 day claims processing deadline.	
Call center management	
Abandoned call rate.	≤ 5%
Average speed of answer.	95% of calls within ≤ 30 seconds
Average call blockage rate.	≤ 1%
Average hold time.	≤ 3 minutes
Service level.	≥ 85%
Quality score.	≥ 95%
Account administration	
Electronic eligibility online within two business days.	98%
Electronic report delivery by 25th of month for prior month for monthly reports, and 30th of month for previous quarter for quarterly reports.	100%
Web-portal availability using member ID.	99%
Credentialing	
Compliance with 36 month re-credentialing cycle.	100%
Annual delegation review aggregate score.	95%
Appeals	
Submission of information necessary to adjudicate a non-urgent member appeal is sent to the plan within three business days.	100%
Submission of information necessary to adjudicate expedited member appeal within 24 hours.	100%
Complaints and Grievance	
Submission of information necessary to resolve a member complaint and/or a member grievance is sent to the plan within five business days.	100%

Payment Integrity subcontracts

All prospective subcontractors go through a formal request for proposal (RFP) process with guidance from AmeriHealth Caritas' Sourcing department. This includes the following:

- RFPs are sent out to potential subcontractors, which includes RFP scope of work (SOW) and goals/objectives.
- Subcontractors are required to submit references from other clients as part of the RFP response.
- Each potential subcontractor is required to do an on-site presentation.
- A scorecard based on key functions is prepared and weighted for all subcontractors to aid in the final selection process.

Post-contract award, AmeriHealth Caritas Payment Integrity establishes goals with the subcontractor to support implementation and ongoing performance. Payment integrity utilizes standard reports generated by the subcontractor and weekly/monthly meetings to monitor:

- Progress of achieving the goals.
- Adherence to state and/or provider contractual requirements.

Pharmacy Benefit Management

PerformRx has provided PBM services to AmeriHealth Caritas plans since 1999. Our integrated pharmacy and medical approach has led to published clinical programs with notable financial and health outcomes. PerformRx was one of the first PBMs to obtain URAC accreditation in 2010, and was re-accredited in 2013 affirming their commitment to quality. Based on the history of positive outcomes and commitment to quality, AmeriHealth Caritas Iowa will be partnering with PerformRx to implement an integrated approach to managing Medicaid members in Iowa.

The following core competencies and quality metrics are evaluated to ensure the effectiveness and ability of PerformRx to meet the needs of any AmeriHealth Caritas plan:

Relevant Experience	Clinical Programs	Fraud, Waste, and Abuse	Drug Therapy Management
Care Management Support	Prior Authorization	IT	Reporting and Analytics
Contact Center / Member Services	Implementations	Pharmacy Network Management	Mail Order
Specialty Pharmacy	Financial Management	Account Management	Quality Assurance
Compliance	Audit	Accreditations	

The PBM is held to the following performance guarantees to ensure all requirements and standards are met throughout the term of the contract:

Service	Guarantee
Account Management Onsite Meeting	4 Meetings per year with Health Plan or as requested by Health Plan, to include a minimum of one annual face to face meeting
Accuracy in Plan Changes	Accuracy in plan changes rate will be at least 98% provided, however that if there are not sufficient changes that one (1) error would result in not meeting the standard, one (1) error will be allowed.

Service	Guarantee
Eligibility	Ninety-eight percent (98%) of properly formatted daily eligibility loads will be completed within one (1) business day of receipt.
Claims Adjudication Accuracy	Ninety-nine percent (99%) of all claims received in PerformRx format will be processed accurately.
System Availability	Claims processing system will be available no less than 99.5% of the time.
System Response	Point-of-Sale average daily processing time shall not be more than three (3) seconds ninety-nine percent (99%) of the time, excluding scheduled maintenance and telecommunications failure.
Abandonment Call Rate	Five percent (5%) or less of all calls will be abandoned.
Average Speed Answered	Average time to answer a Customer Call will be thirty (30) seconds or less.
Paper Claim Turnaround Time	PBM guarantees that member submitted claims will be reimbursed or responded to within seventy-two (72) hours of receipt of the paper claim, or as otherwise required.
Implementation Timeliness	100% Timeliness of Project Delivery—Within Agreed Upon Delivery Time
Prior Authorization Turnaround Time	95% of prior authorizations are completed within twenty-four (24) hours and 99% will be completed within 48 hours with no obligation to review by client excluding weekends and holidays.

4. Describe the policies and procedures used for auditing and monitoring subcontractors’ performance.

We understand that accountability for the completion of a function or responsibility, even when performed by a subcontractor, remains with us. Our subcontractor oversight programs are designed to ensure that all subcontractors are qualified to perform the delegated services, that they remain qualified throughout the term of the contract and that they perform their responsibilities in accordance with the terms of their agreement and the requirements of the Medicaid program(s) that they have been contracted to support.

Management and Administrative Services

Given the scope of services to be undertaken by AmeriHealth Caritas Services, plan performance of AmeriHealth Caritas Iowa itself will largely be a reflection of AmeriHealth Caritas Services’ performance. AmeriHealth Caritas rigorously monitors key performance indicators specific to each health plan with results reported to management at the health plan and AmeriHealth Caritas Services’ on a weekly and monthly basis. The reporting frequency is determined by the nature of the specific performance metrics. Detailed operational reports reflect standard performance metrics including, but not limited to: customer quality, first call resolution and service levels (speed to answer and abandonment rates); complaints, grievances and appeals resolution timeliness and quality; claims processing accuracy and timeliness; eligibility and enrollment accuracy and timeliness; as well as encounter data acceptance and completeness. In addition to standard performance metrics, those requirements are unique to the Iowa

High Quality Healthcare Initiative, which are included and will be incorporated in the contract between AmeriHealth Caritas Iowa and AmeriHealth Caritas Services.

In addition to performance metrics monitoring, AmeriHealth Caritas Services meets bi-weekly with each health plan through Plan Business Oversight (PBO) meetings to track and if necessary escalate operational issues through to resolution and to discuss business process improvement initiatives. First Alert meetings are also held to address critical issues that may arise outside of the regularly scheduled PBO meetings. Quarterly Market President Meetings are also convened at which performance metrics and trends are discussed to ensure compliance with contractual requirements, internal service level requirements and performance improvement outcomes.

Any performance issues that are identified through metrics reporting and/or performance management meetings are tracked via an issues tracking database to track timeliness of issues resolution, identify trends and to ensure an accounting of all issues and their resolution outcome.

Oversight of this subcontracted relationship is also carried out by the local Compliance officer, who will be responsible for auditing and monitoring AmeriHealth Caritas Iowa's performance (and thus AmeriHealth Caritas Services' performance) against the requirements of our contract with DHS. This is a model that we have successfully deployed in our other managed care lines of business across the AmeriHealth Caritas enterprise.

We understand that accountability for the completion of a function or responsibility, even when performed by a subcontractor, remains with us. Our subcontractor oversight programs are designed to ensure that all subcontractors are qualified to perform the delegated services, that they remain qualified throughout the term of the contract and that they perform their responsibilities in accordance with the terms of their agreement and the requirements of the Medicaid program(s) that they have been contracted to support.

Key performance indicators and contractual metrics are reviewed monthly by the AmeriHealth Caritas Operating Committee, which reports directly to the Chief Executive Officer (CEO). The Operating Committee is a cross-functional team representing all departmental functions, meets weekly to review all operating reports. If non-performance is identified, an action plan will be reviewed with the Operating Committee and executed immediately. If an issue related to time-to-pay for claims is identified, the Operating Committee will immediately address this issue by identifying the "root cause" and execute a corrective action plan. Nonperformance issues, although very infrequent, are identified and addressed timely due to AmeriHealth Caritas' robust performance oversight.

Clinical subcontracts

Our oversight activities are guided and supported by a corporate delegation oversight policy that is compliant with NCQA accreditation requirements and is maintained by our corporate Quality department.

We have staff dedicated to subcontractor oversight, including a full-time NEMT specialist, who monitors performance on a monthly basis against documented performance standards. These standards include timely claims payment, encounters processing and call center performance. At a minimum, we require performance consistent with industry standards. Question 2.2.3 highlights some of typical performance standards (e.g., claims processing ≥ 99 percent).

Most subcontractor performance metrics are tracked on a monthly basis — the remainder are tracked quarterly — and compiled into a report that is presented to our quality committee(s). We review month-over-month results to identify performance trends and quickly address any deficiencies.

On an annual basis, we audit all subcontractors to ensure that their credentialing, utilization management and other business processes and procedures are continuing to meet our requirements. The results of these audits are compiled and submitted to the appropriate quality committee(s), along with any recommendations.

Payment Integrity subcontracts

The following policies are in place to monitor subcontractor performance in the Payment Integrity department. If a subcontractor is found to be non-compliant or unable to perform services as contracted, the subcontractor would be terminated. To date, no payment integrity subcontractor has been terminated by AmeriHealth Caritas.

Policy name: Vendor Identified Retrospective Overpayment and Recoveries (covers sub-contractor HMS)

Policy description: This policy outlines the process for claim identification, plan approval and retraction of provider overpayments from claim data mining by HMS. The policy includes procedures for:

- Overpayment project identification and plan approval.
- Vendor retrospective overpayment recoveries.
- Provider dispute process.
- Monthly cost savings meetings.

Policy name: Retrospective Vendor Complex Medical (covers sub-contractor HMS)

Policy description: This policy outlines the process for claim identification, plan approval requesting of medical records, review of medical records and retraction of claim overpayments. The policy includes procedures for:

- Identification and approval.
- Medical record request mailings.
- Medical record review.
- Provider dispute process.
- Monthly cost savings meetings.

Policy name: Subrogation (covers sub-contractor Discovery Health Partners)

Policy Description: This policy provides the guidelines by which the subrogation unit supports the recovery of funds paid on behalf of plan members, who were involved in third party liability (TPL) accidents or incidents where third-party resources exist. The policy includes procedures for:

- Subrogation case files processing.
- Subrogation referrals to state.
- Provider initiated claim retractions.
- State initiated casualty claim requests.
- Subpoenas.

Additionally, all payment integrity subcontractor performance is monitored on a monthly basis to review dollars saved and recovered. Reports are distributed to the health plan and reviewed in monthly meetings. External and internal numbers/figures are reconciled to assure accuracy.

- Internal reporting on savings and recoveries.
- External reports submitted to AmeriHealth Caritas from vendors.

We meet with all subcontractors on a weekly basis to review current edits, savings, recoveries and any issues that may have arisen.

Pharmacy Benefit Services

AmeriHealth Caritas Iowa is committed to complying with all relevant laws, regulations and contractual requirements, and to ensuring that our subcontractors are compliant, as well, including PerformRx. AmeriHealth Caritas Iowa will leverage our strong corporate subcontractor oversight program and will monitor and evaluate PerformRx's performance on an ongoing basis. Our proven oversight program ensures compliance with external accrediting bodies, as well as with any state, federal and contract requirements.

Additionally, AmeriHealth Caritas Iowa will monitor all subcontractor performance, leveraging a continuous quality improvement methodology as relevant for each function. This methodology relies on components including initial and ongoing delegation audits, review of performance on key performance indicators, and follow up and investigation into quality of care issues and member grievances. Performance will be monitored over time to identify unfavorable trends in a timely manner so that course corrections can be initiated before performance falls below regulatory and contractual standards.

Our proposed plan is a comprehensive approach to ensure both members' and Iowa's needs are met. We are prepared to submit our oversight plan to DHS for approval and will partner with you to ensure our monitoring plan meets the state's needs.

Our monitoring plan includes:

- AmeriHealth Caritas' Delegation Oversight team will monitor performance on contract standards on a monthly basis. In addition, Delegation Oversight will complete an annual audit of PerformRx on behalf of the AmeriHealth Caritas plans for contract and regulatory compliance.
- Regional Pharmacy Directors will also support oversight of PerformRx through bi-weekly (at a minimum) reviews to discuss issues, concerns, regulatory and compliance changes, and any other processing issues that have been identified and need resolution. The Pharmacy Directors will work with PerformRx in reference to state audits, on-site visits and/or desktop audits and any other benefit-related items. They also monitor contract compliance.
- The AmeriHealth Caritas Iowa Market President will meet with PerformRx monthly to discuss higher-level items and plan-specific initiatives.
- AmeriHealth Caritas Iowa will complete quarterly drug utilization reviews (DURs) to evaluate trends and spend.
- AmeriHealth Caritas Iowa's Compliance staff will hold monthly compliance meetings to address regulatory/state/contract items. We also have clinical meetings to look at the formulary processing with the PerformRx clinical pharmacists assigned to AmeriHealth Caritas Iowa.
- AmeriHealth Caritas Iowa will hold quarterly pharmacy summits to address pharmacy concerns, governance and initiatives/projects for efficiencies, enhancements and better business planning.

- PerformRx will support statutory reporting, and work directly with AmeriHealth Caritas Iowa for issue resolution, data anomalies and pharmacy issues as they pertain to state reporting.

5. Describe the enforcement policies used for non-performance, including examples.

Management and Administrative Services

Key performance indicators and contractual metrics are reviewed monthly by the AmeriHealth Caritas Operating Committee, which reports directly to the CEO. The Operating Committee is a cross-functional team representing all departmental functions, meeting weekly to review all operating reports. If non-performance is identified, an action plan will be reviewed with the Operating Committee and executed immediately. If an issue related to time-to-pay for claims is identified, the Operating Committee will immediately address this issue by identifying the “root cause,” as well as executing a corrective action plan. Non-performance issues, although very infrequent, are identified and addressed timely due to AmeriHealth Caritas’s robust performance oversight. AmeriHealth Caritas Iowa will also notify DHS any time a subcontractor is placed on corrective action.

Clinical subcontracts

We monitor on an 18-month rolling cycle to identify any patterns of poor performance over time. When a subcontractor has a significant or persistent failure to meet agreed-to performance standards, we seek out the root cause and implement a corrective action plan. The corrective action plan (CAP) is reported to the appropriate quality committee, and regular progress reports are provided to the committee. AmeriHealth Caritas Iowa will also notify DHS any time a clinical subcontractor is placed on corrective action. We require a subcontractor to meet the performance standard for three consecutive months before closing the corrective action plan. A subcontractor who continues to miss performance standards may be terminated for cause and may be subject to financial penalties.

Examples of enforcement

Example 1: NEMT subcontractor

For an NEMT subcontractor, a CAP was implemented when the subcontractor did not meet the average speed-to-answer (ASA) standard for three consecutive months. The standard required an ASA of ≤20 seconds. The subcontractor’s actual performance was:

Month	Average Speed to Answer (seconds)	
May 2013	13	
Jun 2013	11	
Jul 2013	14	
Aug 2013	23	
Sep 2013	31	
Oct 2013	16	
Nov 2013	24	

Month	Average Speed to Answer (seconds)	
Dec 2013	31	
Jan 2014	42	← CAP process was initiated following Jan 2014 results
Feb 2014	32	

Our internal NEMT specialist worked with the subcontractor to identify root cause and identify steps to take to resolve the problem. As a result:

- The subcontractor concluded that the call center staffing was inadequate to handle the call volume and committed to increase staffing levels by 20 percent.
- The subcontractor reviewed staffing procedures and decided to assign more senior call service representatives to cover our account.

Our NEMT specialist met with the subcontractor’s representative on a weekly basis to review progress. We required improvement to be demonstrated in three consecutive months.

By the time the CAP was closed at the end of May, a combination of proper staffing levels and favorable process changes resulted in achieving the desired results.

Example 2: Vision subcontractor

During a pre-delegation audit for a vision subcontractor, we determined that the credentialing and re-credentialing requirements had not been met. A score of 95 percent or greater was required. The actual audit results were:

- Credentialing file review score — 79.44 percent.
- Re-credentialing file review score — 50.71 percent.

We implemented a CAP and required the subcontractor to re-credential its entire vision network. We then conducted a follow-up audit to evaluate whether the deficiency had been corrected. The actual results in the follow-up audit demonstrated achieving a score of 99 percent. The subcontractor has remained in compliance with the credentialing and re-credentialing requirements since that time.

Example 3: Dental subcontractor

During a quarterly review of a dental subcontractor’s UM files, we determined that the subcontractor was out of compliance with 13 of the NCQA-required UM requirements. We implemented a CAP that required the subcontractor to revise its UM processes and implement other changes to ensure compliance with NCQA requirements. We have continued to monitor progress on a quarterly basis. In the most recent quarterly review (conducted on 90 randomly selected cases) the subcontractor scored 100 percent in nine of 13 elements, and 95 percent in the remaining four elements.

Pharmacy Benefit Management

AmeriHealth Caritas Iowa’s contract with PerformRx includes performance guarantees to ensure consistent quality delivery of all services. PerformRx will provide AmeriHealth Caritas Iowa with a monthly report on actual performance metrics against the guarantees to identify any areas of non-performance. Non-compliance with performance guarantees will result in the imposition of financial penalties.

Performance guarantees include but are not limited to:

- Claims processing timeliness.
- Systems availability.
- Accuracy of eligibility load (based on data provided by the health plan).
- Network access requirements.
- State reporting requirements.
- Prior authorization turnaround time.
- Contact Center average speed of answer.

6. Describe how subcontracting relationships will provide a seamless experience for members and providers.

AmeriHealth Caritas Iowa will ensure a seamless and largely invisible subcontracting experience for our members and providers. This is done through integration and control of subcontracting processes. Details by subcontracting type are below:

Management and Administrative Services

Subcontracted services are fully integrated within AmeriHealth Caritas' operational structure to provide a seamless experience for our members and providers. AmeriHealth Caritas Services has associates in the respective areas working directly and/or indirectly to service the members and providers. For example, the Contact Center is an area that specifically has associates dedicated to serving members and providers for a specific plan. Associates are also cross-trained to ensure continuity of care and service. We have employed this model successfully in other Medicaid and Medicare managed care markets throughout AmeriHealth Caritas, and we are able to maintain a strong plan-specific identity in our lines of business with our management services subcontractor model. This is due in large part to the close relationship between these corporate affiliates, and their functioning as a family of companies.

Vision

Our vision subcontractor administers comprehensive eye medical/surgical benefits. For providers who provide both routine and medical eye services, this means there is only one payer to whom they submit claims. Providers in our other models have reacted very positively to this model.

NEMT

NEMT is integrated into our care management model. We work with our subcontractor to ensure their services are seamlessly incorporated into our care plan with the member. Below are examples of systems we have in place to ensure this integration:

- Requests for elevated levels of service (e.g., wheelchair van, stretcher van, etc.) are routed to our Rapid Response team for authorization. The Rapid Response team works closely with the Care Management department.
- The non-emergency medical transportation subcontractor alerts the Rapid Response team when care-management needs arise (e.g., ambulatory member now on crutches or needs wheelchair).
- The Rapid Response team also addresses Members' special needs.

- Care management will work with members traveling long distances to find a more convenient provider.
- Care management will engage the NEMT subcontractor when members present with specific transportation needs (e.g., need for meals and lodging).

Nurse call line

For all AmeriHealth Caritas Iowa members, support is just a phone call away. We encourage members to have a relationship with their primary care provider (PCP). However, when members cannot reach the doctor's office or the Medical Management department during off-hours, registered nurses are always available to assist members at the 24/7 Nurse Call Line. For additional detail on the 24/7 Nurse Call Line, please refer to the response for 8.4.

During the implementation of the 24/7 Nurse Call Line, the Delegation Oversight team works with the Care Management team and other departments of the health plan to assure that information relevant to the support of the membership is shared and available to all teams. This includes local community resource directories, information on internal programs/referral processes, hours of operations and administrative information (for direction on questions such as "Who do I call to get a new ID card?") and escalation workflows. This tight interface ensures the members' questions and any issues are quickly addressed or warm-transferred to the appropriate area in the most seamless fashion. Ongoing training programs are provided to all health plan departments that interface with the 24/7 Nurse Call Line, such as Care Management, Member Services, and Provider Services.

In addition to the service interface, the 24/7 Nurse Call Line also provides overflow and non-business coverage for the Rapid Response team phone lines. Our integrated service model is built into our telephony platform, and is seamless for the management of inbound calls. In the event that there is a building emergency or other situation that causes the health plan staff to be unable to answer member calls, the phone system will automatically route calls to the 24/7 Nurse Call Line as a back-up, supporting unit. This assures that regardless of the time, situation or day, clinical staff is always available to address a member's question or concerns for any health plan phone number that is dialed.

Payment integrity

AmeriHealth Caritas' Payment Integrity department works with subcontractors and providers, and each subcontractor and health plan is assigned a client relations manager. It is the responsibility of this person to ensure that all policies and procedures for payment integrity are adhered to in this relationship. In addition, the client relations manager works with both the health plan and subcontractors to make sure the communication flow between them is seamless and all issues are dealt with and resolved in a timely fashion.

Pharmacy Benefit Management

PerformRx, being a subsidiary of AmeriHealth Caritas, remains fully aligned with all health plan initiatives. The commitment to member care is a priority and all PBM processes and programs are designed with members in mind. The PerformRx clinical team attends health plan case management and clinical initiative discussions to ensure any pharmacy-related clinical programs are fully in line with health plan activities.

The relationship between AmeriHealth Caritas and PerformRx ensures an entire organizational focus on minimizing overall health costs rather than optimizing drug spend at the expense of medical cost. PerformRx associates are driven by common corporate goals and shared organizational values. PerformRx's associates maintain a daily focus on improving members' lives and ensuring appropriate total medical costs.

With higher levels of coordination and aligned incentives, PerformRx inherently drives value for the health plan as a whole. Easy and timely exchange of data facilitates identification of quality and cost savings opportunities, while aligned incentives focus priorities and help ensure the organization executes on these opportunities. The tight operational integration between PerformRx and AmeriHealth Caritas means members and providers will receive the same high-quality service regardless of whether they are interacting with the PBM or the health plan. Even when interacting with PerformRx, members will have a completely unified user experience.

There are many ways the integrated AmeriHealth Caritas and PerformRx relationship can benefit Iowa, including:

- All member information can be sent as if from the health plan.
- Collaboration on clinical program design so that member outreach is conducted through a single channel by the health plan.
- Members' access to pharmacy information via the health plan's Member Portal.
- A single point of contact for the health plan, the PerformRx account manager, will ensure all impacted areas of PerformRx are aware of any activities and operations related to the health plan.
- Collaborative communication to providers of any changes to formulary or benefits.

2.3 Financial Stability

1. Provide verification of the financial requirements described in the subsections of Section 2.3.

AmeriHealth Caritas Iowa is a direct, wholly owned subsidiary of AmeriHealth Caritas Health Plan and is a member of the AmeriHealth Caritas Family of Companies (AmeriHealth Caritas); the financial results of the family of companies are reported on a consolidated basis under the audited financial statements of BMH LLC (BMH). BMH is also the direct owner of AmeriHealth Caritas Services (formed as "AmeriHealth Mercy Services" in June 2012). AmeriHealth Caritas Services provides staffing and administrative services to companies within AmeriHealth Caritas. BMH is jointly owned by Independence Blue Cross (Independence) and Blue Cross Blue Shield of Michigan (BCBSM), two of the country's largest nonprofit Blues plans. Independence holds a 61.26 percent ownership interest in BMH, with the remaining 38.74 percent held by Blue Cross Blue Shield of Michigan.

The consolidated financial statements of BMH include all of the members of AmeriHealth Caritas, including but not limited to the accounts of AmeriHealth Caritas Health Plan and its subsidiaries (which will include AmeriHealth Caritas Iowa once it becomes fully operational and has financial results to report).

BMH provides financial resources to health plans to meet or exceed ongoing financial requirements and support initiatives that improve member health outcomes and strengthen provider relationships. As of December 31, 2014, BMH had cash and cash equivalents of \$^{Confidential & Not for Public}, investments of \$^{Confidential & Not for Public}, total assets of \$^{Confidential & Not for Public} and member equity of \$^{Confidential & Not for Public}. BMH is prepared to provide the initial capitalization, as well as provide ongoing capital support, as necessary. Additionally, BMH has the ability to request capital contributions from Independence and BCBSM to support strategic initiatives and leverage resources.

BMH Audited Financial Statements for the years ended December 31			
	2012	2013	2014
Liquidity Ratio	558.2%	465.3%	614.3%
Leverage Ratio	13.1%	23.1%	20.4%

BMH is committed to providing the minimum capitalization of \$1.0 million for AmeriHealth Caritas Iowa to receive its certificate of authority to operate a health maintenance organization (HMO) in the state of Iowa. Since Iowa has adopted the NAIC’s Risk Based Capital requirements, BMH is committed to ensuring that AmeriHealth Caritas Iowa meets these requirements on an ongoing basis.

BMH’s audited financial statements for the years ended December 31, 2012, 2013 and 2014, are included in our financial statement submissions.

Insolvency protection account

Upon award of the contract, AmeriHealth Caritas Iowa will project the amount of the annual capitation and maintain two months of this amount in a restricted insolvency protection account that may be drawn upon only with the authorized signatures of two persons designated by AmeriHealth Caritas Iowa and two persons designated by DHS.

Surplus fund

AmeriHealth Caritas Iowa acknowledges that it must maintain in surplus at all times, in the form of cash, short-term investments allowable as admitted assets or restricted funds or deposits controlled by DHS, an amount equal to 150 percent of AmeriHealth Caritas Iowa’s average monthly Medicaid claims fund. AmeriHealth Caritas Iowa will project the monthly amount upon award of the contract and ensure that it meets the requirement. As noted, the surplus amount will be monitored on a quarterly basis.

Working capital

AmeriHealth Caritas Iowa is committed to maintaining working capital in the form of cash or equivalent liquid assets controlled by DHS at least equal to the total amount of the designated Medicaid administrative funds from the most recent three-month period of capitation payments.

2. Describe how you will comply with the requirements for reinsurance. Will you obtain reinsurance contracts or submit a plan of self-insurance?

AmeriHealth Caritas Iowa will maintain reinsurance agreements or a plan of self-insurance throughout the contract period, including any extensions. AmeriHealth Caritas Iowa will also file the agreements and/or plans with DHS, as well as duly notify DHS of any modifications and cancellations.

AmeriHealth Caritas Iowa will utilize a comprehensive process to determine its reinsurance arrangements or its self-insurance plan. Factors supporting AmeriHealth Caritas Iowa’s proposed reinsurance arrangements will include, but not be limited to, the number of members enrolled, the benefits covered by a reinsurance policy, (such as inpatient services, pharmacy, etc.), utilization history, large claim reinsurance quotes from reinsurance carriers for various cost thresholds and other factors traditionally utilized in purchasing reinsurance coverage. AmeriHealth Caritas Iowa will evaluate the expected net cost of

insurance of these proposals by comparing the premium to an expected cost of claims in excess of the threshold.

After receiving a contract award, AmeriHealth Caritas Iowa will obtain large-claim reinsurance quotes from several reinsurance carriers for various cost thresholds and finalize its analysis of whether to purchase reinsurance or develop a self-insurance plan.

When its analysis is complete, AmeriHealth Caritas Iowa will share with the state the risk analysis, assumptions, cost estimates and rationale supporting our proposed reinsurance arrangements. If any reinsurance is provided through related parties, AmeriHealth Caritas Iowa will provide a disclosure of the entities and details causing the related party relationship, at that time.

AmeriHealth Caritas Iowa's proposed reinsurance arrangements shall meet all requirements of the RFP including, but not limited to:

1. Copying DHS on all required filings with the Iowa Insurance Division.
2. Holding a certificate of authority from the Iowa Department of Insurance.
3. Filing of all contracts of reinsurance or a summary of our plan of self-insurance with DHS.
4. Reinsurance contracts and stop-loss agreements shall provide that the Commissioner of Insurance be given notice of termination by certified mail at least 30 days prior to the effective date of termination of the reinsurance contract or stop-loss agreement.
5. Ensuring that retention levels are reasonable in light of the HMO's financial condition and potential liabilities.
6. Maintaining reinsurance agreements throughout the contract period, including any extension(s) or renewal(s), and providing prior notification to DHS of our intent to purchase or modify reinsurance protection for certain members enrolled.

2.4 Maintenance of Records

1. Describe your system for maintaining financial and medical records that fully disclose the extent of services provided to members.

AmeriHealth Caritas Iowa has robust policies and procedures for maintaining records (financial, medical and otherwise). Our policies and procedures help support systematic identification, control, maintenance, storage, retention and destruction of financial and medical records across our systems which meet or exceed the needs set forth or referenced in Section 2.4 of the SOW. As an example, all vital records within AmeriHealth Caritas are retained for either 10 years from use or permanently, depending upon the type of record. We will meet or exceed any additional requirements that may be set forth by the state, including responses to record requests.

2.5 Disclosures

1. Provide disclosures as described in the subsections of Section 2.5.

The ownership disclosure forms, which are the only disclosures required under section 2.5 at this time, are included in our proposal under Tab 6.

2.6 Debarred Individuals

1. Describe mechanisms to ensure compliance with requirements surrounding debarred individuals.

AmeriHealth Caritas Iowa will not contract with or employ individuals and entities, vendors, suppliers and contractors that have been excluded from participation in Federal healthcare programs. As a condition of employment, each candidate will be required to undergo a pre-employment screening, including drug testing and a background check. Each offer of employment is conditional upon the candidate successfully passing the drug screening, background check, and physical (if applicable), prior to the first day of employment. The background check includes, at a minimum, verification of:

- Social Security number.
- Education.
- Present/former addresses.
- Professional licensures or job specific requirements as mandated by any federal, state or locality.
- Criminal and civil case history/records (including pending cases, of which any convictions that would exclude hiring, be adjudicated prior to the start of employment).
- Driving records (if applicable to the position).
- Public records.

To ensure that we do not employ individuals and entities, vendors, suppliers and contractors that have been excluded from participation in federal healthcare programs, the background check will also include verification of federal and state exclusion information available from the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and System for Award Management (SAM), Medicare Exclusions Database (MED) and State-based sanction and licensure databases.

As a condition of continued employment, AmeriHealth Caritas Iowa will continue to monitor associates, vendors, suppliers and contractors that have an existing business relationship by systematically searching for their names (or engaging a qualified vendor to search) in the federal and state exclusion databases on a monthly basis, or as frequently as updates are made by the federal and state agencies maintaining them.

AmeriHealth Caritas Iowa's contracts with providers will require prompt notification to AmeriHealth Caritas Iowa if a provider is debarred or suspended from participation in Medicaid/Medicare, the Children's Health Insurance Program (CHIP), and/or any federal healthcare program. Such contracts will also contain provisions that require prompt notification to AmeriHealth Caritas Iowa 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 Caritas Iowa will terminate its contractual relationship with the provider.

AmeriHealth Caritas Iowa, with support from AmeriHealth Caritas, is committed to working with the Iowa DHS in its efforts to combat Medicaid fraud. As such, AmeriHealth Caritas has a robust process to ensure that AmeriHealth Caritas Iowa also does not contract with any healthcare providers or facilities that have also been excluded or debarred from participating in federal healthcare programs and to prevent any payments (including indirect payments) of federal and state healthcare funds to excluded or debarred entities.

Similar to the process for our associates, AmeriHealth Caritas conducts a search of the following websites monthly to capture exclusions and reinstatements that have occurred since the previous search:

- OIG LEIE.
- SAM.
- National Practitioner Data Bank (NPDB).

Once identified as a suspended, debarred, sanctioned or excluded provider, immediate actions are taken to terminate the provider within our system and refer the case to the AmeriHealth Caritas Special Investigation Unit for investigation and referral to Iowa DHS. Additionally, all practitioners and facilities identified by these searches are immediately configured within the AmeriHealth Caritas claims adjudication platform to have their submitted claims denied.

Any new non-participating provider or facility submitting a claim goes through a validation process to confirm the provider is not on any of the lists stated above. This is accomplished during the initial steps of claims adjudication, where claims processors access validation portals provided by payment integrity vendors to validate the provider's information. AmeriHealth Caritas screens new, participating and non-participating providers using the resources also described above.

2.8 Organizational Structure

1. Describe your proposed organizational structure and indicate which operational functions will be conducted in Iowa and which functions will be conducted out-of-state.

As mentioned earlier, AmeriHealth Caritas Iowa is a direct, wholly owned subsidiary of AmeriHealth Caritas Health Plan and is a member of AmeriHealth Caritas Family of Companies (AmeriHealth Caritas). AmeriHealth Caritas' financial results are reported on a consolidated basis under the audited financial statements of BMH LLC ("BMH"). BMH was organized in 2011 as the entity through which Independence Blue Cross (Independence) and Blue Cross and Blue Shield of Michigan (BCBSM) would jointly own and invest in the Medicaid managed care businesses conducted by AmeriHealth Caritas Health Plan, its subsidiaries, and its sister company, Keystone Family Health Plan. On June 4, 2012, BMH formed AmeriHealth Caritas Services, LLC for the purpose of providing administrative services to other affiliates within AmeriHealth Caritas (all of which are subsidiaries of BMH). See Tab 4: Bidder's Background, which depicts the ownership structure of AmeriHealth Caritas.

Our organizational chart also located in Tab 4 includes local, regional and corporate positions that will be responsible for successful ongoing operations of AmeriHealth Caritas Iowa. Functions managed at the local level will include health plan administration, health plan finance, medical management, provider network management, community outreach, quality improvement, regulatory affairs, program integrity and compliance. The organizational charts below depict the assignment of resources at the local level for these functions.

The staffing chart shown in 2.9 provides specific information by position on which jobs are local, regional and corporate. Corporate positions work from our corporate offices in Philadelphia, regional position locations vary, and local positions reside in the plans.

2. Describe how your administrative structure and practices will support the integration of the delivery of physical health, behavioral health and long term services and supports (LTSS).

The use of an Interdisciplinary Care Team (ICT) allows care to be customized to meet the specific needs of an individual member or beneficiary regardless of the type of service required. The ICT will meet members or beneficiaries at the locations that are most convenient to them, and communicate with them using their preferred methods of communication. The team is made up of professionals, paraprofessionals and non-professionals who possess the knowledge, skill and expertise necessary to accurately assess and respond to an individual's care needs. In addition, the team includes the member and any family, caregivers or informal supports. This whole-person approach helps to identify the specific needs of the individual and crosses the spectrum of physical and behavioral health, as well as identifying the social or environmental issues and need for long term services and supports. The plan of care will be based upon the individual member's needs and preferences and is always designed with the member and/or the member's representative, as appropriate. This process is designed to be inclusive of the member's support system, when desired.

AmeriHealth Caritas' Integrated Healthcare Management (IHM) model fully integrates all aspects of a member's health including physical health, behavioral health, long-term services and supports, medications and social services. This integrated model positions delivers improved health outcomes and financial performance.

AmeriHealth Caritas Iowa's structures and practices reflect our IHM model, including:

- Our medical management team is composed of licensed nurses, licensed social workers and paraprofessionals supported by physicians, psychiatrists and psychologists. Our collaborative care approach allows for each clinician on the team to obtain support and advice from specialists in a variety of disciplines, such as child psychiatry, developmental disabilities, pediatricians, obstetricians, pharmacists and other board certified specialists.
- A portion of our staffing model for local care management is based on the model developed for our integrated Medicare-Medicaid plans (MMPs) in South Carolina and Michigan based on our assumptions of the proportion of members requiring LTSS. This staffing model differs from our model used for traditional TANF populations.
- Support functions are integrated. For example, we have an integrated claims platform, which pays all claims types — physical health, behavioral health and long-term services and supports. Our care management, provider and claims platforms have been validated as ready to serve members requiring LTSS as demonstrated through our successful readiness reviews in South Carolina and Michigan.

For additional information regarding our structure, procedures and practices regarding care coordination, please see Section 9 of this response.

2.9 Staffing

1. Describe in detail your staffing plan and expected staffing levels

AmeriHealth Caritas Iowa has developed a staffing model based on the expectations and SOW described in the RFP, including an organizational chart depicting ownership and operating structure in Tab 4 of the submission. Upon contract award, and following contract negotiation, AmeriHealth Caritas Iowa will

finalize its staffing plan and forward it to DHS for approval. Listed below is the staffing plan with job titles, headcount and location. Titles that are listed in bold indicate required positions.

Department/Function	Title	Head-Count	Staff Location
Administration	Contract Administrator	1	Local
Community Relations and Member Outreach			
Community Outreach	Director, Community Relations/ Member Outreach	1	Local
Community Outreach	Manager, Community Relations/ Outreach (Field)	1	Local
Community Outreach	Supervisor, Community Relations/ Outreach (Field)	2	Local
Community Outreach	Community Relations Representative	10	Local
Community Outreach	Marketing Coordinator	3	Local
Subtotal Community Relations and Member Outreach		17	
Plan Administration			
Operations	Director, Plan Operations and Administration	1	Local
Operations	Facilities, and Emergency Management Specialist	1	Local
Provider Network Operations	Director, Local Operations/Provider Network Operations	1	Local
Provider Network Operations	Manager, Network Operations	1	Local
Provider Network Operations	Provider Network Analyst	5	Local
Provider Network Operations	Coordinator, Provider Operations	2	Local
Member Services	Director, Member Engagement	1	Local
Information Solutions	Information Systems Manager	1	Local
Information Solutions	Tech Analysts	1	Local
Administrative Assistants	Admin Assistants	4	Local
Subtotal Plan Administration		18	

Department/Function	Title	Head-Count	Staff Location
Medical Management			
Administration	Medical Director	1	Local
Pharmacy	Pharmacist Director/Coordinator	1	Local
Care Management	Director, Integrated Care Management	1	Local
Care Management	Care Manager	26	Local
Care Management	Care Connector	12	Local
Care Management	Care Management Manager	2	Local
Care Management	Supervisor, Care Management	3	Local
Care Management (Maternity)	Care Manager	7	Local
Long Term Care	Long Term Care Manager	1	Local
Community Care Management	Community Program Manager	1	Local
Community Care Management	Clinical Educator	2	Local
Community Care Management (Registered Nurse)	Community Care Management Care Manager	2	Local
Community Care Management (Master of Social Work)	Community Care Management Care Manager	2	Local
Community Care Management	Community Care Management Care Connector	6	Local
Community Care Management	Community Care Management Coordinator	2	Local
Appeals & Grievances	Grievances & Appeals Manager	1	Local
Appeals & Grievances (Registered Nurse)	Clinical Care Reviewer	2	Local
Appeals & Grievances	Appeals Coordinator	5	Local
Rapid Response	Manager, Rapid Response	1	Local
Rapid Response	Supervisor, Rapid Response	2	Local
Rapid Response	Care Connector	10	Local
Rapid Response	Care Manager	3	Local
Rapid Response-EPSDT	Care Connector	4	Local

Department/Function	Title	Head-Count	Staff Location
Utilization Management	Medical Directors, Utilization Management	2	Local
Utilization Management	Clinical Care Reviewer UM	20	Local
Utilization Management	Utilization Management Tech	6	Local
Utilization Management	Durable Medical Equipment (DME) Specialist	6	Local
Utilization Management	Utilization Management Manager	2	Local
Utilization Management	Supervisor UM	4	Local
Behavioral Health	Behavioral Health Manager	1	Local
Behavioral Health	Medical Director	1	Local
Behavioral Health	Psychiatrist/Psychologist Advisor	1	Local
Behavioral Health	UM Supervisor	2	Local
Behavioral Health	UM Clinical Care Reviewer	7	Local
Behavioral Health-After Hours Clinical	Clinical Care Manager	3	Local
Behavioral Health	Care Manager	6	Local
Behavioral Health	Care Connector	3	Local
Quality Management	Quality Management Manager	1	Local
Quality Management	Quality Performance Management Specialist-non clinical	3	Local
Quality Management	Cultural Linguistic Appropriate Services (CLAS) Coordinator	1	Local
Quality Management	Community Outreach Solutions Specialist	8	Local
Quality Management	Quality Management Registered Nurse (Quality Performance Specialist-Clinical)	2	Local
Quality Management	Clinical Auditor	3	Local
Quality Management	Clinical Trainer	2	Local
Subtotal Medical Management		181	

Department/Function	Title	Head-Count	Staff Location
Provider Network			
Provider Network	Director, Provider Network Management	1	Local
Provider Network	Provider Network Account Executives	8	Local
Provider Network	Provider Communications Specialist	1	Local
Provider Network	Manager, Provider Network Management	2	Local
Provider Network	Credentialing Coordinator	6	Local
Subtotal Provider Network/ Provider Network Operations		18	
Service Operations			
Service Operations (IS/operations)	Encounters Analyst	2	Corporate
Service Operations (Configuration and testing)	Analyst	9	Corporate
Service Operations (Claims processing)	Claims Administrator	1	Corporate
Service Operations (Claims processing)	Claims Examiners, Claims Research	40	Corporate
Service Operations (Member-Provider Services)	Member Services / Provider Services Manager	2	Corporate
Service Operations (Member-Provider Services)	Customer Service Representative	35	Corporate
Service Operations (Provider Claims Services)	Customer Service Representative	10	Corporate
Service Operations (Provider Maintenance)	Provider Maintenance Technician	5	Corporate
Service Operations (Enrollment and Welcome Calls)	Enrollment Specialist / Customer Service Representative	6	Corporate
Service Operations (Cost Containment)	Cost Containment Analyst	1	Corporate
Service Operations (Other operations)	IPQ, Quality, Auditing	15	Corporate
Subtotal Service Operations		126	

Department/Function	Title	Head-Count	Staff Location
Information Solutions			
Information Solutions	Apps, EDI, Production Control, Desktop Support, Business Engagement	12	Corporate
Subtotal Information Solutions		12	
Finance			
Finance	Chief Financial Officer	1	Local
Subtotal Finance		1	
Compliance			
Compliance	Compliance Officer	1	Local
Compliance	Compliance/Regulatory Analyst Specialist	1	Local
Subtotal Compliance		2	
Corporate Support Staff			
Corporate Finance	Accounting, Actuarial, Regulatory Reporting, Financial Services	5	Corporate
Payment Integrity	Program Integrity Manager	1	Local
Payment Integrity	Investigator/Recovery Analyst/Research & Reporting Analyst	6	Local
Medical Economics	Medical Economics Analyst	4	Corporate
Marketing and Communications	Web Designer/Plan Communications Manager	2	Corporate
Integrated Document System	Coordinator, Mail Services	4	Corporate
Human Resources	Human Resources Business Partner	1	Local
Other Corporate		7	Corporate
Subtotal Corporate Support Staff		30	
Grand Total		406	

Exhibit 2.9-A: Estimated AmeriHealth Caritas Iowa Staffing

The Contract Administrator is responsible for the overall management of the program and ensures that expected outcomes are met or exceeded. The Director, Plan Administration is second in command and is responsible for plan operations, member engagement, and data/technical needs. This function has strong ties to the corporate service operations functions. The local plan operations leader and member engagement leader provide direction to the corporate resources on managing and resolving operational issues. This allows us to leverage our existing structure, gain efficiencies and provide corporate resources with a local feel (due to the direction provided by the local health plan operations and member engagement leaders).

Call center staffing levels are determined by taking the following data into consideration: anticipated volume of calls per day, access functions managed by call center personnel, performance standards, hours of operation, translation services and the projected number of members served. Defined functions and skill sets will indicate what staff capacity is needed: competency, level of expertise/experience and licensure.

2. For staffing positions proposed in your staffing plan, provide job descriptions that include the responsibilities and qualifications of the position, including the number of years of experience.

AmeriHealth Caritas Iowa's staff will be able to provide the expertise and local knowledge needed to best serve Iowa Medicaid members and meet or exceed the requirements set forth by Iowa DHS. All job descriptions are provided within Attachment 2.9: Job Descriptions (at the end of this section) and include the details specified by Iowa.

3. Confirm that a final staffing plan, including a resume for each Key Personnel member, will be delivered within ten (10) calendar days after notice of award.

AmeriHealth Caritas confirms that this will happen within 10 days after notice of award. It will include a resume for each of the key personnel members.

We believe in developing and promoting talent within our organization. We have engaged our Talent Management team to begin identifying "high potential" associates who are qualified and ready to relocate to Iowa to fill key roles.

Our Talent Acquisition team has extensive experience with securing highly skilled, competent staffing resources within short time frames. We have engaged a recruitment firm to assist in securing high-caliber candidates for key staff and clinical positions so that we are prepared for a January 2016 implementation.

4. Describe your back up personnel plan, including a discussion of the staffing contingency plan for:

a. The process for replacement of personnel in the event of a loss of Key Personnel or others.

The Talent Acquisition and Talent Management teams meet on a regular basis to remain up-to-date on open positions. The teams maintain a talent pipeline (especially for critical roles), and we aim to fill key roles internally whenever possible. We have an external research firm on retainer, as well as internal and external experts on executive and key staff talent search to ensure these roles are rapidly filled with the most qualified candidates in every location.

AmeriHealth Caritas Iowa will have access to the AmeriHealth Caritas sourcing contract with RightSourcing for vendor management services. This resource includes more than 40 vendors, many of whom provide temporary staffing.

Building bench strength is a priority at AmeriHealth Caritas. Talent review and succession planning are more than good ideas — they are essential elements for an enterprise in growth mode. Talent management consultants and human resources business partners work with people managers at the senior vice president, vice president and director levels to evaluate talent throughout the organization and identify successors for critical roles. An overarching goal of this process is to ensure that successors are developed and ready to replace key staff. Once identified, these candidates participate in individual and group development on an ongoing basis. AmeriHealth Caritas' talent review and succession planning process is an annual endeavor, beginning in spring.

b. Allocation of additional resources in the event of an inability to meet a performance standard.

Should additional resources be needed to meet a performance standard, the health plan would receive assistance from corporate resources until the performance standard is met and a permanent solution is in place. When performance is not being met, work is prioritized to place resources where the need is until the need is met and the performance is stabilized. Training is delivered to the local health plan associates to ensure that any new processes are understood and utilized consistently. Performance issues are raised at the senior executive level and monitored closely until issues are resolved.

c. Replacement of staff with key qualifications and experience and new staff with similar qualifications and experience.

AmeriHealth Caritas' Talent Acquisition is continuously scanning the market for high potential external candidates. Through our use of proprietary software we are able to identify top talent at competitors nationwide. AmeriHealth Caritas manages the talent pipeline on a continual basis with an eye toward achieving bench strength for critical roles. After the annual Talent Review and Succession Planning process, the talent management team actively works to develop successors and identify gaps through the use of best-in-class processes and data management. We are working to develop people to be ready for critical roles. Programs such as Executive Leadership LINC (a leadership development program) and others help to develop competencies and skills needed for key roles. When this program was developed, the goal was to achieve 25 percent career mobility within AmeriHealth Caritas; however, we have more than doubled that number.

d. The time frame necessary for obtaining replacements.

The time frame necessary for obtaining replacement positions may vary depending on the role. Generally, it takes an average of 63 days.

e. The method of bringing replacement or additions up to date regarding the Contract.

Replacements/additions will attend job-specific training as needed per role. The training (instructor-led, virtual, computer-based, or on-the-job training) will include information regarding the contract as appropriate for the position being filled.

5. Describe which staff will be located in Iowa, and where other staff will be located.

The staff listed as “Local” in Exhibit 2.9-A will be located in Iowa. Local staff will primarily consist of:

- AmeriHealth Caritas Iowa administrators (including the Contract Administrator/Market President and Chief Financial Officer [CFO]).
- Community relations and member outreach representatives.
- Medical management staff (e.g., medical director, care managers).
- Quality Management personnel.
- Provider Network staff (e.g., Provider Network account executives, Credentialing coordinators).
- Compliance staff.

Corporate staff will be located in Philadelphia, PA.

a. Describe how out-of-state staff will be supervised to ensure compliance with Contract requirements and how Iowa-based staff shall maintain a full understanding of the operations conducted out-of-state.

The Plan Contract Administrator/Market President is fully accountable for understanding and ensuring compliance to all contractual requirements regardless of whether operations are conducted in-state or out-of-state. Under the supervision of the Regional President, the Contract Administrator/Market President communicates frequently with regional and corporate resources to ensure that systems and procedures ensure contract adherence.

In addition, the Director of Provider Network Operations and Director of Member Engagement act as liaisons between local and regional/corporate resources. The Plan Director of Provider Network Operations and the Plan Director of Member Engagement meet with the corporate leaders on a monthly basis, at a minimum, to review performance and adherence to contractual obligations, and any changes to policies and procedures. These roles monitor the out-of-state functions to ensure work is being conducted per the requirements. The Compliance Director will also be well-versed on the specifics of the contract and will be responsible for communicating any updates or changes to contractual requirements to the local health plan, as well as appropriate regional and corporate resources, regardless of location.

Training programs, team meetings and coaching are scheduled as needed to address information about the health plan. As new administrative workflows or processes are implemented, the local associates return to formal and informal training sessions to ensure they are utilizing the most up-to-date information. Updates are shared via electronic training materials and posted within our online help resource systems.

In addition to the above, Market President Meetings with the local team as well as the Corporate and Regional out-of-state operational teams are convened at which performance metrics and trends are discussed to ensure compliance with contractual requirements. Performance metrics are determined based on DHS contractual requirements.

Any performance issues that are identified through metrics reporting and/or performance management meetings are tracked via an issues tracking database to track timeliness of issues resolution, identify trends and to ensure an accounting of all issues and their resolution outcome.

Oversight of the contract requirements is also carried out by the local Compliance officer, who will be responsible for auditing and monitoring AmeriHealth Caritas Iowa’s performance against the requirements

of the contract with DHS. This is the model that we have successfully deployed in our other managed care lines of business across the AmeriHealth Caritas enterprise.

Key performance indicators and contractual metrics are also reviewed monthly by the AmeriHealth Caritas Operating Committee, which reports directly to the Chief Executive Officer (CEO). The Operating Committee is a cross-functional team representing all departmental functions that meets weekly to review all operating reports.

b. Indicate the location of the Iowa office from which key staff members will perform their duties and responsibilities.

We are in the process of securing corporate facilities in downtown Des Moines. This location provides the largest pool of qualified candidates needed to fill RFP-required roles as well as other roles required in our staffing model. In addition, we are committed to building AmeriHealth Caritas Iowa Community Wellness Centers in Des Moines, Sioux City and Cedar Rapids, which will provide locations for members to receive health services and administrative support, will serve as a reliable source of primary care, as needed. Key staff may be located at these Community Wellness Centers on occasion to perform certain duties as needed.

6. Describe your process for ensuring all staff have the appropriate credentials, education, experience and orientation to fulfill the requirements of their position (including subcontractors' staff).

Our Regulatory Affairs department communicates contractual requirements to our Human Resources department to ensure that we are hiring associates and subcontractors with the appropriate credentials, education, and experience. Upon hire, AmeriHealth Caritas utilizes the services of First Advantage, a leading global provider of background screening solutions. First Advantage provides AmeriHealth Caritas with the following verification services:

- Education and training.
- Professional degree.
- State license.
- FACIS (Fraud & Abuse Control Information System).
- Office of Inspector General (OIG).
- Healthcare Credentialing.

To ensure the utmost data integrity, First Advantage employs a dedicated team of credentialing professionals to gather and validate data and swiftly return the results using secure, web-based technology approved by the U.S. Department of Homeland Security Safety Act.

7. Describe how you will ensure that all staff is knowledgeable in Iowa-specific policies and operations.

AmeriHealth Caritas Iowa will prepare our associates to successfully support Iowa policies and operations. We have developed a comprehensive enterprise onboarding and training program designed to orient and prepare our staff to deliver on our commitments to Members. These programs reflect our experience in serving Medicaid members for more than 30 years. Upon hire, we will complete the following:

Accommodate and acclimate by providing the tools and resources needed to create immediate capability for associates to deliver results on behalf of members.

Assimilate by assisting associates with networking and mentoring opportunities to create interactions that enable them to learn, navigate and generate successful results.

Accelerate by communicating and gathering feedback and current information to enable and enhance delivery of superior, consistent, timely results.

Through our comprehensive onboarding, functional business training, policies and procedures training, compliance, associate and leadership development, and ongoing learning and training on program changes, we create a continuum of learning from day one through the associate's entire time working with us, serving our members and communities.

8. Describe in detail your staff training plans (including subcontractors' staff) and ongoing policies and procedures for training all staff.

AmeriHealth Caritas of Iowa has already begun to review extensive market assessment data to understand the needs of the Iowa Medicaid population. Iowa contract requirements will be incorporated into all training, and our approach is to consider the whole person's physical, behavioral and pharmacy needs, as well as the social barriers he/she may be facing, which differ for members in urban and rural areas. All of this is incorporated into training for staff that interacts with members. Additional areas of focus are: diversity and inclusion, cultural competence, health equity, CLAS and Compliance. We will design, develop and deliver comprehensive training and development programs and materials for all operations, medical management, long-term services and supports (LTSS), pharmacy, and behavioral health associates who will support the Iowa health plan locally and in our regional and corporate offices. Additionally, all contractor staff is trained on these same elements depending upon the specific role being filled.

The process begins with our recruitment efforts. Our recruitment strategy identifies candidates who already possess the necessary experience and skills needed to provide high-quality service to our Iowa members, providers and partners. For example, a step in our recruitment process specific to associates who will have direct interaction with our members is an upfront skills and computer proficiency test. The test requires those candidates to pass a proficiency assessment to move forward with the interview process. The AmeriHealth Caritas of Iowa recruitment team and the hiring unit interview new potential associates, and assess and align the required skills and competencies based on the position.

Orientation and training for new hires

From the first day of employment, we will prepare associates to become an integral part of AmeriHealth Caritas of Iowa. Upon hire, all AmeriHealth Caritas associates are required to complete our enterprise-wide onboarding orientation. During this session, associates learn about our organization, including our mission, values and approach to meeting the needs of our members, providers, business partners and communities in addition to learning about the local Medicaid program they will serve. All associates are provided an onboarding training plan using our dedicated onboarding LINC Web page (see Exhibit 2.9-A). LINC stands for "Linking Individual Contributions to Corporate Results," and we use this approach with all of our learning efforts, starting with new hires.

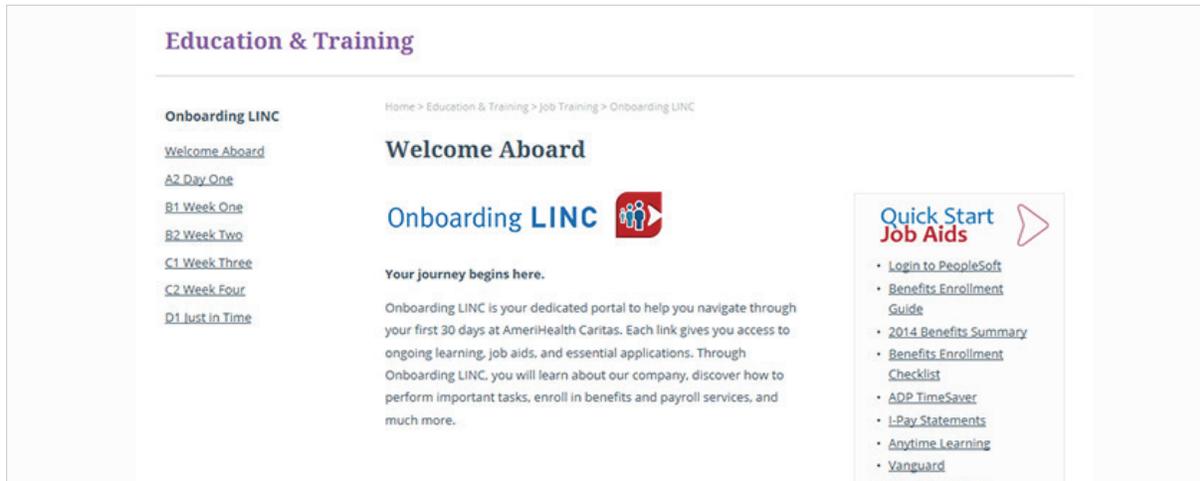


Exhibit 2.9-A: Onboarding training plan

Our dedicated onboarding specialists review the mandatory training requirements, which include compliance and security awareness, as well as job-specific training, leadership/management skills training, and other training as required to ensure strong skills and performance excellence in service to our members. Additionally, all associates attend cultural sensitivity training upon hire and on an annual basis. Our sensitivity training includes:

- Diversity awareness and inclusion.
- CLAS.
- Health equity.
- Health disparities.
- Cultural competence.

Our learning management systems provide access to online reference materials, videos and training courses in many different topics, such as systems software skills, business skills, personal development and professional effectiveness skills. Easily accessible and user-friendly, all associates are provided access to more than 10,000 learning topics, as well as their individual onboarding training program.

New hires begin job-specific training within the first week of their start date. Existing staff training is done throughout the year as new workflows or processes are implemented. Based on job-specific roles and business needs, bi-monthly or quarterly training opportunities on various topics are offered via open enrollment and target-audience assignments. The training offerings address process improvements, workflow changes and system functionality updates. The schedule is posted in our online training registration system and reminders are sent to ensure engagement. If additional areas of educational opportunities/needs are discovered as a result of quality audits or management performance assessments, then individual or group training and coaching is delivered to mitigate and close gaps in knowledge.

New associates in key roles begin extensive job-specific departmental training. The duration of these training programs vary based on the job-specific work but include delivery through classroom, one-on-one instruction, self-directed instruction, “on the job” side-by-side training and learning labs. All new-hire training programs incorporate training on policies and procedures as well as workflow processes. All formal training programs have built-in self-assessments on progress, mastery check points and final learning assessments.

Our new hire training programs include quality audits throughout the sessions. Dedicated quality auditors assess associates during the training process. If areas of opportunity are discovered as a result of audit scores or testing, the associate or group of trainees are retrained and reassessed until they reach proficiency. Through our continuous quality assurance process, we are able to identify skill and learning gaps and/or specific areas of challenge. Associates complete skill-based assessments to test their knowledge. Upon completion, associates are required to pass a readiness assessment, which evaluates their general knowledge and readiness on this particular skill or topic.

Associates who require additional technical training will attend programs specifically geared to the unique skills and competencies required for their role. For example, clinical staff members attend programs that are specific to systems and processes that impact the clinical team's day-to-day responsibilities and include training topics such as Motivational Interviewing, System of Care, Model of Care and InterQual training. Additionally, our clinical associates are routinely evaluated on their interpretation and application of utilization management guidelines. On a quarterly basis, we deliver and evaluate the results of an inter-rater reliability test. The test is comprised of questions that address the use and application of InterQual criteria, clinical policies, workflow processes, and standard operating procedures. In the event an associate does not pass the test, he or she is enrolled in a remediation training session and is retested on those topics. Additionally, audits are conducted on a quarterly basis to identify and address areas of educational opportunity. Training is set up on an individual or group basis as appropriate. Monthly training is offered on specific topics that relate to workflow, process and guidelines.

Associates who speak directly to our members are required to participate in a phone lab training session and side-by-side training with an experienced associate. During the phone lab training session, new associates handle live telephone calls from members and providers, assisted by the trainer and support staff. On occasions where the new associate becomes challenged, the experienced trainer and business support staff immediately engage so we are able to maintain our one-call resolution standard.

As part of our continuous efforts to achieve one-call resolution, associates interacting with members participate in Mental Health First Aid (MHFA) training. MHFA is included on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP). Associates learn to identify the risk factors and warning signs of mental illnesses, and develop a greater understanding of their impact and the common supports. Our MHFA training program prepares our associates to interact with a person in crisis and connect the person to help. First Aiders do not diagnose or provide any counseling or therapy, but instead, offer concrete tools and answer key questions, like "What do I do?" and "Where can someone find help?" Our Certified Mental Health First Aid instructors provide a list of community healthcare providers, national resources, support groups and online tools for identifying mental health and addiction treatments.

Our internal training teams and instructional designers work with subject matter experts to design, develop and implement programs that continue to build the skills needed for success after new hire training. Our programs are built with learning assessments that track the learners' knowledge. Comprehension is based on a passing score of 80 percent proficiency that must be met to successfully complete the course. Online tracking is used to capture attendance, comprehension scores and completion of training initiatives. Our learning management systems allow us to track, monitor and report on compliance programs related to training.

Department- job specific training

In addition to training received by all associates, there are departmental and job-specific training and educational programs. Below are high-level overviews of some of our departmental and job-specific training topics and programs.

Provider Network Management and Operations

We believe that the relationship we build with our provider community is paramount to cultivating a robust network in support of member needs. We are committed to diligently training our associates to establish collaborative and supportive relationships with providers to nurture an environment where our members have access to care and a choice of practitioners. New and existing associates who support our provider community actively participate in training to ensure that they understand our philosophy and work hard to collaborate and communicate effectively to meet provider needs. This comprehensive training plan will include topics specific to the Iowa health plan, as well as:

1. Provider demographics.
2. System of care.
3. Provider systems training.
4. Policies and procedures.
5. Access and availability standards.
6. CLAS and health equity training.
7. Specialty network coordination.
8. Quality training.
9. Costs and outcomes of health services information, and more.

The goal of our staff provider training program is to ensure associates who interact with our providers, directly or indirectly, are equipped with comprehensive knowledge and skills. We understand that training our staff to support, inform, and listen to our provider community is important to the delivery of healthier member outcomes.

Provider Network Management (PNM) team

As part of our standard practice, we will assemble a team of Iowa provider network managers (PNMs) who live and work in Iowa, have extensive experience with providers and a thorough, first-hand knowledge of the communities they serve. This affords us a distinct advantage in identifying and mitigating concerns on a pre-emptive basis, before they become access issues for members.

Provider Network Operations (PNO) team

The Provider Network Operations team provides assistance in the resolution of provider issues. The account executives in PNO are trained on the proper protocols to submit provider issues into an internal database; network operations staff is trained to enter these issues for centralized tracking and resolution into MACCESS EXP (EXP) system. Once the complaint or inquiry is researched and the course of action required for resolution is determined, the assigned department coordinates and tracks all activity related to resolution of the submitted issue. All documentation employed with provider issues, including is received outside of Iowa's formal dispute process, is managed through the Provider Network Operations team and the EXP database.

Member Outreach team

A supplemental source of support to our provider network and provider office staff will be our Member Outreach team. The Member Outreach team learns to assist with outbound appointment setting, either on-site at the provider office or off-site. The Member Outreach team staff will learn how to coordinate transportation to and from the appointment to ensure it is not a barrier. The Member Outreach team is

also trained to educate members in effectively navigating the health care system and to assist members in remedying any issues they experience.

Operations – contact center

From the first day of employment, associates hired for the Contact Center are prepared to become integral members of the Contact Center of Excellence (CCOE). Upon hire, our dedicated training unit conducts an extensive training program for new hires. The Operations New Hire Training program consists of five weeks of classroom instruction, as well as side-by-side “on the job” training. It is mandatory for new hires to complete Health Equities, CLAS and Cultural Health computer based trainings (CBT), in addition to a facilitated class titled “Diversity in the Workplace.”

The following is an overview of training topics that will be included in the AmeriHealth Caritas Iowa new hire program:

- Iowa geography, including correct pronunciation of place names.
- Iowa-specific Medicaid benefits.
- Key contact numbers, such as the enrollment broker and DHS.
- Health Care fundamentals.
- Health Care terminology.
- Medicaid basics/program overview.
- Member eligibility.
- Soft skills.
- What it means to provide superior customer service.
- How to handle member complaints and dissatisfaction.
- How to handle difficult members.
- How to handle a member with limited English proficiency skills.
- Diversity and cultural competency.
- Corporate compliance, including HIPAA.
- Use of core technology and system.
- Phone lab, including supervised live calls.

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

Pharmacy – contact center

In Pharmacy, the training approach ensures the staff is trained and updated regularly, and that the client implementation plans and benefit updates have been communicated. This approach includes the following topics as they relate to changes and updates:

- **New business implementation** — Outlines new business policies and procedures, operational standards, protocols, and service requirements. In addition, all existing businesses are re-implemented with refresher training, updated policies and procedures, operational standards, protocols, and service requirements. Any client specific protocols that require system enhancement/change are delivered as part of this training program.
- **Line of business refresher** — Outlines the line of business's policies and procedures, operational standards, protocols, and service requirements. In addition, scenario-based case studies are used to provide targeted skill/knowledge development of the lines of business's policies and procedures, operational standards, protocols, and service requirements.

Our Contact Center supervisors and their team leads, who act as support to the supervisors, conduct daily huddles/meetings with Contact Center staff to discuss all issues regarding particular service needs. These meetings are established for our Contact Center representatives to receive education and updated information. We retain the agenda and "huddle minutes" for reference, which become historical data as part of our PerformRx Online Help file. Inter-office communications, including targeted voicemails, allow our staff to keep current on any particular updates.

Further, our Contact Center staff is kept informed of client-specific requirements through an internal, web-based tool that ensures all Contact Center associates have client-specific materials readily available for reference.

Credentialing training

The Credentialing department has an assigned trainer for enterprise-wide credentialing efforts. This trainer is responsible for reviewing all state and federal contract requirements and NCQA standards to ensure the department staff is working with the most current information. Training is conducted at the start of a new plan, as well as when any changes or updates are made to state, federal, or NCQA requirements. The trainer assembles and shares an all-inclusive training document covering the steps needed to ensure proper credentialing and re-credentialing. The trainer is also responsible for tracking and trending questions or issues that may arise from associates. Re-training is available, as needed.

Policies and procedures developed by the department manager include all state, federal, and NCQA credentialing and re-credentialing requirements. Credentialing staff are required to review these policies and procedures and receive updates as changes to the requirements occur. The policies and procedures are reviewed annually and presented to the Credentialing Committee for approval. New staff is trained on existing credentialing and re-credentialing requirements, upon hire.

System of care training

Our System of Care training is composed of training topics centered on developing the knowledge, skills, and competencies needed to support our members from a bio-psychosocial approach. The training ensures associates who interact directly with the member fully understand how the biological, psychological, social and environmental factors impact the member's complex health care needs. During the training, associates learn about the various vehicles used to deliver superior services to our members with a "no wrong door," interactive, member-centric approach. Associates are trained on systems used to manage the flow of information from and to the members to ensure we have a fully integrated view of their needs. Associates have the tools and resources available to effectively evaluate the member's health using an assessment and triage process. Additionally, associates learn how to properly assist the member, provider, family, caregivers and social organizations by helping them to comfortably navigate through the health care and societal systems. Using a variety of interactive activities,

scenario simulations, PowerPoint presentations, role-plays and lectures, associates are provided a 360° viewpoint of how we deliver a System of Care that leads to physically, behaviorally, socially and environmentally healthier members.

Medical Management – Clinical Services and Quality

New hires in Utilization Management and Care Management complete a comprehensive two-week, role-based training program, which includes handling quality-of-care concerns and clinical criteria. The instructor-led program includes system training, which incorporates processes, workflow, policies, and procedures. Associates learn correct protocols for using our electronic quality-of-care concern trigger tool. If a potential quality-of-care concern is triggered, the tool sends an alert for investigation. Associates are trained to extract and review reports daily, assess the concern, and implement the proper protocols and plans based on the issue and member needs. When the tool is updated, associates are required to attend training sessions to ensure their knowledge is current and accurate. Additionally, annual educational opportunities are offered to increase associates' knowledge. As new material is developed and implemented, updates are shared electronically and all associates are required to attend a webinar training session on the updates. An online application is used to track requests for training, enrollment, attendance, and the post-training evaluation. All training sessions are designed with assessments to ensure knowledge transfer and a post-training evaluation of the program to develop improvements. Below is a list of topics included in the care manager training schedule:

- Jiva (care management platform) proficiency.
- Care manager workflow and adding episodes.
- Starting cases.
- Conducting and reviewing assessments.
- Conducting disease-specific assessment.
- Reviewing self-assessments.
- Creating comprehensive care plans.
- Updating care plans.
- Motivational interviewing.

Refresher training

Refresher training is scheduled as needed to address the specific needs of individual associates and teams. As new workflows or processes are implemented, associates are informed or trained to ensure they are utilizing current information. Updates are shared via electronic training materials and posted online. An electronic application is used to capture attendance, comprehension scores, and completed training. Our learning management systems and procedures enable us to track, monitor, and report on all compliance and competency development trainings. If areas of educational opportunity are discovered as a result of audit scores or testing, then individual or group training is delivered. Additionally, associates attend weekly update meetings with their management teams to discuss issues and share new information and ideas. All associates participate in individual meetings with their direct managers on a regular basis, where they receive information related to their performance and professional needs. Continuing educational opportunities are offered on various topics related to process, workflow, system functionality, and professional development. Training schedules are communicated via email and through our online registration tool. Reminders are sent to ensure the learning is accessible to associates, regardless of location.

Ongoing/annual training

Compliance training

In coordination with Corporate Compliance and Program Integrity, part of every associate's onboarding includes a structured Fraud, Waste and Abuse (FWA) education and training program. This training is provided to new associates as part of orientation during onboarding, and then again at other times as required by federal and state regulations. The training program provides our Program Integrity department's mission and purpose, identification of suspicious FWA scenarios, and the referral process.

- The training for compliance with the False Claims Act provides detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections with respect to the role of laws in preventing and detecting FWA.
- The Code of Ethics and Conduct training contains specifics on the federal and state False Claims Acts, the rights of associates to be protected as whistleblowers, and our company's policies and procedures for detecting and preventing FWA.
- Associates are informed that strict compliance with the plan Code of Conduct and the requirements of the Corporate Compliance program is a condition of employment, and that:
 - The promotion of and adherence to compliance with the Code of Conduct and the requirements of the Corporate Compliance program are elements of evaluating supervisors and managers.
 - AmeriHealth Caritas has a policy concerning the non-employment or retention of associates who are sanctioned for a violation of the Code of Conduct or the requirements of the Corporate Compliance program, or are excluded from participation in the Medicaid and/or Medicare programs.
 - AmeriHealth Caritas has a policy concerning disciplinary action for noncompliance with the company's Standards of Conduct.

Additionally, associates complete cultural competency and diversity training annually and as part of the onboarding course work to ensure they understand and can deliver services to support a diverse member population. The following courses are part of this curriculum.

Diversity in the Workplace

This course focuses on how to leverage the diversity that exists within the organization. It defines diversity and dispels some common myths that surround the topic. The importance of diversity within the ever-changing workplace is described, including the impact of globalization. Additionally, this course discusses the barriers and challenges that must be overcome in order to create a diverse and engaging work environment. Materials are designed to support blended learning activities aligned with this course and are available from the Resources Page.

Diversity and You

This course identifies strategies to help associates become aware of their attitudes toward diversity, increase their acceptance of diverse cultures, people, and ideas, and become advocates for diversity within the workplace. Materials designed to support blended learning activities aligned with this course are provided.

Managing Diversity

This course defines diversity, highlights the benefits of a diverse workforce, and discusses how the importance of embracing diversity is ever-growing and expanding. Associates learn how to identify societal changes and how they are mirrored in the workplace. Evidence is presented to show that the most forward-looking organizations recognize the importance of managing a diverse workforce effectively. The point is made that managers who have the skills to lead a diverse team successfully are highly valued, and this translates to strong business results. This course covers how to prepare to manage a diverse team by understanding key diversity issues, setting ground rules, and providing techniques for managing. Materials designed to support blended learning activities that align with this course are provided.

Cultural Competency — health equity and disparities training

This Health Equity training course provides participants with key knowledge and awareness needed to identify health equity and disparities. At the conclusion of the course, associates will be able to define, describe, recognize, and explain how health inequities and disparities affect members, as well as how they impact their roles and responsibilities. All associates participate in this annual training each April, which includes training topics determined by the AmeriHealth Caritas Health Equity Council.

Cultural Competency – Culturally and Linguistically Appropriate Services (CLAS) and cultural health

The CLAS and Cultural Health training course is the second module in our Cultural Competency curriculum. This program provides participants with key knowledge and awareness needed to define cultural competence and health literacy, and how they affect health equity. At the conclusion of the course, a participant will be able to define CLAS and identify the standards which govern their work. Additionally, participants will be able to explain individual, team, and plan roles in supporting CLAS standards and achieving health equity.

Behavioral skills training (soft skills)

Annually, we focus training efforts on specific desired behaviors and competencies outlined in our Everyone Leads model. This model defines expectations on how we go about accomplishing results. Annually, training courses and programs are aligned to it that sharpen skills that enable continuous learning in support of better serving our customers. In 2014, we focused on a program that offered associate support through feedback sessions with their direct managers, quality assurance departments, and/or Human Resources staff, as needed, to ensure comprehension and quality of demonstrated skills. Every year, associates are rated on how well they have demonstrated these skills as part of our annual performance review process. At AmeriHealth Caritas, how we achieve results is just as important as the results themselves. We distinguish ourselves with the behaviors and skills with which we serve our members, our partners and each other.

The following is a list of some of the Everyone Leads training classes offered in 2014 to associates at all levels:

- Reaching for Stellar Service.
- Caring for Customers.
- Helping your Team Work.
- Diversity in the Workplace.
- Creative Decision Making and Problem Solving.
- Cultivating Winning Attitudes and Countering Negativity.
- Defusing Emotionally Charged Situations.

- Handling Difficult People.
- Handling Conflict with Tact and Finesse.
- Team Grammar — The Essentials of English Grammar for Business.
- Write Better, Quicker, Clearer.
- Ethics Training in the Workplace.
- Developing your Emotional Intelligence.
- Managing Projects and Priorities.

Contractor Staff

All contractor staff is trained based on the specific role being filled. The training may consist of formal and informal training methods. As with associates, the contractor staff's training will provide them with the knowledge, skills and aptitude needed regarding the business and industry, technology and system navigation, policies and procedures, regulatory and compliance requirements, and delivering service excellence. Additionally, contractor staff is required to demonstrate proficiency and performance of all job related roles and responsibilities to remain a part of our contingent workforce.

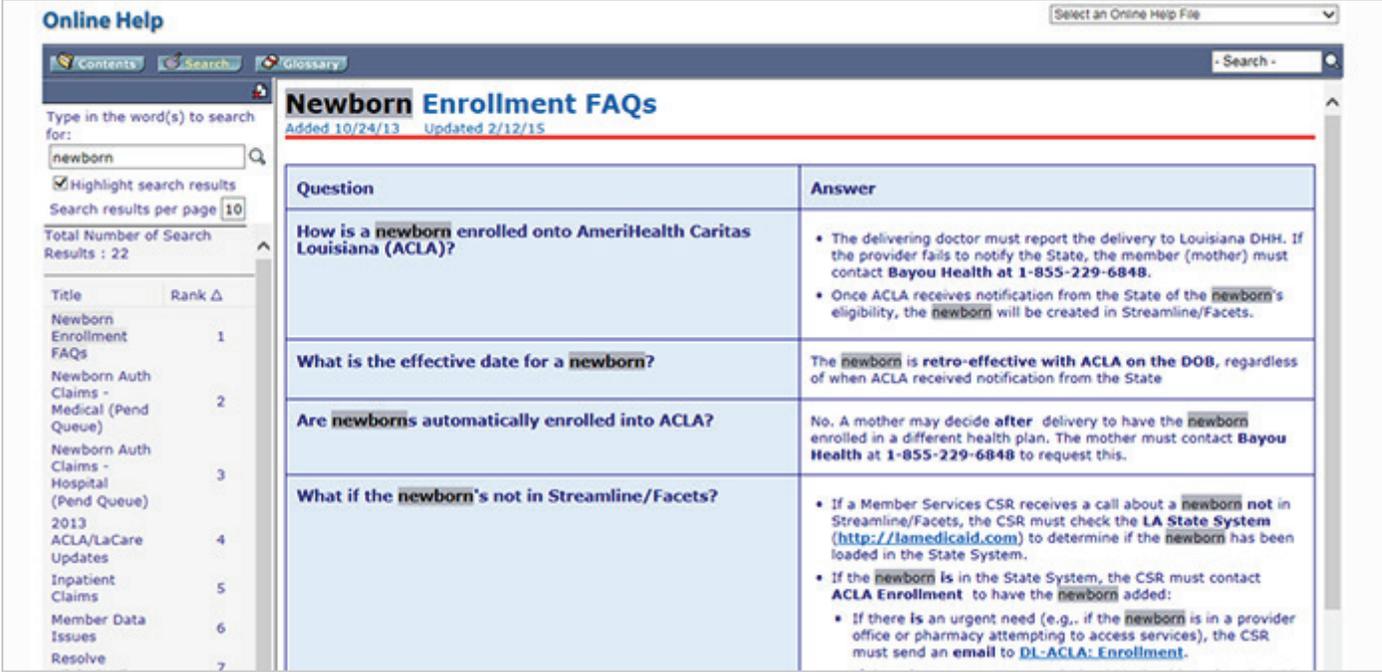
AmeriHealth Caritas Iowa staff training plan FAQs:

When are new and existing associates trained?

New hires begin job-specific training within the first week of their start date. Existing staff training is done throughout the year as new work flows or processes are implemented. Based on job-specific roles and business needs, bi-monthly or quarterly training opportunities on various topics are offered via open enrollment and target-audience assignments. The training offerings address process improvements, workflow changes and system functionality updates. The schedule is posted in our online training registration system and reminders are sent to ensure engagement. If additional areas of educational opportunities/needs are discovered as a result of quality audits or management performance assessments then individual or group training and coaching is delivered to migrate and close gaps in knowledge.

How are new program updates disseminated?

AmeriHealth Caritas uses a proven framework to ensure programmatic changes are implemented timely and policies and procedures are reviewed and updated as required. The plan designates a central intake point for incoming DHS communications. This function will be handled by AmeriHealth Caritas Iowa's Compliance and Regulatory Affairs department. The Compliance and Regulatory Affairs team is responsible for disseminating all regulatory communications, as well as performing subsequent reviews to ensure changes are implemented on a timely basis. The Compliance and Regulatory Affairs team will distribute regulatory updates electronically and in person. Regulatory updates and step-by-step instructions for following guidelines are also recorded in multiple systems, including online help, AmeriHealth Caritas's electronic reference guide. A screenshot of our online help tool is shown below.



The screenshot shows the 'Online Help' interface. At the top, there's a search bar with 'newborn' entered. Below it, a table of 'Newborn Enrollment FAQs' is displayed. The table has two columns: 'Question' and 'Answer'. The first question is 'How is a newborn enrolled onto AmeriHealth Caritas Louisiana (ACLA)?'. The answer states that the delivering doctor must report the delivery to Louisiana DHH, and if the provider fails to notify the State, the member (mother) must contact Bayou Health at 1-855-229-6848. The second question is 'What is the effective date for a newborn?'. The answer states that the newborn is retro-effective with ACLA on the DOB, regardless of when ACLA received notification from the State. The third question is 'Are newborns automatically enrolled into ACLA?'. The answer states 'No. A mother may decide after delivery to have the newborn enrolled in a different health plan. The mother must contact Bayou Health at 1-855-229-6848 to request this.' The fourth question is 'What if the newborn's not in Streamline/Facets?'. The answer states that if a Member Services CSR receives a call about a newborn not in Streamline/Facets, the CSR must check the LA State System (http://lamedicaid.com) to determine if the newborn has been loaded in the State System. If the newborn is in the State System, the CSR must contact ACLA Enrollment to have the newborn added. If there is an urgent need (e.g., if the newborn is in a provider office or pharmacy attempting to access services), the CSR must send an email to DL-ACLA-Enrollment.

Exhibit 2.9-C: AmeriHealth Caritas On-Line Help screen

A series of events is triggered when AmeriHealth Caritas receives formal correspondence from DHS. The first step involves logging the issue into the DHS communication folder on a system shared drive for all-associate access, as well as electronic notification of the matter to appropriate stakeholders. AmeriHealth Caritas maintains customized email distribution lists, such as leadership, enrollment and production control groups, to communicate with targeted staff.

DHS communications are then discussed in detail at the appropriate plan meetings. AmeriHealth Caritas holds several cross-functional meetings on a regular basis (weekly, bi-weekly or monthly dependent on the work group and the need) for planning purposes. For example, AmeriHealth Caritas Iowa leadership will convene weekly, while the larger group including regional and enterprise AmeriHealth Caritas leadership meets bi-weekly. An example of the larger group meetings is the bi-weekly plan/business oversight meeting conducted with leaders from Compliance, Operations, Information Systems, Provider Network Management, Medical Management, Pharmacy and Behavioral Health teams. In this meeting all changes requiring system updates for the plan are reviewed, priorities are established for all new requests and status on all active requests are assessed. Ad hoc stakeholder meetings are scheduled as needed.

For all changes, the affected functional departments determine the impacts on operational components and current policies and procedures, and assess any required changes. Depending on the change, the functional department will communicate the changes to their associates through formal training, on-line scripting, on-line help and/or team meetings. All changes requiring systems updates will go through our standard user acceptance testing and linkage testing with the state when appropriate. Prior to implementation, it is the responsibility of each functional department to communicate and train their associates on the programmatic changes, as well as update all supporting policies and procedures.

Approximately 30 days after major contract revisions go-live, the Compliance and Regulatory Affairs team conducts a business process review. These reviews may include desktop policies and procedures, workflow verifications, associate interviews, or end-to-end process audits. If necessary, the Compliance and Regulatory Affairs team works with the stakeholders to address any identified deficiencies. In addition to

maintaining current workflows in online help, all revised policies and procedures and formal DHS communications are maintained on a company-wide shared drive for associate reference.

How does AmeriHealth Caritas track training completion?

Learning management systems – tracking and reporting

Our learning management systems enable us to monitor and track training completion. Associates are automatically assigned required training programs and sent communications via email, the intranet and during team meetings. Additionally, associates receive automatic email reminders for their assignments, and management receives completion reports. Associates are provided access to the learning management systems, which are available 24/7 via a customized web address. Designated administrators manage the backend system and technical efficiency. Technical support and help is available during defined business hours and off-hours via email. Our learning management systems manage a repository of eLearning materials: courses, books, job aids, videos, simulations and skill-briefs. A robust on-demand reporting function tracks completion rates, assessment scores, time to complete, number of attempts, overdue assignments, etc. Additionally, the following capabilities are available:

- Detailed reporting for all management teams.
- Associates can track and manage their own progress within the application.
- Records are maintained for all learning programs and reports can be provided both internally and externally.
- Where necessary, certificates of completion can be printed by the associates.
- An organizational snapshot and dashboard can be created to view progress, content hits and completions.
- Transcripts are kept for all learners through their lifecycle at the company.

Additionally, our online registration allows associates to search for courses for skill development and business knowledge. Associates can easily enroll or disenroll in our course offerings and choose programs based on a variety of modalities, including eLearning, virtual and classroom learning. This allows all associates to participate in a variety of learning events regardless of their geographic location.

How is comprehension measured?

Training materials, regardless of modality, are designed with key concepts, mastery check activities, and evaluations to measure associates' immediate reaction to the training material, program, and facilitator. There are skill check assessments to measure the associates' comprehension and retention of the key learning objectives. Our standard assessment scores are set with an 80 percent passing requirement. Associates not achieving a passing score on first testing are required to review learning and retake the assessment until mastery is achieved. New hire programs are continuously updated to ensure that materials are added that accurately reflect current policies and procedures. Additionally, all newly developed materials will be added to our online resource system to ensure associates have immediate access to the most current information.

2.11 Coordination with Other State Agencies and Program Contractors

1. Describe how you propose to work with other program contractors, subcontractors, state agencies and third-party representatives.

AmeriHealth Caritas has a long and successful history of partnering with states to address their unique and diverse needs and challenges. We have begun the process of meeting with key Iowa stakeholders to develop a plan of action in tackling the significant diverse needs of the populations served currently by the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (hawk-i) programs. We will invest in the Iowa marketplace creating new jobs, facilities and programs.

AmeriHealth Caritas Iowa is committed to being a long-term partner with Iowa. We care about our members and are focused on building relationships and programs with other program contractors, subcontractors, state agencies and third-party representatives. Through a collaborative relationship between AmeriHealth Caritas Iowa and the Iowa Department of Public Health, Iowa Department of Education, Iowa Division of Mental Health and Disability Services, Agency Child Welfare and Juvenile Justice Services, Ombudsman's Office, Community Based Agencies, Iowa Department of Inspections and Appeals and other program contractors, our common goal of improving the lives of our members will be reached. The examples below highlight a few of our collaborative relationships in other markets:

Pennsylvania, like the rest of the nation, is currently suffering the worst overdose epidemic in its history. To help combat this devastating and unnecessary loss of life, the General Assembly enacted Act 139 of 2014, which became effective November 29th. Act 139 allows first responders and other bystanders who previously did not have access, to obtain and use naloxone - the lifesaving overdose antidote medication. In early 2015, AmeriHealth Caritas partnered with the Pennsylvania Department of Drug and Alcohol programs to bring this lifesaving medication to law enforcement officers.

In 2014, AmeriHealth Caritas partnered adult literacy providers in the Philadelphia region, including the Community Learning Center, Mercy Neighborhood Ministries of Philadelphia, Congreso, and OIC Philadelphia to implement a new General Educational Development (GED) initiative that supports members who want to further their education. This program covers GED exam fees and provides coaching and support for members, every step of the way, as they work towards earning their GED.

In 2013, AmeriHealth Caritas discussed with representatives of the Commonwealth of Pennsylvania a program to assist ex-offenders. This program included assistance with housing, meeting parole requirements, job training, healthcare services and other social supports to ease the transition and ensure the success of release.

AmeriHealth Caritas has a strong history of interacting and working with other program contractors, subcontractors, state agencies and third-party representatives to improve the health and well-being of our members. We are excited to have the opportunity to bring this same collaborative approach to Iowa.

2. Describe how you propose to work with IDPH related to IDPH-funded substance abuse services.

AmeriHealth Caritas Iowa is fully committed to a close collaboration with the Iowa Department of Public Health (IDPH) for the substance abuse services for individuals qualifying under IDPH programs separate from Medicaid. IDPH participants are those residents who are not eligible for Medicaid but seek substance

abuse treatment services from IDPH and have income at or below 200 percent of the federal poverty guidelines. This collaboration with IDPH will focus on the following areas:

- **Identification of a primary contact person** — As one of the key personnel, the behavioral health manager will be responsible for ensuring that all behavioral health operations are in compliance with the contract. Internally, the behavioral health manager will be connected to all functional areas and will serve as the liaison and primary contact for IDPH related to the provision of IDPH-funded substance abuse services.
- **Financial coordination and reporting** — Separate funding will be received by AmeriHealth Caritas Iowa from IDPH and there will be distinct funding and service requirements associated with the IDPH-funded substance abuse services. AmeriHealth Caritas Iowa will provide financial services and supports to meet the IDPH obligations under the federal block grant and state appropriations for the program. The financial risk is held by the provider for the IDPH-funded substance abuse services. Thus, AmeriHealth Caritas Iowa will collaborate with IDPH on providing the accurate and designated prospective reimbursement each month to the contracted IDPH-funded substance abuse network providers.
- **Benefit and payment configuration** — IDPH participants are only eligible for a subset of covered services. AmeriHealth Caritas Iowa will work closely with IDPH representatives to ensure that benefit and payment configurations are fully compliant with IDPH requirements. Furthermore, the IDPH-approved sliding fee schedule and TPL requirements will need to be implemented by network providers and will be built into the claims and benefit configuration systems for IDPH-funded services.
- **Treatment review and prior authorization requirements** — Authorization will not be required at any level of service for the IDPH population. Retrospective utilization monitoring and sampling will be used to ensure the appropriate application of clinical criteria at the provider level. This will include court-ordered treatment coverage for IDPH participants. If outliers are identified, AmeriHealth Caritas Iowa will work with the originators of the court-ordered substance abuse services to educate them on observed utilization patterns and appropriate alternatives for consideration.
- **Special programs** — AmeriHealth Caritas Iowa will collaborate with IDPH to assure that specialized programming, including outreach services for intravenous drug users, tuberculosis services and methamphetamine services are delivered according to best practices and guidelines established by IDPH.
- **Credentialing and contracting of providers** — AmeriHealth Caritas Iowa will assure that IDPH-funded substance abuse services will only be delivered by IDPH-licensed substance abuse providers or by an appropriate hospital-based substance abuse treatment program.
- **Information system interfaces** — Close collaboration of respective Information Services/Information Technology managers will be necessary to assure that AmeriHealth Caritas Iowa can receive, process and report data to and from the IDPH Service Management and Report Tool (I-SMART). This will include capabilities for receiving data from network providers on all clients receiving substance abuse services, including those IDPH-funded.

2.13 Written Policies and Procedures

1. Describe your process for developing and maintaining written policies and procedures for each functional area.

AmeriHealth Caritas has processes in place to assure uniform and consistent policy development, revision and communication throughout the company. Each functional area within AmeriHealth Caritas has a uniform

policy and procedure that helps guide the development and maintenance of policies. This includes how to:

- Assess and determine the need for a policy and procedure.
- Draft the policy and procedure, including internal departmental development and drafting and cross-functional consultation and review.
- Obtain stakeholder approval of the draft policy and procedure.
- Prepare the final policy and procedure.
- Communicate the policy and procedure.
- Establish a policy and procedure review plan.

Policies and procedures are maintained, as introduced above, through a systematic process. All policies and procedures are reviewed on an annual basis, e.g., within one year from the date identified as the current effective date, as required by law, regulation or contract, or as otherwise determined by AmeriHealth Caritas leadership. Though most policies and procedures are reviewed annually, all policies and procedures are reviewed once every three years, at a minimum. Active policies and procedures are maintained by the department/functional head, maintaining a signed paper copy at all times.

2.14 Participation in Readiness Review

1. Submit a detailed implementation plan which identifies the elements for implementing the proposed services, including but not limited to:

Please see Tab 6 of this response for a copy of the implementation plan, which identifies elements for implementing the proposed services, which include (i) contractor's tasks; (ii) staff responsibilities; (iii) timelines; and (iv) processes that will be used to ensure contracted services begin upon the contract effective date.

AmeriHealth Caritas has a proven track record of implementing new business on time, and with all functions in place to serve our Members and Providers. Over the past five years, we have implemented 15 new business opportunities in eight states. In each implementation, we successfully launched on time with all phone systems, member programs, medical management and claims systems operational. We have a dedicated project management team with more than 750 combined years of new business implementation and project management experience. We have developed, and continuously improve, our New Business Playbook. Our Playbook is a stable and predictable implementation model based on lessons learned and industry best practices, and has been successfully used to implement Medicaid managed care plans in other markets. It incorporates standard project management tools and artifacts, business workflows, baseline business requirements, process flows, standard forms and presentation templates, communication plan, readiness review and testing processes, and project governance structures. Based on our past experience, ongoing improvement, and dedication to our mission, we are fully confident in our ability to meet or exceed the needs of Members and Providers in Iowa.

Leveraging a comprehensive project plan to implement Iowa High Quality Health Care Initiative

The plan will consist of following components:

- Project management methodology.

- Issue management and resolution.
- Proven implementation team.
- Itemization of activities.
- Interdependencies.
- Project governance.
- Enterprise risk management.
- Readiness review.
- Project schedule.

Approach to project management and governance

AmeriHealth Caritas has an established a cross functional Program Management Office (PMO) that incorporates project management methodologies, market experience, understanding of the population we are serving and lessons learned from prior implementations to develop a comprehensive project plan that will drive the delivery of tasks. The implementation plan and project schedule will be tailored to ensure the delivery of all requirements outlined in the scope of work and to ensure contracted services begin upon the contract effective date.

Project management

AmeriHealth Caritas's project management methodology provides a standard template for each project deliverable, ensuring consistency and completeness. It also brings discipline and standardization to each implementation project, providing the tools, project governance, risk identification and mitigation, issues resolution and escalation process, techniques, project leadership and training necessary to maximize the efficient 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.

Our project management methodology was built on the following principles (based on product, and cycle-time excellence [PACE] methodology):

- **Project governance** — Decision making authority and stage-gate approval.
- **Project team structure** — Functional owners with the authority to make decisions with the necessary supporting resources to ensure effective execution of all tasks and clearly defined roles and responsibilities.
- **Project plan** — Detailed project schedule with key dependencies and resource needs identified.
- **System design** — System architecture and design to support business units with the delivery of services outlined in the scope of work.
- **Product strategy and design** — Implementation of key processes and technology to enhance the member experience to differentiate AmeriHealth Caritas product offering from others in the market.
- **Resource management** — Ensure the appropriate resources with the right skills are available when needed based on the project schedule. A dedicated project management team with more than 750 combined years of new business implementation and project management experience.
- **New business activation playbook** —A stable and predictable implementation model that has been modified based on lessons learned. AmeriHealth Caritas has developed a new business activation playbook which has been successfully utilized in other markets. The playbook incorporates standard project management tools and artifacts, business desk top procedures, baseline business

requirements, process flows, standard forms and presentation templates, communication plan, readiness review tool, testing processes, go-live checklist, project closure checklist and project governance structure. The new business activation playbook is built within a SharePoint server which allows for easy access to all implementation artifacts and helps manage document version control. The SharePoint site provides a single point of reference for all resources working on the project ensuring that they have access to all available information.

The overall project will be monitored and managed by reports and adherence to the project schedule. The project schedule will be monitored through status reports and updates to our risk management plan during each step of the implementation. The following project artifacts will be used to effectively manage the project:

- **Performance management executive status report** — The weekly status report is a key tool used to quickly and accurately identify and address issues and delays in implementing the new health plan.
- **Performance management governance grid** — This grid consists of the project team's roles and responsibilities.
- **Project plan dashboard report** — The dashboard provides an overview of the project. The components are project team engagement; project health and performance; project plan deliverables; project health overview; project issues log; functional area status, provider agreement build, agreement user acceptance testing (UAT); membership and UAT milestones.
- **Plan of record** — A detailed scope of work with critical milestones, resources, budget request, and dependencies.
- **Preliminary risk review** — Risks are tracked on the risk log and monitored throughout all phases of the project. This log tracks preliminary risk drivers, mitigation strategies and owners.
- **Project change request form** — This form is used to track any need from the business that causes scope, schedule or requirements changes. This form assures that the project team has documented all 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 Caritas 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 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 Iowa High Quality Health Care Initiative requirements are developed and validated, the AmeriHealth Caritas issue log will be used to 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 assessment, analysis and resolution

As issues are identified, AmeriHealth Caritas' 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 the Iowa health plan. We will document all issues that arise on the issues log in our SharePoint server system. 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 48-hour period.
- Response to general questions pertaining to activities will be directed to appropriate workgroup(s).
- 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, resource 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 the senior management for final approval.

Proven implementation team

Effectively and efficiently implementing Medicaid managed care programs is a key component of our core business competency. AmeriHealth Caritas has identified a dedicated team to ensure the successful implementation of the Iowa High Quality Health Care Initiative program. Our implementation team is led by experienced project management professionals and subject matter experts from core business areas such as Behavioral Health, Information Technology, Medical Management, Customer Services, Claims Payment, Enrollment, Finance, Communications and Marketing, Pharmacy, Provider Network Management, Data Analysis and local and regional AmeriHealth Caritas 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.

Itemization of activities

The AmeriHealth Caritas project implementation team has established a detailed project schedule and has committed significant resources to be prepared for the January 1, 2016, start date of the Iowa High Quality Health Care Initiative. The project schedule is included in the response. The end-to-end operational execution of our Iowa project schedule promotes ownership, accountability and ensures that all activities are accurately identified and quickly implemented. Our implementation team has identified the Iowa program's "critical path" and we are proactively managing the integrity of the project schedule. AmeriHealth Caritas' work shall, in all respects, conform to the timelines established under the RFP for deliverables.

Project governance

The PMO's approach is based on industry standards of best practices and an established project management methodology offers the appropriate levels of monitoring and control throughout the lifecycle of projects. AmeriHealth Caritas implementation project governance structure utilizes the following teams:

Steering Committee

A key feature of this committee is the exceptional level of focus and involvement by our senior leadership.

As members of the steering committee, this group:

- Provides strategic vision, direction and motivation.
- Removes barriers to success through immediate response to escalation.
- Makes timely decisions and streamlines levels of approvals.
- Drives accountability through all phases of implementation.

The steering committee is composed of the following roles:

- Chairman/CEO
- Regional President
- Sr. Vice President and Chief Information Officer
- Sr. Vice President, Enterprise Operations
- President, PerformRx Division (Pharmacy)
- Sr. Vice President PerformCare (Behavioral Health)
- Sr. Vice President, Legal Affairs and Corporate Counsel
- Sr. Vice President, Government and External Affairs
- Sr. Vice President, Market Expansion
- Sr. Vice President, Financial Officer
- Sr. Vice President, Chief Development Officer
- Sr. Vice President PerformCare (Behavioral Health)
- Sr. Vice President, Chief Development Officer
- Sr. Vice President, Compliance and Risk Management
- Sr. Vice President, Performance Management
- Sr. Vice President, Government and External Affairs
- Vice President, Human Resources

Core team

Chosen for functional excellence and project knowledge, the core team is focused exclusively on serving the needs of the project implementation. This team is accountable for the success of the implementation.

Key attributes of this team are:

- Empowered to make project-related decisions.
- Roles, accountabilities and responsibilities are clearly defined.
- Adept at project management, communication, facilitation and coordination.
- Responsible for action items, open issues, risks, contingency and mitigation plans.
- Responsible for escalating issues and risks to the steering committee.

See Exhibit 2.14-B: Core Team below for an overview of the core team. Each function shown has a single point of accountability.

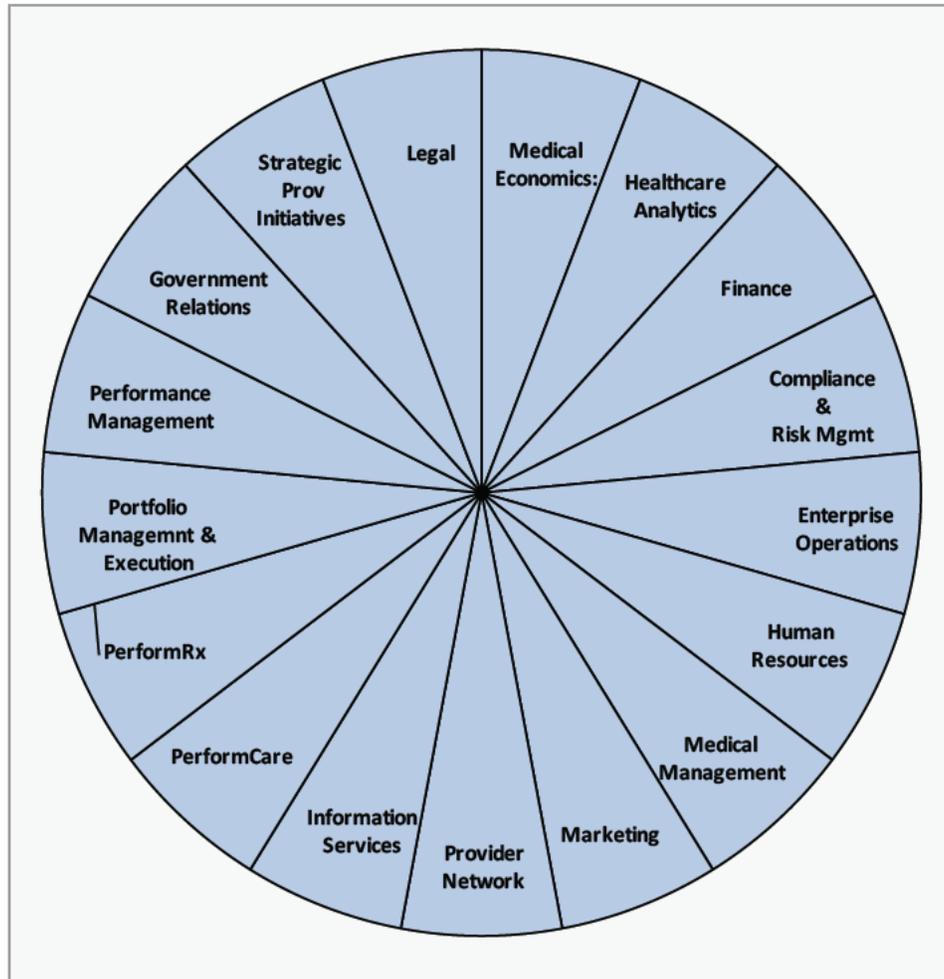


Exhibit 2.14-B: Core Team

Project Execution Team

The project execution team is composed of the Program Management Office (PMO) and business staff.

Key attributes of this team are:

- Functional, facilitation or project expertise.
- Responsible for escalating issues and risks to the core team.

AmeriHealth Caritas has successfully implemented new business by integrating staff from the business into the project team. This leads to a seamless transition of business knowledge and project background from implementation to ongoing operations. Using this team model has proven to be highly effective in previous implementations.

Enterprise risk management

AmeriHealth Caritas has developed and implemented an enterprise risk management (ERM) program, which supports ongoing capabilities to identify, assess and manage our current and emerging key risks at all levels of the organization. Our ERM framework was developed in accordance with a widely used risk and control framework, and with all applicable risk management requirements issued by federal and state regulatory authorities. Key objectives for the ERM program include:

- Reduce potential exposure through formal and consistent risk management.
- Create an integrated approach to assess business risk across AmeriHealth Caritas.
- Standardize risk monitoring and reporting (tracking risks, issues and action items).
- Promote a risk aware culture.

Our ERM framework includes a risk management governance structure, a consistent process for continually identifying, assessing and responding to risks, and integration of risk information with key organizational processes. This allows us to identify risks through execution of strategic and operational planning, performance management and project management, and business and technology operations. This occurs at the corporate level as well as within separate lines of business. The framework is flexible and tailored to the AmeriHealth Caritas environment. As a result, business managers are better positioned to understand and proactively track and manage key risks and issues associated with execution of our plans, and support AmeriHealth Caritas participation in new growth opportunities. The ERM framework also allows us to achieve efficiency by linking existing risk management activities, and better anticipating emerging risks and trends.

Integration of ERM with the project management office

The ERM process has been integrated with our new business implementation model as well as our project management office (PMO) methodology, allowing us to proactively identify and assess implementation and project related risks and issues for key initiatives, and to manage those risks throughout the life cycle of the project. Formal ERM participation on the steering committee exists, and a project risk profile is developed for each significant implementation and/or project effort. A risk profile is created by the project team, using the ERM process, at the initiation of a project. Throughout the course of the project, issues and risks are tracked, monitored, mitigated or escalated as needed. The project risk profiles are also mapped to risk profiles within impacted lines of business as well as the corporate risk profile to ensure that an aggregate view of risk is considered.

Value to the business

By creating a framework that spans all levels of the organization and also can be implemented cross-functionally, a common risk language can be used to identify areas where risk may be present, as well as discuss appropriate actions and mitigations that can be taken to avoid any significant impacts to a project, a line of business or the company as a whole. In addition, risks can be identified and addressed more quickly to ensure all projects and initiatives are delivered as agreed upon.

Readiness review

During the initial phase of the implementation process (planning phase), AmeriHealth Caritas creates the following artifacts that are used to validate internal readiness: plan of record (scope of work), contract compliance matrix and business requirements traceability matrix to assure a successful demonstration of

our ability to comply with all RFP requirements. The internal readiness review is a major milestone in assuring a successful transition period for the State of Iowa.

- **Plan of record** — Detailed scope of work with critical milestones, resources, budget requests and dependencies.
- **Contract compliance matrix** — Matrix which captures the entire requirements outlined in the RFP, state contract and AmeriHealth Caritas RFP response.
- **Business requirements traceability matrix** — Matrix that identifies all business requirements and testing approach to validate the requirements have been deployed based on the approved business requirement.

All three tools are inputs for the readiness review checklist that will be used to validate readiness. AmeriHealth will conduct an internal review prior to the state's formal readiness review to validate all requirements have been met and/or identify gaps that need to be remediated prior to go live date. AmeriHealth Caritas will use a number of methods to validate readiness: face-to-face functional interviews, desktop reviews of all policies and procedures, review results of user acceptance testing and system demonstrations. Results are collected, scored and presented to the steering committee to make a final go/no-go readiness decision. A no-go decision will require the development of a formal mitigation strategy to resolve areas of deficiencies. Additional decision checkpoints will be added as needed.

AmeriHealth Caritas exercises a rigorous and robust project management methodology to ensure that we are able to provide the highest level of care and best outcomes for our members. We are committed to implementing a project governance structure that clearly defines responsibilities and authorities, empowers the core team and removes barriers to success.

Project schedule

Please see Tab 6 of this response for a copy of the implementation plan/project schedule which identifies elements for implementing the proposed services, including (i) contractor's tasks; (ii) staff responsibilities; (iii) timelines; and (iv) processes that will be used to ensure contracted services begin upon the contract effective date.

2. Confirm that you will revise the implementation plan and keep it updated throughout the readiness review process.

AmeriHealth Caritas' systematic approach focuses on delivering a high quality product on time and within scope for the Iowa High Quality Health Care Initiative plan. We will manage our project schedule and update it through weekly team meetings, weekly status reports and updates to our risk management plan during each step of the implementation. The implementation plan will be revised and updated throughout the readiness review process to ensure that all aspects of the plan are implemented successfully.

2.15 Confidentiality of Member Medical Records and Other Information

1. Describe your plans to ensure that health and enrollment information is used in accordance with the requirements set forth in the Health Insurance Portability

and Accountability Act and other applicable federal and state privacy laws and regulations.

Leveraging HIPAA-compliant files and transactions to securely transmit information

- Affirm the supplier’s use of the HIPAA-compliant files and transaction standards.
 - AmeriHealth Caritas is fully complaint with the Operating Rules recently established for eligibility and claim status (Phase 1) and EFT and ERA (Phase 2).
- Capability to generate, accept and load HIPAA transaction and response files.
 - IBM Standards Processing Engine (SPE) is used to verify compliance on all encounters HIPPA transactions. SPE is the next evolution of the IBM Universal Transformation strategy, providing a modular and more comprehensive solution for transforming documents based on industry standards. With SPE we are able to apply validations for both incoming and outgoing EDI X12 transaction sets up to level 5 SNIP with plans to support up to level 7 SNIP if necessary.
 - IBM Websphere Transformation Extender (WTX) for exchanging a wide variety of files and data, including HIPAA X12 electronic transactions. Currently updating to highest level of compliance due to Louisiana.
 - Currently exchanges inbound and outbound data through secure file transfer protocols (SFTP) or secure virtual private networks (VPNs), including eligibility/enrollment data, claims/encounters data for physical health, behavioral health, pharmacy, laboratory results, vision, dental and transportation.

List of HIPAA transaction standards

Standard	Transaction
ASC X12 837 D	Health care claims — dental.
ASC X12 837 P	Health care claims — professional.
ASC X12 837 I	Health care claims — institutional.
NCPDP D.0	Health care claims — retail pharmacy drug.
ASC X12 837 P and NCPDP D.0	Health care claims — retail pharmacy supplies and professional services.
NCPDP D.0	Coordination of benefits — retail pharmacy drug.
ASC X12 837 D	Coordination of benefits — Dental.
ASC X12 837 P	Coordination of benefits — Professional.
ASC X12 837 I	Coordination of benefits — Institutional.
ASC X12 270/271	Eligibility for a health plan (request and response) — Dental, professional and institutional.
ASC X12 999	Implementation acknowledgment.

Standard	Transaction
ASC X12 TA1	Transaction acknowledgment.
ASC X12 824	Application advice.
NCPDP D.0	Eligibility for a health plan (request and response) — retail pharmacy drugs.
ASC X12 276/277	Health care claim status (request and response).
ASC X12 834	Enrollment and disenrollment in a health plan.
ASC X12 835	Health care payment and remittance advice.
ASC X12 820	Health plan premium payment.
ASC X12 278	Referral certification and authorization (request and response).
NCPDP D.0	Referral certification and authorization (request and response) — Retail pharmacy drugs.
NCPDP 5.1 and NCPDP D.0	Retail pharmacy drug claims (telecommunication and batch standards).
NCPDP 3.0	Medicaid pharmacy subrogation (batch standard).

Safeguarding systems against unauthorized access

Security management provides the protection and detection of improper access and usage of network resources and services as well as their containment and recovery. It also monitors operator access to network management control consoles and logs configuration changes.

- Archiving and audit trails; data warehouse:
 - Maintain audit trails for seven years.
- CheckPoint full disk encryption (FDE) — All laptops, tablets, and desktops distributed for new deployments have CheckPoint hard drive full-disk encryption (FDE) active.
- Physical protections/perimeter access controls.
- Authentication:
 - Increased security testing for any application that will be exposed to the Internet.
 - Daily security report to the CIO (not sure full distribution).
 - More frequent white-glove penetration testing.

Supporting HIPAA compliance through security and access management

The architectural foundation of our critical security infrastructures, such as intrusion detection system (IDS) and intrusion prevention system (IPS), is to “fail open” in the event of a hardware failure. This eliminates any impedance on network traffic related to the appliance failure.

AmeriHealth Caritas’ IPS is based on “inline” technology, protected by a pair of zero power high availability (ZPHA) devices. These devices were developed to specifically address the need of organizations to retain

constant connectivity and monitoring capability. The ZPHA device automatically detects loss of power to the IPS and immediately provides redundant network connectivity, preventing any network downtime that might impact business operations.

Authentication is handled by Aladdin, our two-factor authentication solution, leveraging Cisco security appliances. This model ensures continued support for external access to the AmeriHealth Caritas network.

AmeriHealth Caritas leverages a dual layer DMZ topology to assure additional security, and to separate public Internet connectivity with private business partner's connectivity. Additionally, our Internet facing DMZ can support secured FTP connections with support for SFTP, FTPS, HTTPS/S, & SCP2 and FIPS 140-2 validated cryptography.

Orion NetFlow Traffic Analyzer

Orion NetFlow Traffic Analyzer (NTA) enables us to capture flow data from continuous streams of network traffic and convert those raw numbers into easy-to-interpret charts and tables that quantify exactly how the corporate network is being used, by whom, and for what purpose — enabling us to identify and manage instances of abnormally high bandwidth use.

Security testing and monitoring

Technologies embedded in the information security infrastructure like IDS, IPS, Websense, and Log Rhythm continuously monitor our public facing entry points and devices residing on our network. These solutions are configured to alert key personnel when any change to a system, environment and/or logical configuration occurs within our local and extended networks.

Additionally, our Information Security department contracts with a trusted third-party vendor to provide four unannounced penetration tests each year to ensure our wide area security design is hardened and up-to-date relative to the evolving threats. These tests probe the information security protection architecture by utilizing external hacking methods. This ensures AmeriHealth Caritas that the current security technology and systems deployed to protect and manage our data and electronic assets are working as expected. They assist in refining and tuning the threshold configurations that provide intelligent responses to activities as they occur.

Any new Internet-facing application that uses PHI undergoes both code review and penetration testing prior to deployment. Existing Internet-facing applications that use PHI are also code reviewed and penetration tested with any significant changes.

Data loss prevention (DLP) prevents the sending of PHI or personally identifiable information (PII) through an unsecured connection and instead directs the email to a secure email server. DLP identifies data patterns, keywords and other diagnostic algorithms to ensure data is protected.

The Information Security staff continuously monitors all internal and external alerts received by the monitoring tools (IDS, IPS, Syslog, DLP and Log Rhythm). These alerts automatically react and respond to suspect and malicious network traffic and/or immediately contact on-call resources to begin the security incident response team (SIRT) process to investigate and mitigate the potential threat.

AmeriHealth Caritas understands the criticality of our information and telecommunication systems platform in providing uninterrupted service to Iowa Medicaid members. Redundancy built in at all layers of the technical architecture, up to and including primary and secondary data centers, combined with proven recovery, monitoring and 24x7x365 support by domain experts help to ensure this uninterrupted service by exceeding Iowa's required systems availability and recovery time objectives.

Ensuring covered entities can securely access needed information

AmeriHealth Caritas leverages a number of technology solutions that enable associates to access critical business functions from anywhere, at any time, from any device.

- **Availability standards:**
 - Defined support staff is required to be accessible 24 hours a day, seven days a week.
 - DHS access to systems and information.
 - Data replication.
- **Portals:**
 - Members forced to relocate due to a disaster, or choosing to relocate for other reasons, can access AmeriHealth Caritas' Member Clinical Summaries and EPSDT Clinical Summaries through the Member Portal.
 - Encouraging EHR.
- **Staff/operations/business continuity:**
 - Access critical business functions from anywhere, at any time, from any device.
 - Citrix Receiver provides AmeriHealth Caritas associates with access to all XenApp and XenDesktop applications from any device, including smartphones, tablets, PCs and Macs.
 - N.4.i specifies business continuity scenarios for issues with "integrity of transactions" and "integrity of data."

Hardware

- **EMC VMAX technology provides redundant and fault-tolerant storage to all of our servers:** If storage attached to a server fails for any reason, this technology provides a seamless transition to a redundant, high-performance storage disk. Server access to the EMC storage is redundant through multipath switching which provides servers redundant paths to storage disks through multiple storage switches.
- **All of our mission-critical business systems such as Facets®, Jiva, and our data warehouses:** HP Serviceguard is designed to protect applications from a wide variety of hardware and software failures. It provides support for multiple nodes, which are organized into a high-availability enterprise cluster that delivers highly available applications and services. If a particular server (node) on the cluster fails, it enables us to transfer the applications supported by the failed server to a secondary server (node) designated as a back-up server. We also employ redundancy within server enclosures to mitigate hardware failures. This includes redundant internal disks, fans, power supplies, network interface cards, and network connections.
- **Windows availability technology and Microsoft clustering:** We leverage Microsoft clustering technology for critical applications, like our integrated care management platform, workflow solution, and HIPAA gateway, which run on Microsoft platforms. Clustering addresses the impact to a physical server failure by grouping several servers together, some in active-passive and others in active-active clusters. When any active server in the cluster goes down due to any failure, a secondary server in the cluster takes up the operations of the failed server, minimizing impact to the critical applications.
- **Data replicated services** (Oracle DataGuard and Sybase Replication) in the secondary data center.

- **Windows scalability and recovery technology and VMware vSphere, HP LINUX Business Critical Solutions:** Over 80 percent of AmeriHealth Caritas' servers are virtualized, providing advanced protection, flexibility, and dynamic scalability. AmeriHealth Caritas partners with VMware's proven server and data center virtualization solutions built on VMware vSphere. Virtualized servers can easily be relocated from one physical machine to another as needed. This high level of virtualization enables AmeriHealth Caritas to rapidly recover in case of any physical server faults or a site failure event. Virtualization also allows us to provision servers faster, reducing the time needed to bring them on line, while meeting enterprise application SLAs with a more resilient solution. We also leverage HP Linux Business Critical Solutions for a similar virtualization and failover technology on our HP Superdome 2 environments. We also utilize VMware to provide virtual desktop solutions, which establish a stateless workspace that is available from anywhere at any time. This provides rapid recovery from desktop software corruption by allowing us to provision a brand new user desktop from a pre-defined image. This technology helps reduce desktop maintenance costs and greatly reduces the time required to set up and provision new users.
- **Unix scalability and recovery technology and HP ICAP:** Incorporated in our HP-UX Superdome 2 environments, HP's Instant Capacity (ICAP) technology allows dynamic allocation of system resources to address increased load on servers in the event of a failover supported by the Serviceguard technology. If a particular primary server in our environment fails, this technology will allow us to allocate additional CPU and memory resources to the secondary server to support maintaining the desired level of application performance on that server. This ultimately provides resources on demand, maintaining system performance with increasing and/or variable business demand.

2.16 Material Change to Operations

1. Describe how you will inform DHS in advance of any material changes, and how far in advance DHS will be informed.

AmeriHealth Caritas will ensure prompt communication when initiating a material change, thorough testing with affected stakeholders, controlled promotion of changes to production control operations, and utilize our best-practice methodology to ensure impacts to supporting systems are addressed.

Communicating material changes to the DHS

AmeriHealth Caritas Iowa will use proactive measures to anticipate and communicate system changes. This is achieved through the change management and release management communications process depending on the type of change and the affected parties. The health plan will notify the designated Agency contact at least 90 calendar days before the projected date of change for software release updates or conversions of core transaction systems including claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management.

Change management

AmeriHealth Caritas manages systems changes initiated through key stakeholders to an enterprise project management office (EPMO) where changes are evaluated and prioritized. Large projects are managed through the EPMO and smaller maintenance projects are managed through IS domain leaders. All projects, large or small, follow a standard best practice systems development life cycle. This process ensures engagement and communication with key stakeholders to plan changes, validate requirements, design and test solutions.

Communication is a common component across these processes, which is centrally managed by a project manager through a cross-functional project team and key stakeholders, including DHS, as appropriate to ensure contract compliance.

An example of stakeholder engagement to ensure a smooth transition to a major system change was the conversion from 4010 HIPAA standards to 5010 HIPAA standards in late 2011. One high-impact change was that providers could no longer submit a P.O. Box as the rendering address. Claims submission with a P.O. Box would cause the claim to reject and not pay.

In order to minimize the impact on providers, we implemented an active, targeted outreach program. Each week, a scorecard was produced with the number and list of providers who would not pass the P.O. Box edit of the 5010 HIPAA standard, and the providers were contacted for education about the new claim requirement. A claim performance dashboard was utilized to (1) measure the trends to establish a baseline, (2) educate providers to modify their systems, (3) re-measure their progress and (4) to enforce rejections once trending was below threshold.

As a result of the proactive provider engagement, we were able to reduce the provider's use of P.O. Box addresses from over 30 percent to less than 1 percent, thereby significantly reducing provider claim rejection when the 5010 claim edit was enabled.

2. Confirm that DHS may deny or require modification to proposed material changes if, in its sole discretion, it determines that such changes will adversely impact quality of care or access.

AmeriHealth Caritas Iowa will seek prior approval of the requested material change from DHS. AmeriHealth is always available to discuss the proposed change with the applicable DHS staff, if desired, and understands DHS can deny and/or modify such changes.

3. Describe your ability to communicate material changes to members or providers at least thirty (30) days prior to the effective date of the change.

Following an AmeriHealth Caritas enterprise-wide policy, AmeriHealth Caritas Iowa communications will always be targeted for distribution at least 30 days in advance of a material change to give members and providers sufficient notice (as per contractual language between the health plan and the provider) to allow both groups time to adjust and accommodate the change. Communication can, and will, happen through multiple channels (i.e., mail, phone, plan website, Member Portal, Provider Portal, mobile app).

The enterprise has a corporate Provider Communications team that coordinates enterprise provider communications. Each local plan also has a provider communications team dedicated to the local market which is part of the Provider Network Management (PNM) team of the local plan. The PNM team is connected to the provider community, and is in touch with local trends, provider concerns, state policies and requirements. Provider communications are two-fold in nature: firstly, communications specific to state and local requirements, trends, goals and initiatives, and secondly, national issues such as ICD10 and HEDIS are developed across the enterprise and cascaded to the local market plans. In this way, local and national issues, requirements are distributed to providers in a timely manner. Attachment 2.16-A, "Provider Communications Distribution Guidelines," describes the process followed by corporate and local provider communications staff to ensure accurate and timely provider communications.

Attachment 2.9: Job Descriptions

Administration

Contract Administrator

Job Summary

The primary purpose of the job is to:

Responsible for overseeing the entire operations of the contract. Has full and final responsibility for contract compliance. Responsible for the strategic direction growth and leadership of the Plan. This role is responsible for managing the P&L , managing of the associates, achievement of all profitability and membership goals as well as subsidiary operating costs. Provides leadership direction, and an overall vision to the organization, in an effort to maintain and improve the performance of the business revenues, membership, external relationships, and profits. Directs the operations of The Plan. Demonstrates AmeriHealth Caritas philosophy and values and ensures that philosophy and mission drive the day-to-day operating environment. Develops and maintains appropriate external relationships in support of the plan. Develops strategic plans, budgets, and management action plans as a basis for management decision making. Fosters constructive positive relationships between the plan and its providers.

Job-Related Experience and Skills

- 5-10+ years of experience including leadership experience and progressive responsibility in Business or Government, health care management required
- BA/BS Business/Health Care Industry, Master's Degree preferred

Community Relations & Member Outreach

Dir. Community Relations/Member Outreach

Job Summary

The primary purpose of the job is to:

Has responsibility for achieving state-wide membership goals and the assured delivery of plan-defined messages to Medicaid beneficiaries and plan members throughout the state in accordance with the ACFC annual marketing and communications plan. In addition, the Director is responsible for achieving and maintaining positive relationships with key community organizations and assuring that staff is appropriately trained to comply with the Department of Human Services' contractual and administrative regulations and the requirements of the National Committee on Quality Assurance.

Job-Related Experience and Skills

- 10+ years of business experience including a minimum of 5 years of marketing management and supervisory experience
- Bachelor's Degree Marketing or related field or equivalent experience in Medicaid marketing and/or sales

Mgr., Community Relations/Member Outreach (Field)

Job Summary

The primary purpose of the job is to:

Under the supervision of the Director of Community Relations/Member Outreach, this position is responsible for providing daily management of the Community Relations/Member Department and staff. This includes, but is not limited to, providing direction to field staff and management of outreach and health education activities. Collaborates with community partners to determine unmet health education needs and establish and sustain programs and partnerships. Oversees and maintains specific activities and department functions to further promote and strengthen the plan's overall company position and goals. Responsible for the supervision of Community Relations Representatives and Marketing Coordinators.

Job-Related Experience and Skills

- Minimum of 5 years of health care, human services, and/or community outreach experience
- Bachelor's Degree in health care, human services or a related field or equivalent work experience
- Ability to travel (75%) extensively within assigned communities; Valid driver's license required; Leadership and negotiation skills; Ability to manage multiple projects and meet deadlines; Excellent oral and written communication skills; Ability to define problems, collect information and recommend solutions; Ability to exercise sound judgment; Excellent decision-making and follow-up skills; Attention to detail and ability to plan and organize.

Supervisor, Community Relations/Outreach (Field)

Job Summary

The primary purpose of the job is to:

Responsible for the supervision of the Community Relations/Member Outreach staff. Responsible for developing partnerships with community leaders and social service agencies in support of Plan members. Assists in the implementation of strategic marketing initiatives to achieve individual and regional membership goals. Assists the Director Community Relations/Member Outreach in implementing the mission of ACFC according to guidelines.

Job-Related Experience and Skills

- Minimum of 2 years of supervisory experience
- Minimum of 3 years' experience in the field of Medicaid Managed Care
- Bachelor's Degree Marketing or a related field or equivalent business experience

Community Relations Representative

Job Summary

The primary purpose of the job is to:

Under the supervision of the Supervisor, Community Relations/Member Outreach, this position promotes The Health Plan's programs throughout the state via site visits and participation in community events. Identifies and directs potential Medicaid and uninsured candidates appropriately to The Plan's programs. Develops, implements and manages community event opportunities and coordinates these activities with the Community Relations staff. Educates potential Medicaid recipients on how to enroll and access the enrollment broker system for plan enrollment. Assists members with concerns and directs them to the Member Services department.

Job-Related Experience and Skills

- 1-2 years of sales, service, support or community-based marketing
- Associate's Degree preferred

Marketing Coordinators

Job Summary

The primary purpose of the job is to:

The Coordinator, Marketing is responsible for coordinating activities related to projects and initiatives and for providing general support to the Community Relations/Member Outreach department. Responsibilities and tasks include.

Community Relations:

Provides support and implements marketing projects, including special events coordination, calendar management, meeting/event planning and logistics, committee and working group engagement coordination. Maintains the department contact management Access database and calendar. Maintains and updates document library and organizes SharePoint information, documents, reports, and associated supporting organizational processes and procedures. Tracks and updates departmental calendar/list of priorities, commitments and initiatives to include actual and projected due dates and current status. Serves as Internal web content administrator for the Public Affairs and Marketing Department site. Organizes the preparation, conference premium inventory, marketing collateral and distribution of promotional supplies, equipment and other needed materials, including processing invoices and tracking payment. Anticipates and prioritizes work accordingly and works well independently. A certain degree of creativity, judgment and latitude is required.

Marketing Business Office:

Provides general support to enhance departmental efficiencies and facilitate effective communication. The Coordinator has primary accountability for the development and maintenance of web-based communication tools, and departmental electronic libraries. Creates and delivers monthly Market Share, Member and Provider reports. Assists department staff in developing presentations and reports. Maintains and updates departmental calendar/list of priorities, commitments, and initiatives to include actual and projected due dates and current status. Responsible for maintaining and updated document library and organizing SharePoint information, documents, reports, and associated supporting organizational processes and procedures.

Job-Related Experience and Skills

- 3-5 years of marketing or related work experience or a bachelor's degree
- Bachelor's Degree preferred
- Account Management, Attention to Detail, Database Management, Event and Conference Management, and Project Management, Problem Solver

Plan Administration

Dir., Plan Ops & Administration

Job Summary

The primary purpose of the job is to:

Understand state program contractual and regulatory requirements (benefit and payment rules, data and information submission specifications, performance and service level requirements, etc.) and ensure requirements are met for the plan. The Director of Plan Administration acts as a liaison between the state, health plan and enterprise functions and is accountable for all contractual obligations and ensures that both local and corporate resources deliver on all commitments

Job-Related Experience and Skills

- 3-5 years of experience. Understanding of Medicare/Medicaid operations -benefit administration
- Bachelor's Degree

Long Term Care Manager

Job Summary

As an integral member of the AmeriHealth Caritas Iowa Team, the Long Term Care Manager will Serve as an internal consultant to Care Managers, Medical Director, and Provider Network Management regarding long term care services and providers in the state. This role will also serve as a subject matter expert for long term care training for internal care teams and external audiences and will support coordination of long term care with other clinical and social services across the continuum of care

Job-Related Experience and Skills

- 5-10 years of experience
- Bachelor's Degree
- Previous management experience including hiring, training and performance management. Thorough knowledge of Long Term Care and Home and Community Based Services (HCBS) guidelines, rules and requirements

Facilities & Emergency Management Specialist

Job Summary

The primary purpose of the job is to:

The Facilities & Emergency Management Specialist is responsible for project building needs and facility operations. Manages lease agreements and security contracts. Coordinates the development, implementation and maintenance of emergency management plans for site in the event of a local or statewide emergency including any disruption to normal business operations.

Job-Related Experience and Skills

- 8 years of facilities management/business experience; 5 - 7 years of progressive work experience in Emergency Management and Business Continuity/Disaster Recovery areas preferred
- Bachelor's Degree
- Facilities Management Professional Certification (FMP) preferred; Continuity Planning (EMCP) Certified preferred; Business Continuity/Disaster Recovery (CBCP) certification or equivalent experience

Director, Local Ops/Provider Network Operations

Job Summary

- The Director of Local Ops/Provider Network Operations oversees the network operations function and is responsible for the accuracy and completeness of provider data and information, provider and claims education, quality oversight for all operations and administrative functions; and will assist in the establishment and achievement of business objectives based on the company's overall strategic plan and operating goals.
- Responsible for the accuracy and completeness of provider data and information as the entry point for such data into Enterprise systems.
- Responsible for provider and claims education including all provider materials to include but not limited to provider handbook, provider website, provider newsletter and the, provider directory
- Responsible for quality oversight for all operations and administrative functions; serves as the Chairman of the Quality of Service Committee; initiates and oversees corrective actions plans for those services not in compliance with state contract.
- Oversees the company's desktop support services and staffing to assure that all local associates have access to appropriate hardware and connectivity for all plan systems.
- Responsible for design, development and implementation of processes to assure compliance with the Plan contract.
- Responsible for the analysis of provider reimbursement and updating codes and fee schedules for correct reimbursement to providers.
- Assists in the establishment and achievement of business objectives for the area of responsibility based upon company's overall strategic plan and operating goals

Job-Related Experience and Skills

- Bachelor's degree in business or health related discipline such as Healthcare Administration or Healthcare Management or equivalent business experience. Master's Degree preferred.
- Minimum 8 years progressive business management experience, preferably in Healthcare
- Minimum 5 year's management experience, in a managed care setting, managing teams and projects.
- Working knowledge and strategic understanding of medical billing principles, procedures, ICD-9, ICD-10 and/or CPT medical billing codes and documentation.
- HIPAA, NCQA and Facets experience preferred

Mgr., Network Operations

Job Summary

The manager of network operations manages the day-to-day activities of the Network Operations department and staff, ensuring department staff remain current in all aspects of Federal and State rules by creating and modifying departmental policies and leading major system upgrades to reflect such changes

Job-Related Experience and Skills

- 5-10 years in Managed Care
- Bachelor's Degree

Provider Network Analyst

Job Summary

Responsible for research and analysis. This role supports new business provider recruitment and contracting, and may also be responsible for research and analysis related to provider claims issues The Provider Network Analyst Identifies systematic and procedural issues resulting in processing reports and initiating actions to produce reports extracts, manipulates, and evaluates accuracy of provider data for new implementations.

Job-Related Experience and Skills

- 5-10 years of experience: healthcare industry, office experience
- Advanced experience with sophisticated databases. Full competence in report preparation, layout and design.
- Ability to plan, organize and handle multiple tasks.
- In depth expertise in data analysis and data mining. Superior analytical skills.

Coordinator, Provider Ops

Job summary

Provides coordination and tracking support for the network operations team monitors and distributes credentialing for internal, external and delegated entities., and coordinates and tracks provider and facility record and agreement processes

Job-related experience and skills

- 2-3 years in an HMO environment with experience in a relevant area required.
- Working knowledge of PC applications in a windows based environment, especially in Access and

Dir., Member Engagement

Job Summary

Responsible for the leadership, direction, and implementation of the strategic vision for all services that impact or interface with plan members. Reporting to the Director of Plan Operations and Administration, this position is responsible for working collaboratively with enterprise call centers to ensure that plan requirements and cultural competencies are met, in order for members to have positive experiences. Additional areas of responsibility include the direction of all member communications and collateral materials, including member education, member advocacy, support enrollment and eligibility functions, health education, analysis of action plan disenrollment rates, grievance tracking and reporting, and member satisfaction.

Job-Related Experience and Skills

- 3-5 years, with preference for 5-10 years
- Understanding of Medicare/Medicaid operations -benefit administration
- Bachelor's Degree

Information Systems Manager

Job Summary

The Information Systems Manager provides strategic direction and leadership for data and technical services provided by the plan including telecommunication systems, operating systems and all hardware and software located in-house and at remote locations. Oversees the study, creation and implementation of structures and algorithms to improve communication, understanding and management of health plan information. Interfaces with internal/external customers, including State Agencies, on all issues related to data. Identifies and defines data, technical needs and solutions, manages departmental resources and determines/prioritizes multiple project requirements and deliverables to ensure successful implementations. Directs the planning, implementation and operations of local Information Technology in a manner aligned with ACFC corporate IT initiatives and in support of company-wide goals and objectives. Through a matrix reporting relationship, provides guidance to the local Informatics/Medical Economist Analysts on the reporting needs of multiple Select Health departments. Directs local project management resources to ensure timely execution of projects and implementation of plan/organizational initiatives.

Job-Related Experience and Skills

- 5-10+ years
- Progressive Health Care business experience and IT/Project Management
- Bachelor's Degree BA/BS degree in Health Care, MIS, or related field

Tech Analysts

Job Summary

Provides technical support for associates. Responsible for providing support concerning issues pertaining to the operation of all technology. The function is typically performed during normal business hours but may require flexible or "off-hours" support from time to time.

Job-Related Experience and Skills

- High School / GED

Admin Assistants

Job Summary

This position supports leaders in various functional area(s). This position is responsible for performing administrative tasks such as entering data, compiling reports, assembling binders, building spreadsheets, distributing correspondence, recording and dispensing meeting minutes, and making copies. In addition, this individual is tasked with creating presentations, updating manuals and coordinating mass mailings.

Job-Related Experience and Skills

- High School / GED – Associate’s Degree preferred
- 3-5 years office experience
- Proficiency with Microsoft Office Suite (Word, Excel, Power Point). Access is a plus. Consistent word processing speed and accuracy of 50 or more words per minute.

Medical Management

Medical Director

Job Summary

The Medical Director reports directly to the Contract Administrator (Market President) and has a dotted line reporting relationship to the Regional Chief Medical Officer. The position is responsible for market-based clinical leadership and execution of all health care affordability and clinical quality initiatives to achieve goals. The Medical Director is accountable for ACFC quality initiatives to improve HEDIS and other quality ratings and collaborates with the local provider community and state regulatory agencies to improve care. The Medical Director is a seasoned professional who faces outward to and interacts with the Plan’s membership and physician community, physician and health system networks, medical/physician professional associations, government representatives, and advocacy groups to advance clinical excellence and the delivery of cost efficient care.

Job-Related Experience and Skills

- 5-10 years of experience:
- Minimum five years practice experience in his/her area of specialty
- A minimum of five (5) years of medical management and general management experience in a managed care environment is preferred.
- MD or DO: Board Certified Physician
- An unrestricted license to practice medicine in the Plan’s state and any other state in which he/she works
- Valid driver’s license

Pharmacist Director/Coordinator

Job Summary

Supports corporate, regional and local medical management and pharmacy goals in implementation of pharmacy related clinical program initiatives and clinical policy, participates on the plan's Quality committees (e.g. Quality of Service and Quality of Clinical Care), and ensures compliance with respective state Medicaid contract requirements, participate in meetings with state agencies as the health plan pharmacy representative, and respond and/or resolve identified regulatory issues, participates in onsite visits to hospital systems and selected physician group practices and pharmacies, provides on-site consultation and education to Plan nurses, case managers, and/or physicians

Job-Related Experience and Skills

- 3-5 years of experience: Operational and Clinical pharmacy experience in a Managed Care or Hospital setting. Medicaid and Medicare experience strongly preferred. P&T Committee experience required.
- R.Ph. required at a minimum

Dir., Integrated Care Management

Job Summary

Responsible for the leadership, direction and strategic vision for the Integrated Care Management processes for the Plan. To include case management, disease management and health management. Includes focusing staff efforts to contribute to EPDST and HEDIS measures. Responsible for the design, development implementation and ongoing improvement of health outcomes outreach and education. Responsible for assuring compliance with State and Federal regulations, contractual obligations and NCQA requirements.

Job-Related Experience and Skills

- 5-10 years preferred; 3-5 years of management experience
- Bachelor's Degree in Nursing
- Registered Nurse

Care Manager

Job Summary

The Care Manager (RN/SW) assists members appropriate for care coordination and case management services in achieving their optimal level of health. The Care Manager (RN/SW) is responsible for engaging the member and providers to assess, plan and establish individual member goals. Will facilitate and coordinate care for the members while assuring quality and use of cost-effective resources. The position will function as a single point of contact and be an advocate for members in the care coordination program. Assess members to determine care coordination and case management needs for all referred members. Completes comprehensive assessment of environmental, Psycho-social and support needs. Identifies problems/barriers for care coordination and appropriate care management interventions. Creates a plan of care to assist members in reducing/resolving problems and or barriers so that members may achieve their optimal level of health. Identifies both short and long term goals and associated time frames for completion. Shares goals with the member and family as appropriate. Identifies and implements the appropriate level of intervention based upon the member's needs and clinical progress. Schedules follow up calls as necessary, makes appropriate referrals. Implements actions to address member issues. Documents progress towards meeting goals and resolving problems. Coordinates care and services with the Account manager, Complex RN Case Manager, and member, family members as appropriate, PCP, Specialist, and Facility/Vendor Providers.

Job-Related Experience and Skills

- 3-5 years of experience: of Case Management preferred. 3 years nursing experience in related clinical setting. Managed Care experience preferred with focus on Medicaid population preferred.
- Bachelor's degree
- Registered Nurse, graduated from an accredited Diploma, Associates Degree or Bachelor's Degree program.

Care Connectors

Job Summary

The Care Connector is responsible for supporting the daily operations of integrated care management and utilization management program interventions. The Care Connector performs in a contact center environment, effectively processing calls from Members, Providers and other areas, internal and external to the company. The CC identifies members with Care Gaps/HEDIS related health conditions and assists them in accessing care through Plan benefits and community resources. Under the direction of Clinical staff, the Care Connector will provide members with educational materials and carry out strategies to increase health care adherence and reduce barriers to care.

Job-Related Experience and Skills

- 1- 3 years of experience: proficient PC skills in a Windows based environment including word processing, spread sheets and working in database programs; Working knowledge of Plan Benefits and Services is preferred; proven ability to keep accurate and timely records and documentation according to established processes
- High School/GED

Care Management Manager

Job Summary

Responsible for providing oversight and administrative management of the Care Management Department and related teams, care plan development, and care plan implementation, ensures effective daily operation of the Care Management Department utilizing all applicable statutory provisions, contracts and established policies and administrative procedures, while participating in the State's Drug Utilization Review (DUR) Board Meeting and Mental Health Quality Assurance Committee, ensuring compliance with corporate, federal, and state confidentiality standards to ensure the appropriate protection of member identifiable health information

Job-Related Experience and Skills

- Three years case management experience in relevant scope preferred, one year required
- Bachelor's Degree
- Current unrestricted RN Licensure in the state of Indiana required.
- Case management certification preferred, those seeking case management certification considered
- Professional certification in a clinical specialty needed
- Experience in use of financial information for planning purposes
- Valid Driver's license and clean driving record required; reliable transportation and appropriate auto insurance necessary
- Demonstrated ability to assess department's work quality and develop/implement process improvements to achieve contractual and oversight compliance.
- Maintain a current knowledge of company policy and procedures, OMPP Requirements, NCQA/URAC recommendations impacting Care Management assessment, access and delivery of services. Maintain understanding of managed care and Care Management role and impact on services including but not limited to, prior authorization, inpatient review, discharge planning, home health, and SNF/Rehabilitation Services.
- Demonstrated competency in use of healthcare data.

Sup, Care Management

Job Summary

Supervises the Intake Nursing team that provides clinical assessments and customer clinical management. Works with the Clinical Program Manager to develop policies and procedures. Oversees the call volume and service standards for the team. Oversees hiring, training, and evaluation of staff.

The Supervisor provides supervision of the following activities: Initial patient assessments on multiple disease states, home care coordination, coordination and documentation in the patient record, and clinical review of all information needed to complete the Schedule First Order Nurse function according to operational policy and procedures.

Provides supervision and ensures that the nursing staff can provide and coordinate clinical related information, evaluate patient clinical needs for specific therapies that treat chronic diseases, terminal illnesses, genetic disorders, bleeding disorders, and others within our Specialty Pharmacy. As Evidenced by: answering questions; researching information; completing requests, advising internal and external customer groups on drugs or drug therapies and disease states, nursing practice and company operations.

Job-Related Experience and Skills

- 5-10 years of professional practice; 1-3 years of supervisory experience
- Active nursing license in the state
- RN preferred

Community Care Program Manager

Job Summary

As part of the Community-based Care Management program, the Community Care Program Manager will provide site and operational leadership for a health team in an assigned market, in addition to acting as a care manager for the target population, providing in home environmental and physical assessments for high risk members to identify unmet needs and barriers to care and to establish a care management plan of care. May provide basic clinical care within scope of practice (RN, SW) in collaboration with members medical management team, establishes point of contacts in collaboration with community medical/behavioral health teams As well as community based social services and local community stakeholders; works closely with and leads Community Health Connectors as they deliver in- community care, support pathways to establish connections to appropriate services and provide coaching and education for chronic disease management.

May serve as the program subject matter in the collaboration with Program Director.

Job-Related Experience and Skills

- Minimum of three years of similar level or related experience including demonstrated expertise conducting health assessments and delivering care in a clinical environment.
- Bachelor's Degree; Registered Nurse or LS/MSW
- Ability to travel extensively within assigned communities. Valid drivers license required

Clinical Educator

Job Summary

The Clinical Educator plans, develops, and conducts clinical education and training programs for provider and provider staff necessary to meet the organizations clinical integration initiatives. The trainer is responsible for maintaining a current knowledge base with regards to rules, regulations, policies and procedures relating to the implementation of provider training initiatives.

Job-Related Experience and Skills

- 3-5 years' experience with providing behavioral health and/or clinical training or consultation
- 1 year experience working with a managed care system required
- One of the following professional licenses is preferred: RNLSW (licensed social worker), LCSW (licensed clinical social worker), LMFT (Licensed Marriage and Family therapist), LPC (Licensed professional counselor).

Community Care Mgmt. Care Manager

Job Summary

As part of the Community-based Care Management program, the Care Manager collaborates broadly for the identification of members/consumers appropriate for care coordination and/or case management program services in a community setting. The Care Manager collaborates with all levels of Medical Management department staff for appropriate integration of Community Based Medical Management programs with other existing and planned initiatives, aligning with annual operating plan and strategic growth initiatives. The Care Manager provides in home environmental and physical assessments for high risk members to identify unmet needs and barriers to care and to establish a care management plan of care. The Care manager may provide basic clinical care within scope of practice (RN, SW) in collaboration with members' medical management team. Establishes point of contacts in collaboration with member community medical/behavioral health teams. Works closely with and directs and supervises the work of Community Care Connectors as they deliver in-community care, support pathways to establish connections to appropriate services and provide coaching and education for chronic disease management. May serve as a program subject matter expert and/or assist the Community Care Program Manager with operational responsibilities

Job-Related Experience and Skills

- Minimum of three years of similar level or related experience including demonstrated expertise conducting health assessments and delivering care in a clinical and community environment.
- Bachelor's Degree
- Registered Nurse: An unrestricted license to practice nursing in the Plan's state and any other state in which he/she works.
- Ability to travel extensively within assigned communities. Valid driver's license required

Community Care Mgmt. Care Connector

Job Summary

The Community Care Connector supports more effective linkages between vulnerable populations and the health care system and social services by building and nurturing a trusted relationship with member through community based visits and phone calls. Under the clinical direction and oversight of the Medical Director and clinical care managers, the Community Care Connector serves to connect members to needed care and supports care transitions for vulnerable populations. Community Care Connectors may be assigned to work with designated primary care teams, including using the PCP office as work base.

Job-Related Experience and Skills

- High School/GED
- Community based care experience preferred, Medical assistant training preferred, must be familiar with neighborhood of assignment, fluent in language of members served
- Requires completion of medical exam/testing as required by Federal and State regulations upon conditional offer of employment and post-employment.

Community Care Management Coordinator

Job Summary

As part of the Community-based Care Management program, the [insert title] assists with standardization, auditing and the day-to-day guiding of the activities of the administrative assistant staff to ensure compliance to data management processes and outcome tracking detail for new and existing community care hubs. This position also plays a key role in the onboarding and training of new and existing community care connectors and administrative staff across the enterprise.

Job-Related Experience and Skills

- 1-3 years of related experience
- Bachelor's Degree

Grievances & Appeals Manager

Job Summary

The Grievances & Appeals Manager oversees and directs the functions of the appeals team and is responsible and accountable for maintaining the Plans compliance with all regulations and NCQA/URAC standards related to the member and provider appeals. This responsibility includes all interdepartmental and intradepartmental coordination, communication, education and committee structure and support.

Job-Related Experience and Skills

- 10+ years of experience in healthcare management/administration
- Bachelor's Degree: Nursing/Health Related Field

Clinical Care Reviewer

Job Summary

The Clinical Care Reviewer is responsible for completing medical necessity reviews. Using clinical knowledge and nursing experience, the nurse reviews provider requests for inpatient and outpatient services, working closely with members and providers to collect all information necessary to perform a thorough medical necessity review. It is within the nurse's discretion to pend requests for additional information and/or request clarification. The nurse will use his/her professional judgment to evaluate the request to ensure that appropriate services are approved and recognize care coordination opportunities and refer those cases as needed. The nurse will apply medical health benefit policy and medical management guidelines to authorize services and appropriately identify and refer requests to the Medical Director when guidelines are not met. The nurse will maintain current knowledge and understanding of the laws, regulations, and policies that pertain to the organizational unit's business and uses clinical judgment in their application.

Job-Related Experience and Skills

- 3 or more years of experience in a related clinical setting.
- Licensed Practical Nurse or Registered Nurse graduated from an accredited program.
- Current unrestricted Practical Nurse license or Registered Nurse license.
- Valid Driver's License and reliable automobile transportation for on-site assignments and off-site work related activities.

Appeals Coordinator

Job Summary

The Appeals Coordinator is responsible for ensuring that all provider appeals, member complaints and grievances, presented by providers, members or their representative are resolved in accordance with established policy and procedures, Department of Public Welfare, NCQA, and Federal/State guidelines. The Senior Appeal Coordinator takes a lead role in assigning the responsibilities of a Provider Appeal Coordinator and a Grievance Coordinator. The Appeals Coordinator audits files prepared by department. Serves as a peer resource and preceptor for the Appeals department. Independently communicates with Advocacy Groups, Community Representatives, Providers, Physicians, and all ACFC departments including but not limited to Legal and Government Affairs, to interpret and enhance understanding of policies and procedures for provider appeals, member complaints and grievances. The Appeals Coordinator acts independently when representing the company internally and externally at IBC appeals committee meetings, Hospital and provider operational meetings, etc.

Job-Related Experience and Skills

- High School diploma or the equivalent required. BA/BS in a health related field preferred.
- 5 to 7 years customer service with in a health care environment required.
- 5 years' experience in an active Medicaid appeals environment required

Mgr., Rapid Response

Job Summary

The Rapid Response Manager oversees a non-clinical team of Supervisors and Care Connectors and is responsible for providing direction, organization and monitoring of all rapid response Contact Center services including collaboration with the following various units: Integrated Care Management Units, Utilization Management, Quality Management, Public Affairs and Marketing, Provider Network Management, Operations, PerformCare and PerformRx. In collaboration with Clinical staff, the rapid response manager will guide Care Connectors to perform within their scope of responsibilities while assisting members in improved health care adherence and reduction of barriers to care

Job-Related Experience and Skills

- Three to five years experience: Strong people-management skills/experience;
- Solid knowledge of contact center processes to provide accountability in high volume call environment, managing audits/reports
- Strong knowledge base of health care resources, ideally with managed care experience
- Proven ability to promote excellent customer service skills, skilled in conflict resolution and problem solving
- Skilled in working with diverse teams and able to collaborate with various disciplines within the Plan

Supervisor, Rapid Response

Job Summary

Under the supervision of Manager, Rapid Response Team, the Supervisor of the Rapid Response Team is responsible for providing daily oversight of the Rapid Response unit and provides direction, organization, and monitoring of all Rapid Response Team Services. Responsible for direct supervisory oversight of staff who conducts care management screenings, care coordination, case management, coordination of daily workflows, and other functions of clinical and non-clinical Rapid Response staff. May be required to maintain a personal care management caseload.

Job-Related Experience and Skills

- 3-5 years of experience
- Nursing/Licensed Nurse

Medical Directors, Utilization Mgmt.

Job Summary

The Regional Medical Director for Utilization management provides medical leadership to a multidisciplinary regional team for utilization, prior authorization, provider relations and case management functions. Primary responsibility lies in leading the development and implementation of medical policy as it relates to health services utilization.

Job-Related Experience and Skills

- 8+ years' experience in senior management and or Medical Director experience; 7 years Utilization Review and Case management experience
- 15+ years progressively responsible managerial experience
- MD/DO degree required

Clinical Care Reviewer UM

Job Summary

Under the direction of the unit Supervisor, the Clinical Care Reviewer is responsible for completing medical necessity reviews. Using clinical knowledge and nursing experience, the nurse reviews provider requests for inpatient and outpatient services, working closely with members and providers to collect all information necessary to perform a thorough medical necessity review. It is within the nurse's discretion to pend requests for additional information and/or request clarification. The nurse will use his/her professional judgment to evaluate the request to ensure that appropriate services are approved and recognize care coordination opportunities and refer those cases as needed. The nurse will apply medical health benefit policy and medical management guidelines to authorize services and appropriately identify and refer requests to the Medical Director when guidelines are not met. The nurse will maintain current knowledge and understanding of the laws, regulations, and policies that pertain to the organizational unit's business and uses clinical judgment in their application.

Job-Related Experience and Skills

- 3 or more years of experience in a related clinical setting.
- Licensed Practical Nurse or Registered Nurse graduated from an accredited program.
- Current unrestricted Practical Nurse license or Registered Nurse license.
- Valid Driver's License and reliable automobile transportation for on-site assignments and off-site work related activities.

Utilization Management (UM) Tech

Job Summary

The Utilization Management Tech functions under the direction of the Supervisor to coordinate, generate and track both incoming and outgoing correspondence, faxes and authorizations related to prospective, concurrent and post service review functions. Interacts with facilities, vendors, providers, and other staff to facilitate receipt of information, and /or records for prompt review and response. Compensation plans for physicians, licensed nurse reviewers, staff, and consultants who conduct medical management do not contain incentives, directly or indirectly, that encourage barriers to care and service in making determinations.

Job-Related Experience and Skills

- High School Diploma or GED required.
- Minimum 1 year general office and/or customer service experience required.
- Work experience in healthcare setting required.
- Knowledge of medical terminology required.

Durable Medical Equipment (DME) Spec.

Job Summary

The DME Specialist is, responsible for intake of requests for Durable Medical Equipment and outpatient therapy authorizations, including telephone support, data entry, submission to the plan Medical Director for medical necessity review, completion of service authorization detail lines, and member/provider notification process. Responsible for precertification and recertification process for Durable Medical Equipment and selected outpatient therapies. Follows departmental workflow for prior authorization of request, including documenting receipt of request, and member eligibility, Authorizes services based on plan guidelines. If unable to approve, submits the request to AmeriHealth Mercy Health Plan Medical Director for medical necessity determination. Completes detail lines in the appropriate system to reflect authorization or denial of services. Follows denial process to provide initial verbal/facsimile notification to provider(s) and generates appropriate written notification to provider(s) and member.

Job-Related Experience and Skills

- Minimum one-year experience in a healthcare related field such as Home Health Agency, Medical Equipment Company or managed Care experience
- High School/GED

Utilization Management Manager

Job Summary

The Utilization Management Manager oversees staff performance with regard to prior authorization, medical necessity determinations, concurrent review, retrospective review, continuity of care, care coordination, and other clinical and medical management programs. These responsibilities extend to physical and behavioral health care and transportation services, while ensuring effective daily operation of the Utilization Management Department and utilizing all applicable statutory provisions, contracts and established policies and administrative procedures to remain compliant with federal and state regulations. This role will prepare reports and conduct analysis of operations / services as required by departmental, corporate, regulatory, and State requirements, and will work collaboratively with the Information Services Department on identifying required data for reporting. The UM manager will partner with community agencies and contracted vendors to develop and maintain collaborative contact to assure members have access to the appropriate resources and will act as a liaison with outside entities, including but not limited to physicians, hospital, health care vendors, social services agencies, member advocates, OMPP and other select entities.

Job-Related Experience and Skills

- 3-5 years of relevant clinical practice required
- Three years case management experience in relevant scope preferred, one year required
- Current unrestricted RN Licensure
- Professional certification in a clinical specialty needed
- Experience in use of financial information for planning purposes
- Valid Driver's license and clean driving record required; reliable transportation and appropriate auto insurance necessary
- Demonstrated ability to assess department's work quality and develop/implement process improvements to achieve contractual and oversight compliance.
- Maintain a current knowledge of company policy and procedures, InterQual criteria access and delivery of services. Maintain understanding of managed care and impact on services including but not limited to, prior authorization, inpatient review, discharge planning, home health, and SNF/Rehabilitation Services.
- Demonstrated competency in use of healthcare data.

Supervisor UM

Job Summary

Under the supervision of the Manager for Utilization Management, this position is responsible for providing daily oversight of UM Nurses, UM Technicians and staff members within Utilization Management. Responsibilities include providing clinical, technical and operational support and direction, including organization and monitoring of all medical services. Responsible for direct supervisory oversight of professional and front line staff receiving requests for authorizations from external customers which encompasses providers and members, as well as from the internal customers.

Job-Related Experience and Skills

- 3-5 years progressive experience in an acute care setting. Minimum 3 years of experience in managed care utilization review.
- Unrestricted, current RN license

Behavioral Health Manager

Job Summary

The Behavioral Health Manager is responsible for acting as a liaison between the State, providers (PCP), members and care management team. The Behavioral Health Manager will be responsible for promoting physical and behavioral health integration and outreach activities with members, providers, and the plan. The position will also be responsible for collaboration with the multidisciplinary team to ensure the member's needs are assessed and addressed in a timely manner. The Behavioral Health Manager will work to facilitate communication between the physical health team and the behavioral health team to maintain open dialogue, integration and continuity for the members. Position includes responsibilities to develop, adopt and promote primary care practice guidelines under the direction of the Behavioral Health Medical Director. These guidelines will be used to support the provision of behavioral health services provided in primary care setting, including provider pharmacy prescribing practices (e.g. ADHD prescribing). The Behavioral Health Manager will also support the Behavioral Health Medical Director in review of utilization trends (e.g. Emergency, pharmacy) and quality outcomes.

Job-Related Experience and Skills

- 3-5 years of experience
- Master's Degree: MSW, LSW

Medical Director (Behavioral Health)

Job Summary

Responsible for guiding development of all Behavioral Health programs and guidelines, providing administrative and clinical guidance and expertise to senior management and staff to enhance and improve the quality of care and services provided to the Plan's members. Reporting to the Medical Director. Must be located in Iowa or available to Iowa for consultation. The Behavioral Health Medical Director liaison is responsible for providing clinical behavioral health supervision to AmeriHealth Caritas Iowa.

Job-Related Experience and Skills

- 5-10+ years of experience
- Must be licensed in state(s) assigned as a physician and recognized by licensing authority.

Psychiatrist/Psychologist Advisor

Job Summary

The Psychologist Advisor ("PA") is responsible for providing consultation and determinations for clinical cases in need of review. The PA supports the clinical department in applying Medical Necessity Criteria, to render determinations to complaints & grievances for specific levels of care. In addition, the PA will assess clinical aspects of quality of care issues pertaining to best practice standards. The PA will provide quality monitoring related to the plan model. The PA will perform quality improvement activities consistent with qualifications as approved by the Credentialing Process and verified through an NCQA Credentialing Verification Organization.

Job-Related Experience and Skills

- 5-10 years: clinical behavioral health
- Licensed Psychologist

UM Supervisor

Job Summary

The UM Supervisor is responsible for providing daily oversight of UM Nurses, UM Technicians and staff members within Utilization Management. Responsibilities include providing clinical, technical and operational support and direction, including organization and monitoring of all medical services. Responsible for direct supervisory oversight of professional and front line staff receiving requests for authorizations from external customers which encompasses providers and members, as well as from the internal customers.

Job-Related Experience and Skills

- 3-5 years progressive experience in an acute care setting. Minimum 3 years of experience in managed care utilization review.
- Unrestricted, current RN license

UM Clinical Care Reviewer

Job Summary

Under the direction of the unit Supervisor, the Clinical Care Reviewer is responsible for completing medical necessity reviews. Using clinical knowledge and nursing experience, the nurse reviews provider requests for inpatient and outpatient services, working closely with members and providers to collect all information necessary to perform a thorough medical necessity review. It is within the nurse's discretion to pend requests for additional information and/or request clarification. The nurse will use his/her professional judgment to evaluate the request to ensure that appropriate services are approved and recognize care coordination opportunities and refer those cases as needed. The nurse will apply medical health benefit policy and medical management guidelines to authorize services and appropriately identify and refer requests to the Medical Director when guidelines are not met. The nurse will maintain current knowledge and understanding of the laws, regulations, and policies that pertain to the organizational unit's business and uses clinical judgment in their application. .

Job-Related Experience and Skills

- 3 or more years of experience in a related clinical setting.
- Licensed Practical Nurse or Registered Nurse graduated from an accredited program.
- Current unrestricted Practical Nurse license or Registered Nurse license.
- Valid Driver's License and reliable automobile transportation for on-site assignments and off-site work related activities.

Care Manager & Clinical Care /Care Manager (After Hours)

Job Summary

The Care Manager is responsible for acting as a liaison between the behavioral health department and providers / members to provide care coordination and Care management services. The Care Manager will be responsible for outreach activity with members and providers. The Care Managers will document all activity in the member's medical record in the electronic Care management documentation system. The Care Manager will collaborate with the Clinical Care Managers and the Medical Care Management team in identifying, reviewing and assessing members' need for behavioral health Care management. The Care Manager will assist in providing Care management services for members who have been enrolled in the program.

The Care Manager will screen and facilitate the review outpatient treatment requests within contractual time frames. The Care Manager will process behavioral health appeals.

Job-Related Experience and Skills

- 3-5 years prior experience in behavioral health/human services required; or other equivalent background and experience that would translate well to this position.
- Bachelor's Degree: Social Work, Nursing or Human Services – The degree must be from an institution that is fully accredited by a nationally recognized educational accreditation organization and the individual must have completed a supervised field experience in case management, health or behavioral health as part of the degree requirements.
- Current Certification in Case Management (CCM) or eligible to take exam within 24 months of date of hire
- Must hold a valid, unrestricted State license in a behavioral health specialty or nursing. Acceptable licenses include but are not limited to LBSW, LMSW, RN, LPC
- Customer Service and previous telephone experience preferred, Previous experience in an office setting and/or doctor's office/ hospital preferred, Knowledge of human services system preferred

Care Connector

Job Summary

The Care Connector is responsible for supporting the daily operations of integrated care management and utilization management program interventions. The Care Connector performs in a contact center environment, effectively processing calls from Members, Providers and other areas, internal and external to the company. The CC identifies members with Care Gaps/HEDIS related health conditions and assists them in accessing care through Plan benefits and community resources. Under the direction of Clinical staff, the Care Connector will provide members with educational materials and carry out strategies to increase health care adherence and reduce barriers to care.

Job-Related Experience and Skills

- 1-3 years of experience
- High School/GED

Director, Quality Management (Quality Manager)

Job Summary

The Director of Quality Management is responsible and accountable for the successful, ongoing development, refinement, implementation, measurement, ongoing quality improvement and effectiveness of the Health Plan’s, Line of Business or Product’s Quality Management Program. Works directly with Senior Executives to plan, organize and direct the identification, prioritization and implementation of strategic projects that improve financial, service and clinical outcomes for the Plan, LOB or Product Line. Additionally, the position is responsible and accountable for ongoing maintenance of the Plan’s compliance with state regulations and NCQA/URAC and other appropriate standards for activities related to Quality, Care Management and Utilization Management. This includes credentialing/re-credentialing activity, delegation oversight, quality of care investigations as well as the corresponding inter- and intra-departmental coordination, communication, and education. The Director of Quality Management provides primary oversight and responsibility for the Plan’s, Line of Business or Product Line’s Quality and Medical Management Committee structure and support. In addition, the Director of Quality Management provides functional support to the Network Management, Informatics, Information Solutions, Care Coordination, Utilization Management, and Public Affairs departments to integrate Quality Management initiatives and goals with organizational programs. The Director, Quality Management plays an active role in the dissemination of the Quality Management best practices throughout the AmeriHealth Family of Companies and assists with new business opportunities and implementation.

Job-Related Experience and Skills

- 1-2 years working with Medicaid/Medicare and STAR programs
- 5-10 years in clinical areas
- 5+ years managed care experience.
- 5+ year’s managerial experience.
- Prior URAC or NCQA Accreditation experience
- An unrestricted nursing license to practice nursing in the plan’s state or any other state he/she works. RN license required.

Quality Performance Mgmt. Specialist-non clinical

Job Summary

This position is responsible for the coordination and ongoing monitoring of QI program objectives, including the delivery of performance improvement projects for service and clinical activities, integrating the quality improvement plan into all departments and facilitating HEDIS, CAHPS and NCQA accreditation activities. Implements and supports the overall implementation of quality programs that meet or exceed applicable State, Federal and NCQA standards.

Job-Related Experience and Skills

- Minimum of 5 years of experience in healthcare delivery required. Managed Healthcare experience preferred.
- Bachelor’s degree in health care related field or equivalent preferred
- BSN/RN preferred not required
- Minimum of 3 years of experience in clinical or service quality improvement required
- Successful management of NCQA accreditation survey preferred
- Two years managed Medicaid experience preferred

Cultural Linguistic Appropriate Services (CLAS) Coordinator

Job Summary

Responsible for overall oversight, administration, development, and strategic planning for the AC CLAS (Cultural and Linguistically Appropriate Services) program and access for AC culturally diverse, multi-lingual population. Maintains a comprehensive knowledge of Department of Public Welfare (DHH), National Committee on Quality Assurance (NCQA), Office of Minority Health (OMH) and other regulatory standards related to Cultural and Linguistically Appropriate Services activities. Develops and submits documentation and updates required to meet CLAS compliance including Annual Work Plan, Year End documents (Program Description, Program Evaluation and Work Plan).

Assists in the development and annual review of policies that represent the CLAS function. Reviews and analyzes CAHPS and HEDIS results for comparison of pre and post intervention results. Collaborates with internal departments and external community organizations to ensure adherence to CLAS program and identifying improvements in language access and equity services for both AC's membership. Actively contributes to the assurance of culturally and linguistically appropriate communications. Serve as contributor to Health Education, Outreach and Advisory Committee and solicit recommendations from community groups that are focused on culturally sensitive interventions, improving health care quality and health literacy. Assists efforts that involve piloted interventions, initiatives, education, and partnerships that specifically target non-English speaking members. Conducts ongoing oversight of translation processes to ensure necessary documentation and satisfaction through regular member/associate surveys.

Job-Related Experience and Skills

- 5-7 years in managed care preferably in cultural competency and/or quality management
- Bachelor's Degree: healthcare or related field

Community Outreach Solutions Specialists

Job Summary

As part of the community outreach function, the Community Outreach Solutions [COS] Specialist establishes connection and acts as the primary ACFC contact to a targeted member population through home visits and outreach calls within an assigned territory. This position supports education, proactive retention and care strategies to prevent elevated health care costs and serves as a liaison for the member to the organization.

Job-Related Experience and Skills

- Minimum of 2 years of health care in an office/clinic/hospital setting or human services experience, medical assistant, CAN
- High School/GED; Associate's degree

Quality Mgmt. RN (Quality Performance Specialist-Clinical)

Job Summary

This position is responsible for leading and coordinating the clinical quality review process of member concerns and medical records utilizing of care standards. In addition, responsibilities also include supporting the annual medical record review activities including HEDIS and, Clinical Practice Guidelines. The position also supports accreditation and clinical quality performance improvement activities.

Job-Related Experience and Skills

- Registered Nurse
- Proficient with Microsoft Office applications including Word, PowerPoint, Excel required
- Knowledge and understanding of QI functions in an MCO preferred
- Knowledge of Medicaid and Medicare preferred
- 3-5 years quality improvement experience required
- 2-4 years of experience in project facilitation/management role

Clinical Auditor

Job Summary

As a member of the Corporate Clinical Auditing team, the Clinical Auditor coordinates and completes associate quality audits of clinical staff, focused reviews, and problem identification. Provides coaching and feedback to associates as necessary. Provides routine/scheduled and ad hoc audit reports, including trend identification and root cause analysis. Coordinates development of action plan for identified issues. Participates and assists in the development of necessary protocols, policies and procedures, and operational strategies for Clinical Services. Provides a report tracking compliance with timeliness as mandated by applicable legislative and accrediting organizations, including trend identification and root cause analysis. Coordinates development of action plans for identified issues. Responsible for ongoing development of audit tools to meet business needs. Participates in Quality Reviews and Inter Rater Reliability process as requested. Works with the management team to develop and provide individual and department-level performance improvement plans and activities as well as plan/process follow-up.

Job-Related Experience and Skills

- 1-2 years of specific clinical knowledge / experience in Utilization Management and/or Case Management
- Master's Degree or Registered Nurse

Clinical Trainer

Job Summary

The Clinical Trainer/System Administrator plans, develops and conducts education and training programs for staff necessary to meet the organization's business objectives, regulatory guidelines and improve skills and professional growth and development.

Assists with training on utilization of Medical Management software platform and applications utilized by Utilization Management and Case Management staff as requested. Maintains a current knowledge base with regard to rules, regulations, policies and procedures relating to the implementation of all Medical Management functions: Intake, Prior Authorization, Concurrent Review, Discharge Planning, Alternate Services, DME, Appeals and Case Management. Coordinates clinical and process orientation for all new hires. Works with Clinical Services system vendors and IS to ensure medical management applications function appropriately and that all upgrades, enhancements and implementations are successful. Coordinates system configuration changes, including tables, options, rules, and assessments and oversees system testing to make sure systems are working as expected. Works with various IS and vendor project managers to coordinate creation and successful migration of customizations. Sets up, maintains, updates, as needed, provider portal rules and trigger tools. Maintains the integrity of the rules engine. Assist with training and support of the provider portal users.

Uses clinical knowledge and criteria expertise to assist with creation and delivery of inter-rater reliability testing and InterQual end user training. Arranges and coordinates guest speakers offering educational programs with the provision of CEUs for professional staff.

Job-Related Experience and Skills

- 3-5 years of nursing experience, in related clinical setting in addition to Case Management and/or Utilization Management
- Current Registered State License

Provider Network

Dir. Provider Network Management

Job Summary

The Director Provider Network Management is responsible for all hospital, physician and physician extender network development and management. This position is also responsible for implementing strategies to improve provider satisfaction. This position will interact with Hospital and Physician Practice Chief Executive Officers, Chief Financial Officers, Directors of Managed Care and other high level executives. Ensures department achieves annual goals and objectives and is responsible for strategic planning of hospital and physician network development and management while complying with established contracts.

Job-Related Experience and Skills

- A minimum of 3 years Managed Care Provider Contracting and Reimbursement experience to include in depth knowledge of reimbursement methodologies and contracting terms; 1-2 years Medicaid experience preferred.
- Minimum 10 years of progressive business management and negotiation experience. Minimum 5 years management experience, managing teams and project management.
- Bachelor's degree in Business or health related disciplines such as Healthcare Administration or Healthcare management or equivalent business experience. Master's Degree preferred.

Provider Network Account Executives

Job Summary

The Account Executive I is responsible for building, nurturing and maintaining positive working relationships between Plan and its contracted providers. The Account Executive conducts orientation sessions, makes education visits, functions as a pro-active practice account leader and coordinates resolution of provider issues. This role is also responsible for the accuracy and timely management of the assigned territory provider contracts, while monitoring and managing provider networks; ensuring appropriate access to services throughout the plan's territory in keeping with state contract mandates.

Job-Related Experience and Skills

- 1-2 years Medicaid experience preferred; 1 year in a Provider Services position
- 3 years in the managed care/health insurance industry
- Bachelor's Degree

Provider Communications Specialist

Job Summary

The primary purpose of the job is to:

The Senior Communications Specialist leads the team responsible for all communication tasks that impact either internal or external customers from the provider perspective: coordination of all written and on-line communications to physicians, hospitals, and ancillary providers. Responsible for the development and implementation of provider and member education programs that increase the effectiveness of providers' and members' compliance with Plan rules and requirements. Develops and implements Provider Education programs that meet the overall strategy and priorities of AmeriHealth Caritas i.e., EFT, ERA, Emergency Room utilization and plan needs – such a Quality scoring presentations, PA provider data requirements, new products offerings.

Job-Related Experience and Skills

- 1 – 2 years' leadership and project management experience in member and/or provider operations in a healthcare or Managed Care Organization to include experience in training and communication material development similar to this job's content.
- 1-2 years Medicaid experience preferred
- Bachelor Degree in Communications, English, or Marketing or equivalent combination of education and work experience in a Health Care Field preferred.

Provider Services Manager / Mgr., Provider Network Management

Job Summary

Responsible for managing the day-to-day activities of the Network Management department and staff. Responsible for assisting the Leader with departmental activities related to provider satisfaction, education, and communication. This position is also responsible for all provider network recruiting and contracting management activities. Ensures that the department and staff remain current in all aspects of Federal and State rules, regulations, policies and procedures and creates or modifies departmental policies to reflect changes. Ensures department achieves annual goals and objectives.

Job-Related Experience and Skills

- 1-2 years Medicaid experience preferred.
- 5 years provider contracting/reimbursement experience in healthcare setting; 3 years of supervisory/ management/ leadership experience, preferably in a managed care setting.
- Bachelor's Degree: Bachelor's business or health related discipline such as Healthcare Administration or Healthcare Management or equivalent business experience

Credentialing Coordinator

Job Summary

Responsible for assisting, coordinating, planning, and administering the operational and administrative activities for the Credentialing Department under the direction of the Director of Quality Operations. Leads staff in the execution of managing the Credentialing production environment by promoting effective operations through standardization and process improvement. Implements new procedures and instructs personnel regarding them. May provide leadership direction and mentoring to Credentialing staff. Ensures the volume of work produced meets or exceeds productivity, timeliness and quality standards, while providing support to all Data Analysis functions as required in maintaining a set work wide database of fully credentialed providers.

Job-Related Experience and Skills

- 3-5 years of office experience
- Associate's Degree Required. Bachelor's Degree preferred.
- Proficient database skills.
- Proficiency in Microsoft Office, Excel and Access.
- Excellent written and verbal skills.

Service Operations

Encounters Analyst

Job Summary

The Encounter Data Analyst is responsible for developing state reports and/or deliverables required for financial encounter reconciliation and compliance to state encounter requirements. Performs quantitative and qualitative analyses of encounter reconciliation and analyses of cash payment of claims against state records. Identifies gaps based on analyses of large data sets and makes recommendations to remediate gaps between encounter data on a cash basis to the cash disbursement journal. Responsible for assuring the accuracy and validity of both source data and results and interpreting results into recommendations. Presents findings to Enterprise Encounter leadership and to internal customers.

Job-Related Experience and Skills

- Minimum of three (3) years of analytics /reporting experience in the health care industry with some exposure to claims, encounter, or other patient data.
- Bachelor's Degree

Analyst

Job Summary

Audit all Facets claim configuration changes and review all documentation of configuration for thoroughness. Communicate with the configuration analyst, configuration team lead, tester and requestor as required to ensure that request is completed as intended.

Job-Related Experience and Skills

- 1-3 years of advanced level claims experience and auditing experience
- 3-5 years of system configuration and Microsoft Access

Claims Administrator

Job Summary

The Manager of Claims is responsible for the coordination of all operational activities related to the Claims Unit (claims processing, provider claims services, research and projects). Manages the activities of the department. Ensures that priorities/tasks are completed on time. Identifies and resolves operational issues using well-defined/documented processes, expertise and judgment. Ensures that performance standards are met in accordance with the (SLA). Coaches team to meet and/or exceed performance goals. Measures performance and makes promotional and disciplinary decisions. Assists in the development of a consolidated operating budget. Makes efforts to control costs while seeking ways to increase productivity, improve quality and enhance revenue. Hiring responsibility for operations associates. Provides career/professional development to new and existing team members. Keeps abreast of new developments in area(s) of responsibility and ensures timely communication to team. Responsible for internal and customer initiated audits, regulatory reviews and customer certifications (HEDIS and NCQA). Manages operational programs to provide information necessary to improve production. Works with Work Force Management to ensure staffing allocations are managed and assigned based upon production and SLAs.

Job-Related Experience and Skills

- 3+ years' experience in healthcare, managed care or insurance industry environment required
- 5+ years of management experience
- College degree (BS/BA) or equivalent work experience required

Claims Examiners, Claims Research

Job Summary

Reviews and adjudicates claims based on provider and health plan contractual agreements and claims processing guidelines. Follows all internal processes and procedures to ensure activities are handled in accordance with departmental and company policies and procedures.

Job-Related Experience and Skills

- 1 year of prior claims experience
- High School/GED

Member Services / Provider Services Manager

Job Summary

The Member Services Manager, Call Center is responsible for the coordination of all operational activities related to Off-hours, Enrollment/Third Party Liability (TPL), Member/Provider Services, Research, Claims/Provider Claims, Panel Transfer, Enrollment and Hire Ahead areas.

Job-Related Experience and Skills

- Minimum of 3 years' experience in healthcare, managed care or insurance industry environment required.
- 5-7 years of management experience
- Bachelor's Degree

Customer Service Representative

Job Summary

Responsible for responding in a timely, professional and courteous manner to all customer (member, provider and other customers) inquiries. This includes inbound and outbound member and/or provider phone calls or correspondence regarding benefit, eligibility or customer issues. Makes outreach welcome calls to new members and conduct Health Risk Assessment Surveys as needed. Provides member education and assist members with PCP selection and assignments. Follows internal processes and procedures to ensure all activities are performed in accordance with departmental and company policies and procedures.

Job-Related Experience and Skills

- 1-3 years of customer service/contact center experience strongly preferred; at least 1 year outbound contact center experience, desired
- High School/GED

Provider Maintenance Tech

Job Summary

Under the direct supervision of the Provider Maintenance Supervisor, the Provider Maintenance Technician is responsible for maintaining both participating and non-participating provider records in the provider database, mapping claims in the invalid provider queue, resolving provider related issues for claims suspended to Provider Maintenance. Coordinates the panel transfer process. Completes projects as assigned by Supervisor. Interacts with internal/external clients on provider maintenance activities.

Job-Related Experience and Skills

- Minimum 1 year related work experience in healthcare
- Associate's degree /commensurate work experience

Enrollment Specialist / Customer Service

Job Summary

Under the direct supervision of the Operations Supervisor, responsible for updating member information in Healthcare System to reflect State System eligibility. Ability to review data and provide root cause analysis of identified issues to various levels of management. Handles calls and inquiries from customer service for internal and external clients on the Enrollment Hotline. Works to reconcile inbound and outbound eligibility reports on a daily basis. Perform a once- a month reconciliation of the plan membership in addition to the weekly updates.

Job-Related Experience and Skills

- 1 year data entry and analyzing of data
- High School / GED

Cost Containment Analyst

Job Summary

Research, analyze and process projects or correspondence for all Lines of Business. Analyze complex operational claim overpayment issues and provide technical resolution. Consistently meets or exceeds production standards for Cost Containment maintaining 98% financial and procedural accuracy.

Job-Related Experience and Skills

- 1-3 years of experience. Facets preferred
- High School/GED

IPQ, Quality, Auditing

IPQ Representative

Job Summary

The Provider Maintenance Invalid Provider Queue Representative is responsible for resolving all claims that are routed to the Invalid Provider Queue through the Claims Adjudication process. Completes projects as assigned by Supervisor. Interacts with internal/external clients on provider maintenance activities.

Job-Related Experience and Skills

- 3 years related work experience in healthcare.
- Associate's degree / commensurate work experience

Quality Auditor

Job Summary

Under the direction of the Manager, Quality, performs financial, compliance, and operational monitoring and audits to review and assess the efficiency and effectiveness of PerformRx systems, programs, and procedures. Completes special projects and analyses. Assists in internal/external audits.

Job-Related Experience and Skills

- Minimum of two (2) years compliance or internal audit experience required
- Associate's Degree or equivalent work experience

Information Solutions

Production Control Operator

Job Summary

Performs complex duties in the operation of computers, job scheduling, file transfers and peripheral equipment to process data with emphasis on the diagnosis and reporting of operational problems. Monitors/controls console of multi-user computer system. Observes equipment to detect error messages, faulty output or machine stoppage. Takes action to correct error or stoppage and continue operations. Notifies Shift Lead, or above, of problems, while providing production run instructions. Submits runs and/or run parameters to the computer systems. Assists in and takes responsibility for job recovery by communicating with users, programmers, operators and other I.S. personnel.

Job-Related Experience and Skills

- Minimum of 2 years work experience with Information Systems preferably in the Production Control functions including job scheduling, job scheduling tools, production migrations, and problem reporting.
- Bachelor's Degree in Business Administration, Information Systems Technology, or equivalent experience in a business/technical environment

Deskside Support Analyst

Job Summary

The Deskside Support Analyst provides deskside support, PC hardware/software installations/moves/adds/changes and, in times of high call volume, also provides front-line telephone support for AC associates and affiliates. Analyst is responsible for calls concerning issues with the overall operation of all technology, including but not limited to personal computer hardware and peripherals, telephones, standard and supported applications and connectivity to remote systems. Additional responsibilities include systems administration, projects and researching and formally documenting new solutions for the team. The function is typically performed during normal business hours but may require flexible or "off-hours" support from time to time. Off-hours pager support is required as scheduled

Job-Related Experience and Skills

- 1 - 3 years of technical support experience including hands-on experience working with PC hardware/software
- Associate's Degree: 2-year technical degree preferred or proven success as a Service Desk Analyst

e-Business Analysts

Job Summary

E-Business Analyst is responsible for the overall management of all PerformRx Web based and E-Business offerings including but not limited to Web Site design and maintenance, Member, Provider and Client Portals, Electronic transactions with internal and external vendors and Intranet sites. The E-Business Analyst is also heavily involved in project implementation, vendor oversight and management as well as development of improved E-Business solutions

Job-Related Experience and Skills

- 5 yrs. E-Business Experience, 3 Yrs. project implementation and technical project management and deliver required. 3 Yrs. PBM Experience or Healthcare preferred
- Bachelor's Degree or equivalent work experience; Master's degree preferred
- Web Content Management Systems and Web Development systems required

Business Engagement Consultant

Job Summary

This position leads the discovery, planning and implementation of Enterprise IT systems and Business Processes in support of business operations in order to improve cost effectiveness, service quality, security, and business development. This position is responsible for implementing defined strategies, while ensuring stable and secure day to day operations of the Business technology environment. The Consultant will act as the primary contact for customers developing and managing business partner relationships

Job-Related Experience and Skills

- 5 or more years' experience managing multiple projects simultaneously.
- Proven relationship-building skills, including seven or more years of consulting experience (internal or external) with customer areas in analysis, planning, initiating and implementing complex customer-driven IT projects.
- IS Management and Customer Relationship Management within the HealthCare Industry, and strong knowledge of enterprise customers, business processes, applications, systems and workflow.
- Bachelor's Degree

Finance

Chief Financial Officer /Dir. Finance

Job Summary

The Chief Financial Officer/Director Finance is Responsible for coordination of local activities related to finance facilities and systems. This Chief Financial Officer develops, implements and monitors compliance with local policies and procedures related to finance, systems and facilities. This role is also responsible for reviewing expense reports, purchasing requisitions, monitoring budget variances and coordinating the reinsurance process throughout the year. The Chief Financial Officer provides ad hoc financial support to senior management, middle management and corporate departments as needed.

Job-Related Experience and Skills

- 5-10 years of management experience
- 10+ years of financial or cost accounting
- Bachelor's degree (Master's preferred)
- CPA preferred
- Demonstrated understanding of GAAP reporting, treasury operations, corporate taxation and legal principles
- Familiarity with healthcare services reporting and regulation.
- Demonstrated analytical, financial analysis and planning skills.

Compliance

Compliance Officer/Dir. Compliance & Regulatory Affairs

Job Summary

Under the general direction of the Contractor Administrator, the Director, Compliance and Regulatory Affairs provides strategic advice and guidance for achieving ACFC goals and objectives while complying with contract requirements and Medicaid regulations for both physical health and behavioral health managed care business. He/she is responsible for the development and implementation of a Compliance Program for physical health managed care business to ensure compliance with key business requirements and to minimize risk issues. He/she also provides strategic guidance to the implementation of policy and initiatives in response to emerging federal health care policy. The Director, Compliance and Regulatory Affairs, manages the annual contract amendment process, facilitating timely review and comment and maintaining appropriate change control procedures.

The Director, Compliance and Regulatory Affairs assist the Contract Administrator with the development and execution of departmental strategic planning and budget activities. He/she directs the administrative functions for the Government Affairs Office and provides information and recommendations to the Contract Administrator on matters that may impact departmental goals and the budget. He/she directly manages a team of professional associates and supports the development of highly skilled and knowledgeable associates. He/she represents the Executive Director in his/her absence.

The Director, Compliance and Regulatory Affairs operates independently with minimal management oversight, and is able to manage competing priorities and deadlines that are subject to frequent change. He/she must possess and exercise excellent professional judgment in all interactions.

Job-Related Experience and Skills

- 5+ years' management experience in healthcare/insurance, preferably in Medicaid Managed Care.
- Bachelor's degree

Compliance/Regulatory Analyst Specialist

Job Summary

Assists with the implementation of the Compliance Program for state managed care business. Conducts research of contracts and regulations to maintain the contract monitoring tool for contract compliance reviews. Also provides assistance with the annual contract language negotiations process. Supports the Director, Regulatory Affairs with reviewing, analyzing and summarizing trends in Medicaid policy and develops written summaries of their findings. Also provides government relations support to the Government and External Affairs Department and assists with resolving constituent issues from local legislator offices. Identify and analyze new trends in public policy that could affect current and future business. Reviews health policy and industry journals and publications. Monitors trade organizations, non-governmental organizations, think tanks, and governmental organizations. Makes recommendations regarding application of findings to the PA Rate team and PA Political Strategy Team. Supports ad hoc requests for government market, regulatory, legislative research and analysis and answers questions on a variety of legislative policy issues.

Job-Related Experience and Skills

- 2 or more in healthcare/ insurance, preferably in managed care
- Bachelor's Degree or equivalent experience
- Familiarity with government programs and contracts

Corporate Support Staff

Accounting, Actuarial, Regulatory Reporting, Financial Services

Accountant, Senior

Job Summary

Maintain the general ledger and preparing supporting schedules/reconciliations. Prepares and posts all journal entries in accordance with current financial standards and as required to accurately present financial activity in the general ledger. Prepares, reviews, and analyzes schedules (financial analysis package) supporting the financial statements. Reconciles accounts to supporting documentation. Researches and remediates reconciliation variances. Prepares interim and annual external audit deliverables pursuant to external auditor requests. Maintains layouts for analysis package schedules and other relevant reports using the PeopleSoft/Hyperion reporting software. Identifies process inefficiencies, recommends efficient process alternatives, and facilitates implementation of such process improvements. Develops standardized schedules/entries across all lines of business. Creates and maintains policies and procedures. Performs other job related duties and projects as assigned. Adheres to AMFC policies and procedures.

Job-Related Experience and Skills

- 3+ years progressive Accounting Experience.
- Bachelor's Degree in accounting; CPA preferred

Actuarial Analyst

Job Summary

Calculates, monitors and assesses impact of benefit and provider reimbursement changes, cost containment programs, on medical cost and trends by performing medical cost projections and developing reforecasts to anticipate the annual budget process

The actuarial analyst performs monthly reviews of outstanding claim liabilities to assist in determining appropriate medical expenses and book reserves

Job-Related Experience and Skills

- Relevant health plan, HMO, or health insurance experience
- Bachelor's Degree in business, finance, economics or related quantitative field.
- Working knowledge of reserve estimation techniques and medical claims coding
- Strong knowledge of personal computer, spreadsheet, and database applications used for analysis. Excel, Access, and SAS.
- Actively pursuing actuarial credentials

Statutory Reporting

Job Summary

The Financial Reporting Analyst is responsible for generating ad-hoc and regulatory reporting for a variety of Behavioral Health Programs and for ensuring reporting requirements are met and that data is accurate and valid, while developing monthly claims reserves. This role is responsible for reporting claim reserves to County Oversight Actuary (ies).

Job-Related Experience and Skills

- 1-2 years in reporting environment required.
- Bachelor's Degree in finance, economics, information science, actuarial science or related field required

Sr. Financial Analyst

Job Summary

Compiles and analyzes financial and cost information for the organization. The Financial Analyst will support the strategic planning, cost, and analysis processes for PerformRx Specialty Pharmacy and will act as liaison for financial data and processes to functional area management at all levels. The position will also play a key role in developing financial models for new business opportunities. Position will interact with associates at all levels in the organization, external clients, and vendors.

Job-Related Experience and Skills

- Minimum five years progressively responsible experience in financial analysis, preferably Healthcare
- Experience working with cost and financial models and Activity-Based Costing.
- Bachelor's Degree: major in finance, accounting or closely related field. MBA preferred

Program Integrity Manager

Job Summary

Responsible for oversight of the Contractor's special investigations unit (SIU) activity. The Program Integrity Manager will serve as the liaison between the MCO and state agencies, law enforcement, and federal agencies. The Program Integrity Manager must be informed of current trends in fraud, waste, and abuse as well as mechanisms to detect such activity.

Job-Related Experience and Skills

- Law enforcement
- Accredited Health Care Fraud Examiner (AHFI) preferred
- Certified Insurance Fraud Investigator (CIFI) preferred
- Fraud Claim Law Specialist (FCLS) preferred
- Minimum ten years healthcare fraud investigation leadership experience
- Data analysis experience

Investigator/Recovery Analyst/Research & Reporting Analyst

Investigator

Job Summary

Responsible for conducting comprehensive investigations of reported, alleged or suspected fraud involving the full range of products within AmeriHealth Caritas Family of Companies. Ensure compliance with all requirements related to Special Investigation Units and fraud, waste and abuse investigations. Conducts comprehensive interviews with providers, members and witnesses to obtain information which would be considered admissible under generally accepted criminal and civil rules of evidence. Analyze data as part of the investigative process using available fraud detection software and corporate resources. Represents the Special Investigations Unit (SIU) in conducting settlement negotiations with providers, counsel and/or other associated parties.

Job-Related Experience and Skills

- 3-5 years conducting comprehensive insurance investigations; interacting with state, federal and local law enforcement agencies
- Bachelor's Degree preferred
- Accredited Health Care Fraud Examiner (AHFI) preferred
- Certified Insurance Fraud Investigator (CIFI) preferred
- Fraud Claim Law Specialist (FCLS) preferred
- Valid driver's license required

Recovery Analyst

Job Summary

Performs analysis of and modification(s) to current business and systems processes, procedures and practices, to optimize department operations and efficiencies. Performs subcontractor oversight as directed. Conducts as assigned medical claim reviews for all lines of business (LOB's), focusing on billing issues, authorization issues or system-related problems. Documents, analyzes, reports and communicates issues and resolution recommendations to appropriate areas within and outside of the department. When necessary, attends depositions and court appearances regarding custodian of records and/or COB, Subrogation, TPL and Cost Containment issues.

Job-Related Experience and Skills

- 0-2 years in business analysis; 2 years analytical experience; 2-3 years working with medical data systems (claims, TPL or Recovery background)
- Working knowledge of claim coding and familiarity with DRG classification system and associated processes as relate to business needs
- Information Science, HealthCare or related field or 5 years' equivalent combination of education and experience required. Bachelor's degree preferred

Research & Report Analyst

Job Summary

Manage cases from receipt of referral through conclusion of review; prepare all referral documentation for investigation; perform preliminary review of documentation for an investigation; perform follow-up procedures for requests to providers for medical records or other documentation. Performs research and creates reports to monitor progress of cases in assigned line of business. Within areas of job responsibilities, identify systemic issues of fraud waste and/or abuse for the AmeriHealth Mercy Family of Companies. Initiate the request and follow up for re-processing of claims as a result of Fraud, Waste, and Abuse Audits/Investigations. Provide claims processing technical support/expertise to team members. As assigned by management, audit claims for correct coding issues and identify potential recoveries. Maintains the FWA hotline call log and provides weekly reports. Responsible for timely and accurate transfer of claims and accompanying claims issues from CFI to the Cost Containment department and following up on those claims until their ultimate disposition. Updates case tracking system with progress and follow-up actions. Provides report of this activity.

Job-Related Experience and Skills

- 1-3 years of analyst experience
- Associate's Degree or equivalent coursework or experience

Medical Econ Analyst

Job Summary

Supports corporate, plan-level, and departmental strategies and goals by effectively applying both business knowledge and technical expertise to support business initiatives and solve business problems. Develops and implements data-driven solutions to meet business requirements by producing data sets, reports, and analytics across a variety of subject matters – including, but not limited to, medical and quality management, network management, contracting, marketing and member outreach, and new business development.

Translates business requirements into production of both ad hoc and recurring reports and data sets. Responsible for assuring the accuracy and validity of both source data and results and interpreting results into recommendations. Presents findings to business customers, both internal and external. Assures the ongoing high performance level of the overall department through continued knowledge acquisition and knowledge sharing with co-workers.

Job-Related Experience and Skills

- Minimum of three (3) years of data/reporting in the health care industry. Demonstrated skills with at least one reporting application as outlined in the Informatics Job Ladder
- Bachelor's Degree

Web Designer/Plan Communications Manager

Web Designer

Job Summary

Designs, programs and maintains the look and feel of our internet 12 + Web sites and customer portals and provides support for our intranet by working with the Web Designer I. This involves developing a graphic design that effectively communicates the goals, direction and needs of the Company. This position participates in the planning, organization and growth of the internet Web Sites by meeting with the clients to discuss ideas or needs for the layout and organization of the Web sites, the types of colors or images to use (photos, illustrations, videos, etc.), and other matters concerning overall graphic design. These designs incorporate graphical user interface (GUI) features and necessary client-side scripting in HTML, DHTML, JavaScript, and CSS. A Web Designer II must have experience with Adobe Dreamweaver, Adobe Photoshop and Adobe Illustrator and handles more advanced graphic design and programming than a Web Designer I.

Job-Related Experience and Skills

- 2-5 years' experience with client-side scripting languages such as JavaScript, VBScript, DHTML, and CSS; 2-5 years' experience with making changes to pages that contain server side code such as ASP or ASP.Net
- Software Experience: Dreamweaver, Photoshop, Adobe Illustrator, Flash
- Programming Language Experience: HTML, XHTML, JavaScript, CSS
- Operating System: Windows XP/7
- Browsers: Internet Explorer, Firefox, Google Chrome, Safari
- Web Servers: Microsoft IIS
- Demonstrated knowledge of cross-browser and platform issues required
- Demonstrated experience in training end users preferred
- Web Content Management System experience a plus
- Bachelor's Degree: IT, Graphic Design, or similar discipline is required. Web Technologies or Multimedia Certifications considered in lieu of education

Plan Communications Manager

Job Summary

The primary purpose of the job is to:

In partnership with line of business leaders, the plan manager carries out the health plan's strategic communications strategy through the use of corporate communications resources. In addition to the execution of strategic communications tactics, the plan manager

Job-Related Experience and Skills

- A minimum of five years of experience managing teams and projects
- 5-7 years of progressively more responsible corporate communications experience
- Bachelor's Degree

Coordinator Mail Services

Job Summary

Responsible for learning all the functions within Integrated Document Service with a concentration on the following duties within Production Service.

Job-Related Experience and Skills

- High School/GED

Human Resources Business Partner

Job Summary

Provides human resources consultation and support to a designated medium sized business unit and/or corporate function, including senior leaders. Uses knowledge of various human resources functions, including staffing, compensation, benefits, training, and associate relations to provide tactical HR support to line managers. Consults with business unit management in the strategic planning process and development of human resources strategies that support the unit's business needs. Delivers tools to enable managers to coach staff and comply with HR policies and programs. Participates in the hiring process. Provides training on core HR processes. Provides process support and associate relations coaching for client group. Acts as a liaison to other human resources functions when necessary. May manage HR projects for client area(s). May have supervisory responsibility.

Job-Related Experience and Skills

- 1-3 years as Business Partner; 3-5 years in Human Resources
- Bachelor's Degree

Attachment 2.16-A: Provider Communications Distribution Guidelines

AmeriHealth Caritas Family of Companies

Provider Communications Distribution Guidelines

Updated March 2015

Please use the standards below to guide your distribution of provider communications.

STEP ONE: Plan for Distribution

- Consider the overall timing and frequency of recent provider notices and plan your next distribution accordingly.
- Allow space between distribution of notices and avoid over-communicating. For example, try not to exceed two notices in one week or eight total notices in one month.
- Avoid sending communications on the days right before or after holidays, if possible.
- Distribution of Routine Items
 - Routine items:
 - Not urgent.
 - Go out regularly or pertain to on-going projects.
 - Examples include reminders, general updates, some newsletters, etc.
 - When sending routine provider communications out by fax, email and/or web posting, complete distribution within five (5) business days of receipt of final, approved material.
 - When sending routine provider communications out by print and mail, complete distribution within ten (10) business days of receipt of final, approved material.
- Distribution of Time-Sensitive Items
 - Time-sensitive items:
 - Contain effective dates of new plan policies or processes.
 - Require providers to take action or make changes in how they do business.
 - Pertain to a specific project or issue.
 - Examples include invitations, implementation notices, AOP goal materials, etc.
 - When sending time-sensitive provider communications, complete distribution:
 - With enough time to allow at least 30-days' notice prior to the change.
 - With enough time for the provider to complete the requested action.
 - According to the timeline of the project.

ABOUT SECURITY

Consider the following best practices to help keep information secure:

- Distribute communications in PDF format, internally and externally.
- Only share editable documents (Word, PowerPoint, etc.) with reviewers and collaborators.
- If a document contains an electronic signature, always convert to PDF before sharing internally or externally.

STEP TWO: Share Internally with Stakeholders

- Prior to external distribution, share the communication internally by email with all stakeholders. This way, stakeholders are prepared for provider comments and questions.
- Stakeholders may include:
 - PNM/PNO Directors and Managers.
 - PNM Account Executives.
 - Operations Directors and Managers (with oversight of Provider Services telephone line).
 - Online Help
 - Staff participating on the project team.
 - Any other provider-facing staff impacted by the content of the message.
 - Telecom – oversight of Fax Server.
- Remember to include:
 - PDF of the communication.
 - A message briefly describing the subject of the material, target audience, and schedule/method of distribution. A sample message might say: The attached provider communication regarding implementation of new claims edits for radiology services will be distributed on August 7th by fax and email to network radiologists, cardiologists, orthopedists and pulmonologists. This communication will also be available in the provider area of the plan's website.

STEP THREE: Share with External Audience

- Use the RightFax application to distribute FAX items:
 - See Attachment A - RightFax Training Guide.
 - Ensure that current, appropriate fax numbers are loaded into the RightFax application prior to distribution. If necessary, request or pull an updated list of fax numbers.
 - Program the fax in advance to go out at a scheduled time by using the “Delay Send” feature (see Attachment A for detailed instructions), preferably after 6:00 pm
 - Notify Telecom in advance of the scheduled fax blast. Include scheduled time, page count and number of fax numbers included in the blast.
- Use the “Web Maintenance Request Form” on iNSIGHT to request EMAIL items and WEB POSTINGS:
 - See Attachment B – Provider Communications Web Maintenance Request Guide.

- One detailed request is sufficient for both services.
- Include suggested subject line and message body content for the email message. Otherwise, the digital services team will compose this copy.
- Include suggested web content and/or a link to the location of PDF files for web posting.
- Coordinate the PRINTING AND MAILING of materials through IDS, Corporate Sourcing or via direct contact with a local vendor, depending on the particular need.

STEP FOUR: Record What Was Sent

- For future reference and to help plan future communications, keep a log of the communications sent out.
- The log might include:
 - Communication title.
 - Audience who received it – list provider types and exact numbers, if known.
 - Dates and/or methods of distribution.
 - Costs for printing/ mailing, if known.
 - Any feedback received from providers or internal stakeholders.
 - Notes for next time. What worked; what didn't?

3. Scope and Covered Benefits

Please explain how you propose to execute Section 3 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Overview

AmeriHealth Caritas Iowa will meet or exceed all of the requirements set forth in Section 3 of the RFP Scope of Work, across all applicable populations and statewide in Iowa. Leveraging the infrastructure and expertise of AmeriHealth Caritas Family of Companies (AmeriHealth Caritas) and its 30 years of experience, AmeriHealth Caritas Iowa will provide all of the benefits and additional services in a highly effective manner for Iowa Medicaid members. We will partner and collaborate with the Department of Human Services (DHS) to ensure our benefits and programs help meet the state's goals of improving access and quality.

Our integrated model of care takes a holistic, person-centered approach — it incorporates and coordinates physical health, behavioral health, pharmacy needs and social supports in addressing member needs across all populations. We will customize our value-added services and programs to ensure they meet the specific local needs of our Iowa members, as we have done in other plans. We will do this through local, on-the-ground collaboration and investment in Iowa communities.

AmeriHealth Caritas Iowa will comply with all needs stated within this section, including areas not specifically addressed in the questions below.

- AmeriHealth Caritas' 30 years of experience provides the infrastructure and expertise needed to deliver in Iowa.
- AmeriHealth Caritas Iowa will partner with the DHS to ensure benefits and services are most effectively provided to members.
- Our local, person-centered care model and approach aligns with the needs and goals of Iowa, improving health outcomes for members.

3.2.2 Benefit Packages

1. Describe your proposed approach to ensure benefit packages will be delivered in accordance with a member's eligibility group.

AmeriHealth Caritas Iowa's processes and information systems are designed to ensure benefit packages are aligned to, and delivered in accordance with, a member's eligibility group.

Eligibility transactions indicating a member's enrollment in AmeriHealth Caritas Iowa are processed chronologically and loaded into the Facets® system — our core claims administration platform and core information repository for member and provider data — within 24 hours of receipt of the file ensuring the most current data is available in the system for provider and AmeriHealth Caritas Iowa utilization. Eligibility transactions are automatically compared to our existing member records with updates to existing records made or member additions executed as appropriate. This eligibility and enrollment process utilizes nationally accepted HIPAA-compliant transactions, daily 834 transactions and monthly 834 files.

Facets stores member eligibility, eligibility group benefit parameters, utilization and authorization requirements, coordination of benefits (COB) and third party liability (TPL) information. In addition, Facets stores provider network status and pricing agreements — all of which support the timeliness, completeness and accuracy of service identification and reimbursement. Based on this information, the Facets system automatically aligns members within specific eligibility groups to the appropriate benefit packages and associated business rules such as COB and TPL. It ensures covered and non-covered services are noted for the accurate adjudication of claims. AmeriHealth Caritas Iowa will also be able to receive proprietary files containing supplemental data such as Primary Care Provider (PCP) assignment data, special needs details, and/or other demographic information to be utilized to align members and provide additional detail to AmeriHealth Caritas Iowa and providers as appropriate.

AmeriHealth Caritas Iowa will provide information about our covered benefits to the member as well as to AmeriHealth Caritas Iowa Customer Service representatives and Medical Management staff. We will to ensure covered services for a specific member are clearly understood and managed.

- A summary of benefits specific to the member's benefit package displays in the Member Portal and on the mobile application for easy access by the member.
- Our Member 360 Application displays member benefit information to the Customer Service representatives to assist in handling benefit and related inquiries.
- Medical Management staff has access to a member's covered benefits through our care management system, as well as through our Member 360 Application.

2. Describe your ability to provide covered benefits and services.

AmeriHealth Caritas Iowa is confident in our ability to provide the covered benefits and services required in the Contract. AmeriHealth Caritas has more than 30 years of experience in Medicaid managed care and is devoted to our members across 16 states and the District of Columbia. We have deployed Facets as an efficient platform for the integrated business processes, policy approval protocols, network management and care coordination systems to assure prompt payment on behalf of eligible members for approved services (see for example Section 13.4). Our first priority is the health and care of our members, and AmeriHealth Caritas has explicitly fostered a business culture devoted first not only to service delivery, but also to monitor our performance in terms of access, quality and effectiveness. Furthermore, we have a proven track record of improving health outcomes for our members and strengthening the communities we serve.

In addition, given the broad set of eligibility groups in Iowa, AmeriHealth Caritas Iowa is focused on delivering a strong and diverse provider network to meet the needs of Iowa members, including providers for in home services, meals on wheels, handy man services, home renovation services, PCPs, specialists, hospitals, out-patient services and ancillary services. Please see section 6 for our complete provider network strategy.

3.2.4 Integrated Care

1. Describe proposed strategies to integrate the delivery of care across the healthcare delivery system.

AmeriHealth Caritas Iowa's Integrated Healthcare Management (IHM) model fully integrates all aspects of a member's health including physical health, behavioral health, long-term care services, medications and social services. This integrated model positions AmeriHealth Caritas as a national leader in healthcare

solutions, delivering improved health outcomes and financial performance. This model involves a single point of contact across behavioral health, physical health and pharmacy domains, coupled with a person-centered approach. Additional benefits include increased member and provider satisfaction and greater member retention. Our IHM model is described in detail in Section 9 of our response.

AmeriHealth Caritas' data-driven approach identifies and stratifies members based on physical health and behavioral health needs (detailed in Section 9 – Care Coordination). The results of the stratification process guide our engagement with members toward the most appropriate interventions given their conditions and needs. These interventions are initiated by our care management team and include behavioral health supports.

Our care management information systems integrate physical health, behavioral health and pharmacy data (and dental if/when applicable) producing a 360 view of the member that will be accessible to the AmeriHealth Caritas Iowa care team. In addition, we share this data in accordance with applicable privacy regulations, with providers and other care team members. We build a person-centered care plan based on member preferences, needs and strengths which is also shared with the care team. Our team utilizes data and event-triggered alerts to provide actionable information at the point of the member encounter. To best meet the needs of the member, with physician oversight, our care management staff works as multidisciplinary teams that encompass a wide variety of backgrounds and experience.

To complement and reinforce our team-based, information-driven approach we will be implementing a full range of provider incentives and value-driven payment models to reward individual caregivers and independent providers who contribute to members' health in this coordinated fashion. See Sections 6.1.2 and 10.3 for a more complete description of AmeriHealth Caritas Iowa's commitment to value-based purchasing.

3.2.5 Emergency services

1. Describe your strategies to reduce inappropriate use of the emergency room and to address members who frequently utilize emergency services.

Overall ER Diversion Program

The AmeriHealth Caritas Iowa Rapid Response team's emergency room (ER) strategy will employ a multi-faceted approach and will consist of three areas of focus:

- **Education** — Empowering members with information on the appropriate use of healthcare resources. This includes the provision of newsletter articles and educational materials, but also includes the counseling of members and by addressing any barriers to care. Care Coordination staff continuously support re-direction to the assigned PCP for care at the member's medical home.
- **Prevention** — Helping members receive care in the most appropriate setting that supports their highest and healthiest level of functioning and avoids clinical decline. When a member is in need of care, the Care Coordination and the Rapid Response teams will be available to assist with scheduling appointments and arranging for transportation. Members are encouraged to see their PCP annually and complete age/gender appropriate wellness screenings and testing. In addition to the Care Management department, members will also have access to a nurse for symptom counseling and health information provided by the AmeriHealth Caritas Iowa 24/7 Nurse Call Line. This service is available through a stand-alone, toll-free number 24 hours a day, seven days a week and also serves as

an after-hour service for our Rapid Response team. Members are encouraged to call the 24/7 Nurse Call Line when they have symptoms and are unsure where to seek care. The 24/7 Nurse Call Line staff direct the members to the appropriate level of care using evidence driven guidelines.

- **Intervention** — Identifying utilization patterns and anticipating members' needs. In partnership with the AmeriHealth Caritas Informatics Team, the Care Coordination department reviews ER utilization on a monthly basis. Members are identified based on usage, and stratified into three tiers (high, medium, and low) depending on frequency and timeframe. Campaigns are designed to address each level of utilization, and include communication with the assigned PCP.

This approach is supported by many programs built to achieve two primary goals:

1. Ensuring all members have access to and are educated around the appropriate setting of care.
1. Deploying data driven interventions to members who frequently utilize emergency service.

1) Ensuring all members have access to and are educated around the appropriate setting of care

Member Outreach

We are committed to building a network that meets the needs of Iowa members and ensuring our members are educated around how and where to get care. We will communicate available resources to members through the PCP/patient-centered medical home (PCMH) relationship, our member services line, relationships with urgent care centers, and directly to the member through educational materials.

AmeriHealth Caritas Iowa will send guidance about care in the appropriate setting on a quarterly basis to members who are medium and high-utilizers.

How and Where to Get Care

■ Get Care **Now**
 ■ Call First
 ■ Get Care **Quickly** (within 24 hours)
 ■ Get Care **Soon**

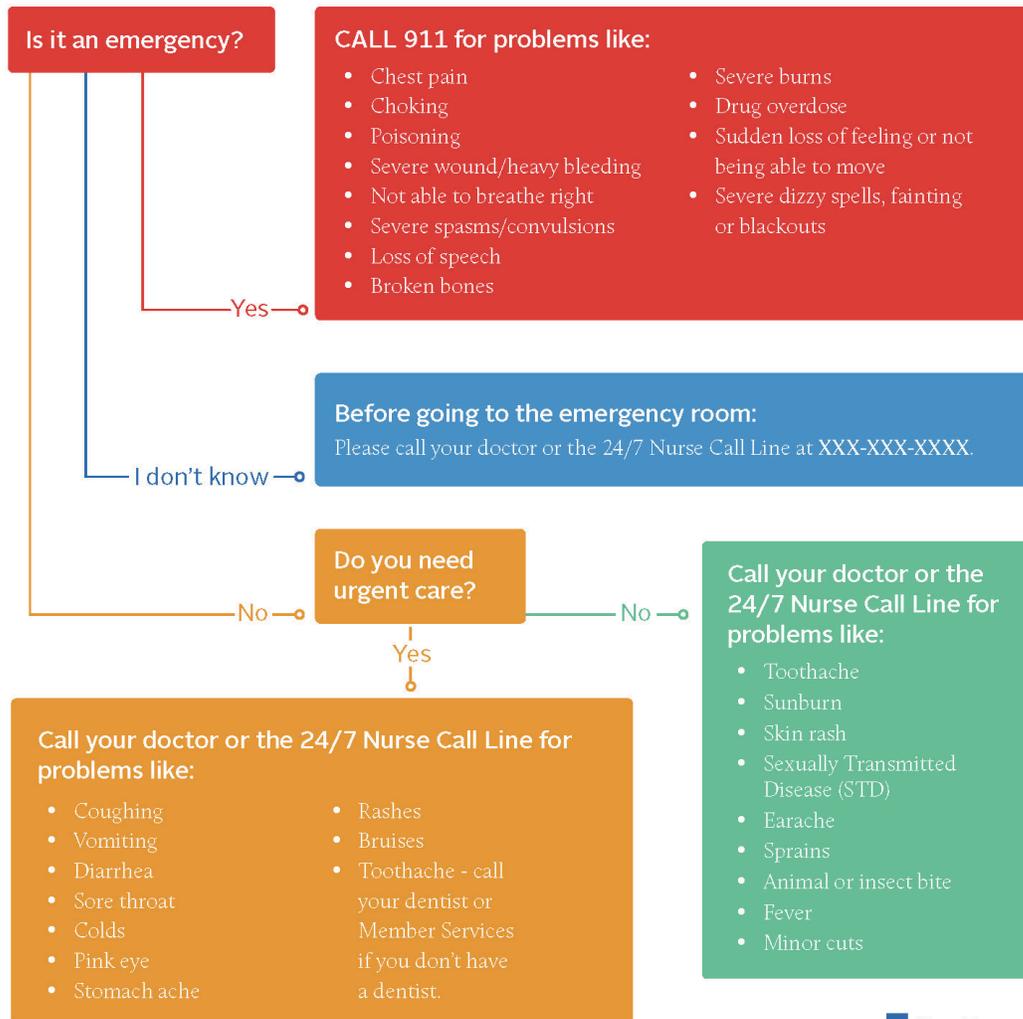


Exhibit 3.2.5-A: Member Material for Accessing the Right Care

24/7 Nurse Call Line

Our 24/7 Nurse Call Line is also available to members as a resource to find the most appropriate care for their conditions.

24 hours a day/7 days a week AmeriHealth Caritas Iowa Nurse Call Line X-XXX-XXX-XXXX

This is to help you learn about your health condition. It is not to take the place of your doctor. If you have questions, talk with your doctor. If you think you need to see your doctor because of something you have read in this information, please contact your doctor. Never stop or wait to get medical attention because of something you have read in this material.

You can have this information in other languages and formats at no charge to you. You can also have this interpreted over the phone in any language. Call Member Services 24 hours a day, 7 days a week at 1-888-756-0004. For TTY, call 1-866-428-7588.

Quý vị có thể có thông tin này bằng các ngôn ngữ và định dạng khác miễn phí. Quý vị cũng có thể có thông tin này thông dịch ra bất kỳ ngôn ngữ nào qua điện thoại. Xin gọi Dịch vụ Thành viên phục vụ 24 giờ/ngày, 7 ngày/tuần theo số 1-888-756-0004. Đối với người sử dụng TTY, xin gọi số 1-866-428-7588.

Usted puede tener esta información en otros idiomas y formatos sin costo alguno para usted. También puede tener esto interpretado por teléfono en cualquier idioma. Llame a Servicios al Miembro al 1-888-756-0004 las 24 horas del día, los 7 días de la semana. Para TTY, llame al 1-866-428-7588.

NB-1522-11



Exhibit 3.2.5-B: Nurse Call Line Member Material

Urgent Care and Retail Clinics

While AmeriHealth Caritas Iowa will strongly encourage members to seek preventive care from their PCP, there are times when a member has an urgent care need. In these situations, members can obtain information about urgent care access through:

- The health plan website, where a listing of contracted urgent care and retail clinics will be posted
- Contact with our member services hotline, the Rapid Response team, or Care Management Departments, where trained staff are able to direct members to a network urgent care/retail clinic provider.

Exhibit 3.2.5-C is an example of an urgent care clinic list distributed to members. As discussed in Section 6, we have worked with some PCPs to offer “open hours” and to correctly identify urgent care and walk-in clinics. We provide urgent/walk-in care site information to our 24/7 Nurse Call Line, Member Services department, and Rapid Response team. We also work closely with our PCP networks to identify those providers that offer several “unscheduled” appointments throughout the day. This process has provided our Rapid Response team an easy way to resolve immediate member appointment needs in other markets. In PS and SC groups have offered to set aside time for urgent care appointments for our members. In these instances, each physician has unscheduled slots of time available for these appointments every hour.

Urgent Care Centers

Urgent care is for conditions that are serious, but not emergencies. The condition may require attention from a doctor, but not in the emergency room (ER).

If you need urgent care, but you are not sure if it is an emergency, call your doctor first. If you cannot reach your doctor, call the Nurse Call Line at 1-888-632-0009. Your doctor or the nurse will help you decide if you need to go to the ER, the doctor's office or an urgent care center near you.

If you are advised to visit an urgent care center, please see the list of centers accepting AmeriHealth Caritas Iowa members below. You must present your AmeriHealth Caritas Iowa member ID card upon sign-in.

Center	Address	City, Streette ZIP	Phone
Iowa Clinic Urgent Care	1410 Sw Tradition Drive	Ankeny, IA 50023	1-515-875-9696
Mary Greeley Medical Center	1111 Duff Avenue	Ames, IA 50010	1-515-239-2011
Muscatine Urgent Care	1903 Park Avenue, Ste 2	Muscatine, IA 52761	1-563-263-1903
UnityPoint Clinic – Westside – Urgent Care	2375 Edgewood Road SW	Cedar Rapids, IA 52404	1-319-396-1983
UnityPoint Clinic – Urbandale – Urgent Care	2901 86th Street	Urbandale, IA 50322-4201	1-515-276-3406
UnityPoint Clinic – United Medical Park – Urgent Care	1753 W Ridgeway Avenue	Waterloo, IA 50701-4544	1-319-833-5888
UnityPoint Clinic – United Medical Park – Urgent Care	7481 Highway 65/69	Des Moines, IA 50320	1-319-553-0828
UnityPoint Clinic – Southglen – Urgent Care	7481 Highway 65/69	Des Moines, IA 50320	1-515-953-1500
UnityPoint Clinic – Prairie Medical Park – Urgent Care	4612 Prairie Parkway	Cedar Falls, IA 50613-7971	1-319-553-0828
UnityPoint Clinic – Merle Hay – Urgent Care	4020 Merle Hay Road	Des Moines, IA 50310	1-515-278-0949
UnityPoint Clinic – Marion – Urgent Care	2996 7th Avenue	Marion, IA 52302	1-319-377-4844
UnityPoint Clinic – Lakeview – Urgent Care	6000 University Avenue	Des Moines, IA 50266	1-515-241-2600
UnityPoint Clinic – Hiawatha – Urgent Care	1001 N Center Point Road	Hiawatha, IA 52233	1-319-375-6100
UnityPoint Clinic – Fort Dodge – Urgent Care	804 Kenyon Road	Fort Dodge, IA 50501	1-515-574-8484
UnityPoint Clinic – Express Care – Mulberry – Urgent Care	1518 Mulberry Avenue	Muscatine, IA 52761-3433	1-563-264-9508
UnityPoint Clinic – Express Care – Bettendorf – Urgent Care	3415 53rd Avenue	Bettendorf, IA 52722-6976	1-563-742-4350
UnityPoint Clinic – Ankeny Prairie Trail – Urgent Care	2515 SW State Street	Ankeny, IA 50023	1-515-964-6999
UnityPoint Clinic – Ankeny – Urgent Care	1105 N Ankeny Boulevard	Ankeny, IA 50023-4003	1-515-964-4600
Convenient Care at UnityPoint Health – Finley – Urgent Care	350 North Grandview Avenue	Dubuque, IA 52001	1-563-589-2606

Member Services: 1-888-756-0004

TTY: 1-866-428-7588

This is to help you learn about your health condition. It is not to take the place of your doctor. If you have questions, talk with your doctor. If you think you need to see your doctor because of something you have read in this information, please contact your doctor. Never stop or wait to get medical attention because of something you have read in this material.



Exhibit 3.2.5-C: Illustrative Member Material That Provides Available Urgent Care Centers

2) Deploying data driven interventions to members who frequently utilize emergency services

Interventions for Super-Utilizers

AmeriHealth Caritas Iowa's goal is to target our interventions where they have the most impact: the super-utilizers. We go directly into the community to engage the members who use the most care and need the most services. These members generally have multiple complex chronic medical problems, and in addition often have mental health issues and difficult social and economic situations. These are “high need” and “high cost” members. Because these members need a different approach, we utilize strategies tailored for their individual needs, including the community-based care management teams and community health workers that support connect members to the right care at the right time. This results in benefits both to the member and the health care system. Upon discharge following an inpatient stay, we use home health visits, medication reconciliation, and coordination of follow-up visits. The Rapid Response team, Community Care Management team (CCMT), and Community Education Outreach team (CEOT) are the core that drives down the inappropriate use of ER for these members. Super-utilizers are identified by reviewing their medical records following an inpatient stay. We then provide outreach, intensive coordination and in-person care management to make sure needs are met. The member story below is one that shows how we connected a member with chronic pain with the CCMT to finally make a difference in his life.

David was our first member in the CCMT Program. With 37 ER visits in 2013, including same day ER visits in various regions, David also changed PCPs 12 times since his enrollment, had a high utilization of prescribed narcotics and used multiple pharmacies.

After unsuccessful outreach attempts, the community outreach team contacted his PCP, who stated that David's behavior would not change until his chronic pain management needs were met. The Rapid Response team coordinated directly with a pain management provider to implement a protocol and to coordinate with his PCP. David has had no ER visits since the community outreach team engaged him with home visits and with continued telephonic case management.

The Rapid Response team also receives follow-up calls from the 24/7 Nurse Call Line. This allows us to more quickly intervene for members that are calling the line for triage assistance.

Community outreach initiatives for high utilizers

In addition to our super-utilizer program, we also have community outreach initiatives aimed at high utilizers. High utilizers are those members in the next tier of utilization. While super-utilizers represent the top two percent of highest members from a cost perspective, the “high utilizers” are generally those in the next three percent to four percent of the membership. Such members may not have catastrophic illness but are individuals who have a high use of the health care system. From an ER perspective we define ER high utilizers as those who have over a several month period with more than four ER visits a month. There may be a variety of reasons for such high utilization of ER services ranging from chronic pain to failure of care coordination to psychiatric disturbance. See Exhibit 3.2.5-D for an overview of our ER Utilization Review process.

For example, in our affiliate health plan in Louisiana, AmeriHealth Caritas identified the top 100 ER utilizers starting in January 2014. The graph in Exhibit 3.2.5-E demonstrates a cohort of members identified as top 100 ER utilizers. This group was tracked for a period of six months starting in January 2014 with 682 ER visits. By February, the number had significantly dropped and then there continued to be modest declines for the final 4 months (despite a mild increase in March). Overall in the six month period, there was a 65 percent reduction in the number of ER visits for this group of members. This is a result of aggressive targeted outreach by the Rapid Response teams.

Top 100 ER Utilizers in January Tracked for 6 Months

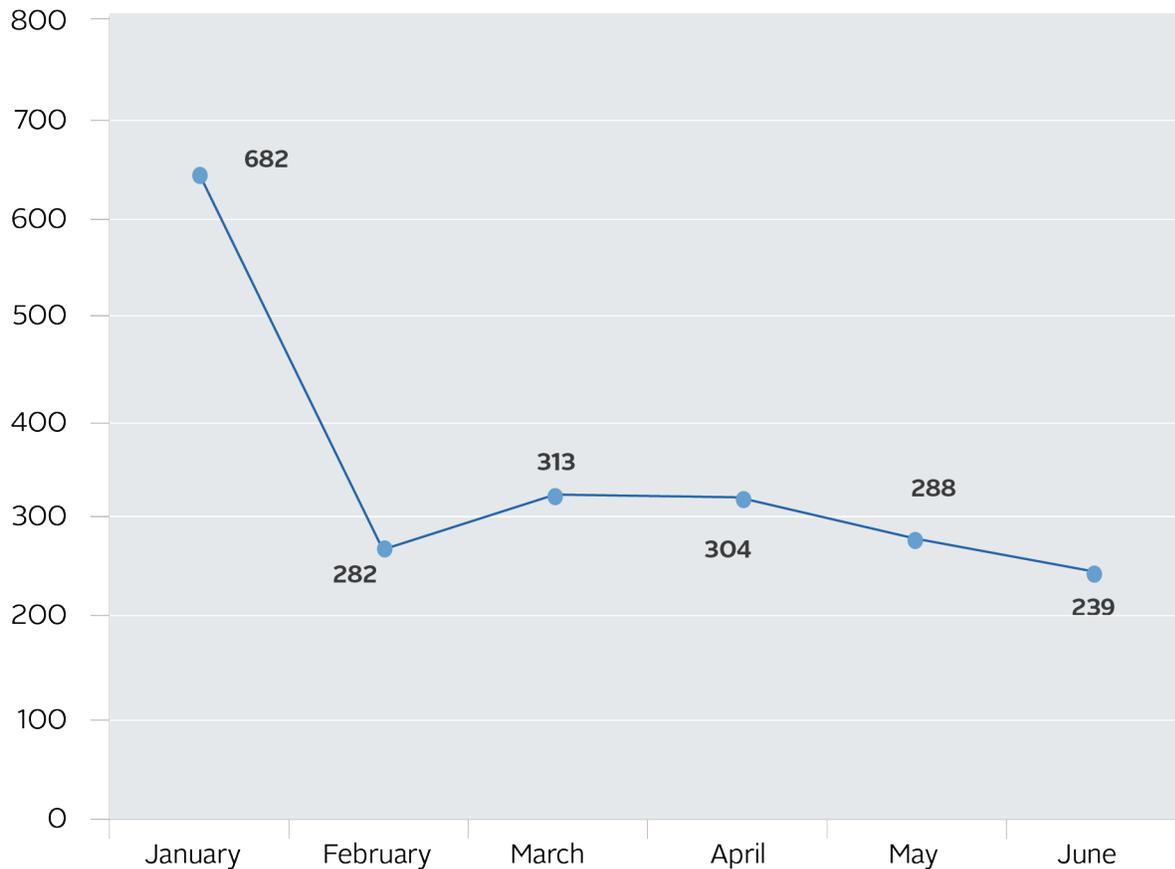


Exhibit 3.2.5-E: ER Utilization Example

Example program: 4 Your Kids Care

The 4 Your Kids Care program engages families who have recently visited the ER for non-urgent services and offers basic, hands-on training and education on how to best care for their children when they get sick. This program teaches parents and caretakers how to make better health decisions, provides information regarding when to take their child to the ER, and encourages the relationship between members and their PCPs or pediatrician. The program consists of a three-hour workshop utilizing a medical bag (including basic first aid supplies) and a manual that supports the education provided. Childcare and transportation is offered to all members.

Since the 4 Your Kids Care program was implemented in 2011, more than 2,800 parents/caretakers in one of our affiliated plans have attended the class. 2012 Program Statistical Outcomes (one year look back and one year look ahead) indicate a 25 percent drop in ER utilization and costs for those who attended.

Example: Ear Infection

Mary Ellen is a teenage first time mother of a 2-year-old daughter. Mary Ellen is single but no longer on good terms with her parents. Her daughter has had sniffles and a cough since spring allergies began. Two

weeks ago the child has been pulling on her ear but otherwise has been without fever, irritability, or change in eating. Everything has been fine except the ear pulling. The mother was concerned that her daughter had an ear infection even though the rest of the symptoms were not worrisome. But Mary Ellen did not know that. She had no role model or good source of information. So “to be safe” she took her child to the ER on multiple occasions just to ensure that there was no ear infection.

There are hundreds of examples of members who use the ER for simple advice and reassurance. Such families become good candidates for training on the appropriate use of facilities.

2. Describe your plans to ensure a response within one (1) hour to all emergency room providers twenty four (24)-hours-a-day, seven (7)-days-a-week.

Our phone lines will be open 24 hours per day, seven days per week. We have plans in place to ensure responses to ER providers well before an hour.

During normal business hours, providers can access our Utilization Management department or the Rapid Response line with an average of 30 seconds speed of answer for both these lines. Providers can call a single line and we will facilitate the connection to the correct department based on whether they need assistance with an authorization or help coordinating care for a member in the ER.

Providers will have access to an on-call nurse and medical director after hours, weekends and holidays. The AmeriHealth Caritas Iowa staff will have remote access to our Medicaid Management Information System (MMIS) so they can handle any issues/requests that come through.

3. Describe your plans to track emergency services notification of a member's presentation for emergency services.

Notification of a member presenting to the ER will be entered into our care management system Jiva® so information can be tracked/trended. Data points will include the time, date and method of notification, facility and presenting diagnosis if available. Notification can be sent in via fax, phone or the online Jiva portal. We use this process across our plans and it has proven to be effective, accurate and efficient.

AmeriHealth Caritas Iowa will also load available Admission-Discharge-Transfer (ADT) data feeds from hospitals and health information exchanges into our care management system, including notification of a member's admission to an emergency room. Based on the member's clinical history and risk score, the emergency room notification will create an alert in the care manager's work queue. Information on the emergency room admission will also be transmitted to the member's PCP via our secure provider portal.

4. Describe your plans for reimbursement of emergency services, including what processes will be implemented to determine if an emergency condition exists.

From our extensive experience in Medicaid markets, we have determined that there is limited value in performing prudent layperson review for the purpose of not paying claims for an ER visit where the presenting symptoms do not meet the prudent layperson definition. Those programs limit payment to the facility with no real impact on member behavior. We believe that resources are better spent providing access to alternative provider settings (e.g., non-ER) and educating members (e.g., self-management). To help address opportunities with ER efficiency and savings, AmeriHealth Caritas Iowa's plan is to implement programs designed to drive appropriate ER utilization, as described earlier in the section.

5. Describe your plans to document a member's PCP referral to the emergency room and pay claims accordingly.

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

AmeriHealth Caritas will not place payment restrictions on claims for an ER visit based on presenting symptoms or the presence of a PCP referral to the emergency room. Should the need arise to implement a PCP referral program, our claim system can be configured to pay in accordance with the referral requirement.

3.2.6 Pharmacy Services

1. Describe your proposed approach for delivering pharmacy benefits, including the use of any subcontractors.

PerformRxSM, a URAC-accredited pharmacy benefits manager (PBM) is AmeriHealth Caritas Iowa's chosen PBM. PerformRx is a wholly owned subsidiary of AmeriHealth Caritas and has proven success in increasing the quality of care while managing costs for the managed Medicaid population. PerformRx serves 4.4 million lives across the country, both within AmeriHealth Caritas and in non-affiliated government-sponsored and commercial health plans. PerformRx is committed to delivering high quality PBM services to Iowa Medicaid, Iowa Health and Wellness Plan and Healthy, and Well Kids in Iowa on a statewide basis.

PerformRx's approach for delivering pharmacy benefits utilizes a combination of proprietary technologies and high-touch, personal attention to control overall costs while providing the best care to members. Everything PerformRx does supports its mission: to help customers, doctors and patients use effective medication therapy to improve health and wellness.

As a mission-driven organization that was built on the foundation of providing health care services to those most in need, PerformRx's service delivery model was specifically designed to assist government programs. PerformRx's drug therapy management (DTM) program is URAC-accredited (one of four PBMs to achieve this distinction) as well as a recipient of the Case In Point Platinum Award in 2013. In addition to Medicaid, PerformRx also supports Medicare plans with robust Star Rating support and clinical programs.

Operational Services

- **Pharmacy Network Management** — PerformRx maintains a network of over 65,000 pharmacies nationwide that meets all retail, long-term care, home infusion and Indian tribal access requirements.
- **Rebate Contracting and Administration** — Rebate management includes services such as contract negotiation with pharmaceutical manufacturers and data submission, as well as financial reconciliation, reporting and audit support.
- **Pharmacy and Member Call Centers** — PerformRx maintains pharmacy and member call centers staffed by certified pharmacy technicians. The contact center provides translation support for over 200 languages with ground level fraud detection and prevention.
- **Member Portal** — PerformRx maintains a web-based Member Portal that combines pharmacy and medical data into one application that improves member decisions, delivers a user-friendly

experience, and provides personalized educational material, alerts and reminders. This service is integrated with the plan Member Portal so members can access this information through one account.

Regulatory Services

- **Quality Management** — PerformRx maintains a quality management program that ensures consistent operations and clinical outcomes through internal audits, policies and procedures and a Quality Management Committee. PerformRx is both PBM and DTM URAC-accredited.
- **Fraud, Waste and Abuse Program** — The PerformRx fraud, waste and abuse (FWA) program is designed to detect FWA, log issues and resolve them in conjunction with AmeriHealth Caritas Iowa. When a FWA case is identified, PerformRx assigns a single associate to investigate and resolve the issue with AmeriHealth Caritas Iowa.
- **Auditing and Monitoring** — PerformRx's Compliance and Quality (CIQA) department will be responsible for creating and executing an auditing and monitoring plan for the year for the functions that the PBM provides. This plan will be developed by the PerformRx CIQA department after identifying which functions are most "at risk" for non-compliance.
- **Guidance Interpretation** — PerformRx will provide AmeriHealth Caritas Iowa with bulletins that identify how the PBM plans to address any new or changing requirements. These bulletins will be sent shortly after the release of guidance and will be provided through PerformRx's Account Management team.

Clinical Management Services

PerformRx focuses on the clinical aspect of PBM services, and defines its business model as clinically-based. More than 80 percent of PerformRx staff members are clinicians. The company's clinical culture influences every decision that the company makes, from the design and implementation of proprietary technology to the interactions fostered with health plans.

- **Formulary Management** — PerformRx is able to offer a range of formulary options designed for each specific population type to maximize cost savings and any rebate potential while meeting state and federal mandated requirements. All formulary decisions in Iowa will be based on scientific and economic considerations to achieve appropriate, safe and cost-effective drug therapies. Formulary services provided by PerformRx will include but are not limited to formulary development and management, pharmacy and therapeutics (P&T) support, drug utilization review (concurrent, prospective and retrospective) and pipeline monitoring. The formulary in Iowa will be developed in consultation with State guidance.
- **Prior Authorization** — All drug-related prior authorization-related services will be performed by pharmacists and certified pharmacy technicians in PerformRx's Prior Authorization department. Functions completed as a part of this service include the review and processing of prior authorization requests, coverage determinations and appeals using the PerformPASM application (proprietary web-based prior authorization review tool). Certain specialty medication authorizations will require additional AmeriHealth Caritas medical director review. All policies will be reviewed and approved by AmeriHealth Caritas Iowa.
- **Adherence Programs** — Adherence Programs are specialized services through DTM. Several different methods will be used in Iowa to influence an increase in member medication adherence. Pharmacists will conduct targeted member and provider communications related to adherence issues through phone calls and mailings. We will also offer enhanced programs through PerformRx utilizing new technology to reach members real time. HealthNHand[®] sends alerts to members via text message, Pillstation[®] monitors member adherence through a "smart" pill tray that tracks utilization and Health[®]

is an interactive tablet device for the members to take assessments, provide feedback, and learn how to care for their disease.

- **Opioid Management** — AmeriHealth Caritas Iowa will employ strategies targeting both members and prescribers to enhance opioid management. The SafeUseNow program uses evidence-based analytics to identify, engage and monitor prescriber patterns. The Opioid Overutilization Program will be modeled after the PerformRx directed program implemented by other AmeriHealth Caritas affiliate plans. The program is designed to assist in the prevention of opioid drug overutilization by members. An additional program goal is to promote safe drug utilization and reduce the likelihood of adverse outcomes. For members with demonstrated patterns of obtaining opioid prescriptions from multiple prescribers, emergency rooms and pharmacies, AmeriHealth Caritas Iowa will implement procedures to limit the member's ability to obtain opioid prescriptions to one prescribing physician through a Recipient Restriction program.
- **PerformPA®** — PerformPA® is the HIPAA-compliant web-based system that will be used by PerformRx in Iowa to process prior authorizations, coverage determinations and appeals. The system integrates pharmacy data, member information and formulary files to create a streamlined, efficient process. The system also links to a web form where prescribers can submit requests for prior authorizations from the Internet, creating a paperless workflow. Through the web form, prescribers also have an opportunity to receive an approval response immediately without any manual intervention. For certain medications in Iowa, when a prior authorization is submitted, the prescriber will be prompted with a series of questions. If the responses provided are in alignment with the clinical criteria for medical necessity, the prescriber will receive instant automated approval notification. . AmeriHealth Caritas Iowa will provide oversight and guidance for all pharmacy prior authorization policies.
- **PerformPRO®** — PerformPRO® is a tool used by pharmacists and pharmacy technicians for the PerformRx DTM and medication therapy management (MTM) programs. The tool is linked to the AmeriHealth Caritas integrated data warehouse and automatically identifies target populations, calculates drug adherence rates, identifies gaps in care, recommends additional therapy and consults First DataBank clinical models. We will utilize the tool in Iowa to direct communications to providers and members.
- **Specialty Utilization Management** — PerformRx will also provide enhanced support options for specialty drug utilization management in Iowa. The PerformRx comprehensive specialty drug utilization management program leverages expertise from all major clinical functional areas to provide specialty formulary management, disease management programs, utilization management and call center support. All specialty program utilized in Iowa will include the involvement of nurse case managers and/or pharmacists. Current disease-specific programs utilized by all other AmeriHealth Caritas affiliate plans include the following disease states: hepatitis C, multiple sclerosis, bleeding disorders and rheumatoid arthritis.
- **PerformSpecialty®** — PerformSpecialty® is a full service specialty pharmacy wholly owned by PerformRx. Through PerformSpecialty, PerformRx is able to provide a full complement of specialty pharmacy services. Its specialty pharmacy model is based on personalized member service. PerformSpecialty will manage the entire intake and fulfillment process for specialty drugs for AmeriHealth Caritas Iowa, including utilization management reviews. PerformSpecialty's comprehensive process will include the following five components: (1) referral; (2) intake coordination; (3) clinical services; (4) financial services; and (5) fulfillment services.

Medicaid Cost Containment Strategy

Maximized Generic Utilization

PerformRx formularies are designed with cost containment in mind. Clinical efficacy is always considered first followed by cost impact. A higher utilization of generic medications is the primary step in cost containment measures. PerformRx will maximize utilization of generic medications for AmeriHealth Iowa using the following strategies:

- Mandatory generic.
- Tiered design.
- Combination of both.

A mandatory generic benefit design will achieve the highest rate of generic utilization. This benefit design either excludes or requires prior authorization for any multi-source drug that has a generic alternative. An aggressive plan design would also limit drug class choices to generic drugs only when appropriate. For example, Lipitor would not be a preferred drug in any AmeriHealth Caritas plan since there are several clinically viable alternatives available in this class. This strategy is extremely effective but, by definition will reduce the choices available on the formulary. This tactic is ideal in situations where there is limited ability to promote generic use through other mechanisms like increased co-payments (i.e., most Medicaid populations).

A tiered benefit design promotes the use of generic products by giving incentives for the consumer to choose the lower cost option. This is usually handled by placing generic drugs on a preferred tier with a lower co-payment. This design is ideal for plans that must offer a very comprehensive benefit package and by including most products on the formulary in some capacity (i.e. most commercial plans).

A combination of these designs can also be deployed. A tiered structure combined with step therapy and prior authorization protocols can create a comprehensive benefit package and maintain a high generic utilization rate. The use of automatic (or electronic) step edits can drive the utilization in a favorable direction with less member and/or provider dissatisfaction.

Over-the-counter (OTC) products are a very cost effective option compared to prescription products. Many drug classes now have viable OTC options that can increase the cost effectiveness of the benefit design. The most effective method to promote the use of OTC products is through step therapy protocols. These are designed to ensure that the lower cost OTC products are used prior to administering a prescription product. Other AmeriHealth Caritas affiliate plans have used step edits, which require the use of an OTC product first, with much success in non-sedating antihistamines, ophthalmic antihistamines and proton pump inhibitor categories of medication management. AmeriHealth Iowa will also utilize this approach in consultation with PerformRx.

PerformRx has also developed and implemented cost containment programs specifically aimed at optimizing spend through efficiency where possible. A sample program is its 90 Days at Retail initiative. This is a product service cost containment measure aimed at mandating a 90 day generic supply of extremely low-cost generic medications. Due to the low cost of certain generic medications, the dispensing fee can sometimes be much higher than the actual drug being dispensed. This is one example of a program that has been successful for AmeriHealth Caritas Medicaid plans in multiple states.

Formulary Adherence Initiatives

We believe a formulary's efficiency begins with adherence. In consultation with AmeriHealth Caritas Iowa, PerformRx will prepare a variety of formulary compliance and education communications targeting

members, pharmacies and physicians to ensure proper formulary adherence. These communications include:

- Web-based searchable and printable formularies.
- Periodic mailings of hard-copy formularies and mailings to members of formulary changes.
- Targeted mailings to update providers regarding drug formulary and preferred status.
- Specific formulary material, such as prior authorization criteria, step therapy protocols and formulary updates are available to members.

We will also employ monthly Pharmacy Dashboard Report in Iowa that includes the percentage of overall formulary compliance and generic utilization rate. This report also includes a Prescriber Profile Report which provides physician prescribing patterns including formulary compliance percentage by physician. PerformRx supports health plans using this report to conduct academic detailing and education for prescribers where we go to different offices and review the Prescriber Profile Report and discuss any areas of opportunity for increase formulary adherence.

Drug Therapy Management (DTM)

AmeriHealth Caritas Iowa will implement the PerformRx DTM program in Iowa. DTM is a member-centric pharmacist outreach program designed to optimize therapeutic outcomes and decrease overall cost. Pharmacists and pharmacy technicians review integrated data (e.g., pharmacy, medical, lab, vision and dental), identify gaps in therapy and proactively address any identified issues through personalized consultations with patients and prescribers. As mentioned, PerformRx's DTM program is URAC-accredited (one of only four PBMs in the industry), award-winning (Case in Point Award and URAC Silver Best Practice Award), and has outcomes published in industry journals (Medicaid Health Plans of America and American Journal of Managed Care). Examples of DTM programs include Asthma Adherence, Diabetes Polypharmacy, Chronic Obstructive Pulmonary Disease, Statin Adherence and Diabetes Dosing Initiative.

Integrated Drug Therapy Management

Care coordination combined with DTM has the most impact on cost containment. High-touch member management increases adherence, reduces waste and abuse, and aids in preventing emergency care utilization. AmeriHealth Caritas is vested in collaborative holistic member management through our DTM program.

Member and prescriber interventions are completed with the intent of eliciting a change in a member's drug therapy, reducing the incidence of adverse drug events, and improving adherence to medication regimens. The Perform Rx DTM team uses its proprietary integrated DTM tool, PerformPRO, to identify and proactively correct medication related problems (MRPs) for members. DTM strategies can be applied to any disease state or membership mix to target any MRPs.

Case study 1: PerformRx's DTM team collaborated with the Case Management team of one of AmeriHealth Caritas' Pennsylvania affiliates, Keystone First, to resolve clinically significant medication related problems and reduce hospitalization rates for members with diabetes on 15 or more unique medications. Ultimately, this collaboration demonstrated improved member outcomes (as evidenced by decreased inpatient and ER admissions) and lowered overall costs. An article on this collaborative DTM pilot between PerformRx and Keystone First was published in the National MHPA Center for Best Practices Diabetes Compendium.

Case study 2: Across all of our Medicaid plans, AmeriHealth Caritas has worked towards a goal of increasing HEDIS scores by improving drug adherence. In 2013, AmeriHealth Caritas undertook a specific goal to improve member adherence by at least four percent in each of the following drug classes:

antihypertensives, asthma controllers, hypoglycemics, and statins. The specific classes were chosen as they are HEDIS measures and overlap with Pharmacy Quality Alliance and Centers for Medicare & Medicaid Services (CMS) endorsed measures. PerformRx initiated activities completed to support the goal included:

- Proactive and reactive automated refill reminder calls which allowed the member to transfer to member representative if they need any assistance.
- A medication adherence survey was deployed for members to identify the cause of adherence to develop personalized intervention strategies.
- Developed Proportion of Days Covered (PDC) reports to track adherence rates.
- Provided overdue refill reports for health plan care management.
- Developed medication adherence training materials and modules for health plan staff.
- Enrolled high-risk non-adherent members into DTM.

As a result of our program and activities completed through PerformRx and AmeriHealth Caritas health plan collaboration, the results surpassed the four percent increase in adherence goal. For the drug classes targeted an 18.4 percent increase in overall adherence was seen from January 1, 2013 to December 31, 2013.

Subcontractors

PerformRx subcontracts certain pharmacy network auditing and claims processing to strategic partners which will be utilized in Iowa.

Argus Health Systems

PerformRx has been in strategic partnership with Argus Health Systems to provide claims processing for PBM services since 1999. PerformRx conducts regular oversight meetings with Argus as well as quarterly performance reporting, yearly audits and an annual review of the Argus SSAE 16 SOC 1.

Xerox, Audit and Compliance Solutions

PerformRx has made the decision to outsource network pharmacy auditing to avoid any perception of bias. Xerox Audit and Compliance Solutions has been conducting pharmacy audits for PerformRx since 2005. PerformRx conducts an annual oversight visit to review Xerox policies, the policy and procedure manual and standard reports. PerformRx also hosts monthly audit operations meetings as a means of ensuring appropriate oversight and monitoring of network audit operations.

2. Describe your ability and experience in obtaining and reporting drug rebates.

Effective rebate management has been an important and successful part of PerformRx's overall PBM strategy since 1999. Rebate management includes services such as contract negotiation with pharmaceutical manufacturers to data submission, as well as financial reconciliation, reporting and audit support. PerformRx has experience with rebate management in 12 states for 21 different Medicaid plans adhering to all state specific regulations.

PerformRx's combination of detailed rebate reporting will ensure that formulary rebate accrual and the correct rebate payments are reconciled. PerformRx will generate a number of rebate invoice submission and collection reports that detail rebate revenue.

PerformRx will comply with any State contractual reporting terms in Iowa. Perform Rx rebate reports currently vary by state, from high-level executive summaries to more detailed reports including by manufacturer, drug name and National Drug Code (NDC). These reports and supporting information are

currently, made available in a variety of electronic formats including Excel, Adobe PDF or a text file, and are provided typically on a quarterly basis.

PerformRx Rebate Management Reports include:

- **Client Manufacturer Rebate Summary Report** contains a Manufacturer-Level Rebate Summary and NDC-Level Rebate Report. These reports are provided to accurately invoice and collect a particular health plan's rebates.
- **Manufacturer-Level Rebate Summary** specifies health plans' rebate utilization.
- **NDC-Level Rebate Report** details drug level rebate data elements.

PerformRx will work with AmeriHealth Caritas Iowa and the State to determine the specific report data elements required as well as the most appropriate frequency, design and format to meet your specific rebate program reporting needs.

Formulary management is a key component of an effective rebating strategy.

PerformRx continually reviews the formulary for changes in the net cost of drugs. As market changes occur, all opportunities will be vetted and discussed during the plan P&T process. Specific recommendations will be made by PerformRx to take advantage of net cost changes. Once approved, these changes will be implemented as normal benefit design modifications.

When a rebate contract changes, the PerformRx Formulary and Informatics team will analyze AmeriHealth Caritas Iowa utilization data and determine any potential impact(s). Proposed changes to the formulary will be communicated through the established P&T Committee process. For any proposed changes to the formulary, PerformRx will provide monographs and/or class reviews incorporating the net price after rebate to estimate the cost impact. The documents are specific to each type of impacted formulary or plan. We will also provide rebate specific impact estimates when requested. These reports will be accompanied by a recommendation that describes the best cost related course of action.

With the understanding that maximization of rebate opportunities is an essential goal, PerformRx will ultimately base recommendations for formulary and utilization management programs on clinical efficacy first, then on financial data. Utilization management strategies will be approved by the plan and applied to adhere to clinical guidelines and/or to drive utilization to the product with the greatest financial value.

3. Describe any relevant experience resolving drug rebate disputes with a manufacturer.

We have the experience to efficiently and quickly resolving disputes with pharmaceutical manufacturers. Nearly all manufacturer contracts contain provisions for handling disputes. If a manufacturer disputes any portion of a report, the manufacturer will provide notice of the dispute in writing, along with the reason. Then, the manufacturer and PerformRx shall in good faith attempt to reconcile the dispute. Where necessary, the legal teams of both PerformRx and the manufacturer are engaged if contract interpretation or adherence is in question.

In one situation a dispute occurred with a manufacturer over the rejection of their claims filled in the state of Florida. The manufacturer prematurely discontinued payment of rebates to our Florida plans. As is our general practice, we notified the manufacturer via email of our dispute and followed up until resolved. In this particular case, we sought the advice of legal counsel to ensure we were entitled to the rebate amounts billed. This particular situation resolved favorably for PerformRx and our customers.

4. Describe your plans for responding to all drug prior authorization requests within twenty-four (24) hours and dispensing at least a seventy-two (72) hour supply in an emergency situation.

Our average turnaround time for prior authorization reviews is typically half of the particular state's compliance standard. The staffing model for the Prior Authorization department is evaluated and updated accordingly based on formulary structure, prior authorization criteria, projected membership and population demographics,

For a 24-hour turnaround time requirement, we typically experience an eight to 12 hour actual turnaround time. If an expedited medication is required, an Urgent Prior Authorization Request Form is submitted or phoned into the Pharmacy department, which typically has a turnaround time of less than four hours.

As standard practice, if we cannot make a determination within 24 hours of receipt of a prior authorization request, we authorize a temporary supply until the request is either approved or the member receives written notification of the denial. The amount of a temporary supply given is based on the health plan's direction.

Scenario 1

It is standard operating practice to offer a three-day emergency temporary supply for non-formulary medications or medications rejecting at the point-of-sale as a result of a prior authorization requirement. Only one temporary supply per generic code number (GCN) will be allowed. The dispensing pharmacy will have the ability to place an override code into the claims processor which will allow a temporary supply to adjudicate.

All temporary supplies are documented in an internal tracking system. If a prior authorization/letter of medical necessity is denied by the prior authorization clinical staff, a second temporary supply will not be granted.

Scenario 2

If AmeriHealth Caritas Iowa members are entitled to a three-day temporary supply of medication, we will offer a three-day temporary supply and allow multiple temporary supplies until the prescribing physician can be contacted.

5. Describe your method for providing online and real-time rules-based point-of-sale claims processing for pharmacy benefits.

Our current pharmacy claims processing system is RxNova™. RxNova processes real-time point of sale (POS) retail and mail order claims, batch electronic claim files, paper claims and pharmacy reimbursements. RxNova features a user interface that is flexible, fast, accurate and dependable at the POS. RxNova currently supports over 300,000 unique benefit programs and more than 440 error codes for customers. Table-driven edits are built into the system so edits are quickly implemented without programmer intervention.

RxNova processes our POS claims including non-network retail and manual retail, mail order, batch electronic claim files, paper claims and pharmacy reimbursements in D.0 format.

The RxNova claims processing system allows for multiple copay/coinsurance based formulary tiers, as well as varying copays within the tiers, step therapy, prior authorization, quantity limit and other edits. It also can provide individualized patient edits, pharmacy edits, COB claims, TrOOP and MOOP tracking, transition claims and other benefits.

Benefits are coded through distinct layers of hierarchy: customer name, client name, group name and coverage code. Benefits can be set at any one level or any combination of levels in congruence with specific requirements. Some examples include: formulary, copay, drug utilization review (DUR) and deductible.



Customer Name/Customer ID — 4-digit, numeric ID assigned by PerformRx. Highest level associated with a group of members. The Customer ID is a key field in benefit identification and plan reporting parameters. The Customer ID dictates the PCN. Each customer has a unique number and therefore a unique PC.

Client Name/Client ID — 4-digit, numeric ID assigned by PerformRx or the client. A code used to uniquely identify a client within its customer. A Client is a collection of groups that have similar benefit parameters. A Customer may have unlimited Client Name/Client ID's. **For Medicare: this number is typically the CMS contract number.**

Group Name/Group ID — Alpha-numeric, 30-digit maximum ID assigned by PerformRx or the Client. A group is a subdivision of the enrollment data as defined by the Customer. The term "Group" as used on-screen and with reports refers to the Group ID. **For Medicare: this number is typically the PBP number for the CMS contract.**

Coverage Code — Alpha-numeric, 6-digit ID assigned by PerformRx or the Client. The Coverage Code identifies a specific combination of prescription drug benefits given to a group or member.

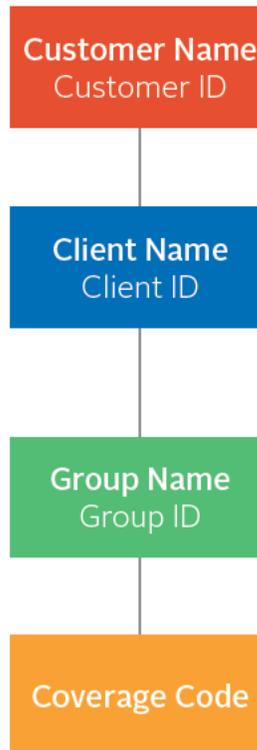


Exhibit 3.2.6-A: Sample Benefit Design Hierarchy

All PBM's applications are web-based

AmeriHealth Caritas Iowa has the capability to both view and update eligibility online through the RxNova interface. Permission-based access will be configured at your discretion to determine the types of access permitted (e.g., view, add, update and delete). Only those users that AmeriHealth Caritas Iowa identifies will have the clearance to update eligibility information.

PerformRx's pharmacy prior authorization application, PerformPA, is a web-based application. Just as with RxNova, AmeriHealth Caritas Iowa will have full access to the application. User accounts are created in PerformPA with different levels of role-based access. For example, users can be granted full access

(meaning they can actively approve or deny requests) or read-only access that confines them to submission status checks.

All user activity is automatically logged to ensure proper use. The activity data is also used to create reports by user name for tracking purposes. These types of reports are useful when completing audits. Other types of reports include, but are not limited to, individual reviewer trends, performance and turnaround time. Prior authorization reports (for example utilization reports) are also available.

For claim queries, AmeriHealth Caritas Iowa will use an ad hoc reporting tool, RxFocus II. RxFocus II is a web-based application provided by PerformRx through our claims processing partner. It provides the user with near real time pharmacy-based information and multidimensional ad hoc analysis through an internet browser in a secure environment.

RxFocus II provides the following services:

- Data management and analysis.
- On-line desktop reporting.
- Executive summary reporting.
- Predefined reports.
- Ad hoc queries.
- Drill down functionality.
- HIPAA compliance.
- Security.
- Data integrity.
- Data integration.
- Physician profiles.
- Member profiles.
- Cost modeling from benefit designs.
- User ease of execution/user friendly.
- Clinical applications.

PerformRx's online formulary management tool has the ability to store as many versions and types of formularies requested by AmeriHealth Caritas Iowa. These formularies are updated as benefit design changes are made. The formulary is accessible through a Web interface, which supports numerous search options. The Web interface can be updated as often as required and is searchable by drug name, drug class, or alphabetic search. PerformRx also posts a PDF version of the formulary for download and print. Members have access to the searchable formulary via the member portal on PerformMAX.

We have access through the public Internet through a web browser, which is encrypted by HTTPS.

AmeriHealth Caritas Iowa will have desktop access to the system for online system updates. Access is established via a secure connection. Permission-based access will be configured at your discretion to determine the applications and types of access permitted (inquire, add, update and delete).

Member Portal

The Member Portal is a user-friendly and informational tool to help the health plan members take more control of their care. Once the member logs in, they can access a wealth of information. They can retrieve materials pertinent to their specific benefit needs, create their own personal health records, explore frequently asked questions and answers, and check the status of their prior authorization requests.

Through the Member Portal, members can access additional resources such as:

- Claims history.
- Benefit Information.
- Searchable and printable formulary.
- Pharmacy locator.
- DTM communications.

Drug Pricing Tool

The drug pricing tool offers members a glimpse at the cost involved with their medication through an accessible platform. First, the member searches for and selects the drug in question. Then they look up their pharmacy (retail or mail order) and enter the quantity and day's supply. The system will then calculate the price of the drug considering the member's current benefit and provide a drug price. The information returned will also list any coverage restrictions that may apply. The pricing returned will be displayed in one of three ways:

1. If a brand name drug is entered, the system will display both the brand and generic prices.
2. If a generic drug is entered, the system will only display the generic price.
3. If there is not generic equivalent available, the system will only display the brand price.

6. Describe your plans to implement retrospective drug use review to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits, or associated with specific drugs or groups of drugs.

AmeriHealth Caritas health plans are risk-bearing managed care organizations, we are sensitive to the need to be vigilant and proactive in the area of FWA, and we have significant experience in program integrity.

PerformRx monitors unusual patterns of utilization behavior among members, as well as prescribing patterns of participating physicians. PerformRx and AmeriHealth Caritas Iowa follows up with members and physicians to take corrective action as appropriate. Suspected fraud and abuse is referred to the Special Investigation Unit (SIU) for investigation and the SIU will report cases of suspected fraud or abuse to DHS.

PerformRx offers an extensive menu of point of sale (POS) edits that AmeriHealth Caritas Iowa will utilize, including drug exclusions, maximum dollar limits, maximum quantity limits, and duplication of therapy and day supply limits. At the POS, we reject inappropriate prescriptions in order to prevent a mistake or the likelihood of FWA from happening in the first place.

We have been providing drug utilization programs since 1999. Our Drug Utilization Review (DUR) program ensures prescriptions are appropriate, medically necessary and unlikely to result in adverse medical consequences. The DUR program will provide Iowa with the control necessary to achieve utilization management and financial goals.

Our concurrent, retrospective and prospective DUR programs minimize improper drug utilization by:

- Reviewing prescription claims for therapeutic appropriateness prior to medication dispensing.
- Applying criteria that include the member's medical history and clinical parameters.
- Focusing on members with conditions that place them at the highest level of risk for harmful outcomes.

Depending on the method of issue discovery, the member or physician may be contacted by phone or mail. Prescriber education is completed periodically to address appropriate therapy regimens.

Retrospective DUR Program

The retrospective DUR program performs ongoing periodic systematic reviews of drug utilization and prescribing patterns to ensure prescriptions for outpatient medications are appropriate, medically necessary and not likely to result in adverse medical effects.

The retrospective DUR program is designed to:

- Educate prescribers and network pharmacists to identify and reduce the frequency and patterns of fraudulent, abusive or medically inappropriate/unnecessary care.
- Enhance the quality of pharmaceutical care and improve member outcomes.
- Be customized for each plan, ensuring their specific pharmacy utilization management and financial goals are met.

Our comprehensive retrospective DUR Program includes sub-programs including but not limited to Recipient Restriction, Opioid Overutilization, SafeUseNow and targeted FWA reporting.

Recipient Restriction

The Recipient Restriction Program identifies members with patterns of misuse or abuse of medical and pharmacy services, and restricts them to one pharmacy. This restriction allows PerformRx and the AmeriHealth Caritas Iowa to better monitor the member's behavior, thereby ensuring member safety and prescription compliance. To identify candidates for the Recipient Restriction Program, suspects of misuse or abuse are first identified through the following methods:

- Prescriber/pharmacy network recommendations.
- Inquiries from other functional departments.
- Special investigations.
- Department of Public Health.
- Suspect Report.

Once a member is suspected of misuse or abuse, and the member meets the state approved criteria for Recipient Restriction AmeriHealth Caritas Iowa recommends using the following criteria for eligibility for the program: The member is receiving controlled substances from two or more physicians and using two or more pharmacies for a period of six consecutive months.

Once the member meets the above recommended criteria, a clinical pharmacist begins to analyze six months of pharmacy utilization patterns and 12 months of medical claims data. If the analysis indicates that the member is a candidate for Recipient Restriction, the clinical pharmacist notifies AmeriHealth Caritas Iowa.

Opioid Utilization Management

The Opioid Utilization Management program assists in the prevention of overutilization of opioid drugs by members and promotes safe drug utilization to reduce the likelihood of adverse outcomes. The Drug Therapy Management (DTM) department identifies potential opioid over utilizers based on drug claims data through clinical thresholds and prescription patterns set at the quarterly P&T committee meeting. Written inquiries are sent to the prescribers of the opioid medication about appropriateness and medical necessity. At least three attempts are made to schedule telephone conversations with all prescribers. After

the intervention, the consensus reached by the prescribers is implemented by PerformRx with a member-level claims edit as appropriate. The member and prescriber will receive a written notice of the results of case management.

SafeUseNow

The SafeUseNow managed care risk model provides prescriber, member and pharmacy risk assessment to help control prescription drug abuse. As prescribers are the primary source of prescription drugs within a managed care network, the program begins with the prescriber. SafeUseNow identifies, engages and monitors targeted prescribers to reduce prescription drug abuse.

The SafeUseNow program utilizes 17 predictive risk factors discovered in a multi-year study of physician prescribing, pharmacy dispensing and member utilization of controlled substance drugs. It is an actionable solution for systematically and efficiently combating the misuse, abuse, addiction and diversion of controlled substance drugs.

Identification

SafeUseNow uses a PSI Score™ model to identify prescribers whose behavior may contribute to prescription drug misuse, abuse, addiction and diversion. The PSI Score model is a weighted composite measure factoring in multiple sources of information, including predictive metrics, behavior risk factors and opioid-specific information as well as pharmacy, prescriber and member metrics.

Using the PSI Score, SafeUseNow is able to identify elements of risk for a specific prescriber, for all members being treated by a specific prescriber, for all pharmacies at which those members present a prescription, and for all other prescribers treating the same members. Scores are calculated monthly using automated data feeds and are able to identify demographic and geographic trends, as well as changes in prescribing behavior over time.

Engagement

Prescribers identified as being strong candidates for prescription drug abuse reduction will be engaged by SafeUseNow. The prescriber will be introduced to an educational program designed to improve appropriate prescription drug prescribing.

The program uses a social-learning theory framework to present risk-class appropriate strategies to minimize abuse, and promote appropriate prescribing and member safety. Each prescriber will receive one-on-one interaction with the goal of optimizing responsiveness and behavior change.

Monitor

Prescribers who have been involved in the SafeUseNow program will be monitored to detect changes in behavior and measure the effectiveness of the intervention program. SafeUseNow will measure prescriber behavior changes over time and utilizes a feedback loop to improve intervention service effectiveness.

SafeUseNow will also identify prescribers who refuse to engage in the program as well as prescribers who are unresponsive to the program. Resistant prescribers are triaged to other risk management functions.

Expected Outcomes

Created in 2014, the SafeUseNow model has already demonstrated a \$17 per participant, per month savings. SafeUseNow is expected to provide a reduction in prescription drug misuse, abuse, addiction and diversion. Measurable results include:

- Reduction in inappropriate opioid drug use.

- Reduction in opioid drug spend.
- Reduction in opioid-related ER admissions.
- Identification of high-risk providers in the network.

Pharmacy Network Fraud, Waste, and Abuse

There are two components to our approach to detect, prevent and mitigate FWA within our pharmacy program. First, we contract with a third party vendor to conduct routine pharmacy network audits.

PerformRx provides our pharmacy audit contractor with 100% of paid claims on a monthly basis. Using proprietary algorithms and predetermined edits, the pharmacy audit contractor identifies pharmacies for desktop and in-store audit reviews. The algorithm consists of a number of customized rule sets which identifies potential pharmacy claim discrepancies. Some of the criteria for these rule sets are:

- Gross Claims Volume and Cost
- Controlled Substance Utilization
- DAW submissions
- One Time submissions for maintenance drugs, antibiotics, etc.
- U&C submissions
- Incorrect prescriber submissions
- Incorrect days' supply submissions
- Percentage of prescriptions filled for a specific provider
- Maximum dose limits
- Compounds

Based on the audit score determined by the algorithm, and other triggers, PerformRx will schedule a desktop or on-site audit with the pharmacy. PerformRx will audit a statistically appropriate subset of the client's network. The client can choose to increase or decrease the number of audits conducted each year.

For both desktop and on-site audits, pharmacies will receive written notification of the audit at least 14 calendar days in advance of the audit. Desktop audits will ask the pharmacies to submit documentation directly to our audit vendor, while on-site visits will be scheduled. All audits are performed manually by third party network auditors, with approximately 5% of the network typically audited (3-4% desktop, 1% on-site).

Recoveries are identified when the documentation at the pharmacy does not match what was billed to the claim. Pharmacies are granted a two-level appeal process for audit decisions before the audit is final. Once final, PerformRx will withhold the recoverable amount from future pharmacy payments. Since plans are responsible for pharmacy funding, recoveries from pharmacy network audits result in 100% pass-through for ingredient cost (pharmacy payment from the client).

The number of audits is determined by what PerformRx and the client agree on, with audits being performed each month. PerformRx will work with the client if they choose to use an alternative auditing approach.

Secondly, any adverse findings indicating potential FWA is referred to the SIU for review. The SIU has staff dedicated to proactively reviewing pharmacy paid claims data to identify potential patterns of prescription drug abuse, possible diversion and doctor shopping. Examples of routine reports reviewed by the SIU include, but are not limited to:

Patient CII Summary

This report gives a quarterly summary of all members receiving CII Medications. The health plan can use this report to investigate the appropriateness of patient CII usage. The higher CII percentage would identify the members that may be at a higher risk of abuse.

Pharmacy CII Summary

This report gives a quarterly summary of all pharmacies dispensing CII medications including number of claims, unique members, and average number of claims per member and total cost of CII claims. It can be used to identify pharmacies that are dispensing a high percentage of controlled drugs.

Patient Over \$10k in Claims

This report gives a summary of any member accruing more than \$10,000 in claims that is also visiting multiple physicians and pharmacies in any given quarter, which can be an indicator of member physician or pharmacy shopping.

Physician Over 200

This report summarizes all physicians prescribing more than 200 Hotlist claims and surpassing \$50,000 total payments per year. Hotlist drugs are: high priced HIV, cancer and psychotropic medications. Reports are broken out by quarter with escalating claims and total payment amounts accumulating to a total equaling or exceeding 200 claims, and equaling or exceeding \$50,000 for the year. This report is useful in identifying physicians prescribing these types medications who may not specialize in this field, or are prescribing these medications to members absent a legitimate medical purpose (ex: HIV medications being prescribed without a diagnosis of HIV).

Controlled Drug Utilization — Member Summary

This report gives a summary of members that may be over-utilizing controlled medications. Many members that display over-utilization of controlled medications are at high risk for fraud, waste and/or abuse of these products. These members may also benefit from care management, as there is a high probability that many of these members are being improperly managed for various legitimate medical conditions (depression, anxiety, pain, etc.).

Controlled Drug Utilization – Pharmacy Summary

This report gives a summary of pharmacies that are dispensing the highest number of prescriptions for controlled substances. This report can be used in conjunction with the member and provider-controlled drug reports to determine if there is any risk of fraud, waste and abuse of these medications.

7. Describe your plan for monitoring your PBM as described in Sections 3.2.6.6.1.3 and 3.2.6.6.1.4.

AmeriHealth Caritas Iowa is committed to complying with all relevant laws, regulations and contractual requirements, and ensuring that our subcontractors are compliant as well, including PerformRx. AmeriHealth Caritas Iowa will implement our strong corporate subcontractor oversight program and will monitor and evaluate all subcontractor performance (including that of our PBM subcontractor, PerformRx) on an ongoing basis. Our proven oversight program ensures compliance with external accrediting bodies, state, federal and Contract requirements. Additionally, AmeriHealth Caritas Iowa will monitor all subcontractor performance, leveraging a continuous quality improvement methodology, as relevant for

each function. This methodology relies on components including initial and ongoing delegation audits, review of performance on key performance indicators, as well as follow-up and investigation into quality of care issues and member grievances. Performance will be trended over time to identify unfavorable trends in a timely manner, so that course corrections can be initiated before performance falls below regulatory and contractual standards.

Our current draft plan is a comprehensive approach to ensure both member and Iowa's needs are met. We are prepared to submit our oversight plan to DHS for approval and will partner with Iowa to ensure our monitoring plan meets the state's needs.

Our monitoring plan includes the following:

- AmeriHealth Caritas' Delegation Oversight team will monitor performance on contract standards on a monthly basis. In addition, Delegation Oversight completes an annual audit on PerformRx on behalf of the AmeriHealth Caritas plans for compliance, contract and regulatory items.
- Regional pharmacy directors will also support oversight of PerformRx through bi-weekly (at a minimum) reviews to discuss issues, concerns, regulatory and compliance changes as well as any other processing issues that have been identified and need resolution. The pharmacy directors work with Perform Rx in reference to state audits, on-sites and any other benefit related items. They also monitor contract compliance.
- The AmeriHealth Caritas Iowa market president will meet with PerformRx monthly to discuss higher-level items and plan specific initiatives.
- AmeriHealth Caritas Iowa will complete quarterly drug utilization reviews (DUR) to evaluate trends and spend.
- AmeriHealth Caritas Iowa Compliance staff will hold monthly compliance meetings to address regulatory/state/contract items. We also have clinical meetings to look at the formulary processing with the PerformRx clinical pharmacists assigned to AmeriHealth Caritas Iowa.
- AmeriHealth Caritas Iowa will hold quarterly pharmacy summit to address pharmacy concerns, governance in addition to initiatives/projects for efficiencies, enhancements and better business planning.
- PerformRx will support statutory reporting for, and work with, AmeriHealth Caritas Iowa directly for resolutions, data anomalies and pharmacy issues as it pertains to state reporting.

3.2.7 EPSDT Services

1. Describe your plans to ensure the completion of health screens and preventive visits in accordance with the Care for Kids periodicity schedule.

AmeriHealth Caritas Iowa will provide early and periodic screening and preventive visits to all members less than 21 years of age. Screening exams consist of a:

- Health history.
- Developmental history.
- Complete physical exam.
- Vision screening.
- Hearing test.

- Appropriate laboratory tests.
- Immunizations.
- Nutrition screens.
- Health education including anticipatory guidance.
- Oral health assessment.
- Other tests as needed.
- Referrals for treatment.

Empowering members to stay on top of their periodicity schedule

AmeriHealth Caritas Iowa's Rapid Response team builds strong relationships with members and works with them to ensure the completion of health screens and preventive visits. Before the visit, they provide one to two appointment reminder calls prior to appointments to ensure member appointment is kept and has transportation to appointments. The Rapid Response team also educates members/parents/guardians of available transportation services, including same day service option for immediate care needs at pediatric office or PCP office. The Rapid Response team makes referrals to the Integrated Care Management team when identifying members under 21-years-old as candidate for case management to benefit from ongoing assistance, and educational services and support. Additionally, the Rapid Response team will assist with specialist selection. The Rapid Response team provides coordination services with transportation vendor for the members to be transported to and from health plan sponsored Well Child events (such as "back to school" events). The Rapid Response team supports the "Let Us Know" program in receiving provider referrals via fax or phone calls when members have missed these important well-child visits.

When the Rapid Response team reaches out to the member/parent/guardian to set up the appointments, they provide information on transportation assistance. They also set up services, address barriers to care, educate on importance of well visits and use opportunity to address gaps in care under family link for other members in the home. In addition, the Rapid Response team promotes appointment coordination for more than one family member during the call and follows up with the provider to verify scheduled appointments were kept. The Rapid Response team will work with DHS to provide member benefit information for children in foster care placement to be passed along to the foster parent. Finally, the Rapid Response team will collaborate with other key departments within AmeriHealth Caritas Iowa to support HEDIS target outreach for EPSDT population.

Our tracking system monitors the rates of adherence by members and providers in relation to EPSDT requirements. We are then able to target those who need assistance in adhering to the well-visit and periodicity schedule. Through this system, we are able to generate reports for members and providers, encouraging empowerment and individual intervention.

Electronically tracking Members' screening and immunization status

Once the data is loaded and the member is assigned to specific conditions and/or measures, the information is fed into AmeriHealth Caritas Iowa's Population Health Management System, Jiva. Our care managers and member services associates are able to identify gaps in care and track if members are hitting their schedules, including well visits for the EPSDT-eligible population. AmeriHealth Caritas Iowa uses:

- **EPSDT Reports:** The reports are pulled on a monthly basis and used to identify EPSDT care gaps, using information from Facets claims reports and DHS Claims Feed, obtained from the data warehouse. That

information is used to determine if the member is compliant for the well-child periodicity appointment. These monthly reports will use IRIS (Iowa's Immunization Registry Information System) data that is loaded into our HEDIS repository.

- **Interim Reports:** Interim reports are also sent monthly to AmeriHealth Caritas Iowa Quality Management and Provider Network staff. This report ensures that we are on target to meet our EPSDT quality measures. The reports include members who are non-compliant with appointments. Once the Rapid Response team reviews the reports, members are provided with reminders that an EPSDT service is due via telephone outreach and materials sent to the home.

Coordinating Referrals and medically necessary follow up treatment post- EPSDT screen

After the member's initial needs are coordinated, the Rapid Response team will connect the member to the necessary care management service programs for ongoing follow-up.

Monitoring Providers' compliance with appointment standards and EPSDT screening requirements

AmeriHealth Caritas Iowa outreach and education programs emphasize a comprehensive outreach strategy. Specifically, we have based our reporting and care gap algorithms on the current American Academy of Pediatrics (AAP) Bright Futures periodicity charts and Advisory Committee on Immunization Practices guidelines. We 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 enforce the use of the Vaccine for Children (VFC) Program by our providers to ensure that unnecessary costs are not incurred.

Partnering with Providers

AmeriHealth Caritas has been successfully driving enhanced pediatric well-care visits using a combination of care gap reporting and our Let Us Know program, which encourages providers to contact our Rapid Response team for assistance with member needs. After the member's initial needs are coordinated, the Rapid Response team will connect the member to the necessary care management service programs for ongoing follow-up.

2. Describe your proposed outreach, monitoring and evaluation strategies for EPSDT.

Multi-channel Outreach Approach

AmeriHealth Caritas deploys a multi-channel outreach approach for EPSDT consisting of mailings, partnership outreach programs with providers, advocates and the community push and pull digital outreach (e.g., text reminders, member portal), outbound calls and inbound calls to discuss EPSDT. For example, our monthly reports are used for automated messaging to the EPSDT population. Our care gap reports identify members missing services at the provider panel level. For high volume providers, an AmeriHealth Caritas Iowa account executive will share this information in person. For medium and low volume providers, we will send this information via the mail. Additionally, this information will be made available to all providers through our Provider Portal. The EPSDT clinical summary is accessible from the Provider Portal and allows provider to see what member had/what is missing. Additionally, care gap alerts are incorporated in the member service system and care management system. Finally, our family link allows us to ensure that all family members are getting the care and services they need. When looking at one member's record, this feature can link to other members of the family to see what they are missing — it allows us to meet the needs for the entire family in one contact.

Making Every Call Count

Our Jiva system has a family link feature so our caller can help additional family members with gaps in care during one outreach call. Additionally, there are automated messaging recorded by the medical director – delivering advice about the importance of well-child visits, screenings, important immunizations as well as providing opportunity for member/parent/guardian to connect to a live Rapid Response associate to assist with scheduling a well-child appointment. Furthermore, the Rapid Response team mails out well-child magnets to remind the family of important milestones in well-child check-ups. Magnets include important numbers: the Rapid Response toll free telephone number, the 24/7 Nurse Call Line and the Member Services line. At the end of this section we have outlined additional innovative and non-traditional outreach methods including:

- Mailings (e.g., birthday cards, magnets, and fact sheets).
- Community events and partnership programs.
- Maternity and baby continuity programs.

Monitoring

Our tracking system monitors the rates of adherence by members and providers in relation to EPSDT requirements. We are then able to target those who need assistance in adhering to the well-visit and periodicity schedule. Through this system, we are able to generate reports for members and providers, encouraging empowerment and individual intervention. As mentioned earlier, we are able to electronically track and monitor members (e.g., EPSDT and Interim reports).

Evaluation

The EPSDT tracking system begins with the data sources used to populate our HEDIS-certified software system, Inovalon. In order to screen and diagnose any gaps in care with our EPSDT eligible members, we load encounter data from Facets, eligibility, claims, pharmacy, lab, data warehouse, state agency supplied data and demographics data into the Inovalon system. Facets data will be supplemented by data obtained from participating providers and IRIS. The report can then be mapped to the data warehouse, where the Member identification and condition is matched to each record. Our annual HEDIS reports and CMS 419 reports are additional tools that allow us to objectively review our strategies and work towards continual improvement, which we review quarterly and submit on an annual basis.

Outreach Examples:

Birthday Cards

Reminder 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 contains information on age-appropriate developmental milestones and safety tips, as well as important resource agencies and telephone numbers. The content of the birthday cards is reviewed annually for accuracy.

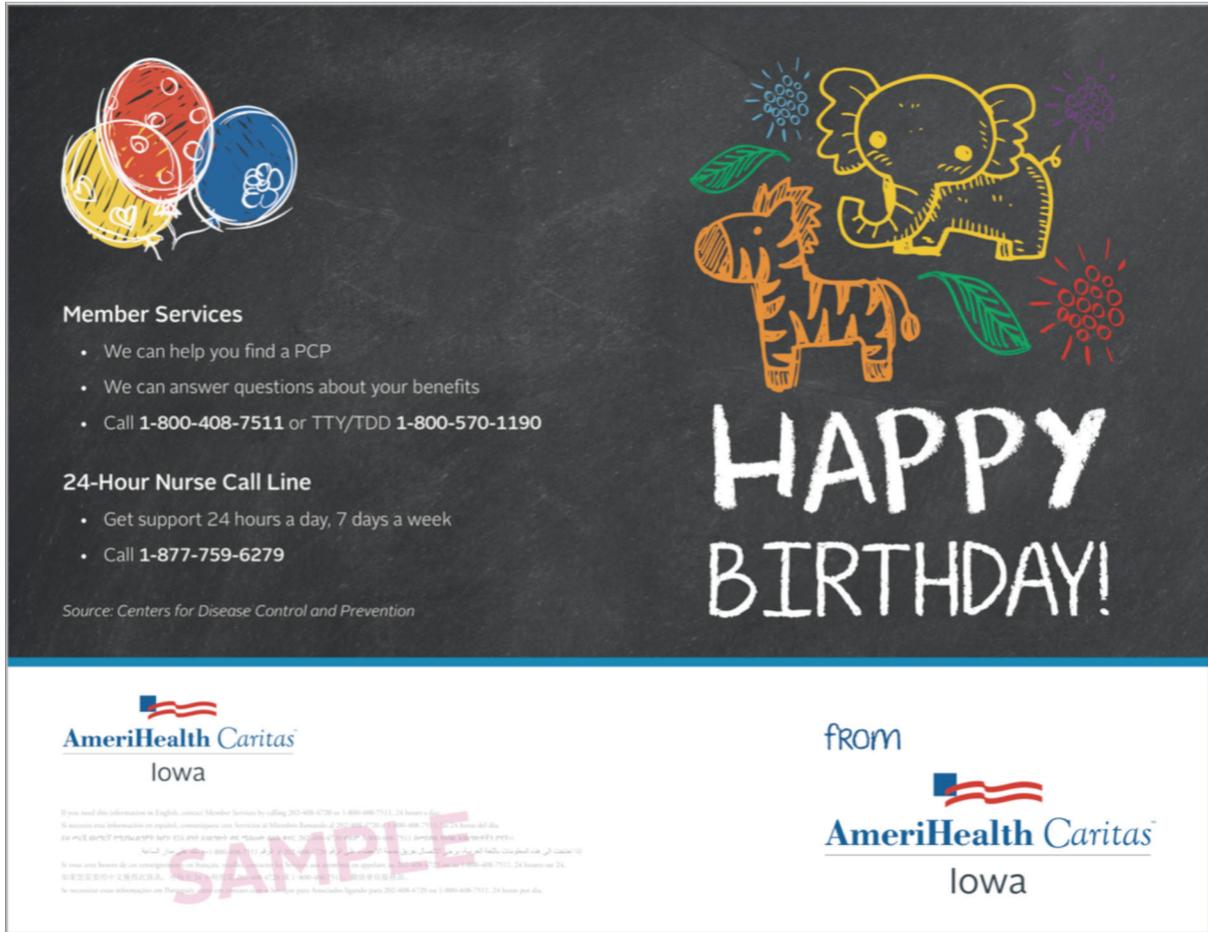


Exhibit 3.2.7.-A: Example AmeriHealth Caritas Iowa Birthday Card

Staying Healthy! **Birthday checklist:**

Your child is 4!

Has your child had a check-up?

The recommended vaccinations (shots) for your child include:

- Chickenpox (varicella)
- Diphtheria, tetanus and whooping cough (pertussis) (DTaP)
- Polio (PV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)

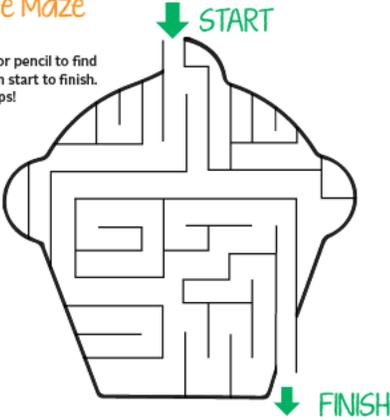
To get your child's **free gift**, call us at **1-877-759-6224** and make an appointment with your child's primary care provider (PCP) for a check-up.

Keep track of your child's shots at home! Visit www.cdc.gov/vaccines/schedules/easy-to-read/child.html for a list of recommended shots.

Eat cake
 Laugh
 Play with friends

Cupcake Maze

Instructions:
Use a crayon or pencil to find your way from start to finish. Watch for traps!



 AmeriHealth Caritas
Iowa

Exhibit 3.2.7.-B: Example AmeriHealth Caritas Iowa Birthday Card

Magnets

The Rapid Response team also biannually sends out magnets to members of PCP practices that have the largest volume of non-compliant members. The magnets are sent to families in English and Spanish in order to support the well-child visit schedule.

 <p>Use this checklist to keep up with your child's well-child visits.</p> <ul style="list-style-type: none"><input type="checkbox"/> 3 – 5 days.<input type="checkbox"/> 1 month.<input type="checkbox"/> 2 months.<input type="checkbox"/> 4 months.<input type="checkbox"/> 6 months.<input type="checkbox"/> 9 months.<input type="checkbox"/> 12 months.<input type="checkbox"/> 15 months.<input type="checkbox"/> 18 months.<input type="checkbox"/> 24 months.<input type="checkbox"/> 30 months.<input type="checkbox"/> Children ages 3 – 21 should have a well-child visit each year. <p>Rapid Response Team X-XXX-XXX-XXXX.</p> <p>_____ PCP name</p> <p>_____ PCP phone</p>	 <p>Utilice la lista siguiente para asegurarse de que sus niños reciben chequeos médicos a estas edades.</p> <ul style="list-style-type: none"><input type="checkbox"/> 3 – 5 días.<input type="checkbox"/> 1 mes.<input type="checkbox"/> 2 meses.<input type="checkbox"/> 4 meses.<input type="checkbox"/> 6 meses.<input type="checkbox"/> 9 meses.<input type="checkbox"/> 12 meses.<input type="checkbox"/> 15 meses.<input type="checkbox"/> 18 meses.<input type="checkbox"/> 24 meses.<input type="checkbox"/> 30 meses.<input type="checkbox"/> Los niños de 3 a 21 años de edad deben de tener una Visita de Bienestar cada año. <p>Rapid Response Team X-XXX-XXX-XXXX.</p> <p>_____ Nombre del médico/PCP</p> <p>_____ Número de teléfono del médico/PCP</p>
--	--

Exhibit 3.2.7.-C: Example AmeriHealth Caritas EPSDT Magnets

Fact Sheets

The Rapid Response team also sends out fact sheets with an accompanying letter that provides contact information to reach a nurse.



Exhibit 3.2.7.-D: Example Letter that Accompanies EPSDT Fact Sheet

Stay Strong. Live Healthy.

Take your child for a well-child visit!

Your child is due for this important checkup. Well-child visits help make sure your child is growing and developing.

A well-child visit is a full head-to-toe physical.

It's not just shots! It may include:

- Eye and hearing tests.
- A blood pressure check.
- A dental checkup.
- A check for proper growth.
- Any needed immunizations (shots) to prevent disease.
- Tips for keeping your child healthy and safe.
- Lead screening before your child's 2nd birthday.

Use this checklist to make sure your child gets all of his or her checkups at these ages:

- | | |
|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> 3 - 5 days. | <input type="checkbox"/> 12 months. |
| <input type="checkbox"/> 1 month. | <input type="checkbox"/> 15 months. |
| <input type="checkbox"/> 2 months. | <input type="checkbox"/> 18 months. |
| <input type="checkbox"/> 4 months. | <input type="checkbox"/> 24 months. |
| <input type="checkbox"/> 6 months. | <input type="checkbox"/> 30 months. |
| <input type="checkbox"/> 9 months. | |

Well-child visits are at no cost to you.

AmeriHealth Caritas Iowa members will not be charged for well-child visits.

Please call your child's doctor to make an appointment.

If you need help, call Rapid Response at X-XXX-XXX-XXXX.

If you have recently taken your child in for this visit, please ignore this card.

**If you need help reading this,
please call X-XXX-XXX-XXXX.**

You can have this information in other languages and formats at no charge to you. You can also have this interpreted over the phone in any language. Call Member Services 24 hours a day, 7 days a week at 1-888-756-0004. For TTY, call 1-866-428-7588.

Quý vị có thể có thông tin này bằng các ngôn ngữ và định dạng khác miễn phí. Quý vị cũng có thể có thông tin này thông dịch ra bất kỳ ngôn ngữ nào qua điện thoại. Xin gọi Dịch vụ Thành viên phục vụ 24 giờ/ngày, 7 ngày/tuần theo số 1-888-756-0004. Đối với người sử dụng TTY, xin gọi số 1-866-428-7588.

Usted puede tener esta información en otros idiomas y formatos sin costo alguno para usted. También puede tener esto interpretado por teléfono en cualquier idioma. Llame a Servicios al Miembro al 1-888-756-0004 las 24 horas del día, los 7 días de la semana. Para TTY, llame al 1-866-428-7588.

Exhibit 3.2.7-E: Example EPSDT Fact Sheet

Community Events and Partnership Programs

AmeriHealth Caritas Iowa is a strong supporter of communities. We routinely include information and educational sessions on EPSDT services and immunizations at community events.

The AmeriHealth Caritas Iowa CEOT will routinely provide assistance to providers by scheduling appointments for members with EPSDT care gaps. We realize the importance of our members receiving the appropriate screenings and other care services, and our providers appreciate the support.

AmeriHealth Caritas Iowa 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 (e.g., “back to school” events) will enable us to effectively connect more members to services. AmeriHealth Caritas has developed several initiatives to enhance EPSDT performance. A few examples are outlined below.

Maternity and Baby Community Programs

Adherence to well-visit schedules begins before the baby is born. AmeriHealth Caritas is involved with national and community organizations that share their commitment to producing brighter starts for babies. AmeriHealth Caritas demonstrates its commitment to moms and babies through our Bright StartSM Maternity Program.

The program has been instrumental in helping new mothers stay healthy and have healthy babies by promoting healthy behaviors and controlling risk factors during pregnancy. Specialized prenatal care management staff is assigned to every pregnant member and helps the members schedule prenatal care appointments, coordinate the health care services they receive and learn about healthy pregnancy behaviors. Those members considered to be at higher risk receive more intensive care management. Our care managers also assist members in choosing a PCP for their child and reinforce the importance of regular well-child visits.



Built on prenatal care guidelines, the Bright Start program is dedicated to promoting healthy behaviors, controlling risk factors during pregnancy, and educating mothers on EPSDT guidelines, with the goal of supporting the delivering of a healthy, full-term infant. Bright Start includes the oversight of the arrangement of home visits through our Nurse Partnership program, a free, voluntary program for first-time moms. When enrolled in the program, a specially trained nurse visits the member throughout her pregnancy and until her baby turns 2- years-old. During these visits, the nurse offers the knowledge and support members need to confidently create a better life for the baby and the mother. As part of the home nurse visit, the nurse reviews the EPSDT screening schedule and ensures that the infant is scheduled for the first visit.

Community Events to Promote Preventive Care

We will partner with various community organizations to participate in and sponsor events where we also provide EPSDT educational materials. We specifically target locations where there are low compliance rates. A few examples that targeted the well-child (3-years-old to 6-years-old) HEDIS measure include:

Back-to-School Events

AmeriHealth Caritas participates in a number of back-to-school events in partnership with legislators. AmeriHealth Caritas hands out educational materials, including EPSDT information, in addition to providing back-to-school supplies for children.

3.2.8 Behavioral Health Services

1. Describe your proposed approach for delivering behavioral health services, including the use of any subcontractors.

AmeriHealth Caritas does not use a subcontractor to deliver behavioral health services. AmeriHealth Caritas' Integrated Healthcare Management (IHM) model fully integrates all aspects of a member's health including physical health, behavioral health, medications and social services. This integrated model positions AmeriHealth Caritas Iowa to deliver improved health outcomes for members and financial performance for the state. Additional benefits of this model — involving a single point of contact across behavioral health, physical health and pharmacy domains, coupled with the person-centered approach — include increased member and provider satisfaction and greater member retention.

The IHM behavioral health model is built upon a consolidated approach to the collection, management, and dissemination of member care information to appropriate members of the care team — a coordinated approach that would be much more difficult if not impossible with a bi-furcated outsourcing of behavioral health services.

Our holistic model-of-care approach incorporates tested strategies of co-location and need-based resource allocation with additional strategies along the behavioral health-physical health integration continuum. These strategies strengthen existing and create new capabilities within the health care delivery system to deliver person-centered care that seamlessly addresses a member's behavioral, physical and pharmacologic needs. AmeriHealth Caritas Iowa's strategies are described in more detail in the sections below, but one particularly salient example is AmeriHealth Caritas' Transition Home program:

Example of AmeriHealth Caritas Iowa's integrated, holistic model of care

Lauren is a 14-year-old girl with a diagnosis of reactive airway disorder (RAD), triggered by viral infections and extreme activity. She was subsequently diagnosed with major depression after a reported sexual assault. Initially participating in outpatient therapy, Lauren stopped taking her medication and attempted suicide in January. She resumed outpatient therapy and restarted on medication. A few months later, she again attempted to end her life by taking a drug overdose.

All mental health inpatient admissions trigger a referral and assessment for case management. To assist Lauren and her mother to successfully transition home and connect with additional outpatient therapy, the AmeriHealth Caritas care manager arranged with the facility to meet with Lauren and her family before one of the scheduled family planning sessions. The care manager gathered assessment information, answered questions related to the authorization process and concerns the family had about costs associated with Lauren's care. The care manager explained the Transition Home process that was available for Lauren where a behavioral health clinician would visit Lauren and the family in their home within seven days of Lauren's discharge. Lauren's family was extremely grateful for the time that the care manager spent with them and pleased that the care manager would continue to be available to them, even after Lauren returned home.

Lauren was discharged and is receiving outpatient therapy. The AmeriHealth Caritas care manager is working with Lauren's mother to arrange an evaluation for an Individual Education Plan (IEP) with the school to address Lauren's poor grades and difficulty paying attention while doing school work.

Our AmeriHealth Caritas Iowa Medical Management team will be composed of medical directors (with both physical health and behavioral health specialty licensure), licensed nurses, licensed social workers and paraprofessionals. The team will collaborate with AmeriHealth Caritas Iowa network physicians, psychiatrists and psychologists, who will participate on the plan's quality committees. Our collaborative care approach allows for each clinician on the team to obtain support and advice from specialists in a variety of disciplines, such as child psychiatry, developmental disabilities, pediatricians, obstetricians, pharmacists and other board certified specialists.

Transition Home Visit Program

The Transition Home Visit Program was created to increase the HEDIS follow-up after psychiatric hospitalization (FUH) rate, decrease 30-day readmissions and resolve urgent needs upon discharge. This started as a pilot program with one outpatient provider completing home visits for one county in southern Indiana where there is limited access to outpatient mental health services. The program has evolved to three outpatient providers completing home visits for our members who live in 54 counties located in the southern, central and northern parts of the state. We are proposing a similar pilot approach, followed by expansion, as a value-added service for the Iowa population.

The process is a collaborative and starts when the member is admitted to the hospital. Upon admission, the utilization management staff notifies the Rapid Response Discharge team who then makes a home visit referral to the appropriate outpatient provider who serves the area where the member resides. The outpatient provider contacts the member/caregiver to explain the home visit program and schedules the first appointment within seven calendar days of discharge. All referrals are tracked on an appointment log in regard to member information and outcome of the home visits. Each week the outpatient providers update the appointment logs, and send them to the Care Management department who then enters the outcome of the appointment and any other pertinent information in the member's electronic medical record.

During the home visit, the licensed therapist provides the appropriate disease education, completes a brief needs assessment, reinforces the importance of attending outpatient services in the community, confirms phone numbers/address and resolves any urgent needs. The licensed therapist also reports any ongoing concerns back to the Care Management department where the care manager promptly follows up with the member/caregiver. The therapist will then schedule a follow up visit within 30 calendar days of discharge to ensure the member is connected to their outpatient community services.

If the home visit is completed within seven calendar days of discharge, the therapist will give the member/caregiver a \$15.00 gift card at the time of the visit. The incentive has been successful in encouraging the scheduling of the home visit within the appropriate timeframe. The outpatient providers are reimbursed at an enhanced rate to account for the travel time, and when members miss their appointments. Upon submitting the claim, the outpatient providers use specific modifiers with the CPT code to flag the system to reimburse the home visit at the enhanced rate. On a monthly basis, claims are verified for all completed home visits within seven days of discharge. If missing claims are noted, there is prompt follow up with the outpatient provider to submit the claim. We share the results of the percentage of completed home visits, and the reasons why some home visits were not completed, with each outpatient provider.

Within AmeriHealth Caritas Iowa affiliate plans, the hospitals were educated about this program by sending two state approved letters (provider/member) that explain the program. There has also been ongoing education via phone conferences and onsite visits.

2. Describe how your proposed approach will incorporate the values outlined in Section 3.2.8.1.

The values outlined in the statement of work reflect the values of AmeriHealth Caritas Iowa recovery model. The model emphasizes recovery principles, most notably focused on the installation of hope, member self-determination, empowering relationships, meaningful productive roles, and eliminating stigma and discrimination. The AmeriHealth Caritas Iowa recovery model is supported by the AmeriHealth IHM.

Our philosophy believes that people with serious mental illnesses do, in fact, recover. Some become fully symptom-free with time, while others live rich and fulfilling lives with some psychiatric problems. One of the basic premises of the recovery model is the role of a behavioral health service system is not to “do for” or to “do to”, but to “do with” — recognizing a fundamental shift in roles, power, and responsibility for providers and consumers alike. It is not about units of care, placement, or “functioning” or even a cure per se. It is about building real lives. It is both a goal or destination and a continual, very human process of growth, change and healing. Our behavioral health affiliate uses the Pennsylvania Office of Mental Health Substance Abuse Services (OMHSAS) definition of recovery:

Recovery is a self-determined and holistic journey that people undertake to heal and grow. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members.

Mental health recovery is a journey of healing and transformation for a person with a mental health disability to live a meaningful life in communities of his or her choice while striving to achieve full human potential or “personhood”.

Recovery is present when individuals live well and fully in the presence or absence of a psychiatric disorder. From a consumer perspective it embodies all that is necessary to manage and to overcome the psychological, physical, identity, economic and interpersonal consequences of having a mental illness. It is also the individual person’s responsibility to him/herself, family and others, to take on the responsibility of choosing, pursuing and sustaining personal recovery. This may include creating a personal crisis plan/advance directive for chosen agents or families to follow.

By all accounts, mental health recovery is a highly personal and individual process. It occurs over time, and is rarely straightforward — often characterized by steps forward and back. Recovery does not always mean that a person will live symptom free or regain all the losses incurred because of psychiatric problems. It does mean that people can and do live without feeling enveloped by mental health issues or that their potential or opportunity is curtailed because of them.

Our IHM model will provide quality services and supports that:

- Facilitate recovery for adults and resiliency for children.
- Are responsive to individuals’ unique strengths and needs throughout their lives.
- Focus on prevention and early intervention.
- Recognize, respect and accommodate differences as they relate to culture/ ethnicity/race, religion, gender identity and sexual orientation.
- Ensure individual human rights, and eliminate discrimination and stigma.
- Are provided in a comprehensive array by unifying programs and funding that build on natural and community supports unique to each individual and family.
- Are developed, monitored and evaluated in partnership with consumers, families and advocates.

- Represent collaboration with other agencies and service systems.

AmeriHealth Caritas Iowa is committed to adhering to the principles outline in the statement of work related to the delivery of behavioral health services.

“Allow each member to choose his or her behavioral health professional(s) to the fullest extent possible and appropriate.”

Freedom of choice of providers is a hallmark of all of our behavioral health programs. For example, here is an excerpt from the Member Handbook in our Pennsylvania affiliate’s behavioral health program that demonstrates our commitment to this principle.

“It is important that you know about the choices you have:

- *You can choose the provider that provides your services.*
- *For each level of care, there are providers available to choose from.*
- *Providers will also talk with you about choices you have.*
- *You can choose providers that are close to you. This might be important if you currently travel to a provider and you want someone who is closer.*
- *You can choose providers that offer the care you need. One provider might meet your needs better than another provider, so you can pick the provider that you like best.*
- *You can select providers who can relate to you and that you are comfortable talking to.*
- *You can select providers who speak your language or provide needed interpretation for you.*
- *It is important that you are comfortable with the provider who is helping you. If you are not happy with a provider, you can choose another provider. To do this, call us and we will talk to you about choices.”*

“Establish policies that support the involvement of the member, and those significant in the member’s life as appropriate, in decisions about services provided to meet the member’s behavioral health needs.”

AmeriHealth Caritas Iowa policies will fully support the involvement of members, family members and others identified by the member to be involved in treatment. This includes stressing this requirement at the provider level through our treatment record review process, service planning meetings, and all care management activities completed by AmeriHealth Caritas Iowa.

“Establish and promote strategies to engage members who may have histories of inconsistent involvement in treatment.”

AmeriHealth Caritas’ approach to integrated care begins with a systematic effort to identify and reach out to members and providers associated with inconsistent treatment patterns. AmeriHealth Caritas has invested in Facets a broad set of surveillance algorithms designed and updated regularly by our clinical team. This system is designed to identify gaps in care and alert care managers to opportunities for improved compliance and crisis management. Care managers rely both on this type of automated systematic surveillance as well as their own routine communication with providers and members to identify opportunities for targeted interventions. Improvements in member compliance and recovery are a shared responsibility among members, providers, care managers and family. Behavioral health homes, described in Section 3.2.9 below, value-based payment models (described in Sections 6 and 10), and member incentives are intended to establish accountability to the members’ compliance and recovery

from behavioral health conditions. In addition they help support and incent coordination among the full care team to ensure a successful recovery.

One of AmeriHealth Caritas Iowa's specific roles in the compliance and recover process is direct member engagement. AmeriHealth Caritas Iowa is devoted to help motivate and engage members in order to increase compliance with treatment and ultimately, outcomes. All of our care managers are trained in motivational interviewing. Motivational interviewing is a collaborative engagement method that addresses a member's motivation and commitment toward changing unhealthful behavior. It is done by identifying, examining, and addressing ambivalent feelings about that change. Motivational interviewing differs from more traditional engagement approaches because it is based on collaboration, not confrontation. It involves eliciting an individual's own thoughts rather than imposing the care manager's ideas. It recognizes that the power for change rests with the member rather than the care manager. Simply put, a person won't change his or her behavior until internally motivated to do so. Motivational interviewing techniques help a person become internally motivated using reflective listening and pointing out quality of life conflicts — for instance, complaining about shortness of breath while smoking two packs of cigarettes every day.

Motivational interviewing helps Jane

Earlier this year, Christopher Bryson, Select Health of South Carolina care manager, wanted to convince Jane, a member with poorly managed diabetes, to schedule behavioral health treatments. After completing motivational interviewing training, Christopher began using reflective listening and open-ended questions to further explore Jane's concerns with getting behavioral care. "Jane was using the word 'uncomfortable,'" Christopher said. "I used the stronger word 'afraid.' After a brief pause, Jane agreed she was fearful, but also concerned she was not seeing her doctor. She acknowledged her behavioral health problems were her biggest barrier to care." Christopher said he then was empathetic which, along with reflective listening and affirmation, strengthened Jane's trust in him. Rather than offer unsolicited advice, Christopher asked permission to offer advice and suggested Jane make counseling her top priority. Jane agreed. She asked her PCP for a referral and made an appointment to visit a professional counselor. Jane later asked Christopher, without any prompting, why she had protein in her urine and how she could better protect her kidneys. Christopher again asked permission to offer advice and helped her understand the consequences of uncontrolled diabetes, the qualities of medications that protect the kidney, and the importance of medication compliance. "I only used a few of the basic tenets of motivational interviewing and saw immediate results," said Christopher. "Our relationship improved. I continued exploring Jane's perceived barriers and advocated the benefits of change — change that can offer hope and energy for her future."

"Services for adult members who have a serious mental illness and members that are children with a severe emotional disturbance (SED) should focus on helping the member to maintain their home environment, education/employment and on promoting their recovery," and "Services for children are most appropriately directed toward helping a child and the child's family to develop and maintain a stable and safe family environment for the child."

The AmeriHealth Caritas Iowa approach will mirror our approach in other behavioral health programs such as those delivered and coordinated in Pennsylvania.

Services for Children with a SED are:

Child-centered: Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

Family-focused: The family is the primary support system for the child and it is important to help empower the family to advocate for themselves. The family participates as a full partner in all stages of the decision-making and treatment planning process including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents, other relatives and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.

Community-based: Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community.

Community resources include not only mental health professionals and provider agencies, but also social, religious, cultural organizations and other natural community support networks.

Multi-system: Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from these systems and the family collaborate to define the goals for the child, develop a service plan, and develop the necessary resources to implement the plan, provide appropriate support to the child and family and evaluate progress.

Culturally competent: Culture determines our worldview and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

Least restrictive/least intrusive: Services take place in settings that are the most appropriate and natural for the child and family, and are the least restrictive and intrusive available to meet the needs of the child and family.

“In the delivery of services and supports, the Contractor is encouraged to explore the use of technology (e.g., telehealth) as a way to expand access and extend reach of behavioral health providers.”

The AmeriHealth Caritas behavioral health network will be comprehensive to allow member choice in providers. As gaps are identified, creativity and collaboration with local leadership will be used to fill those gaps. One of the options is the use of telepsychiatry.

AmeriHealth Caritas has contracted with a telepsychiatry vendor to facilitate telepsychiatry services for our providers. This vendor has a secure platform that is used by both the psychiatrist and originating site to perform psychiatric services with a member through video technology. AmeriHealth Caritas will pay both the psychiatrist and the originating site for their services through claims as long as both sites are network providers. Our goal through this program is to allow the member to be seen by psychiatrists and other specialists in the setting the member chooses. If the member does not want to go to a community mental health center for psychiatric treatment, they can receive it in their PCP office or pediatrician's office through telepsychiatry.

We will use and build upon Iowa's telepsych infrastructure to roll out collaborative model of care with physical health providers. Network psychiatrists will be available to communicate with a physical health provider regarding the member a physical health provider is treating for low level behavioral health needs (i.e., pediatrician working with child who has Attention Deficit Hyperactivity Disorder (ADHD); obstetrician (OB) working with a pregnant woman who is depressed; PCP working with a member with anxiety, etc.).

AmeriHealth Caritas Iowa is interested in partnering with the state to explore some innovative approaches to the use of telepsychiatry including:

1. Providing telepsychiatry in schools for school nurses to use for psychiatric assessments with the goal of early identification of troubled youth that we can intervene with prior to involvement with child protective services or juvenile justice.
2. Providing telepsychiatry for emergency medical technicians (EMTs)/police who are in rural areas where there is no crisis center. Members in crisis end up in the ER or jail quite often and if we had telepsych/telemental services with a behavioral health clinician able to complete a psych assessment through video, the member may be able to be diverted from the ER/jail. The behavioral health clinician could also do some crisis intervention and counseling with the member.

“Work with all providers and other entities serving a member to coordinate services for the purpose of eliminating both gaps in service and duplication of services.”

This approach is the essence of our integrated care management approach, which focused on filling care gaps quickly and effectively, and provides the right service at the right time in the least restrictive setting. Our teams are able to identify gaps and duplications in our integrated medical record. Our Jiva population health management system is used to document all activity from the Care Management team, the Utilization Management team (both physical health and behavioral health) as well as pharmacy, physical health and behavioral health data. Any associate involved in the member's care has access to all of this information and can use it to identify all providers working with a member to engage them in service coordination and keep their medical record updated. Gaps in care are identified for PCPs as well and can be accessed through our portal and member clinical summary. Our Rapid Response team is available to assist the provider and the member in filling these gaps in a timely manner. Through prior authorization requirements and review of claims data, duplications in services are identified. Based on the nature of the duplicate service, contact may be made with the member, the provider or both to ascertain the medical necessity of the services.

3. Describe how your proposed approach will engage families, natural supports, advocacy organizations and network providers in the behavioral health care planning and care delivery process.

AmeriHealth Caritas Iowa's model engages with families, natural supports, advocacy organizations and network providers in the behavioral health care planning and care delivery process. Through person-centered planning and treatment, members take charge of their treatment, choose who is on the treatment team, and establish and prioritize goals on the individualized plan of care. We also believe it is important to work with members to establish a natural / informal support system in their lives. This is a system of individuals who support them but are not paid (i.e., a neighbor or church as opposed to a provider or drop in center).

Member Centered Self-Management Care Plan			
Problems	Category	Goals	Activities
(1) Achieve optimum self-management (member's self-management plan)	Complex Medicaid	<ul style="list-style-type: none"> • Create a Safety Plan-High Priority Goal • Learn about condition • Improve activities of daily living (ADLs)/Functionality. 	<ol style="list-style-type: none"> a. Discuss back up caregivers and family support plan. b. Attend support groups. c. Ask questions as needed to understand treatment plan. d. Identify available support system/caregivers.
(2) Ability to develop and maintain self-management (care manager's plan of care)	Complex Medicaid	<ul style="list-style-type: none"> • Member/caregiver will obtain optimum level of health by participating in self-management of condition(s)-High Priority Goal 	<ol style="list-style-type: none"> a. Self-management plan developed and communicated with member/caregiver by phone. b. Assess and evaluate caregiver's resources and level of involvement. c. Assess for medication adherence, including understanding of medications and frequency. d. Develop a member/caregiver self-management plan with member/caregiver involvement and assess progress towards goals. e. Educate on signs and symptoms of condition to report to provider. f. Contact member/caregiver to review treatment plan. g. Utilize Motivational interviewing techniques.

Exhibit 3.2.8-A: Member Centered Self-Management Care Plan

In our response to 3.2.8.11 below related to the 1915(i) Habilitation Waiver for Chronically Mentally Ill Adults and the 1915(c) Waiver for Children's Mental Health, a strong requirement of both waiver services is for an individualized and person-centered service plan. This is entirely consistent with our integrated care management approach. The overall process will be that AmeriHealth Caritas Iowa will assign a specific care manager to members engaged in care management services. The members are stratified based on their risk for behavioral health and physical health conditions, and matched with the clinician best suited to meet the members' highest risk conditions. Once the member is engaged in care management, assessments are completed to identify all relevant conditions, treatments, providers, natural supports and psychosocial stressors. AmeriHealth Caritas Iowa will incorporate the state's initial assessment and/or initial care plan, where applicable. From this information, an individualized care plan is developed with the member identifying and prioritizing the issues to be addressed. The member also identifies who participates in the treatment team. The team will be person-centered and fully inclusive of the member and any additional family or other member's representatives that he/she would like to participate. If needed, the individualized plan of care will include a crisis plan developed by the member. The service planning team can include professionals and non-professionals, and may include the member, family, other member representatives, the AmeriHealth Caritas care manager, and behavioral health and physical health service providers (including input from the member's PCP).

Network providers are engaged in all aspects of care plan development and the overall care management process. AmeriHealth Caritas Iowa makes strong efforts to keep all involved parties updated on the care plan through dissemination of the Member Clinical Summary to all providers active with the member including the PCP.

Advocacy organizations are generally not engaged in individual service planning or care plans for members, but it is welcomed if the members identify representatives to include in the care planning and care delivery process. However, AmeriHealth Caritas Iowa makes a strong effort to include advocacy organizations in process and policy discussions through invitations to relevant committees or work groups. AmeriHealth Caritas Iowa will identify primary points of contact within the plan for advocacy organizations, and makes every effort to attend and actively participate in advocacy organization initiatives related to behavioral health.

The system of care model is an organizational philosophy and framework that involves collaboration across agencies, members, and caregivers. The goal of this model is to improve services and access as well as expand the array of coordinated community-based, culturally and linguistically competent services and supports for members (and their families) with a serious emotional disturbance. The system of care philosophy is built upon these core values and guiding principles:

1. Member/caregiver-driven, with their strengths and needs determining the types and mix of services and supports provided.
2. Community-based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.

Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

4. Describe your proposed peer support/counseling program.

AmeriHealth Caritas has extensive experience in the management and development of peer support services for persons with serious mental illness. Our Pennsylvania affiliate behavioral health programs have included certified peer support as a required Medicaid covered benefit since 2007.

Based upon the fundamental principles of recovery, peer support services (PSS) are specialized therapeutic interactions conducted by self-identified current or former consumers of behavioral health services who are trained and certified as peer specialists to offer support and assistance in helping others in their recovery and community-integration process. Peer support is intended to inspire hope in individuals that recovery is not only possible, but probable. The service is designed to promote empowerment, self-determination, understanding, coping skills and resiliency through mentoring and service coordination supports. This allows individuals with severe and persistent mental illness and co-occurring disorders to achieve personal wellness in addition to coping with the stressors and barriers encountered during their recovery time.

Peer support is designed on the principles of consumer choice and the active involvement of persons in their own recovery process. Peer support practice is guided by the belief that people with disabilities need opportunities to identify and choose for themselves their desired roles with regard to living, learning, working and social interaction in the community. For this reason, the agreement of the individual to receive services is critical.

On an ongoing basis, individuals receiving the service are given the opportunity to participate in, and make decisions about, the activities conducted. Services are self-directed and person centered with a recovery

focus. PSS facilitate the development of recovery skills. Services are multi-faceted and include, but are not limited to, individual advocacy, education, development of natural supports, support of work or other meaningful activity of the individual's choosing, crisis management support, skills training, effective utilization of the service delivery system as well as coordination of, and linkage to, other service providers.

The purposes of PSS include:

1. Providing opportunities for individuals receiving services to direct their own recovery and advocacy processes.
2. Teaching and supporting acquisition and utilization of the skills needed to facilitate an individual's recovery.
3. Promoting the knowledge of available service options and choices.
4. Promoting the utilization of natural resources within the community.
5. Facilitating the development of a sense of wellness and self-worth.

Specific service goals are based on individual needs and personal aspirations, which may be in the areas of wellness and recovery, education and employment, crisis support, housing, social networking, self-determination and individual advocacy. Goals pertaining to system advocacy will be limited to the coordination with, or linkage to, community resources. The relationship between the peer specialist and the individual served is intended to facilitate accomplishment of the goals specified in the recovery-focused Individual Service Plan (ISP) which is also referred to as an Individual Recovery Plan. Face-to-face contact is critical to develop the relationship effectively, but there may be times when a telephone contact with the individual served may be appropriate.

To promote face-to-face interactions, the AmeriHealth Caritas PSS programs typically will limit telephone contacts to 25 percent or less of the total units delivered each calendar or contract year. The Iowa PSS program also includes transportation to and from behavioral health services and placements. In our existing PSS programs, costs related to travel were included in developing the current rate for PSS and are therefore not billable. However, this is an easy revision that will be made for the Iowa programs.

Typically for initial services, the following registration protocols are followed, but processes and guidelines will be revised based upon Iowa Provider requirements. Providers submit a request for PSS using the *Peer Support Authorization Request* form Attachment 3.2.8-A: Peer Support Registration Form at the end of this section) which includes Admission Guidelines as:

- Recommended by a Licensed Practitioner of the Healing Arts (LPHA), which includes Physician, Psychologist, certified registered nurse practitioner, and Physician's Assistant, acting within the scope of practice. This recommendation is valid for 60 days.
- Member is 18 years of age or older and has a serious mental illness and has a moderate to severe functional impairment that interferes with or limits performance.

In addition, the AmeriHealth Caritas PSS program includes an annual Treatment Record Review process to assure provider adherence to the model. A sample Treatment Record Review Tool for PSS is included as Attachment 3.2.8.4 PSS Treatment Record Review Form.)

After the first year of operation, AmeriHealth Caritas Iowa will set a threshold score for provider Treatment Record Reviews. While it can depend upon the year one base year scoring, it is common that a 70 percent threshold score would be set and then subsequently raised as provider compliance improves. A collaborative continuous quality improvement approach is used including training, ongoing feedback and support to providers who do not attain the threshold scoring levels that are set. Written quality

improvement plans may be requested from PSS providers and other providers to improve documentation and service delivery.

5. Describe your services for prevention and early intervention.

AmeriHealth Caritas believes that early detection of conditions is key to early intervention.

As such, we work with our providers to screen for common behavioral health conditions in the primary care/pediatrician/obstetrician offices. AmeriHealth Caritas has hired clinical trainers who specialize in behavioral health topics to provide a robust education and support program for physical health providers. These trainers develop condition specific tool kits which include guidance on assessing, diagnosing, managing and referring for specific conditions. The tool kits are then personalized for each market to include plan specific resources, such as the disease management programs offered as well as community resources and referral pathways. Account executives in each market are also trained to support their providers in behavioral health issues. The depression/PHQ-9 tool-kit has been developed and is being used currently to train PCPs and pediatricians. There are plans to develop anxiety and substance use disorders tool kits in 2015.

The following prevention and screening programs are in place in various AmeriHealth Caritas integrated and behavioral health programs. We will evaluate the relevancy of each program to the Iowa Medicaid population through our quality management processes. We will initiate those prevention and screening programs best fit to the population and program and consistent with the existing programs that may already be in place in Iowa (e.g., Screening, Brief Intervention, and Referral to Treatment [SBIRT] Iowa).

Depression screening

AmeriHealth Caritas Iowa recognizes that depression is a common co-morbidity of many chronic medical conditions. AmeriHealth Caritas care managers screen each adolescent and adult member engaged in IHM services for depression using the PHQ-9. If depression is suspected, the AmeriHealth Caritas care manager will address this condition with the member, ensure it is part of the individualized plan of care and follow-up to ensure a comprehensive psychiatric assessment is completed and medically necessary treatment provided as prescribed.

Substance Abuse screening

Within our Medicaid data, we have determined that people with co-occurring substance use disorders (SUD) are at increased risk for behavioral health inpatient readmissions. Upon each prior authorization telephone contact requesting a mental health inpatient admission, we ask if they have completed an SUD assessment. If they have not, we ask them to do so. If there are identified SUD issues, we try to get the member to a behavioral health inpatient unit that also addresses SUD (dual diagnosis unit) or when more appropriate referral to a SUD inpatient or residential bed rather than a psychiatric inpatient bed. Additionally, we ensure that the SUD is addressed in aftercare planning.

Our IHM team also screens for SUDs during the initial assessment. If an SUD is suspected, a more comprehensive assessment is completed using one of the below tools.

Screening Tools for Substance Use Disorders

Our Integrated Healthcare Management team uses the Alcohol Use Disorders Inventory Test (AUDIT) and Drug Abuse Screening Test (DAST) for adult members and the CRAFFT for adolescents (see Exhibit 3.2.8-B). The AUDIT was developed and evaluated over a period of two decades by the World Health Organization,

and has been found to provide an accurate measure of risk across gender, age and cultures. The AUDIT is easily administered and carries no licensing costs. It consists of 10 questions about recent alcohol use, alcohol dependence symptoms and alcohol-related problems. As the first screening test designed specifically for use in primary care settings, it is also readily and easily used in emergency room and primary care settings. Similarly, the DAST-10 screening instrument is also used in conjunction with the AUDIT. The Drug Abuse Screening Test (DAST) was designed to be used in a variety of settings to provide a quick index of drug-related problems. The DAST yields a quantitative index of the degree of consequences related to drug abuse. This instrument takes approximately five minutes to administer and may be given in questionnaire, interview or computerized formats to both adults and adolescents. The DAST provides a brief, self-report instrument for population screening, identifying drug problems in clinical settings and treatment evaluation.

The CRAFFT is a behavioral health screening tool for use with children under the age of 21 and is recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents. It consists of a series of six questions developed to screen adolescents for high risk alcohol and other drug use disorders simultaneously. It is a short, effective screening tool meant to assess whether a longer conversation about the context of use, frequency in addition to other risks and consequences of alcohol and other drug use is warranted. The CRAFFT test is a valid means of screening adolescents for substance-related problems and disorders. CRAFFT is a mnemonic acronym of first letters of key words in the six screening questions. The questions should be asked exactly as written.

C	Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
R	Do you ever use alcohol or drugs to RELAX , feel better about yourself, or fit in?
A	Do you ever use alcohol/drugs while you are by yourself, ALONE ?
F	Do you ever FORGET things you did while using alcohol or drugs?
F	Does your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
T	Have you gotten into TROUBLE while you were using alcohol or drugs?

Exhibit 3.2.8-B: CRAFFT Screening Tool

AmeriHealth Caritas found that in our Pennsylvania behavioral health program affiliates, substance abuse providers were screening for mental health issues and history consistently, but mental health providers were not consistently screening for substance abuse disorders. We engaged in a multi-year education campaign. Adoption of substance use screening is now required of all submitted psychiatric evaluations and initiation of mental health therapy. We will provide this same education in Iowa.

AmeriHealth Caritas Iowa will hire clinical trainers to provide trainings for PCPs to learn about behavioral health conditions, how to screen for them, how to provide brief treatment and referral pathways to specialized behavioral health providers. This education includes a module on substance use disorders. PCPs will be encouraged to screen their members for SUDs using one of the above tools or another valid tool of their choosing. They will be given information on what to do if the patient screens positive, including supports provided by the AmeriHealth Caritas Rapid Response and Integrated Healthcare Management teams.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

AmeriHealth Caritas has participated in the Screening, Brief Intervention, and Referral to Treatment (SBIRT) program in our South Carolina Medicaid affiliate targeting OBs and pregnant women. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

This program can be implemented with additional physical health providers and can be tweaked to address mental health conditions. AmeriHealth Caritas Iowa will initially focus on obstetricians and then expand to other specialties based on the specific needs in the state.

SBIRT Iowa is sponsored by the Iowa Department of Public Health, Division of Behavioral Health and funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. The project makes it possible for Iowans to receive pre-screenings, screenings, brief interventions, brief treatments and referrals to treatment. AmeriHealth Caritas would look to coordinate with the existing SBIRT Iowa program to determine if needed expansion could be achieved to similar high risk populations of Iowa Medicaid recipients.

The tentative conclusion that SBIRT services may be associated with a reduction in substance use is supported by a number of randomized controlled trials (e.g. Bernstein et al., 2005; Fleming et al., 1997, 2002; Gentilello et al., 1999, 2005; Soderstrom et al., 2007; WHO, 2008). Based on published reports, reductions in substance abuse can be attributable to the screening procedure alone or combined with the intervention or to other factors. The general consistency of the data across the majority of the sites and of most measures for these outcomes adds strength to the conclusions. As the majority of persons intended to receive an intervention received one, we are confident that the intervention was delivered adequately. Accordingly, the results demonstrate a promising strategy for addressing this public health burden. Overall, the SBIRT program demonstrated that a rapid and simple set of procedures has potential for impacting the public health burden of substance abuse.

SBIRT provides an opportunistic teaching moment for primary care or emergency service providers to take proactive measures for their patients who may be engaged in risky use of substances, but are not currently seeking assistance and are not in need of specialty treatment. The documented cost-savings of approximately \$4 for each \$1 expended for alcohol screening and brief intervention (SBI) (Gentilello et al.,

2005; Fleming et al., 2002) is another potential benefit for these procedures, but requires corresponding cost-savings analysis for illicit drug SBI, particularly for unrecoverable hospital costs (Swanson et al., 2007). For both alcohol and illicit drugs, the SBIRT program in Washington State (S. Estee, personal communication) was calculated to save Medicaid approximately \$2,000,000 for each 1000 Medicaid patients administered these services, with a significant portion attributable to reductions in re-hospitalizations.

Early Identification of Substance Abuse in Members with Bipolar Disorder

AmeriHealth Caritas also believes in educating and outreaching to our members directly for early detection of common behavioral health conditions. Our Pennsylvania behavioral health program affiliates distribute preventive behavioral health information related to early identification of substance abuse in members with bipolar disorder in the target population of ages 18 to 24. After reviewing current scientific literature and Best Practice Guidelines for the treatment of patients with bipolar disorder, AmeriHealth Caritas determined a significant need for distribution of preventive screening material concerning the co-occurring disorder of substance abuse. In developing this Preventive Screening Health Program, AmeriHealth Caritas considered factors such as age, sex, socioeconomic status, ethnic and cultural background as well as the clinical needs and risk characteristics to determine the applicability of the program to the Medicaid population. AmeriHealth Caritas reviewed a sample of claims and demographics. AmeriHealth Caritas committee's determined young adults 18 to 24-years-old, in the transitional age group, are at higher risk due to peer pressure, mood liability, untreated illness and a general lack of education on comorbidity.

Recent findings indicate between 40 percent and 70 percent of individuals with bipolar disorder have a history of a substance use disorder. Notably, a current or past comorbid substance use disorder may lead to worse outcomes for individuals with bipolar disorders, including more symptoms, more suicide attempts, longer episodes and lower quality of life. Some individuals with co-occurring disorders experience trouble keeping a job or doing well in school. Co-occurring disorders can also lead to legal issues, possible incarceration, homelessness, and isolation or social withdrawal.

The American Psychiatric Association Guidelines for the Treatment of Patients with Bipolar Disorder indicates substance abuse issues may obscure or exacerbate mood swings that have no apparent external cause, precipitate mood episodes and/or be used by patients to self-treat in an attempt to improve the symptoms or episodes. Psychiatric symptoms may be masked by the alcohol or drug use and can also interfere with the medication effectiveness. The combination of a mood stabilizer and alcohol or drugs may lead to serious or dangerous side effects or even death.

Clearly, the symptoms of bipolar disorder can exacerbate substance use, and severe addiction can aggravate the bipolar symptoms. Therefore, assessing use and possible dependency is essential to ensure risk is lowered and treatment needs are met. The CAGE-AID screening tool was adapted to include both drug and alcohol questions and has the potential advantage of screening quickly with 4 simple questions. One positive response to the screener would indicate a possible problem and two or more would be clinically significant. What addiction looks like is reviewed on the CAGE-AID screener and a copy of the pamphlet *Comorbidity: Addiction and other Mental Health Illness* is also provided. The pamphlet is written at the 8th grade reading level according to the Flesch-Kincaid Grade Level readability test. The pamphlet reviews the term comorbidity, why comorbidity occurs and treatment options. A cover letter and a postcard survey asking the member for feedback about the program is also included in the mailing. This mailing is sent out to members between the ages of 18 to 24 annually.

In summary, this program was developed in an effort to promote recognition, provide a screening tool and offer treatment options for possible substance abuse issues for individuals in the transitional age group of

18-24. These members have already been identified as having an existing bipolar disorder through claims history but no know substance abuse diagnosis. Educating the member on the symptoms of abuse and the risk factors that may contribute to the development of a substance abuse illness; encouraging self-reporting by screening; and offering treatment for the substance abuse are the key components of the program. The program could significantly impact the member's life by improving his/her quality of life and providing treatment for both disorders. Through treatment the member could potentially lower their risk for physical and behavioral complications, as well as legal and financial implications.

Goals include the following:

- Educate the members with bipolar disorder of the increased risk of comorbidity.
- Increase awareness of the signs/symptoms of abuse.
- Improve the rate of early detection of substance abuse in members with bipolar disorder.
- Increase the rate of members seeking a professional evaluation for substance abuse.

ADHD Screening and Prevention Program

AmeriHealth Caritas also believes in educating and outreaching to our members directly for early detection of common behavioral health conditions. Our Pennsylvania behavioral health programs distribute preventive behavioral health information about ADHD to the parents of children in the target population, which is defined as children turning six years of age during the identified three-month period. ADHD is the most frequently occurring neurobehavioral disorder in childhood and represents the primary reason children are referred to a mental health provider. Providing primary caretakers with the signs and symptoms of the disorder, as well as risk factors that may contribute to their development can help parents identify if their child could benefit from a professional evaluation. In developing this prevention program, AmeriHealth Caritas considered factors such as age, sex, socioeconomic status, ethnic and cultural background, and clinical needs and risk characteristics to determine the applicability of the program to the Medicaid population. Claims data was evaluated to determine the relevant age groups and diagnoses. Along with disruptive behavior disorders, ADHD is among the top diagnoses in children whose behavioral health benefits are managed by AmeriHealth Caritas. The Preventive Health Program was developed in an effort to promote early recognition, diagnosis and treatment of this disorder.

According to the American Academy of Pediatrics (AAP), ADHD affects between four percent and 12 percent of school age children, or as many as 3.8 million children in the United States. The reported prevalence may vary depending on the nature of the population sampled and the method of ascertainment. Recorded rates have also varied substantially as a function of changing diagnostic criteria over time. In addition, prevalence rates differ depending on whether they are based on school samples (6.9 percent) or on community samples (10.3. percent). Boys are more frequently diagnosed with ADHD than girls. Reported ratios vary between 2:1 and 9:1, depending on the subtype and setting. In general, it is believed that girls comprise from 10 percent to 25 percent of children with ADHD. However, this may be an underestimate of actual prevalence resulting from diagnostic expectations because most ADHD research has been conducted on boys. Although early research suggested that ADHD had different gender-related risk factors and characteristics, recent studies have found few differences based on gender. However, in contrast to the clinical presentation of boys, girls with ADHD show less impulsivity and conduct disorder but tend to show more fear, depression, mood swings, and cognitive and language problems. The AAP suggests that only one out of three children with ADHD receive treatment for it. However, it is recognized that early identification and appropriate treatment can improve functioning and minimize morbidity for children with the disorder.

The ADHD Early Identification Program consists of a four-page educational module in newsletter format, entitled Understanding Your Child's Behavior. The contents of the module are designed to assist parents in identifying age-appropriate behaviors and to raise awareness about the signs and symptoms of ADHD. It is written at the 7th grade reading level (7.4) according to the Flesch-Kincaid Grade Level readability test, with a 64.3 percent reading ease. The module also includes an easy-to-score one-page screening tool based on the diagnostic criteria for ADHD contained in the DSM-V. The tool is designed to help parents identify if their child could benefit from a professional evaluation for ADHD. A postcard survey asking parents for feedback about the Program is also included.

The goals of the Program are:

- Educating parents about age-appropriate skills and behaviors.
- Increasing awareness of parents about behaviors that could be indicative of ADHD.
- Improving the rate of early detection of ADHD.
- Helping children identified as a risk for ADHD receive a professional evaluation.

6. Describe how you will ensure providers conduct outreach activities for IDPH participants who are IV drug users.

AmeriHealth Caritas will ensure that providers providing services to Iowa Department of Public Health (IDPH) participants who are intravenous (IV) drug users will perform outreach activities in accordance with the RFP statement of work and applicable state regulations. Providers are required to select, train and supervise outreach workers. The purpose of the outreach is to encourage individuals needing treatment for IV drug use to undergo such treatment consistently. The outreach provides awareness of related communicable diseases, such as HIV, hepatitis C, and tuberculosis. Providers have leeway to use outreach models that are reflective of their local communities and to choose approaches with proven efficacy and/or can be reasonably expected to be effective.

The outreach activities will be one of the initiatives overseen by the Behavioral Health Manager. As one of the key personnel, the Behavioral Health Manager is responsible for oversight of all of the AmeriHealth Caritas behavioral health operations, including coordination with overall quality management initiatives.

Prior authorization cannot be required at any level of service for the IDPH population. For utilization management activities of IDPH services, retrospective utilization monitoring shall be performed to ensure appropriate application of clinical criteria. Similarly, retrospective monitoring of claims and clinical data will be used to identify individuals in diagnostic groups that have a higher likelihood of IV drug use (e.g., opioid-related disorders). A treatment record review process, using a valid random sample, will be completed on an annual basis and the presence and efficacy of outreach activities will be evaluated as part of that process.

More importantly, a prospective process will occur as part of the initial and three-year credentialing cycle. IDPH providers will be required to submit their applicable policies, staffing, and other existing documentation, including outcome and process data related to IV drug use outreach, to AmeriHealth Caritas Iowa for review.

7. Describe how you will support IDPH-funded Women and Children services.

Women who are pregnant and have a substance use disorder will be a priority population, and when identified will be placed within the care management program at AmeriHealth Caritas Iowa. The assigned AmeriHealth Caritas Iowa care manager will closely coordinate with the IDPH-funded Women and Children

Services by establishing close contact with the member and the member's point of contact at the local maternal health center. The centers increase the number of women receiving prenatal care and promote early entry into care. A wide range of health education and support services are available to low-income pregnant women through the IDPH-funded grant program.

The IDPH manages 21 community-based maternal health agencies covering all of Iowa's 99 counties and provides the following services:

- Improves birth outcomes and maternal and infant health, with a particular focus on reducing health disparities and ensuring racial equity.
- Helps pregnant women establish medical and dental homes for their pregnancy.
- Improves health care by linking women to community-based, culturally appropriate services as well as supporting their ability to get the services they need.
- Recognizes the values of psychosocial support in promoting healthy pregnancy.

Close connection of AmeriHealth Caritas Iowa to the community-based maternal health agencies is vitally important, and we are aligned with the role of the maternal health agencies that was outlined in the recent Iowa's Maternal Health, Child Health, and Family Planning Business Plan.

What We Do...



Exhibit 3.2.8-C: AmeriHealth Caritas Care Coordination Overview

Rapid access to the appropriate level of substance use treatment during and after the pregnancy are vital for the health of mother and child especially in the case of high-risk pregnancies that occur in women with substance use disorders. Similarly, as the maternal health agencies screen for behavioral health and related issues such as depression and domestic violence, they will likely also be reaching out to AmeriHealth Caritas Iowa for notification and treatment referrals.

In addition, AmeriHealth Caritas Iowa will bring several existing plan perinatal care programs to Iowa Medicaid recipients.

The IDPH also contracts with 22 agencies covering all 99 counties for preventive health care services for children. The goals of these services include:

- Foster age-appropriate growth and development by promoting early identification of children’s health concerns and referral for diagnosis and treatment.
- Assist families to establish medical and dental homes for their children.

- Target low income families – children on Medicaid and those who are uninsured and underinsured.
- Strive to meet family needs and remove barriers to accessing health care by linking families to community-based, culturally appropriate services.

8. Describe your screening and treatment protocol for children with serious behavioral health conditions. Provide a sample crisis plan and describe how you will work in collaboration with local school systems.

AmeriHealth Caritas’ “No Wrong Door” Approach

For behavioral health services, AmeriHealth Caritas provides a barrier-free single point of contact system to rapidly connect members for referral and crisis services within service access standards, including but not limited to, face-to-face treatment intervention within one hour for emergencies. Our Call Center of Excellence (CCOE) is operational 24 hours a day, seven days a week, 365 days a year. It is available for screening, assessment, and triage referral for emergent/urgent and routine services requests, care determination, and prior authorization for emergent/urgent and routine behavioral health care services. The CCOE response time and abandonment rates exceed NCQA standards; this is measured at least quarterly for all programs.

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

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

On each contact, the MSR will take the opportunity to review the member’s contact information to ensure its accuracy. If updated information is not available, the MSR will obtain the following information from the member: member’s name and basic demographic information, insurance information (including Medicaid eligibility), current services received, including provider name and type of service, and emergency contact information. The MSR will then obtain further information about the member’s needs, and attempt to resolve the member’s issue within that first call. The MSR will conduct a brief crisis assessment with the caller to determine if there is an urgent or emergent issue requiring an immediate referral for crisis services or a warm-transfer to a care manager.

All MSRs and care managers are trained to conduct crisis assessments or appropriately refer calls requiring a community crisis assessment for intake to gather response and disposition information. Should it be required, crisis intervention teams in the community are mobilized to intervene, in a timely way, that promotes improved behavioral health, reduces the likelihood of danger to self and others, and may often divert the need for intrusive, costly psychiatric hospitalizations.

All subsequent level of care decisions are made by licensed care managers, and any decision not to authorize a specific level of care, is reviewed and confirmed or reversed by the medical director or other qualified physician or psychologist reviewer. Care managers are available 24 hours a day, seven days a week and are responsible for responding to emergent and urgent behavioral health care requests, making referrals and authorization determinations, and assuring service access standards are being met.

In emergent and urgent situations, the MSR “warm transfers” (i.e., live transfers) the individual to an appropriate care manager for assessment of the presenting clinical condition or situation. These members include those in crisis situations and those with special mental health care or substance abuse conditions. A care manager will be assigned to become the permanent point of contact for the member, coordinating all service needs between the member, providers and community agencies. The member is informed that they can call the toll-free phone number at any time to reach the assigned care manager. Should there be an occasion when a member calls and the assigned care manager is not available, the member is given the opportunity to speak with an available MSR or care manager supervisor, who will document the call and follow up directly with the assigned point of contact.

If a member requests clinical information but does not present with a crisis or urgent and complex need, a routine referral to a provider will be made. If the member has previously been in or is currently in treatment, the MSR will access data about his treatment services through the shared electronic medical record and will review with the member existing demographic information in the system to ensure its accuracy. In addition, the MSR will obtain additional information about the member’s support system, any treatment challenges, cultural and religious preferences, and other issues that should be considered. The next step for the MSR is to determine if the caller is currently involved in care management services. If the caller is active in care management, they will be warm-transferred to his assigned care manager. If the member is not receiving care management services, the MSR will complete the assessment and initiate appropriate provider referral. Unless otherwise determined by the care manager, the MSR will remain the single point of contact for the individual and will be responsible for following up with the member and the care manager to ensure the member’s needs were met.

Complex Care Management

For those children with serious behavioral health conditions requiring complex care management, a more intensive screening and treatment protocol is used. Upon receipt of the referral, the care manager conducts a health risk assessment to determine clinical status and needs. Based on the assessment results, the care manager will make a level of care determination, document the exchange, refer the member for additional needed evaluation services, and/or provide the member with a choice of culturally competent providers. The care manager will inform the Member about the assessment results and resulting recommendations, keeping the MSR or original point of contact apprised of this through electronic documents and verbal reports. The care manager will spend as much time as needed to ensure the member clearly understands that treatment is focused on him/her and his/her voice must be heard throughout the treatment process before appropriately handing the case back to the point of contact for follow up. If the care manager determines through the assessment process that the member is at risk for advancing to a higher level of care, the care manager will replace the MSR as the point of contact.

Use of the Pediatric Symptom Checklist

For children and youth with serious behavioral health conditions who are referred for AmeriHealth Caritas care management services, we use the Pediatric Symptom Checklist as the primary screening tool to conduct a telephonic assessment to determine the level of case management assignment and to inform the care plan.

There are also several disease specific assessments embedded in our information system that may be conducted to inform the care plan for children and youth with serious behavioral health conditions. This may include:

- GAD-7 Anxiety (ages 14 and older).

- ADHD Vanderbilt (ages 4 to 17).
- M-CHAT-Autism (ages 16 to 30 months).
- Autism Spectrum Disorder (ages 3 and older).
- PHQ-9A- Depression (ages 12 to 17).
- Pediatric Symptom Checklist-Parent Version (ages 4 to 11) for general behavioral health conditions.
- Pediatric Symptom Checklist-Youth Report (ages 12 to 17) for general behavioral health conditions.
- INH-Children with Special Health Care Needs-developmental delays.

Collaboration with Schools

Our work with schools and school districts is a two-pronged approach. We develop and collaborate on processes and services for members with behavioral health needs in the schools and provide education or training to enhance the school's ability to address member needs. Our focus is on educating and increasing the school system's understanding of the needs of children with severe emotional disturbance and defining working relationships that place the child/adolescent at the center of the treatment process. Where available, we work closely with the Student Assistance Program (SAP) Team at each school. These teams are often the first to identify the need for behavioral health services in children/adolescents.

As we have successfully demonstrated in our affiliate health plans, we are available to participate and present at school in-service days, guidance staff meetings, administrative meetings, parent meetings and school sponsored after-hours support groups. Our goal is to educate, inform, and find new opportunities to collaborate to better serve students, families and staff.

One specific area of training that we plan to provide is Mental Health First Aid. Mental Health First Aid is a public education program that introduces participants to risk factors and warning signs of mental illnesses, builds understanding of their impact and provides an overview of common supports. This eight-hour course uses role-playing and simulations to demonstrate how to offer initial help in a mental health crisis and connect members to the appropriate professional, peer, social and self-help care. The program also teaches the common risk factors and warning signs of specific types of illnesses like anxiety, depression, substance use, bipolar disorder, eating disorders and schizophrenia.

Like cardiopulmonary resuscitation (CPR), Mental Health First Aid prepares participants to interact with a person in crisis and to connect the person with help. First Aiders do not take on the role of professionals — they do not diagnose or provide any counseling or therapy. Instead, the program offers concrete tools and answers key questions, like “what do I do?” and “where can someone find help?” Certified Mental Health First Aid instructors provide a list of community healthcare providers, national resources, support groups, and online tools for mental health and addictions treatment and support. All participants receive a program manual to complement the course material.

Mental Health First Aid has two platforms, one for youth and one for adults. The one for youth focuses on the unique risk factors and warning signs of mental health problems in adolescents, builds understanding of the importance of early intervention, and teaches individuals how to help an adolescent in crisis or experiencing a mental health challenge. The course is designed for adults who regularly interact with adolescents, such as school staff, coaches, youth group leaders and parents.

Care managers reach out and work with school staff to address the needs of specific members. This includes providing information on the member's diagnosis and how it impacts his/her ability to participate in school activities and learning skills. It also includes incorporating academic goals into the member's treatment plan, as appropriate, and promoting the inclusion of treatment goals in the academic setting.

We ensure that the member's teacher or other school staff is included on the treatment team. Our care managers will:

- Outreach to the school system to identify available and needed supports.
- Modify the care plan to include services relevant to the school system.
- Coordinate services with the child/adolescent member's Individualized Education Plan (IEP).
- Conduct prospective and concurrent reviews to ensure that services are delivered in accordance with the IEP.
- Participate, as appropriate and needed, in IEP plan review/revision meetings.
- Coordinate with other treatment/service team members including community programs and local and state agencies to support the school system.

For members in need of more intensive levels of care outside the home, we coordinate closely with the home school district so it is able to provide input to the team delivering care in out-of-home placements.

Care managers work with schools to ensure that information about behavioral health issues and intervention options are available. We are available to conduct in-service training on specific behavioral health issues and how to address the needs of members with specific behavioral health problems. We also gather information about the agencies responsible for the implementation of SAP and establish lines of communication.

The second approach is the development of Medicaid-eligible services directly in the school setting. We have had many successful collaborations with providers to offer numerous school-based behavioral health programs to address Member needs and support provider efforts to establish school-based satellite outpatient offices. Successful school-based programs by AmeriHealth Caritas in other states have included the following Medicaid reimbursable services delivered in the school setting:

- Mental health and substance abuse outpatient clinic satellites.
- Outpatient therapeutic classroom.
- Intensive day treatment.
- Mobile therapy and therapeutic staff support services in the classroom.
- Applied Behavior Analysis (ABA) in the school setting.
- Enhanced Integrated Behavioral Services (special schools for autism spectrum disorders).

For the more intensive services delivered in the schools, school input is generally required and an integral part in the determination of the care plan. This primarily includes interfacing with school personnel as a part of treatment team meetings.

Specific Evidence Based Practices for Children/Adolescents

The overall treatment approach by AmeriHealth Caritas is to offer as full a continuum as possible of evidence-based treatment protocols, as long as Medicaid eligibility requirements as a covered service are met.

The Iowa Consortium for Mental Health lists the following specific evidence-based practices for children and adolescents. Where applicable, we have indicated our experience in the development and management of these services. For populations who qualify for these services, they will be covered by AmeriHealth Caritas Iowa in the fee schedule.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

A group, school-based intervention, targeting children in grades six to nine with anxiety or depressive disorders and exposure to significant traumatic events. The evidence-base is still in the process of being established, but it may be a practical application of trauma-focused cognitive behavioral therapy (TF-CBT) in the school setting. This service is provided for members in our affiliate health plan in Washington DC.

Circle of Security

The Circle of Security is an early intervention program, based on attachment theory and research that enhances parents' ability to observe and improve their caregiving.

Functional Family Therapy (FFT)

FFT is a well-documented and highly successful family intervention for at-risk and juvenile justice involved youth. This service is provided for members in our affiliate health plan in Washington DC and is a Medicaid-reimbursable program.

The Incredible Years

From the SAMHSA model programs, The Incredible Years is targeted to younger (ages 2 to 8) children either presenting with or at risk for conduct problems. These programs are typically school or pre-school based and is a Medicaid-reimbursable program.

Multisystemic Therapy (MST)

MST is an intervention for conduct disordered youth that is one of the practices most consistently recognized as "evidence-based" for children and adolescents. This is a Medicaid-reimbursable programs developed by AmeriHealth Caritas. This service is provided for members in our affiliate health plan in Washington DC.

PCIT (Parent-Child Interaction Therapy)

PCIT is empirically-supported treatment for conduct-disordered young children that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. This is a Medicaid-reimbursable program developed by AmeriHealth Caritas. This service is provided for members in our affiliate health plan in Washington DC.

Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)

TF-CBT training is provided and included in our Medicaid-reimbursable programs in Pennsylvania. This service is provided for members in our affiliate health plan in Washington DC.

Wraparound Services for Children

This program is well-established in our Pennsylvania and New Jersey affiliates.

Sample Crisis Plan

Crisis plans are developed with members and families and are intentionally kept clear and concise, with an emphasis on being simple, understandable and actionable for all parties. These are embedded into our care plan in the care management information system and are shared with members, families and providers. Listed below is a representative crisis plan for a child in our Indiana program. An additional lengthier sample crisis plans are included in as Exhibit 3.2.8-C. While similar, the specific format can vary from state program to state program.

- Identify stressors that can trigger a crisis: For example, a child being told what to do may be a trigger for an anger outburst.
- Identify coping skills that can help avoid crisis situations: Deep breathing.
- Identify support systems to contact in a crisis situation: Neighbor
- Identify the nearest Hospital Emergency Department for assistance: Mercy Medical Center (example)
- Identify the Community Mental Health Center /Outpatient provider(s)/PCP to contact: Penn Mental Health (example)
- Provided the following Emergency Assistance Resources: 911; National Suicide Crisis Hotline @ 1-800-784-2433.



Family Crisis Plan

Family's definition of a crisis

Youth self reports to struggling with depression, self harm, cutting, yelling and cursing and failing two classes.

Start date: 12/31/2014

End date: 1/21/2015

Strengths/interests to be used in a Crisis Situation

Youth plays tennis, soccer, likes bowling and going to the gym.

Start date: 12/31/2014

End date: 1/21/2015

Risks/triggers

Youth reported that family arguments can trigger his depression.

Start date: 12/31/2014

End date: 1/21/2015

Strategies to use in a Crisis Situation (what works)

Youth reported that staying active and doing physical activities helps.

Start date: 12/31/2014

End date: 1/21/2015

What helps the Family/Caregiver in a Crisis Situation

Mom has a very large family support group that helps.

Start date: 12/31/2014

End date: 1/21/2015

Who can help a Crisis Situation/Resources to use in a Crisis Situation

Michael (CM) X-XXX-XXX-XXXX Gloria (CM) X-XXX-XXX-XXXX
Crisis hotline X-XXX-XXX-XXXX listen to the prompts and leave a message. Someone will return the call within 10 minutes.
Mon – Fri 5 p.m. – 9 a.m.. Weekends.

Start date: 12/31/2014

End date: 1/21/2015

Exhibit 3.2.8-C: Sample Crisis Plan

Provider Data Verification Form

Are there any Medical Problems? (If Yes, please list details)

N/A

Start date: 12/31/2014

End date: 1/21/2015

Additional Information

N/A

Start date: 12/31/2014

End date: 1/21/2015

You can have this information in other languages and formats at no charge to you.
You can also have this interpreted over the phone in any language. Call Member Services
24 hours a day, 7 days a week at 1-888-756-0004. For TTY, call 1-866-428-7588.

Quý vị có thể có thông tin này bằng các ngôn ngữ và định dạng khác miễn phí.
Quý vị cũng có thể có thông tin này thông dịch ra bất kỳ ngôn ngữ nào qua điện thoại.
Xin gọi Dịch vụ Thành viên phục vụ 24 giờ/ngày, 7 ngày/tuần theo số 1-888-756-0004.
Đối với người sử dụng TTY, xin gọi số 1-866-428-7588.

Usted puede tener esta información en otros idiomas y formatos sin costo alguno para
usted. También puede tener esto interpretado por teléfono en cualquier idioma. Llame a
Servicios al Miembro al 1-888-756-0004 las 24 horas del día, los 7 días de la semana.
Para TTY, llame al 1-866-428-7588.



Exhibit 3.2.8-C: Sample Crisis Plan

9. Describe how you will ensure compliance with the Mental Health Parity and Addiction Equity Act.

In furnishing behavioral health benefits in our other integrated programs, AmeriHealth Caritas has fully complied with the Mental Health Parity and Addiction Equity Act (MHPAEA), and will ensure compliance for all Iowa plans and benefits. There are five main requirements for compliance with the MHPAEA:

1. Ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits;

In the MHPAEA, there are the regulations concerning Non-Quantitative Treatment Limitations (NQTLs) which are defined as treatment limits “which otherwise limit the scope or duration of benefits for treatment” and are not expressed numerically. The primary examples of NQTLs include medical management techniques such as prior authorization. In practical terms, comparable behavioral health services (e.g., office visits) cannot have more restrictive medical management practices applied in comparison to comparable physical health services. As an integrated plan that is not using a behavioral health subcontractor, we have already completed this evaluation for our other integrated plans and will implement the same fully compliant medical management practices in Iowa.

2. Ensuring compliance with MHPAEA for any benefits offered by the Contractor to members beyond those specified in Iowa’s Medicaid state plan;

At this time, AmeriHealth Caritas is not proposing any additional behavioral health benefits beyond those covered services specified in Iowa’s Medicaid state plan. If we were to do so, the health plan would assess both the quantitative and non-quantitative requirements of the MHPAEA Final Rule for compliance.

3. Making the criteria for medical necessity determinations for mental health or substance use disorder benefits available to any current or potential member, or contracting provider upon request;

AmeriHealth Caritas fully complies with this requirement in all current programs and will do so for Iowa. By policy, and as a requirement of applicable state law, AmeriHealth Caritas makes the criteria for medical necessity decisions for behavioral health benefits available to any current or potential member, or contracting provider, upon request. Due to the contractual and proprietary restrictions related to McKesson InterQual criteria, full disclosure of all of their criteria language and algorithms is not permitted, but we do disclose excerpts and summary information to the extent that is allowed by our contract with McKesson.

4. Providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members;

AmeriHealth Caritas fully complies with this requirement in all affiliate health plans and will do so for Iowa. By policy, the specific reason for all medical necessity and benefit denials is delineated in the written denial notices to members and providers. When required, explanations of benefits (EOBs) also include payment denial reasons.

5. Providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits.

AmeriHealth Caritas fully complies with this requirement in all current programs and will do so for Iowa. Out-of-network benefits and processes are the same as those under medical and surgical benefits.

10. Describe how you will provide care that addresses the physical and behavioral health needs of members in an integrated manner.

AmeriHealth Caritas’ IHM model fully integrates all aspects of a member’s health including physical health, behavioral health, long-term services and supports, medications and social services. This integrated model positions delivers improved health outcomes and financial performance. Additional benefits of this model — involving a single point of contact across behavioral health, physical health and pharmacy domains, coupled with the person-centered approach — include increased member and provider satisfaction and greater member retention.

AmeriHealth Caritas’ data-driven approach identifies and stratifies members based on physical health and behavioral health need based on the Four Quadrant Clinical Integration Model (below). The results of the stratification process guides in the direction of members toward the appropriate interventions given their conditions. These interventions are initiated by our IHM team, which includes behavioral health supports.

Currently, AmeriHealth Caritas uses high volume and high cost claims occurrences to target members for outreach and behavioral health/physical health care coordination. In many instances, these members will have already experienced behavioral and physical health issues, some which may be catastrophic, prior to being targeted for intervention.

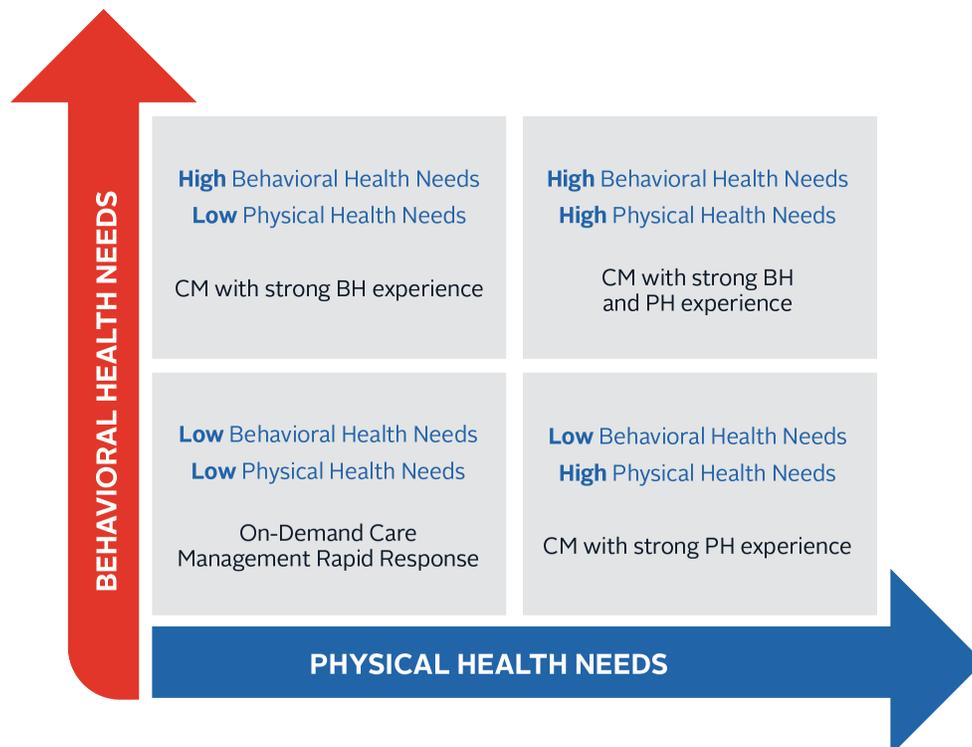


Exhibit 3.2.8-D: AmeriHealth Caritas Behavioral Health / Physical Health Matrix
(Note: CM = Care Manager)

Our model of care approach incorporates tested strategies of co-location and need-based resource allocation with additional strategies along the behavioral health-physical health integration continuum (see below). These strategies strengthen the existing capabilities, as well as create new capabilities, within the healthcare delivery system to deliver person-centered care that seamlessly addresses a member's behavioral, physical and pharmacologic needs.

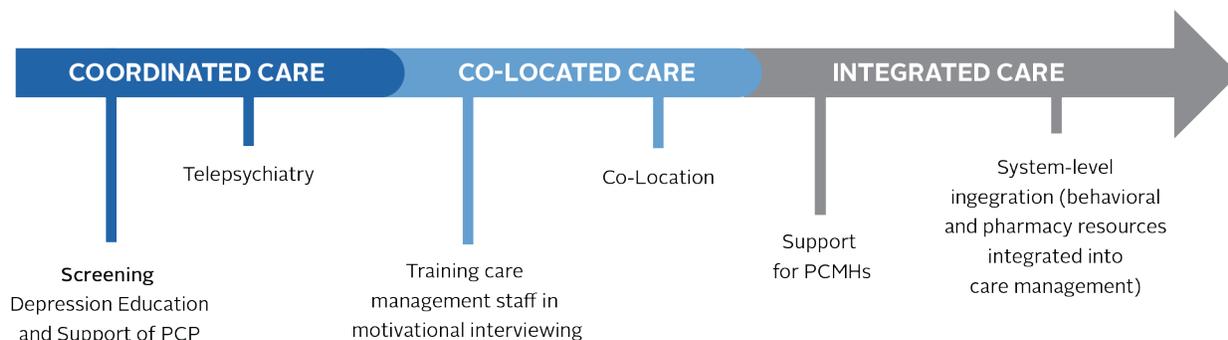


Exhibit 3.2.8-E: AmeriHealth Caritas Care Coordination Overview

1. **Behavioral Health Education and Support of PCPs**, helping them manage the behavioral health needs of our members.
2. **Behavioral Health Telemedicine Services (i.e., telesychiatry)** to deliver psychiatric assessments and care remotely through telecommunications technology, such as videoconferencing.
3. **Co-location** involves integrating behavioral health services into the primary care office, or integrating medical/physical health services into a community mental health clinic.
4. **Training care management staff in motivational interviewing**, a collaborative engagement method that addresses a member's motivation and commitment toward changing an unhealthy behavior

Additionally, AmeriHealth Caritas has supported practices in preparing for National Committee for Quality Assurance (NCQA)-approved certification as a patient-centered medical home (PCMH) through provider training on practice-transformation implementation, resource-sharing, supporting integration of behavioral health services and provider incentivization.

Progress and Accomplishments

In 2014, AmeriHealth Caritas developed a pioneering proof-of-concept predictive model. Advanced predictive analytics was able to identify at-risk members with high behavioral health needs (prior to incurring catastrophic healthcare costs) and report their patterns of utilization or care-seeking behaviors that are indicative of progression to catastrophic care. Medical Informatics educated relevant staff enterprise-wide on predictive analytics. They also initiated additional predictive analytical studies in the areas of 30-day readmissions, superutilizers and IHM for further development into 2015.

Our 2014 accomplishments marked the implementation of several integration strategies to infuse a behavioral health focus in all health plan affiliate activities (not just states with the behavioral health benefit carved-in) and implement team-based accountable management for members with behavioral health care needs. Central to these efforts is the assimilation of behavioral health activity and expertise into the operational care management teams, supported by specialized experience and knowledge from PerformCare. By 2016, these initiatives will be fully integrated into carve-in markets and will become the standard for how we manage physical and behavioral health comorbidities.

In 2014, AmeriHealth Caritas accomplished the following:

- **Behavioral Health Education and Support of PCPs:** AmeriHealth Caritas developed and branded a robust curriculum and physician tool kit for each market. In our affiliate health plan in Washington DC, local staff and community advocates were trained as teachers of the tool kit and have been training local primary care physicians and pediatricians. Twelve sites in Washington DC received the training. Additional sites have been identified and follow up has been occurring with the sites who received the education.
- **Telepsychiatry:** A vendor was identified and extensive review of contract requirements, including security and physician-training provisions occurred we have begun implementation
- **Co-location:** Behavioral health and physical health services were co-located in community health centers and PCP offices.
 - Our affiliate health plan in Indiana embedded one of their nurse care managers into a large community mental health center (Otis Bowen Center). This program in Indiana has been successful in engaging members into care management, closing care gaps and increasing collaboration between physical and behavioral health providers. The program is being expanded to allow the nurse care manager to outreach to members in other locations in the community such as mental health hospitals and the member's home.
 - The pilot was also expanded into our affiliate health plan in South Carolina where a nurse care manager works at the Charleston Department of Mental Health Center one day per week. Initial feedback from the team, including Department of Mental Health (DMH), is that it is successful in meeting members in the community and engaging them into care management. Plans are underway to increase the frequency to two days a week.
 - Plans have been made to co-locate behavioral health clinicians in medical settings in South Carolina. Internal planning sessions were held and an agreement established with the South Carolina DMH who will be providing the behavioral health clinicians. Program description and implementation plans were developed along with potential metrics. We also identified target FQHC sites for the proposed pilot. In this program, behavioral health services are provided for the member in the primary care setting. This helps address the stigma related to receiving services from a behavioral health provider and allows the member to choose the setting of their choice from where to receive the services.
- **Motivational interviewing training:** AmeriHealth Caritas provides a comprehensive training and staff development program for care management and community-based associates to augment engagement and behavior change approaches in care management interactions. Motivational interview training was provided to all care management staff during 2014. In addition, select in-house staff was trained as motivational interviewing trainers to allow AmeriHealth Caritas to continue to provide training to new staff and to expand further training to Community Care Management (CCMT) and Community Outreach Solution (COS) staff. Initial data indicates that the majority of IHM associates are using motivational interviewing with high-risk consumers. Associates continue to receive booster trainings and a coach was hired to provide feedback and additional training for associates in using motivational interviewing techniques.
- **Formalized process for the inclusion of behavioral health and pharmacy** resources into care management rounds.
- **Developed a robust behavioral health education curriculum** for care management and community care management associates, including patient-centered treatment planning, infant mental health and recovery, and resiliency principles. The focus of behavioral health trainings in 2014 was on As stated above, all care management staff participated in a two-day, on site, interactive training on

Motivational Interviewing. Training included a review of the evidenced based treatments and providers in the District as well as information about services not covered by the health plan but available for our members.

Many of our partnering federally qualified health centers (FQHCs) and some non-FQHC providers who have achieved PCMH recognition have a formally integrated behavioral health component.

Integrated PH and BH Case Studies:

Julian was a 4-year-old brought to our care manager's attention by a provider. Julian was receiving initial evaluation and testing due to the preschool teacher telling mom that he may have ADHD and need medications. During the evaluation the psychologist noticed Julian had difficulty understanding speech. The psychologist contacted the health plan's care manager and requested screening for hearing and speech disorders. The care manager engaged the mother and referred Julian for audiology, dental, and vision services. The member is currently engaged in speech therapy as well as behavioral health counseling. Julian's vision screen was normal and he had a successful dental appointment. Mom is looking for a new preschool that will work with her and Julian.

Our care manager had been unable to contact a 16-year-old member, Vicky, over the span of several months because she was not going to her community mental health center (CMHC) appointments. Vicky was admitted to a behavioral health hospital and the care manager gained access to Vicky's father's contact information. Vicky lived with her mother and it seemed Vicky was not getting to appointments because her mother had a number of physical health and behavioral health issues of her own and could not get her there. The care manager determined that the member's mom was also a health plan member. After a medical inpatient stay, the care manager engaged mom in services which increased mom's receptiveness to discuss her daughter. The care manager was able to fully engage mother and daughter, and the mother agreed to allow CMHC to provide in home services to them both for the first time. Vicky is now taking her medications as prescribed and is applying to begin school again; she was being "home schooled" by mom due to her anxiety. Mom is actively participating in behavioral health as well as physical health services and has become more cognizant of her daughter's needs and helping make sure those needs are met.

Carter was a 16-year-old with a seizure disorder, Todd's paralysis, cerebral palsy, developmental delay/disability, asthma and depression. Additionally, the attending psychiatrist suspected schizophrenia. Carter's mom had declined care management services in the past. Carter was removed from school due to uncontrolled seizure activity. Carter's mom was planning home schooling next year if the seizures could not be controlled, and planned to start home therapies if Carter began losing function. Treatment history included: psychiatry, psychology, neurology, ear tubes, a tonsillectomy with adenoid removal, and orthotics to help keep his feet straight and pain free. Carter had several ER visits due to Todd's paralysis as a result of seizures. The family's recent move had caused Carter to have to leave most providers. Carter's mom continued to make the long trip to the pharmacy they left due to how well the pharmacist took care of the family. The care manager was able to connect Carter with providers for dental, primary care, vision and orthotics. Carter has had appointments with each. He is doing well on his medications and has not had a recent seizure.

Integrated Physical and Behavioral Care Plan

Problems identified

1. Smoker.
2. Seizure disorder (member states she is having seizures).
3. Without a mental health provider and medications.
4. Obese.

Interventions

1. Encouraged/educated member on discussing possibility of second neurology opinion.
2. Educated member on importance of smoking cessation.
3. Educated member on disease processes.
4. Assisted member with specialist appointments.
5. Provided member with options for mental health therapy.
6. Provided member with resource letter.
7. Discussed pain reduction options and relaxation techniques with member.
8. Encouraged/educated on a well-balanced diet.

Goals

1. Member will reestablish with mental health provider.
2. Member will follow treatment plan of pain management provider.
3. Member will discuss breathing issues with PCP.
4. Member will see specialists as scheduled.

Follow-up

1. Care manager provided member with mental health service options.
2. Member reports using heat and cold as needed, sleeping with a pillow between her legs to ease lower back pain, taking her medications as directed, planning activities around the time her pain medications peak and following sleep schedule to ensure adequate rest.
3. Member kept pain management appointment and received injections in her back. Member sees this provider every two months, and has next visit scheduled.
4. Care manager will follow up with member to assess readiness regarding smoking cessation.
5. Member reports taking medications as directed with no issues getting medications filled at pharmacy.
6. Member discussed seizure medications with nurse practitioner (NP) at PCP office at her appointment, and NP agreed to continue prescribing this for her. NP also agreed to provide her Zoloft until she can get back into Penn Mental Health (example). Member states Penn Mental Health (example) will take her back after 90 days. Member states she has 50 days left and is aware of when she is able to call to schedule. Member reports she feels a positive difference since resuming the Zoloft.

Co-location example:

Another way that AmeriHealth Caritas encourages the integration of behavioral and physical health is at the provider level so that at every touch point the members can have their needs met holistically. We have several initiatives involving co-location of behavioral health into physical health settings, and of physical health into behavioral health settings.

Co-location: Integrating behavioral health services into the primary care office

This example looks at co-location, making available behavioral health and physical health services at one place – such as the PCP’s office or a community mental health center.

In today’s health care industry, the majority of all behavioral healthcare, elderly behavioral health services and addictive disorder services in the United States are delivered in primary care settings. Those with serious mental illness tend to receive care at community mental health centers while neglecting their physical medical conditions.

The challenge is to integrate health care delivery and behavioral health services to help patients achieve better overall health outcomes. AmeriHealth Caritas, led by PerformCare, has adopted a diversified approach toward expanding access to behavioral health services for members in need. How? By addressing the social, cultural and geographical barriers to care.

“The key to helping our members is to bring the specialty services to the member as opposed to sending the member to the specialty services,” said Dr. Michael Golinkoff, PerformCare president and senior vice president, AmeriHealth Caritas. “We’re expanding member access to important behavioral health care and helping reduce for them the stigma of receiving these services.”

AmeriHealth Caritas and PerformCare are adopting variations of “co-location” models where primary care patients receive medical and behavioral health services in the same practice. The primary care provider may even directly introduce the member to the behavioral health provider at the time of the member’s medical visit (so-called “warm hand-off”), thereby improving the member’s comfort level in seeking behavioral health care. Members visiting these primary care offices have easier access to specialty care and avoid the task of seeking separate behavioral health treatment.

In Pennsylvania, a primary care office inside a federally qualified health center (known as a FQHC) has partnered with a local behavioral health provider to co-locate a behavioral health clinician one day a week to perform behavioral health assessments, provide brief therapy as needed and refer members to specialty psychiatric care, if appropriate.

In Indiana, AmeriHealth Caritas and MDwise Hoosier Alliance have moved forward on a true behavioral health/physical care model. A primary care office in Indiana has hired a behavioral health clinician to provide similar services.

Also in Indiana, another primary care provider is hiring a social worker for a once-a-week group therapy session at a provider practice licensed to dispense suboxone, a treatment for drug addiction. “In addition to being on site at the PCP office, the social worker is a fully integrated staff member of the primary care provider team, helps develop a member’s action plan and documents the activity in the shared medical record,” said Katey Weaver, director, Integrated Behavioral Health, PerformCare.

To address medical needs of members with serious mental illness, Select Health of South Carolina and MDwise Hoosier Alliance have co-located nurse complex care managers at community mental health centers. Their role is to review care gap information and provide holistic complex care management services face to face and by phone, as needed. They perform risk assessments and develop individualized care plan for members.

AmeriHealth Caritas will continue to build and nurture a true behavioral health/physical health integration model, said Dr. Golinkoff. “We are helping members help themselves by providing access to health care when and where they need it most,” he said. “For us, it’s another example of how we’re seeking to achieve performance excellence.”

Testimonial: June 4, 2014: Care manager from affiliate health plan in Indiana

Here is a bit of feedback on my experience using the motivational interviewing approach when attempting to engage members in case management:

Many of the members in my health plan have had problems accessing their benefits for a variety of reasons, and some are angry at the world when I first reach them. They are not at all abashed about taking it out on me. I have found that by using motivational interviewing skills — reflecting on emotion, rolling with resistance — I am able to de-escalate these folks almost immediately. After a few more minutes of conversation, many of these members are eager to engage in care management because they are so delighted to have found someone who listens to them.

I have also found that using the motivational interviewing approach in general helps me engage members because I build a rapport with them before I launch into assessment questions. For example, I might first tell the member I'm calling to see how they've been doing since they got out of the hospital. By the time I introduce care management, the members are already comfortable telling their story and generally like the idea of talking with me again. Plus, many of the assessment questions get answered before they are even asked, so the interaction feels less like an interrogation.

Thanks!

- Renata

11. Describe your mechanisms for facilitating the reciprocal exchange of health information between physical and behavioral health providers and methods for evaluating the effectiveness of such strategies.

AmeriHealth Caritas Iowa has a collaboration process in place to facilitate the reciprocal exchange of health information between physical and behavioral health providers and methods for evaluating the effectiveness of the strategies.

Exchange of health information:

- During every review with behavioral health inpatient providers, AmeriHealth Caritas behavioral health utilization management associates ask the behavioral health inpatient provider to contact the member's PCP and other providers to collaborate care for aftercare planning.
- AmeriHealth Caritas behavioral health utilization management associates send the discharge review from a mental health inpatient hospitalization to the member's PCP to ensure the PCP is aware of the hospitalization and the aftercare plan.
- AmeriHealth Caritas will require that behavioral health providers send initial and quarterly (or more frequently if clinically indicated) summary reports of the members' behavioral health status to the PCP. This requirement will be specified in all Provider Handbooks.
- AmeriHealth Caritas supports PCPs in integrating with behavioral health through telemedicine, co-location and fully integrated models. We have providers in multiple states integrating under these different models.
 - Working collaboratively with county-based mental health administrators, AmeriHealth Caritas has arranged partnerships between FQHCs and CMHCs in our affiliate health plan in Pennsylvania, embedding behavioral health clinicians on-site at the FQHC several days per week.
 - Pediatricians in our affiliate health plan in South Carolina partner with the state mental health provider system to co-locate behavioral health clinicians at the pediatrician office.

- In our affiliate health plan in Washington DC, telepsych is offered in PCP offices which allows the network psychiatrist to see members.
- Providing psychiatric consultation for PCPs who are managing low level behavioral health conditions in members.

Through utilization management and care management activities, AmeriHealth Caritas Iowa will collect and maintain the following information for use in behavioral health coordination efforts.

- Diagnoses and conditions.
- Provider information.
- Behavioral health and physical health collaboration activities.
- Results of health risk assessments (PHQ-9, GAD-7, Vanderbilt, etc.).
- Social determinants of health: housing, vocation, transportation, etc.
- Pharmacy activity.
- Integrated treatment plan.
- Utilization data.

AmeriHealth Caritas Iowa will share information with providers and other stakeholders through routine telephonic communication and through our Provider Portal to contribute to the success of behavioral health coordination.

- Our IHM associates provide information to providers about other providers involved with the member including pharmacy (i.e., the member refilled his/her prescription).
- Behavioral health utilization management associates notify the PCP of behavioral health inpatient discharges and aftercare plans, including the discharge summary, discharge medications and aftercare appointment specifics.
- Our Member Clinical Summary is available through our Provider Portal to network providers involved in the member's care. The Member Clinical Summary includes information on current medications, dosages, and fill dates; chronic conditions; gaps in care; ER visits; inpatient admissions; and recent office visits. Where allowed by law, mental health treatment information is included (but not substance abuse per CFR 42 regulations.)
- HIPAA does not prohibit network providers from sharing information for the purpose of treatment planning. This includes mental health providers.
- Federal law does prohibit the sharing of clinical information pertaining to substance use disorders (SUD) treatment without written consent from the member. AmeriHealth Caritas will encourage/require in the contract SUD providers to obtain written consent to speak to the PCP, health plan and other stakeholders to enable collaboration
- Despite the desire for interdisciplinary collaboration and data sharing, privacy regulations limit the ability to share behavioral health diagnoses and service plans with other care team members. Mitigation plan: we will require behavioral health providers to obtain necessary consents to collaborate with medical providers, especially the PCP, as well as facilitate the transfer of information, where allowed, between providers. Additionally, our Care Management staff will work directly with the member to facilitate sharing necessary information across the treatment team.

Methods for evaluating the strategies

AmeriHealth Caritas Iowa is fully committed to working with Iowa to develop mutually agreed upon strategies and subsequent evaluation criteria for the success of data exchange mechanisms between physical health and behavioral health providers.

Some potential examples include the following.

- AmeriHealth Caritas Iowa will have a formal consent management component in Jiva® — we will be able to track member consent to share additional protected information (e.g. substance abuse diagnosis/treatment) with the PCP. We will also be able to track the percent of members involved in SUD treatment who were asked to consent and those that did consent.
- AmeriHealth Caritas Iowa can also report outcomes (cost, utilization, adherence) for dual-diagnosis members with consent and without consent.

Provider Portal usage metrics

AmeriHealth Caritas Iowa's Provider Portal will be a key tool in providing and exchanging health information with physical and behavioral providers in supporting our comprehensive and system approach to care management and service integration. For in-depth details on our Provider Portal and our care coordination approach, please refer to response Sections 6.1.6 and 9.1.3, respectively.

Case Success Stories

Source: Ann, Indiana 2013

Ella, a 15-year-old female was diagnosed with schizoaffective disorder, moderate cognitive disability (IQ 44) and seizure disorder. Previous IQ was listed as 55 but her father reported new information provided by the school psychologist which indicates member's IQ to be 44 (moderate disability).

Ella was initially diagnosed with childhood schizophrenia at age 9. Father reported that Ella began to experience auditory and visual hallucinations around age 6 and began to exhibit aggressive and out-of-control behavior around age 9. Ella was placed in the care of her father through Child Protective Services in 2011.

Ella had six behavioral health inpatient stays and two residential stays in 2011 and 2012. Admissions were a result of regular aggressive/out of control outbursts at home and school, necessitating constant supervision. Father is currently seeking long-term residential placement for Ella as he is unable to keep her safe in the community. Father was unsuccessful in his attempts to obtain residential treatment and respite services due to Ella's aggression and low IQ. The behavioral health care manager assisted Ella's father to place her in a home for patients with developmental disabilities.

Source: Cherie, Indiana 2011

Nicholas was an 8-year-old male diagnosed with autism and speech impairment. His mother was unable to get him enrolled in speech therapy. The behavioral health care manager assisted his mother with setting up speech and occupational therapy. The behavioral health care manager referred Nicholas for additional community resources. His mother reported these supports have assisted the family significantly and resulted in no further need for hospitalizations for Nicholas.

Source: Cherie, Indiana 2013

Lydia was a 53-year-old female diagnosed with alcohol dependence, opiate dependence and asthma. Lydia had been hospitalized three times in the past two years for alcohol and opiate withdrawal. She reported unmanaged chronic pain as the cause for the opiate addiction. The behavioral health care manager

connected Lydia and her mother with 12 step support groups and outpatient substance abuse treatment.

The behavioral health care manager assisted Lydia with obtaining a referral to a pain management specialist to address the chronic pain. With assistance from the behavioral health care manager, Lydia started eating healthier. She reported to writer at this time she really started to feel better about herself and felt healthy. Lydia continued her outpatient therapy and asked for help obtaining resources to address dental issues. She also made a goal of returning to college in the near future and getting a certification to work as a substance abuse technician. Lydia reported that her cholesterol levels were now back to normal and she stopped smoking. She reported her PCP stated her lungs were now in “great shape” and she did not have COPD as previously suspected. At last contact, Lydia was continuing to maintain her sobriety, her relationship with her mother was much improved, and she no longer had friends with SUD issues.

Source: Janis, South Carolina 2013

Susan, a medical care manager had a member on the phone who reported she was suicidal. The supervisor just happened to be at care manager’s desk to witness the teamwork. Supervisor did not realize what was going on as everyone remained calm. The behavioral health care managers were at the Susan’s desk providing support and recommendations. The supervisor commented: “I had the experience today of seeing why the integration of physical health and behavioral health is so important. Today was an example of teamwork at its best!”

Source: Christopher, South Carolina 2013

Contact with member was the day after the care manager returned from motivational interviewing training. Walter had diabetes and was doing a poor job managing his condition. Walter also had an extensive behavioral health history. He was missing multiple appointments. In the past, Walter would offer reasons for missing appointments that the care manager suspected were not the true cause (i.e., stomachache, car trouble etc.). Walter reported during his initial assessment he “isolates” and the care manager suspected his phobias were keeping him from going to his appointments but he never acknowledged this.

In this call, the care manager explored further why Walter was missing appointments using reflective listening and open ended questions. Walter related he was uncomfortable around others and does not like to go out. Rather than immediately offering advice the care manager affirmed her statement. The care manager also recognized that Walter was expressing his emotions with the word uncomfortable. In reflecting this back to Walter, the care manager escalated it by using the stronger emotion word “afraid.” The care manager replied, “So you are afraid when you leave the house but you seem to realize you need to get out and see your doctor.” After brief pause, Walter elaborated further and agreed that he is fearful but concerned that he is not seeing his doctor, and he acknowledged behavioral health problems are his largest barrier to care. The care manager was able to demonstrate empathy by replying “this must be very difficult for you.”

This was the first time Walter acknowledged this barrier to the care manager and it came as a response to employing reflective listening, affirmation and empathy which resulted in the immediate strengthening of Walter’s trust in the care manager. Rather than offering unsolicited advice, the care manager asked permission to offer advice and suggested Walter make re-establishing with psychiatry his top priority and he agreed. Walter has since asked his PCP to refer him to psychiatry and has made an appointment to see a professional counselor this month. During the following contact the member continued to seem more comfortable with the care manager and the call was very productive. Walter asked, without any prompting, why he had protein in her urine and how he can protect her kidneys. The care manager

immediately recognized this as “change talk” and acknowledged the member's concern and fear with an affirmation statement. The case manager replied, “You are concerned your health may worsen and want to learn to prevent this.” The care manager again asked permission to offer advice. Walter consented and the care manager was able to provide education on the consequences of uncontrolled diabetes, the protective qualities of using Angiotensin II receptor blocker (ARB) medication to protect the kidneys and the importance of medication compliance.

Care Manager's Comment: “I only utilized a few of the basic tenets of motivational interviewing and saw immediate results. I have a lot of work to do with Walter but feel our relationship has improved. I will continue to use motivational interviewing to further explore Walter's perceived barriers. I hope to turn his thoughts to the benefits of change. If I can get Walter thinking of the benefits of change this should instill hope in a better future and this will provide him with the energy for change.”

3.2.9 Health homes

1. Describe your proposed approach for implementing health homes.

AmeriHealth Caritas recognizes the critical role of a health home, especially for members with at least two chronic conditions or one chronic condition and at risk for a second condition. AmeriHealth Caritas Iowa is already engaged in discussions with many of Iowa's qualified health home providers. The Iowa Health Alliance, Mercy Health Network and Unity Point all include qualified health homes. At least nine of the 13 FQHCs (for which we already have letters of intent) are also qualified health homes. The Iowa PCA has expressed interest in working with AmeriHealth Caritas Iowa to expand qualified health homes, as well as enrollment of eligible members. All current qualified health homes will be prioritized for outreach and recruitment for the AmeriHealth Caritas Iowa network.

We were excited to see Iowa Medicaid Enterprise (IME) offers a well-defined and comprehensive health home program. AmeriHealth Caritas Iowa is pleased to partner with IME and local Iowa providers to offer access to quality care coordinated across the health care system through qualified health homes. The health home model of care is the foundation for a value-based strategy of partnering with Iowa Providers to serve the state's highest-needs members.

AmeriHealth Caritas' Integrated Healthcare Management (IHM) model fully integrates all aspects of a member's health including physical health, behavioral health, medication therapy management and social services to deliver improved health outcomes and financial performance. Additional benefits of this model — involving a single point of contact across behavioral health, physical health and pharmacy domains, coupled with the person-centered approach — deliver increased member and provider satisfaction and greater member retention. Results of provider satisfaction surveys across all current AmeriHealth Caritas plans show that we consistently have higher scores than other Medicaid plans in the respective markets. For example, in our health plan affiliate in eastern Pennsylvania, 88 percent of practitioners were satisfied with Keystone First versus 72 percent for competitors. Furthermore, 90 percent of practitioners were satisfied with our South Carolina affiliate versus 76 percent for competitors.

As described in detail in our response to section 9, integration of care is a core component of AmeriHealth Caritas' care management model. True care integration is one of the core features of the AmeriHealth Caritas strategic plan, and the infrastructure AmeriHealth Caritas of Iowa brings (see high-level diagram in section 9.1.3) will help complete the transformation of service delivery to meet Iowa's vision for health homes, enabling clinicians and service providers to integrate and coordinate care as intended. AmeriHealth Caritas employs several mechanisms to coordinate information and services with the

medical/health home to optimize effectiveness and avoid duplication of services. These include a robust Provider Portal described in Section 6.1, Community Care Management teams (CCMT) and community health workers that support connecting members to the right care at the right time. We will provide health homes with a range of automated to hands-on services designed to complement the services available at the health home site.

AmeriHealth Caritas Iowa recognizes the importance of integrating physician and behavioral health services. Our plan is to engage providers of these services for Iowa in assisting them to become health homes and integrated health homes. Underpinned by AmeriHealth Caritas Iowa's assertive outreach to the Iowa provider community, its commitment to financial investments in health home providers, and deployment of targeted incentives and value-based purchasing models, our approach will integrate health homes into a holistic system of care coordination to fulfill the state's commitment to complex high-needs members.

AmeriHealth Caritas Iowa's Strategy for Integrated Health Homes (IHH)

The Iowa Department of Human Services has a well-defined and thorough program and structure for integrated health home services. The model provides an entire team of professionals to assist with comprehensive care coordination. It recognizes the importance of inclusion of the individual and family, as appropriate, as an equal partner in decision making. Peer support and family support services are included and prioritizes care coordination using a whole-person and applies a patient-centered approach which is intended to eliminate "silos" and fully integrate care for persons with the highest needs. AmeriHealth Caritas Iowa will use claims data, as well as other available sources, to identify members who are eligible and may benefit in an IHH. AmeriHealth Caritas Iowa will work with members and families to encourage enrollment and actively engage them in the IHH.

The program will be highly encouraged for all persons that qualify based on a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, major depression or other serious mental health conditions that cause significant impairment in daily functioning for adults. It will also be highly encouraged for children and adolescents with a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual of mental disorders (DSM) that results in a functional impairment.

AmeriHealth Caritas Iowa will adopt the current structure and will contract with existing providers of IHH services. The health plan will endeavor to minimize administrative burden by collaborating with the state and other payers to the extent possible to maintain a standard set of expectations and at a minimum assure compliance with CMS standards. AmeriHealth Caritas Iowa will complete an initial evaluation of gaps in member access to IHH services, as well as implementing a process for ongoing evaluation. We will also develop and execute a strategy for ongoing expansion/enrollment of qualified providers.

AmeriHealth Caritas Iowa will:

- Identify and contract with existing providers who meet the standards of participation of an IHH.
- Provide education and support to IHH providers regarding practice transformation and integrated care coordination.
- Continuously assess the IHH provider's capacity to meet integrated care coordination standards and mentor progress.
- Provide infrastructure and tools to facilitate coordination between behavioral health and physical health providers.

- Work with the state, providers and stakeholders to develop self-management tools for the individuals served based on unique local needs.
- Manage and perform data analytics and outcome measures to be shared with providers and indicated stakeholders to evaluate and improve service effectiveness and cost efficiency of care coordination and service delivery.
- Provide clinical guidelines and other decision support tools.
- Provide technical support and tools for the electronic exchange of health information.
- Develop and maintain the enrollment process.
- Continually evaluate access and need/opportunity for expansion of IHH providers.

2. Describe strategies proposed to increase health homes participation

AmeriHealth Caritas Iowa has begun to recruit Iowa providers into the IHH program. We will complete an initial evaluation of gaps in member access to health homes, as well as implement a process for ongoing evaluation. We will also develop and implement a strategy for ongoing expansion/enrollment of qualified health homes. In other markets, including Louisiana and Nebraska, AmeriHealth Caritas has successfully given support to provider groups to become certified medical homes and we will employ the same tactic in Iowa to advance health homes. The Iowa Primary Care Association has already offered to partner with us through Iowa Health+ to work with Iowa providers to assist them with transformation to qualified health homes.

AmeriHealth Caritas Iowa recognizes that transformation to an effective medical home model of care, a core component of health homes, requires time, resources and expertise that have not always been readily available to some practices. We are committed to collaborating with practices to assist with transformation in order to expand access to this model of care. We can offer the following resources to help Iowa providers achieve, maintain and enhance their medical home status:

- **Initial support:** AmeriHealth Caritas Iowa is committed to collaborating with providers by sharing best practices, real-world examples, learning opportunities and a roadmap tool with step-by-step guidance to assist in transformation and performance improvement.
- **Ongoing growth:** To encourage continued improvement, AmeriHealth Caritas offers providers frequent education and training on the PCMH program (a core component of health homes) and monitors the progress of the practice toward meeting goals. In addition, data transparency through an online portal allows Providers secure and easy access to:
 - a) Key performance data, organized in a dashboard format and including applicable measures.
 - b) Identify members who are eligible for health homes.
 - c) Ongoing support to foster optimal performance and best practices through continuous quality improvement.
- **Provider Toolbox:** Our web-based PCMH microsite gives providers access to our free, online Provider Toolbox of PCMH resources to ensure convenient, flexible, anytime support. The Provider Toolbox includes member engagement materials, topical resources, networking information and opportunities, and community resources, as well as education and implementation tools for providers and their staff. These resources assist with transformation, recognition, and ongoing performance improvement. (<http://pcmh.AmeriHealthcaritas.com/toolkit/index.aspx>)
- **Support for Member engagement:** We help providers involve members in their own care by sharing:
 - a) Condition-specific member engagement materials.

- b) Access to AmeriHealth resources to assist with member engagement and care coordination, including behavioral health and community resources. These include our “Let-us-Know” program, Rapid Response teams, Integrated Care Management teams, and Community Outreach teams.

3. Describe your proposed reimbursement structure for health homes.

AmeriHealth Caritas Iowa will reimburse care provided to our members attached to a designated health home via a per member per month (PMPM) comparable to the current IME payment model. Additionally, we will work with stakeholders to evaluate means by which to incentivize and shape behavior through setting bonus targets for providers that meet certain criteria as determined in conjunction with stakeholders. AmeriHealth Caritas Iowa will consider incorporating the current IME Performance incentive bonus program. AmeriHealth Caritas Iowa will work with health homes to ensure that they have sustainable infrastructure and processes in place for ongoing identification and management of members eligible for, and enrolled in, the program.

4. Describe how you will ensure non-duplication of payment for similar services.

AmeriHealth Caritas Iowa will work with Iowa DHS and Iowa health homes to monitor enrollment of eligible members and to track/analyze available data, including claims data, to ensure that there is not duplication of payment for similar or same services that are offered through or covered under other programs. Reviews will be conducted at least quarterly and may be conducted more frequently in the initial implementation period and/or identified periods of higher enrollment and/or member transition.

3.2.10 Chronic health homes

1. Describe how you will fulfill the requirements of this section in addition to the general Health Homes requirements

AmeriHealth Caritas has core capabilities that will compliment provider partner strengths to ensure a chronic health home model that will effectively improve outcomes, control costs and improve the health status of Iowa Medicaid members. Although some providers have demonstrated the ability to develop and operate successful health homes, many providers lack the infrastructure, experience and trained staff necessary to successfully transition to and sustain this model of care.

For our members, AmeriHealth Caritas Iowa recognizes that the health home is the cornerstone of the member’s care coordination and delivery system. AmeriHealth Caritas Iowa will employ multiple mechanisms to coordinate information and services with the Health Home to optimize effectiveness and avoid duplication of services. We will provide health homes with a range of automated to hands-on services designed to complement the services available at the member’s health home site.

Our Care Management staff will contact each health home during the member’s initial enrollment into the program, as part of the comprehensive assessment and plan of care development process. We will work closely with the health home team to create the member’s plan of care using the health home’s treatment plan as a foundation. This will allow us to complement the health home’s recommendations to develop an enhanced and holistic plan specific to the IME health home program goals. The care manager will remain in close communication with the health home during the implementation of the plan of care should issues or new concerns arise.

Our Integrated Health Management (IHM) program is a holistic solution that uses a population-based health management approach 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 Caritas delivers and coordinates care management, disease management and long term support services.

Our model incorporates a person-centered decision support system that drives communication and care plan development through a multidisciplinary approach to management. The health home team will be integrated as a critical component of this process. The IHM process includes reassessing and adjusting the care plan and its goals as needed. AmeriHealth Caritas Iowa uses leading technology to integrate our medical management departments and functions, including behavioral health, pharmacy management, medical economics and operations.

- The underlying theme in assessing the quality and appropriateness of care for members with special health care needs is our multidisciplinary approach. Members with special health care needs often have multiple chronic, comorbid illnesses that impact both physical and behavioral health. AmeriHealth Caritas Iowa care managers will work closely with health homes to develop holistic treatment plans that make it possible to customize care by combining approaches to address these comorbidities, such as chronic illness, behavioral health issues and psychosocial problems. Each care plan is unique and built to address the specific needs of each member, including the need for social and environmental supports.



- Our model incorporates a member-based decision support system that drives both communication and care plan development through a multidisciplinary, patient-centered approach to management. The overarching goal of the IHM process is to increase members' ability to self-manage and advocate for their own health.
- Data analysis and reporting are an integral part of every aspect of IHM, from population identification through evaluation and effectiveness monitoring.
- We will also use our experience with health information exchange (HIE) technology to provide the health home with member- and panel-level information at their fingertips. Through our Provider Portal, providers can quickly obtain a Member Clinical Summary 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 health home, the Member Clinical Summary provides a snapshot of health care needs and services the member has received in the past.

AmeriHealth Caritas Iowa account executives will work closely with health homes to assist with transformation in order to expand access to this model of care. We will offer resources to help Iowa providers achieve, maintain and enhance their health home status. AmeriHealth Caritas Iowa is committed to collaborating with providers by sharing best practices, real-world examples, learning opportunities, and tools to assist in transformation and performance improvement.

AmeriHealth Caritas Iowa resources will focus on attributes of the health home model of care that drive sustainable change:

- Risk stratified care management.
- Care coordination.
- Improved access to care.
- Member and caregiver engagement.
- Ongoing measurement and improvement activities.
- Timely access and effective use of data (at point of care).

3.2.11 1915(i) Habilitation Services and 1915(c) Children’s Mental Health (CMH) Services

1. Describe your proposed approach for delivering these services.

1915(i) Habilitation Services

The 1915(i) waiver program for habilitation services provides home and community-based services (HCBS) for Iowa plan participants with impairments typically associated with serious and persistent mental illness. The HCBS are designed to assist individuals who meet the eligibility requirements and are approved by the Iowa DHS. There are several specific services that assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to be successful in home and community-based settings. A summary of the services available under this waiver is the following:

- **Care Management** — When the individual does not qualify for targeted case management.
- **Home-based habilitation** — Services provided in the person’s home and community. Typical examples would be assistance with medication management, budgeting, grocery shopping, personal hygiene skills, etc.
- **Day Habilitation** — Services that are usually provided in a day program setting outside the home. Focuses on areas such as social skills, communication skills, behavior management.
- **Prevocational** — Can be provided in a variety of settings, and focuses on developing generalized skills that prepare a person for employment. Typical examples include attendance, safety skills, following directions, and staying on task.
- **Supported Employment** — Assists in obtaining and keeping a job in the community. Assists in placing the individual in a job in a regular work setting with persons without disabilities at minimum wage or higher, and provides support to maintain the job. Typical examples would include: skills assessments, consultation with the employer, job coaching and behavior management.

Based upon public data provided by the Iowa Department of Human Services, approximately 4,000 individuals statewide are receiving services under the 1915(i) waiver program with 80 percent receiving home-based habilitation services, 50 percent receiving care management services, 35 percent receiving day habilitation services, 20 percent receiving prevocational services and 12 percent receiving supported employment.

Consumer Eligibility Criteria

AmeriHealth Caritas Iowa will use the established state eligibility criteria for recommendations for this program:

Consumer must meet one of these two factors:

1. Psychiatric treatment more intensive than outpatient care more than once per lifetime.
2. More than one episode of continuous professional supported care other than hospitalization.

Consumer must then meet two of these five additional criteria:

1. Unemployed, employed in a sheltered setting or limited skills plus poor work history.
2. Need financial assistance for maintenance and is unable to procure by themselves.
3. Severe inability to maintain social support systems.
4. Need assistance with basic living skills.
5. Exhibit inappropriate social behavior requiring interventions.

Consumer Assessment and Re-Assessment Processes

The InterRAI tool(s) as designated by the state will be used for initial determination for 1915(i) waiver services. AmeriHealth Caritas will work with the InterRAI organization to embed the tools within our Jiva® care management information system. For those accessing behavioral health services and meeting the base consumer eligibility criteria outline above, AmeriHealth Caritas Iowa care managers will administer the InterRAI seamlessly as part of their utilization management and care management assessment processes. We will also use claims data mining techniques to identify potential eligible members, accept referrals from providers through our “Let Us Know” program, and allow members to self-refer via our Member Services and Rapid Response teams.

All needs assessments will be administered in a conflict free manner consistent with the Balancing Incentive Program requirements. AmeriHealth Caritas is proposing a 30-day timeline from completion of applicable needs assessments upon initial enrollment or when AmeriHealth Caritas becomes aware of a change in the member’s circumstance requiring a new assessment. For those approved and receiving 1915(i) waiver services, AmeriHealth Caritas will re-assess using the same DHS designated tools at least every 12 months.

Once the assessment and/or reassessment is completed using the InterRAI, we will submit the eligibility assessment within the DHS timeframe (to be determined) through “ISIS” (the DHS individualized services information system) or through another manner prescribed by DHS. In response, DHS will provide AmeriHealth Caritas Iowa with the applicable approval, member liability amount, and waiver budget caps as applicable. AmeriHealth Caritas Iowa will then work with the member and provider network to assure the timely and efficient provision of the approved services, and enter the member into our care management program for the needed service planning and documentation.

Person-Centered Service Planning Process

The overall process will be that AmeriHealth Caritas Iowa will assign a specific care manager to all 1915(i) members approved for or receiving services. A service plan will be developed for each member. This service plan will be reviewed and revised at least every 12 months, when there is a significant change in condition or at the request of the member. The member will be placed in care management and AmeriHealth Caritas Iowa will organize and initially lead a team approach to plan for the care to the member. The team will be person-centered and fully inclusive of the member and any additional family or other member’s representatives that he/she would like to participate. Each service plan will include a specific crisis plan developed by the member. The member also may choose which team member will serve as the lead and the member’s main point of contact. The service planning team will also include professionals such as the AmeriHealth Caritas Iowa care manager, and behavioral health and physical health service providers, including input from the member’s PCP.

The individual identified in the service plan as the primary care coordinator will have at least monthly contact with member (phone or in person) and face-to-face contact at least quarterly.

The member-centric approach to service planning will be done through easily accessible language and open-ended questioning focused on the member's view of recovery:

- What are the member's goals? What does he/she want from his/her life?
- What kinds of supports and services does the member need?
- What network of supports is in place in the member's life? How can positive natural supports be facilitated?
- Who is important in the member's life and who do they want to work with on their plan?

1915(c) Children's Mental Health (CMH) Services

The basic structure and the proposed approach for delivering 1915(c) waiver services will be similar to those described above for the 1915(i) waiver program services, although there are some important distinctions. The intent of the CMH waiver services is to identify and provided additional services/supports in the home and community that are not otherwise available through traditional mental health services and in conjunction with the traditional services creates a comprehensive support system in the home and community for children with serious emotional disturbance. This approach avoids out of home placements through the delivery of the additional home and community based services. All services will be provided within the limits outlined in the approved waiver. After approval for a child, the monthly total cost of CMH Waiver services cannot exceed \$1,967, and the waiver cap of children to be served is 1144.

A summary of the services available under this waiver is the following:

- **Environmental Modification / Adaptive Devices** – items installed or used within the child's home that address specific documented mental health, health of safety concerns. Relevant items for children's with serious emotional disturbance can include various monitoring and safety devices such as smoke alarms, window/door alarms, pager supports, motion sensors and fencing.
- **Family and Community Support Services** – services provided to the child, the child's family members, or to the family as a whole. Typical supports activities include coaching and modeling positive behavior as well as developing skills, such as medication management, stress reduction, personal hygiene and grooming, and socialization skills. Transportation and therapeutic resources (e.g., books, videos) can also be including in this category within established limits.
- **In Home Family Therapy** – skilled therapy approaches with the goal to maintain family unification and a stable living environment for the family unit.
- **Respite** – specialized one-on-one or group respite that can be provided in a variety of settings including the member's home, another family member's home, camps or other organized community programs, Intermediate Care Facilities or Residential Care Facilities, as well as several other identified waiver service settings.

Consumer Eligibility Criteria

AmeriHealth Caritas will use the established Iowa eligibility criteria for recommendations for this program:

1. Zero to 18 years of age.
2. Has a diagnosis of serious emotional disturbance (SEDs) as verified by a psychiatrist, psychologist or mental health professional within the last 12 months.
3. The definition of serious emotional disturbance.

4. The DHS definition of SED is fully consistent with the federal definition found in Federal Register: Volume 58, Number 96. Pages 29422-29425. All references to DSM will be interpreted to be applicable to the most recent published edition, currently DSM-5.
5. “Serious emotional disturbance means a diagnosable mental, behavioral or emotional disorder that (1) is of sufficient duration to meet the diagnosis criteria for the disorder specified by the Diagnostic and Statistical Manual of Mental Disorders (IME specified edition) and (2) has resulted in a functional impairment that substantially interferes with or limits a child’s role or functioning in family, school, or community activities. Serious emotional disturbance shall not include developmental disorders, substance-related disorders, or conditions or problems classified in the DSM as “other conditions that may be a focus of clinical attention (V codes) unless they co-occur with another diagnosable serious emotional disturbance.”

2. Describe your experience serving similar populations, if any

AmeriHealth Caritas has extensive experience with care coordination, care management, utilization management, and person-centered service planning for both the population of adult individuals with chronic mental illnesses and children with severe emotional disturbance. For example, our behavioral health affiliate in New Jersey has experience with the New Jersey System of Care program which is designed specifically for such care coordination across levels of care and funding streams. This program is currently serving over 61,000 children across the state of New Jersey. Additionally, our behavioral health affiliate in Pennsylvania has experience with the HealthChoices program, which covers the entire population of adults with serious and persistent mental illnesses. This program offers a full continuum of services including coordination with targeted care management, county-based administrative case management, and the full continuum of service providers including psychosocial rehabilitation and peer support providers.

3.2.13 Iowa Health and Wellness Benefit Plan

1. Describe how your proposed approach will ensure Medically Exempt members will receive State Plan benefits.

AmeriHealth Caritas Iowa will initially utilize data sent from the state regarding its decision on, and for assignment of, benefit plans for members (sourced from member attestation and referral forms). With this information, Medically Exempt members will receive an identifier in Jiva®, our population health management system, and Facets® to assign their aid category and determine their benefits. After the member is determined to be medically exempt, the member will be enrolled in the Medicaid State Plan. The member can opt-out and then would be enrolled in the Iowa Health and Wellness Benefit Plan.

AmeriHealth Caritas will also identify members that may qualify for state plan benefits from care management and utilization management referrals, and/or internal customized reports that detect members with potentially qualifying health conditions. Additionally, members who feel they may qualify for state plan benefits are free to contact AmeriHealth Caritas Iowa directly. Members will be informed of state plan benefits through the AmeriHealth Caritas Iowa Member Handbook.

AmeriHealth Caritas Iowa commits to working with the state to assure timely communication of Medically Exempt designations and will appropriately classify those members in the AmeriHealth Caritas of Iowa claims payment and member enrollment systems (i.e., Facets® and Jiva®).

2. Describe your proposed strategies for implementing retrospective claims analysis to determine if a member is Medically Exempt.

As introduced above, care management and utilization management data will be analyzed to identify potential members that might qualify to be medically exempt. A potential member's PCP will then receive a form to complete from AmeriHealth Caritas Iowa that will then be sent to the state to make the final determination.

Retrospective claims analysis will be an ongoing process performed monthly and will utilize algorithms that ensure compliance with Iowa's 1115 waiver and the most recent and up-to-date guidance from CMS to make sure members receive needed services in accordance with approved state and federal policy. In addition, we will establish internal protocols to flag and evaluate members in the Health and Wellness Benefit Plan who request benefits indicative of conditions identified in the Medically Exempt definition.

3.2.14 Value Added Services

1. Describe any proposed Value-Added Services. Include in the description:

- a. Any limitations, restrictions, or conditions specific to the Value-Added Services;**
- b. The providers responsible for providing the Value-Added Service;**
- c. How the Value-added Service will be identified in administrative (encounter) data;**
- d. How and when providers and members will be notified about the availability of such Value-Added Services while still meeting the federal marketing requirements; and**
- e. How a member may obtain or access the Value-Added Services.**

AmeriHealth Caritas Iowa looks forward to the opportunity to invest in Iowa's future by supporting members through programs and services that exceed the scope, duration or amount that are required in the Iowa High Quality Healthcare Initiative contract. These programs and services are designed to improve the general health and well-being of members, with the ultimate goal of improving state health outcomes. We will partner with the Iowa DHS to ensure we are addressing what is most needed today and in the future.

Overview of proposed value-added services:

- Free dental supplies (toothbrush, toothpaste and floss).
- Care and case management support for members with behavioral health needs.
- The AmeriHealth Caritas CARECard (a member incentive program tied to completing targeted preventive health measures).
- Enhanced Telehealth services, augmenting existing telehealth infrastructure.
- Free cell phones for eligible members to stay connected to their case manager, doctor and family through our partnership with Tracfone/SafeLink.
- Enhanced member outreach programs (Member Portal, mobile application and text messaging) to maximize the value of every member contact and to support multiple channels for communication based on member preference.
- A variety of enhanced member health and wellness programs and community events.

Value-added Service	a. Limitations / Restrictions / Specific Conditions	b. Providers Responsible	c. How identified in encounters	d. How providers/ members notified	e. How accessed by members
Free dental supplies (toothbrush, toothpaste, floss)	All members obtaining dental services will receive free dental supplies provided by AmeriHealth Caritas Iowa.	Dental providers will distribute, products supplied by Henry Schein, Inc.	Corresponds to dental claims (carved out services); developing invoicing/distribution model in development with Henry Schein for actual supplies provided.	Notification in communications materials, member handbook, distribution to dentists.	Obtained by visits to dental providers.
AmeriHealth Caritas CARE Card (Member incentive program)	Incentive rewards tied to completion of certain preventive health activities including: <ul style="list-style-type: none"> • Adolescent well-visit. • Well child visits. • Immunizations. • HgbA1c test. • Nephropathy test. • Diabetic retinal exam. • Well-visit/BP check. • PAP test. • Chlamydia test. • 1st trimester prenatal care. • Dental visit. • Post-partum visit. 	Will work with Total System Services, Inc. (TSYS) to administer the CARE Card program; benefits can be redeemed only at specific merchant classes (grocery stores, pharmacies)	CARECard will be communicated through New Member Welcome materials, website, Member Portal, newsletters, and other collateral materials promoting preventive health care and availability of "rewards" for completion of such.	Members will be issued cards upon first completion of an eligible preventive health screening or activity with instructions on activation and how benefit can be accessed; providers will be notified of the availability of the CARECard through routine provider orientation and education/training visits as well as through provider newsletters and other media.	Member can redeem value on CARECard as they would any debit card at specific types of retailers which will be identified in initial mailer with CARECard and posted on the website

Value-added Service	a. Limitations / Restrictions / Specific Conditions	b. Providers Responsible	c. How identified in encounters	d. How providers/ members notified	e. How accessed by members
<p>Enhanced Telehealth Services and Tele-monitoring</p>	<p>Accessed by appointment.</p>	<p>Utilizing existing telehealth infrastructure (e.g. University of Iowa, Mercy Health Network) as well as an AmeriHealth Caritas direct-to-consumer (DTC) platform</p>	<p>Telehealth visits will generate claims captured in our standard encounter reporting process.</p>	<p>Members will be notified through their New Member Welcome Packages, health plan website, and other channels.</p>	<p>For AmeriHealth Caritas’ DTC platform, Members will be able to call into a central scheduling center to schedule their telehealth visit. Telehealth visits using existing infrastructure will be accessed in accordance with each program’s scheduling process.</p>
<p>Enhanced Care Coordination and Management</p>	<p>Members will be connected with applicable services based on risk profiling and stratification.</p>	<p>AmeriHealth Caritas Iowa Care Management team in conjunction with Member’s PCP and other providers as applicable.</p>	<p>Not reported in encounters, but captured in Medical Management care plan and internal reporting.</p>	<p>Members and providers will be notified of the availability of services through New Member Welcome Packages, Provider Manual, health plan website, Portals and other channels.</p>	<p>Members will be engaged through care management.</p>

Value-added Service	a. Limitations / Restrictions / Specific Conditions	b. Providers Responsible	c. How identified in encounters	d. How providers/ members notified	e. How accessed by members
Mobile health units	Specific services (dental, maternity) will be available via mobile units to all members.	Vendor/provider in process of being identified and contracted based on data analysis of service needs.	Mobile unit visits will generate claims captured in our standard encounter reporting process.	Members and providers will be notified of the availability of services through New Member Welcome Packages, Provider Manual, health plan website, Portals and other channels	Members will be notified of availability of mobile services on designated dates at specific locations through multiple communication channels.
Enhanced member contact via member portal, mobile app and text	N/A	N/A	N/A	Members will be notified through their New Member Welcome Packages, health plan website, and other channels.	Through appropriate device (PC, tablet, smartphone)
Free cell phones for eligible members to stay connected to their case manager, doctor and family	Eligibility determined by Tracfone via application.	Tracfone administers the "SafeLink" free phone program; Voxiva administers the targeted texting component of the program.	Not reported in encounters, but phone utilization reports provided by Tracfone.	Members will be identified through case management.	Members will be directed to Tracfone application website with assistance as needed.

Value-added Service	a. Limitations / Restrictions / Specific Conditions	b. Providers Responsible	c. How identified in encounters	d. How providers/ members notified	e. How accessed by members
<p>Member programs:</p> <ul style="list-style-type: none"> • BrightStart® maternity program • “Lose to Win” – a six month health education/disease management program targeting Members with diabetes and hypertension • “Focus on Fitness” - free gym memberships at participating locations • Weight Watchers membership for members who qualify at participating locations • Nutritional Counseling with case management referral • Smoking cessation program • Benefit Bank • Mission GED 	<p>Members must complete 12 initial gym visits in order to be eligible for free full-year gym membership</p> <p>Benefits Bank available to all Members at designated locations</p> <p>Mission GED available to those members pursuing their GED</p> <p>Other services available through referral by care manager</p>	<p>Gym memberships provided by participating gyms</p> <p>Weight Watchers provided by participating locations</p> <p>Benefit Bank administered by The Benefit Bank, a non-profit organization supporting the social and financial needs of low-income populations</p>	<p>Nutritional counseling will generate claims activity captured in our routine encounter data submission</p> <p>Memberships (e.g. local gyms Weight Watchers) are tracked by our Rapid Response and Outreach Team (RROT), capturing initial enrollment, member completion of initial visits to qualify for free full year membership</p> <p>Members receiving financial support for their GED will be tracked via internal reporting</p>	<p>Members will be notified through their New Member Welcome Packages, health plan website, and other channels</p> <p>Members will be identified through case management referral for nutritional counseling and other programs as appropriate</p>	<p>Members may directly access free membership at sponsoring organizations (gyms, Weight Watchers)</p> <p>Nutritional Counseling and Smoking Cessation programs will be accessed via care management referral</p> <p>AmeriHealth Caritas has worked with The Benefit Bank® in Pennsylvania and South Carolina, offering a “one-stop” site and assistance with applying for benefits and services including food and heating assistance, tax preparation, and other health and social services. Members will access the Benefit Bank at various designated sites (to be determined)</p> <p>Mission GED will be accessed via application</p>

Value-added Service	a. Limitations / Restrictions / Specific Conditions	b. Providers Responsible	c. How identified in encounters	d. How providers/ members notified	e. How accessed by members
Community Events: <ul style="list-style-type: none"> • Community Baby Showers • Empowerment Tour • Healthy Hoops (asthma education event) • 4YourKidsCare (educational event for moms and families regarding caring for sick children) • Community Health Fairs (screenings, workshops, education) 	N/A	N/A	Attendance lists, no claims generated for health fairs and community events	Members will be notified through their New Member Welcome Packages, website, and other channels; advertising and marketing of community events.	Certain events (Baby Showers, Healthy Hoops, 4YourKidsCare) will be via invitation; other events will be open to the community.

Exhibit 3.2.14-A: Overview of Value-Added Services

2. Provide any applicable data on improved outcomes linked to Value-Added Services you have implemented in other states.

As noted above, the value-added services we provide our members are designed to provide the most value to their health and help support state goals. An overview of outcomes for the services to-be provided is below:

Dental Supplies

At AmeriHealth Caritas Iowa, we believe dental health is a key proponent of general well-being and broader health outcomes. In addition, we also believe there is an opportunity to help our members with basic dental care even if we are not managing these services directly. According to the Centers for Disease Control and Prevention:

- Roughly 78 percent of Americans have had at least one cavity by age 17. Eighty percent of the U.S. population has some form of periodontal (gum) disease.
- In 2007, Americans made about 500 million visits to dentists and spent an estimated \$98.6 billion on dental services.

- Between 2005 and 2008, 16 percent of children ages 6 to 19, and 23 percent of adults ages 20 to 64 had untreated cavities.
- Dental fluorosis (overexposure to fluoride) is higher in adolescents than in adults and highest among those ages 12 to 15.
- Most adults show signs of periodontal or gingival diseases. Severe periodontal disease affects approximately 14 percent of adults ages 45 to 54.
- Twenty-three percent of people ages 65 to 74 have severe periodontal disease.
- Men are more likely than women to have more severe dental diseases.
- Oral cancer occurs twice as frequently in men as women.
- Three out of four patients do not change their toothbrush as often as is recommended. Toothbrushes should be changed every two to three months and after illnesses.

Oral hygiene greatly affects overall long-term health, and promotes a more confident member. When it comes to dental care, prevention through daily cleaning and regular visits to the dentist's office is better not only for your health, but for your budget. It is important for parents to play a key role in reinforcing smart oral hygiene habits. Kids are likely to follow in the footsteps of those who set positive examples and will carry those healthy habits through their own adult lives. It is never too late to take a serious stand in keeping r teeth healthy.

The AmeriHealth Caritas CARECard

The AmeriHealth Caritas CARECard is an innovation AmeriHealth Caritas Iowa is ready to offer its members in Iowa. We designed this program to incentivize members for healthy behaviors. These financial incentives will be focused on elements that will further promote member health and improved outcomes (e.g., CARECard can be limited to purchasing of healthy foods or other wellness items). We will partner with Iowa DHS to ensure the incentive program targets the state's goals.



We believe this innovation, which has shown positive results in other states, can be an effective service and tool for Iowa's Medicaid members. A recent article in Forbes states that consumer incentives are "one of the rare cases in healthcare when everyone wins. Consumers earn rewards for behavior that improves health or reduces cost. The system wins by rewarding for behavior that reduces cost."¹

Noteworthy examples of widespread programs in other states include:

- Florida's Enhanced Benefits Reward Program: Medicaid consumers earned \$15 to \$25 credits for compliance with 19 healthy behaviors.
- Minnesota's Well Child/ Immunization Incentive Program: Medicaid members whose physician verifies that their child has received required immunizations, blood lead testing, and annual check-ups received Target gift cards.

¹ John Nosta. Be Healthy and Get Rewarded--Incentives Driving Engagement. Forbes. April 9, 2014.

- Idaho’s Behavioral Preventive Health Assistance Program: Medicaid consumers who consulted with a doctor about losing weight or quitting smoking could earn a \$100 voucher, to be used for gym memberships, weight management programs, nutrition counseling, and tobacco cessation products.

The federal government, which shares in the cost of Medicaid and establishes program parameters, has also encouraged the utilization of incentive programs. Recently, the Centers for Medicare and Medicaid Services (CMS) established the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) Program, which provides funding to State Medicaid Programs to test the effectiveness of providing incentives to Medicaid Consumers.

Enhanced Telehealth Services and Telemonitoring

AmeriHealth Caritas Iowa will support and augment the current telehealth offerings in Iowa (e.g., University of Iowa, Mercy Health Network) as well as provide and implement a DTC offering to enable increased access to care. For detail on our telehealth solution, please see our Section 6.2 response.

AmeriHealth Caritas Iowa’s telemonitoring program, in partnership with Physician Preferred Monitoring, provides in-home monitoring for members with congestive heart failure or poorly controlled chronic diabetes. The program goals are to increase self-management of these chronic conditions and to improve early intervention, which can prevent ER visits, inpatient admissions and readmissions. Members receive an in-home monitor capable of capturing their weight, blood glucose, and other biometrics. Abnormal results are reported to the member’s care manager and PCP. Preliminary results from our South Carolina affiliate indicate an overall positive return-on-investment for the program.

Enhanced Care Coordination and Management

Community Care Management Team (CCMT) — AmeriHealth Caritas leverages community health workers to extend care management into the community. The teams are deployed to communities that have a concentrated number of high-risk members, including those who have complex care needs, are difficult to engage through telephonic care management, access care primarily through emergency services, or are frequently admitted to inpatient settings. AmeriHealth Caritas currently has CCMT hubs in Philadelphia, PA; Chester, PA; Charleston, SC; and Baton Rouge, LA. Care Management and Utilization Management departments refer members to the care management team to connect them with needed services while reducing adverse events and inappropriate utilization patterns. With more than 150 members actively engaged, early results from year one of the program demonstrated greater than a 10 percent decrease in claims costs and a 25 percent decrease in inpatient admissions.

The example below illustrates the success of this approach.

Sam is a 46 year-old male living in a residential boarding home with type I diabetes, coronary artery disease and a cognitive disability. His medication and glucose monitoring are managed by boarding home staff. Care management was unable to engage him telephonically. When the CCMT first engaged Sam he had not seen his provider for a year, and had 32 admissions in 18 months for diabetes with ketoacidosis. In the month following CCMT engagement, he had one 11-day hospital admission and for the next two years following engagement, he had only one additional five-day hospital admission. The 2011 pre-engagement claim cost for Sam alone was over \$180,000, and was reduced by 96 percent after one-year post-engagement (August 2012–2013).

Rapid Response – The Rapid Response team is designed and trained to intervene and overcome any barrier to care. This includes assisting members with accessing providers, setting up appointments, adhering to medication regimens, arranging transportation, and connecting members to local community resources. Rapid Response nurses also help members address urgent needs.

Community Outreach Solutions (COS) team - The Community Outreach Solutions team is a special group of community health workers who locate difficult-to-engage members. The team reconnects members with care management and provides hands-on care coordination to ensure members access the education, appointments, transportation, and other social supports they need. In 2014, the Community Outreach Solutions team in one of our Pennsylvania affiliate plans met with more than 4,000 Keystone First members with chronic and comorbid conditions and facilitated more than 950 doctor appointments.

Embedded Care Managers - AmeriHealth Caritas Iowa will partner with key providers to embed registered nurse and social worker care managers into the practice site to collaboratively manage the care of members. This includes identifying care gaps, barriers to care, and needed resources and developing an individualized plan of care. The embedded care managers will connect Members to specialists, community-based resources, and MCO resources, as well as proactively follow up to ensure they are accessing the services and care they need.

Free Cell Phone Program

Our Voxiva/Tracfone initiative has dispensed nearly 30,000 free phones (one per household) to our members to date. With text reminders through Voxiva's Text4Babies, Text4Kids, and Text4Health (adult health program), our members can opt into these programs for free and gain valuable access to information and services they need. The free cellphone program is only one example of how AmeriHealth Caritas Iowa is leveraging technology to improve the lives of our members and exceed the goals we will jointly set with the state of Iowa as we partner together in this program.

Member Programs and Community Events

AmeriHealth Caritas Iowa's member programs and community events are designed to address key education, access and treatment needs for our members while also enriching the broader communities in which they live. The programs we are proposing would be customized to meet the needs of Iowa and its members. Below are descriptions of the programs and events we are proposing; however, additional programs which we have implemented and could customize for Iowa are detailed further in Section 8.7 of our response.

Programs for Healthy Birth Outcomes:

BrightStart® - The BrightStart program focuses on promoting prenatal and post-partum care to reduce the incidence of premature and low weight births through intensive case management services, cell phones, and member incentives. The program engages high-risk pregnant members through a customized, high-intensity program that meets the individual member needs and keeps them connected to their care managers. In 2013, 87.5 percent of participating members from our Pennsylvania affiliate Keystone First delivered within 31 days of their due date.



Community Baby Showers – These are designed to engage pregnant moms for the purpose of introducing the Bright Start Program, providing risk assessments to determine needs, offering outside resources, providing dental screenings for pregnant moms. At the baby showers we also provide parenting

preparation courses about infant care, stress management, nutrition, cognitive development and effective parent-child communication. In 2014, more than 120 pregnant members attended community baby showers hosted by our Pennsylvania affiliate Keystone First, and 45 members received dental screenings through Community Baby Showers.

Centering Groups - AmeriHealth Caritas Iowa will partner with the March of Dimes to sponsor centering groups at local OB/GYN offices to help pregnant women develop a support group with other women of similar gestational age. Pending our selection as an MCO in Iowa, we are committed to fund one practice through the March of Dimes Centering Pregnancy® program. Our South Carolina affiliate, Select Health of South Carolina, has seen centering groups increase member satisfaction, prenatal and post-partum visit compliance, and healthy birth outcomes. A key provider partner performed a study that demonstrated that gestational age, birth weight, NICU admissions, and breastfeeding were all positively influenced by three to five percentage points.

Maternity van – AmeriHealth Caritas Iowa is excited about the prospect of leveraging the mobile health care concept to increase access to prenatal care by using maternity vans to close the obstetric provider gaps in targeted Iowa counties. AmeriHealth Caritas Iowa is planning to implement this service after identifying the areas with the greatest potential due to provider shortages.

Programs for Children:

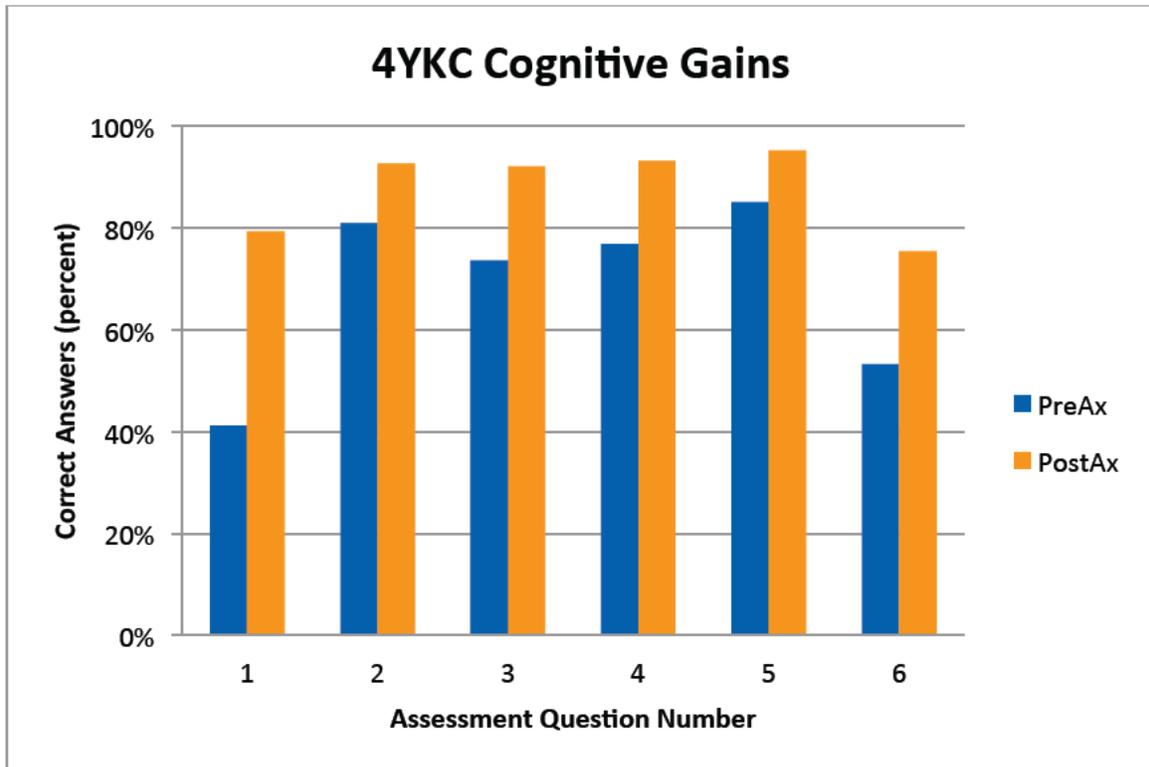
Healthy Hoops – According to the Iowa Department of Public Health, asthma is the most prevalent chronic condition for children. Healthy Hoops is an asthma program for young asthmatics and children who are at risk for obesity or decreased cardiac output is held annually at various community locations. The program uses a coalition of local healthcare providers and community organizations to provide full physical screenings (blood pressure [BP], body mass index [BMI], height/weight, spirometry), individualized asthma action plans and targeted health education. The program seeks to emphasize the importance of appropriate medication use, treatment compliance, and monitored physical activity, using basketball as an innovative approach to promote health management and education for the entire family.



4 Your Kids Care – The 4 Your Kids Care program engages families who have recently visited the ER for non-urgent services and offers basic, hands-on training and education on how to best care for their children when they get sick. This program teaches parents and caretakers how to make better health decisions such as when to take their child to the ER, and encourages the relationship between member and PCP or pediatrician. The program consists of a three-hour workshop utilizing a medical bag (including basic first aid supplies) and a manual that supports the education provided. Childcare and transportation is offered to all members.

Since the 4 Your Kids Care program was implemented in 2011, more than 2,800 parents/caretakers in one of our affiliated plans have attended the class. 2012 Program Statistical Outcomes (one year look back and one year look ahead) indicate a 25 percent drop in ER utilization and costs for those who attended.

- Since the 4 Your Kids Care program was implemented in 2011 in Southeastern Pennsylvania, approximately 2,832 head-of-household Keystone First members have attended. Keystone First one of our Pennsylvania affiliates.
- 2012 Program Statistical Outcomes (one year look back and one year look ahead) show a 25 percent drop in ER utilization and costs for those who attended.



1. Your child is younger than 2-months-old and has a fever of 100.4 degrees. You should:
 - a) Go to the ER;
 - b) Call the PCP; or
 - c) Give the child Tylenol.
2. Your child put something in his/her ear. Using tweezers is a good way to get it out. True or False.
3. Finish the sentence: Fevers are usually:
 - a) NOT normal. You should take your child to the emergency room; and
 - b) Normal. You should call the doctor when your child has one.
4. Using Q-tips is a good way to clean your child's ear. True or False.
5. Aspirin is OK to give to your child when he/she has a fever. True or False.
6. Finish the sentence: Earaches in children under 3 are usually
 - a) NOT normal. You should take your child to the emergency room; and
 - b) Normal. You should call the doctor when your child has one.

*PreAx= Prescreening result, PostAx= Post Screening Result

*Source: 4YKC Surveys, David Keleti 4YKC Article "Reducing Nonurgent ED Utilization in Pediatric Members"

Exhibit 3.2.14-B: 4 Your Kids Care Example Outcomes

Health and Wellness Initiatives:

Health Empowerment Tour — The Health Empowerment Tour is designed to engage and educate participating members, as well as the wider community, on health- and wellness-related issues in a faith-

based setting. The goal of the program is to promote health education, health literacy and preventive health care in low-income communities. Consisting of intensive workshops, the program encourages members to prevent, control, and reverse chronic conditions by focusing on nutrition, physical activity, water intake and medication compliance. Participants meet weekly over the course of six weeks to identify health risks and to learn how to understand and proactively manage their health. Important health topics include breast cancer, diabetes, obesity, stroke and hypertension, heart disease awareness and prevention, stress, depression, and emotional and mental well-being. During the pre- and post- exams, members are screened for total cholesterol, HDL, LDL, triglycerides, glucose, HbA1c, blood pressure, height/weight, and BMI.

In a recent roll out in one of our health plan affiliates in Philadelphia, there was a 13 percent drop in total cholesterol across attendees and a 10 percent drop in overall blood pressure among participants in one of the two participating organizations and an average weight loss of four pounds across two organizations. In addition, participants increased their awareness of nutrition content in foods and their willingness to try healthier foods and substitutes. Over 24 percent of participants lost weight.

Lose to Win — Lose to Win is a six-month diabetes and hypertension program that focuses on disease management techniques through education workshops. The program includes pre- and post-health screenings with members’ PCPs. The program includes a comprehensive curriculum designed to educate members regarding risk factors, nutrition, medication adherence and self-management. The program goals are disease management, improved HEDIS measures and decreased medical costs. Members are screened for total cholesterol, HDL, LDL, triglycerides, glucose, HbA1c, blood pressure, and BMI.

“Focus on Fitness” / Free Memberships — AmeriHealth Caritas Iowa will work with local gyms, YMCAs, Weight Watchers, and similar programs to offer free memberships to foster health and wellness goals. These program offerings have had tremendous success in the markets where we have offered them. On average, AmeriHealth Caritas generates 3,500 initial applicants (representing households and not individual participants) each year with approximately 1,000 completing the initial 12-visit minimum to qualify for free full-year membership. The program has proven successful even in rural regions, as demonstrated by recent experiences for our affiliate health plan in Nebraska, Arbor Health Plan:

City	# of Households	Total # of Individuals	Total # of visits
S. Sioux	46	235	1077
Kearney	41	149	281
Norfolk	26	57	166
Hastings	25	93	418
Scottsbluff	44	112	237
TOTAL	182	646	2179

Exhibit 3.2.14-B: Sample of YMCA benefit use for Arbor Health (Nebraska)

Member Program Case Study: Getting Fit, Family Style

A Nebraska mom joins “Try the Y” for family fun, fitness, and good health.

When Melinda’s son had open-heart surgery at 2-years-old, he weighed less than 25 pounds. He was dangerously small compared to other boys his age. But after the surgery, the weight stayed on and the scale ticked slowly upward. By the time he turned 11, he was five feet tall and 186 pounds. That’s about 60 pounds overweight.

Melinda knew that her close-knit family of seven needed to get active and take control of their health. When she heard about Arbor’s “Try the Y for 90 Days” program, she got a membership at Hastings Family YMCA for herself, her husband, and their five children.

“The first three days were really hard. We were sore and no one wanted to go back,” she says “But we did.” For the first three weeks they went every day until busy summer schedules got in the way. But that didn’t stop them. They still made time for the Y several times a week for at least an hour. They played basketball. They swam. The younger kids ran and climbed through the playmaze. The Y became a place where they spent family time together.

By the end of 90 days, her son had lost more than 30 pounds, and Melinda lost 20 pounds. Her husband, who is borderline diabetic, lost about 15 pounds. “This was a way to get healthy and spend quality time together. We’re a very close family anyway, so when we do something, we do it together,” she says.

Mission GED — Given the correlation between education and health status, AmeriHealth Caritas Iowa will support Members who wish to obtain their GED. This includes reimbursing Members for testing fees and providing motivational coaching. One of our Pennsylvania affiliates, Keystone First, also provides internship and scholarship opportunities to members through the Mission GED program.

Benefit Bank — AmeriHealth Caritas has partnered with The Benefit Bank (TBB™) in Pennsylvania and South Carolina and proposes to bring the service to support Iowa as well. TBB operates through nonprofit organizations using grassroots outreach efforts to connect eligible households with work supports. Since 2006, The Benefit Bank has assisted more than 550,000 households to claim over \$1.63 billion in work and income supports at local TBB sites that aim to reach families “where they live, learn, work, play, and pray.” This model is recognized as a proven best practice for work supports outreach and has been successfully replicated within the TBB National Network which is fully operational statewide in North Carolina, Ohio, Pennsylvania, South Carolina and Texas.

Additional member health and wellness programs which we have implemented and would customize for Iowa are detailed further in Section 8.7 of our response.

3.3 Continuity of Care

1. Describe your strategies to ensure the continuity of care of members transitioning in and out of the program, and transitioning between Contractors and funding streams.

Whether members are transitioning between managed care organizations MCOs or between the managed care and fee-for-service Medicaid programs, AmeriHealth Caritas Iowa has the same goal: support members and ensure they receive the care they need. When receiving members, we do this by first

identifying their health and coordination needs, understanding what has already been done to address those needs, coordinating the transition with the relinquishing health plan and/or service providers, and then ensuring their known needs will continue being met and coordinating with members and providers to address any newly identified needs. When relinquishing members, AmeriHealth Caritas Iowa assists the receiving entity in understanding member needs by sharing member-approved care data, including open authorizations and utilization history, with special consideration for members with open authorizations, special health needs, or who are admitted at the time of transition. AmeriHealth Caritas Iowa continues to provide services to members until they are officially disenrolled from the plan. AmeriHealth Caritas of Iowa understands the opportunity to enhance members' care by strengthening the systems and standards associated with member transitions. The Iowa Health and Wellness Plan and IME's expansion of managed care are dramatically increasing the number and importance of such transitions. We are committed to both receive and share Member Clinical Summaries, plans of care and lists of open authorizations to ensure continuity of care for incoming and departing members. We also encourage the state to review its policies and protocols for health plan transitions to facilitate member satisfaction and continuity of care, and we pledge to work cooperatively with the state to develop a maximally effective approach.

AmeriHealth Caritas of Iowa's commitment

Transitions in care, whether they are between MCOs, Medicaid programs, or even providers, have the potential to disrupt the services needed to optimize members' care plans and reduce member engagement. AmeriHealth Caritas Iowa understands the important role our Care Management teams, Member Services representatives, and Utilization Management (UM) associates play in assisting members through the process and ensuring there is continuity of care.

For members transitioning into our plan, AmeriHealth Caritas Iowa will carefully coordinate their care to support continuity and prevent disruption. Medically necessary services indicated in the member's care plan are continued throughout the transition period, and do not require prior authorization.

Existing providers are allowed to continue service delivery throughout the transition period, regardless of whether they are contracted in AmeriHealth Caritas Iowa's network. We honor any open service authorizations, which may be received from the state or from the relinquishing plan.

Transitioning members also go through the welcome process, which is designed to help AmeriHealth Caritas Iowa fully understand members' ongoing and unmet needs.

AmeriHealth Caritas Iowa recognizes that members who are pregnant, are in the hospital, have special health care needs, or are using durable medical equipment (DME) at the time of transition face higher risks while transitioning between MCOs or Medicaid programs. The transition period for these members includes additional coordination activities, and may include longer care continuation allowances.

When members transition out of our plan, AmeriHealth Caritas Iowa assists the new MCO or fee-for-service representative in coordinating the member's care. We will forward, upon request, a copy of the member's records. This request is completed timely to support continuity in care. For members with open authorizations, special health needs, or who are admitted at the time of transition, AmeriHealth Caritas Iowa proactively alerts the new MCO about the member's ongoing health needs to facilitate continuity of care.

AmeriHealth Caritas Iowa's Care Management teams, Member Services representatives, and Utilization Management associates are dedicated to providing a high degree of care coordination to preserve continuity of care. This care coordination is available to members who are joining the plan, leaving the plan, or transitioning between providers or care settings within the plan.

Coordinating Member Transitions Into and Out of the Plan

Whether members are transitioning between MCOs or between the managed care and fee-for-service Medicaid programs we support members to ensure they receive the care they need. When receiving members, we do this by first identifying their health and coordination needs, understanding what has already been done to address those needs, coordinating the transition with the relinquishing health plan and/or service providers, and then ensuring that their known needs will continue being met and coordinating with members and providers to address any newly identified needs. When relinquishing members, AmeriHealth Caritas Iowa assists the receiving entity in understanding member needs by sharing member-approved care data, including open authorizations and utilization history, with special consideration for members with open authorizations, special health needs, or who are admitted at the time of transition. AmeriHealth Caritas Iowa continues to provide services to members until they are officially disenrolled from the plan.

Receiving New Members

AmeriHealth Caritas Iowa learns of new members joining the plan through daily ASC X12N 834 Benefit Enrollment and Maintenance transactions sent by DHS's Enrollment Broker, as well as the Monthly Eligibility File, which contains the most current record for each recipient and their initial enrollment date information. AmeriHealth Caritas Iowa also receives information on prior utilization through the Enrollment Broker report. Authorization data is received from the relinquishing health plans. Using this information, AmeriHealth Caritas Iowa's Utilization Management team reviews open authorizations and, if the member's records have not already been received, requests additional information from the relinquishing plans or program staff using the standard request form. Our Utilization Management team ensures that the received authorization data — including services approved, authorized date span or visit quantity, and facility/provider names, addresses, phone and fax numbers — is entered in our, our core clinical care management platform, Jiva®.

Authorization data is automatically shared between Jiva and Facets®, our core claims administration platform, on a daily basis. By receiving and entering authorization data in a timely manner, AmeriHealth Caritas Iowa ensures that claims submitted for previously authorized services are not denied.

AmeriHealth Caritas Iowa honors authorizations approved by the relinquishing plan, and does not require additional prior authorizations during the transition period. The UM team contacts the member's PCP, or other providers as appropriate, to verify the member's health status and the need for continuation of services and facilitate arrangements to continue the care. Previous treatment plans remain in place for up to 90 days unless revised by a member and his or her PCP. This includes medication regimens. AmeriHealth Caritas Iowa provides continued access to maintenance medications, antidepressants, antipsychotics, and other drugs that are not on our formulary or preferred drug list throughout the transition period.

Maintaining Provider Relationships

AmeriHealth Caritas Iowa recognizes that maintaining provider relationships can be critical to continuity of care. During the transition period, our Utilization Management or the Rapid Response team coordinates with members and their providers if, at the time of enrollment, they are participating in a previously authorized, ongoing course of treatment. This includes coordinating with out-of-network providers. As needed, our network management team will negotiate a single-case contract for continuing care with a non-participating provider.

During the new member welcome process, all new members are provided with information about AmeriHealth Caritas Iowa, service information, emergency numbers, and instructions on who to contact to ensure that ongoing medically necessary covered services are continued.

Timeframes

The table below outlines the standard timeframes used when continuing and issuing new authorizations for ongoing services for members who are new to AmeriHealth Caritas Iowa. Cases requiring ongoing approval beyond those outlined in the table are reviewed by an AmeriHealth Caritas Iowa medical director.

Domain	Measure	Source	Frequency
Prevention	Hospitalization Rates for Preventable Conditions <ul style="list-style-type: none"> • Dental Conditions • Vaccine Preventable Conditions • Nutritional Deficiencies • Bacterial Pneumonia • Dehydration • Hypoglycemia • Kidney Infection • Angina • Asthma • COPD • CHF • Diabetes Hypertension 	Claims Management System	Quarterly
	Hospitalization Rates for Care Coordination Sensitive Conditions in People with Impaired Mobility <ul style="list-style-type: none"> • Bowel Impaction • UTI • Pressure Ulcers 	Care Management System	Quarterly
Utilization	Nursing Home Admissions and Length of Stay	Informatics	Monthly
	Emergency Room Visits	Informatics	Monthly
	Rate of all-cause hospital readmissions within seven days and 30 days	Informatics	Monthly
	Individuals supported through HCBS state plan and waiver program compared to Medicaid nursing home services	Informatics	Monthly

Domain	Measure	Source	Frequency
Community Integration	Percent of beneficiaries certified as nursing home eligible who are supported with community based services	Care Management System	Quarterly
	Rate of member discharge to the community	Care Management System	Quarterly
	HCBS state plan and waiver participants who receive supports in a home of their own	Care Management System	Quarterly
	Beneficiary satisfaction with care management	Satisfaction Survey	Annually
	Beneficiaries who can identify care manager	Satisfaction Survey	Annually
	Frequency of contact with care manager	Care Management System	Monthly
	Percent of care plans are shared with PCP, other care providers and member/caregiver(s)	Care Management System	Monthly
	Proportion of people reporting that service coordinators help them get what they need	Satisfaction Survey	Annually
Care Transitions	Member of care management team communicates with member 24 hours prior to, and within 24 hours of, discharge to new setting	Care Management System	Quarterly
	Beneficiary medications reviewed within 24 hours of discharge/transition notification	Care Management System	Monthly
	Number of members by place of disposition after discharge from SNF	Informatics	Quarterly
	Readmission rate to SNF	Informatics	
Palliative Care	Proportion of beneficiaries who have signed advance directives	Care Management System	Quarterly

Domain	Measure	Source	Frequency
Behavioral Health	Rate of readmission to psychiatric hospitals within 30 days and 180 days	Informatics	Quarterly
	Number of beneficiaries served by substance abuse program	Informatics	Quarterly
	Ability to get mental health services quickly	Satisfaction Survey	Annually
	Percent of beneficiaries receiving outpatient follow-up after a psychiatric admission within seven days of discharge	Informatics	Quarterly
Functional Status	Percent of beneficiaries who have had functional assessment of ADLs/IADLs	Care Management System	Quarterly
	Improvement in ambulation	Care Management System	Annually
	Improvement in urinary incontinence	Care Management System	Annually
	Improvement in bathing	Care Management System	Annually
	Improvement in transferring	Care Management System	Annually
	Improvement in proportion of days covered (PDC) rate for high-volume drug classes	PerformRx Reports	Quarterly
Medication Management	Percent of members who receive drug regimen review at least annually	PerformRx Reports	Annually
	Percent of members receiving medications identified as high-risk	PerformRx Reports	Quarterly
Self-Direction	Member involvement in care planning	Care Management System	Annually
	Member participation in decisions concerning their treatment	Care Management System	Quarterly
	Members receiving information to make informed choices	Care Management System	Quarterly

Domain	Measure	Source	Frequency
	Members reporting that staff are sensitive to their cultural, ethnic, or linguistic background	Satisfaction Survey	Annually
	Members reporting that they live in a place of their choosing	Satisfaction Survey	Annually
	Degree to which members feel they are informed about available resources in the community	Satisfaction Survey	Annually

Exhibit 3.3-A: Timeframes for Continuation of Authorized Benefits Post-Transition

Continuity of Care for Pregnant Women

AmeriHealth Caritas Iowa ensures that members who are pregnant have access to medically necessary covered prenatal services, delivery, and post-natal care while transitioning into the plan, without requiring additional prior authorizations. Care delivered by non-participating providers is covered until they are transitioned to a network provider (members in their first trimester), until 60 days post-partum (members in their second or third trimester), or until they become ineligible for Medicaid. AmeriHealth Caritas Iowa Bright Start maternity staff will work with the member to assist with the transition to an in network provider if they are in their first trimester, and will reach out to the non-participating provider to ensure the obstetrical needs assessment form (ONAF) is completed in order to obtain all pertinent pregnancy information for the member. This will also assist in ensuring that all pregnancy services by the out-of-network provider are covered and claims paid. Once a pregnant member is identified, she is invited to participate in AmeriHealth Caritas Iowa’s Bright Start maternity management program, which provides care coordination for and member education about all components of perinatal care, including prenatal, neonatal and post-partum services. Members with high-risk pregnancies receive intensive care management services. Bright Start associates are responsible for ensuring pregnant members can access the prenatal services they need to have the healthiest pregnancy possible and get the best care for their newborns.

Continuity of Care for Inpatient Members

For members who are in the hospital on their enrollment start date, a utilization management associate coordinates with the facility’s care manager or discharge planners to facilitate discharge plans and identify the member’s discharge needs. In some cases, for members in targeted populations, an AmeriHealth Caritas Iowa care manager contacts the member to collect information on the member’s living situation, contact information and available discharge supports. AmeriHealth Caritas Iowa recognizes that the plan is responsible for any care the member receives that is not related to the hospitalization but is provided while the member is hospitalized. The Utilization Management department will provide the facility an inpatient authorization to cover the ancillary and professional charges related to the inpatient stay. This authorization will be provided back to the date of the member’s eligibility with the health plan.

As discharge nears, an AmeriHealth Caritas Iowa Utilization Management associate assists with authorizations or arrangements for follow-up care. Once the member is discharged, our care management team works with the member to complete a New Member Assessment and refer to a care manager

depending on the member's transition and ongoing needs. If opened to case management, the care manager will complete a more detailed assessment, care plan with priority goals and ensure appropriate specialist and PCP follow-up is received.

Continuity of Care for Members with Special Health Needs

AmeriHealth Caritas Iowa gives special consideration to members with significant health conditions, recent or upcoming surgeries, and chronic conditions that require ongoing monitoring. Previously authorized medically necessary services are provided for up to 90 days or until the member may be reasonably transferred without disruption and the care plan has been developed and approved. Utilization review nurses will refer these members to the Care Management team for further follow up and coordination.

After identifying these members either from the relinquishing MCO, DHS prior authorization file, or UM referral, an AmeriHealth Caritas Iowa Rapid Response associate or care manager will contact the member to perform an initial Health Risk Assessment. If the assessment results indicate that the member would benefit from case management, the member is invited to participate in AmeriHealth Caritas Iowa's Integrated Health Management (IHM) program.

AmeriHealth Caritas Iowa sees every member encounter as an opportunity to assess for any indication of needed services.

All departments and teams—including Member Services, Rapid Response, Care Management, and UM—are encouraged to refer members to AmeriHealth Caritas Iowa's IHM program.

After an IHM nurse care manager completes a comprehensive clinical assessment, he or she collaborates with the member, the PCP, and any specialists treating the member to establish an individualized plan of care, which typically includes regular monitoring, member education, and coordination of needed services.

Continuity of Care for Member Receiving DME Services

Authorizations for members provided with or approved for durable medical equipment, prosthetics, orthotics, and certain supplies by another MCO or other Medicaid program are continued without need for additional approval for up to 90 days. AmeriHealth Caritas Iowa works with members and their providers to ensure DME services meet medical necessity criteria and health plan requirements. The Utilization Management department will contact the provider, in network or out of network, to ensure that services are not interrupted and authorization is entered in the system to facilitate this transition. If services are going to be needed past the 90 days, and being provided by an out of network provider, the Utilization Management review nurse will work to identify an in network provider and facilitate the transfer of services if appropriate. The Utilization Management review nurse will also notify Provider Network Management if the out of network provider would like to start contracting with the plan. If so, the services would not be transferred to an in-network provider at that time.

Continuity of Pharmacological Care

AmeriHealth Caritas Iowa has detailed processes and systems in place to provide members with continued access to maintenance medications, antidepressants, antipsychotics, and other drugs that are not on our formulary or preferred drug list for at least 60 days after they enroll in the plan, to prevent interruption to their medication regimens. During the transition period, care management and pharmacy benefit management associates work with the member and the prescribing practitioner to either transition the member to a formulary medication or secure ongoing approval for the non-preferred drug.

AmeriHealth Caritas Iowa and PerformRx, our affiliate and pharmacy benefits manager (PBM), are implementing an enhancement that provides new members with information about AmeriHealth Caritas Iowa's pharmacy benefits, filling their existing prescriptions during the transition period, and steps they should take to either identify a covered alternative or continue with their existing prescription beyond the transition period.

Relinquishing Existing Members

AmeriHealth Caritas Iowa continues to support members while they are transitioning out of the health plan. After receiving notice from the enrollment broker or the new MCO that a member is transitioning out of the plan, AmeriHealth Caritas Iowa's Utilization Management department reviews the member's authorization history and prepares the documentation to be sent. This includes:

- Services authorized.
- Authorized date span or visit quantity.
- Facility/provider names.
- Address, phone numbers, and fax numbers.

All authorization information is sent via secure email to the new plan's point of contact. These medical records and supporting documentation are sent in a timely manner. To promote continuity of care, AmeriHealth Caritas Iowa's provider contracts include a provision requiring cooperation in the event the member transitions out of the plan. If the member transitions to a new MCO, the providers are to collaborate with the member and the new plan to support continuation of medically necessary services, including providing the member's medical record, during the transition period. AmeriHealth Caritas Iowa continues to provide members with medically necessary covered services, in accordance with their established treatment plans, up to the official date of disenrollment. If a member is hospitalized at the time of disenrollment, AmeriHealth Caritas Iowa notifies the member's new MCO of that status, and continues to provide services related to the hospitalization until the member is discharged. As appropriate or requested, AmeriHealth Caritas Iowa will collaborate with the new MCO and the member to plan the member's discharge.

Facilitating Transitions Between Providers

AmeriHealth Caritas Iowa maintains as many provider relationships as possible. In instances where a member's treatment plan is managed by an out-of-network provider, AmeriHealth Caritas Iowa may attempt to contract with the provider so that continuity may be preserved once the course of treatment is completed. If that is not possible for whatever reason, an AmeriHealth Caritas Iowa care manager will work with the member and the existing provider to identify a point in time when the member's care can be transitioned to a network provider.

Continuation of care is provided for members with open active treatment plans if a provider managing their care is terminated from the network (either by AmeriHealth Caritas Iowa or of their own volition unless termination is for quality or exclusion reasons). AmeriHealth Caritas Iowa will actively work with members to identify acceptable alternative participating providers to transition their care. As part of continuity planning, members with open treatment plans may continue to receive services with the exiting provider (with exiting provider agreement) until such time as treatment is completed or 90 days whichever comes first.

AmeriHealth Caritas Iowa may authorize ongoing care from non-participating providers, beyond the end date of the previous authorization or the continuity of care period, if there is not sufficient expertise or

access within the regional network to provide appropriate care to the member. In those situations, a single case contract may be negotiated, documenting the approved services, duration and payment in writing.

Member Snapshot: AmeriHealth Caritas Iowa's Member Clinical Summary

AmeriHealth Caritas Iowa enables network providers to quickly and easily review member history and needs, facilitating the member's transition between providers and supporting continuity of care. AmeriHealth Caritas Iowa's Member Clinical Summary provides a snapshot of the member's recent prescription history, chronic conditions, inpatient admissions, ER visits, and office visits. The Member Clinical Summary also includes the member's demographic information, open authorizations, and identified gaps in care. The summary is reflective of plan data and fee-for-service data that was received by the health plan at the time of the member's enrollment. This clinical summary can be printed and sent to the receiving MCO or DHS care management department to allow for additional coordination of the member's needs upon entry into the new MCO. The summary is accessible through AmeriHealth Caritas Iowa's NaviNet Provider Portal which also enables providers to build customized reports from the member information stored in our core claims administration and clinical care management platforms. The Member Clinical Summary, and the other available or customized reports, can be printed or downloaded in CCD or Excel CSV formats, which can then be uploaded into providers' electronic health record (EHR) systems.

To protect member privacy, the Member Clinical Summary is automatically filtered to redact member information about HIV-related information as well as behavioral health (mental health and substance abuse) diagnoses and medications.



Member Clinical Summary
Date of Report: 05/10/2015

Member Information

Name: John Doe
Address 1: 321 Street Road
Address 2:
City, State ZIP: Anytown, PA 10000
Phone: 555-555-5555
Gender: M DOB: 12/12/1987 Member ID: 12345678

PCP Information

Provider name: Jane Smith
Address 1: 456 Street Road
Address 2:
City, State ZIP: Anytown, PA 10000
Phone: 555-555-5555

Medications (within past 06 months)

Fill date	Name and strength	Days supply	Prescriber name	Pharmacy name
05/06/2015	ACETAMINOPHEN-COD #3 TABLET	10	Jane Smith	Rite Aid Pharmacy
05/06/2015	PAIN RELIEVER 500 MG CAPLET	30	Jane Smith	The Community Pharmacy
04/20/2015	VITAMIN B-6 50 MG TABLET	20	Matthew White	Penn Pharmacy
04/20/2015	PROMETHAZINE 12.5 MG TABLET	7	Matthew White	Penn Pharmacy
03/07/2015	BETAMETHASONE DP AUG 0.05% CRM	30	John Clark	Rite Aid Pharmacy

Chronic conditions

There are no data records available for this section.

Gaps in care

Condition	Service	Status	Last service	Next service	Rule
Preventive Health Screens	Adults Access to Care	Due soon	06/19/2014	06/19/2015	At least once per year.
Critical Quality Incentive	Cervical Cancer Screen	Up-to-date	03/05/2014	03/05/2017	Once every 3 to 5 years test dependent.

ER visits (within past 06 months)

Date	Facility	Reason
03/07/2015	Reading Hospital	OTHER PSORIASIS AND SIMILAR DISORDERS – Emergency department visit for the evaluation and management of a patient which requires these three key components: an...

Inpatient admissions (within past 06 months)

From date	To date	Facility	Reason
There are no data records available for this section.			

Office visits (within past 06 months)

From date	Provider name	Speciality	Reason
There are no data records available for this section.			

Imaging

Date	Facility	Reason
09/02/2014	Curtin William M.	76819 – Fetal biophysical profile; without non-stress testing.
06/23/2014	Testa Christopher J.	7681626 – Ultrasound pregnant uterus real time with image documentation follow-up eg re-evaluation of fetal size by measuring.
06/23/2014	ST Joseph Medical Center	76816TC – Ultrasound pregnant uterus real time with image documentation follow-up eg re-evaluation of fetal size by measuring.

Exhibit 3.3-B: Supporting Continuity of Care through the Member Clinical Summary

AmeriHealth Caritas Iowa's Commitment to Meeting Member Health Needs

As a member-focused MCO, AmeriHealth Caritas Iowa is dedicated to identifying and fully understanding our members' initial, ongoing, and/or unmet health needs. From there, associates in our Care Management, Utilization Management, the Rapid Response team, and Member Services departments work with members and providers to ensure those health needs are met. This includes:

- Referring and providing scheduling assistance for members in need of specialty health care, transportation, or other service supports.
- Monitoring members with complex health conditions or comorbidities to identify gaps in care and evaluate treatment adherence/progress.
- Collaborating with members, facility staff, and providers to plan discharges and other transitions in care so that appropriate steps are taken to safeguard members' health and quality of life.

As members transition into our plan, AmeriHealth Caritas Iowa works with each new member to collect information on their existing health needs, care plans and service providers. This is primarily accomplished through the new member welcome process, which includes welcome calls, a welcome packet, and a New Member Assessment. Through these activities, AmeriHealth Caritas Iowa can identify and provide the medically necessary covered services that the transitioning member will need, as well as what internal resources—such as intensive case management, maternity management, or disease management (e.g., asthma, sickle cell disease)—can support the member's continuity and ongoing management of care.

Sharing Information through the New Member Welcome Process

AmeriHealth Caritas Iowa welcomes new members to our program through our welcome packets, welcome calls, and the Member Handbook. These materials are designed to inform members about the MCO, service information, emergency numbers, and instructions on how to obtain services. Continuity of care provisions for ongoing courses of treatment are detailed in the Member Handbook. AmeriHealth Caritas Iowa encourages the members to let us know—either on the welcome call or through our New Member Assessment—if they have special health needs or are receiving ongoing care. These members are referred to AmeriHealth Caritas Iowa's Rapid Response team to ensure appropriate care coordination and care management services are offered to the member to prevent service disruption.

Encouraging Member Engagement through the Welcome Packet

AmeriHealth Caritas Iowa sends welcome packets that include a welcome letter, a Notice of Privacy Practices, the Member Handbook, and a copy of the New Member Assessment. The welcome letter informs members that they will be receiving a call from the plan, but encourages them to reach out to Member Services if they have any questions before then. The letter also includes a brief checklist that encourages members to:

- Read the Member Handbook.
- Select a network PCP if they have not chosen one.
- Schedule an appointment with their PCP within 90 days of enrolling in the plan.

Welcome packets are available in English, Spanish, and a multitude of other languages to ensure the majority of members can access the information. Through our translation vendor, AmeriHealth Caritas Iowa can provide all member materials more than 200 additional languages—including French, Arabic, Nepali, and Burmese—upon request.

The Member Handbook included in the welcome packet details key information about AmeriHealth Caritas Iowa, covered services, and member rights and responsibility. This includes members' right to choose and their PCP, as well as a description of how to do so. Instructions on accessing care, prior authorization requirements, and advance directives are discussed. A description of what constitutes fraud, waste and abuse is also included. AmeriHealth Caritas Iowa's care management programs are discussed, and encourage members to call the appropriate department for more information.

Introducing the Plan through the Welcome Call

The first interpersonal contact most members have with AmeriHealth Caritas Iowa is the welcome call—for members transitioning from fee-for-service, the welcome call may be their first interaction with a managed care plan. After welcoming the member to the health plan, a brief explanation of the program and a confidentiality statement is provided. Covered services, including the availability of interpretation and translation services, are discussed in a friendly and engaging manner.

The Member Services representative provides information about continuation of services through the transition period, and provides key contact information, such as Member Services, Rapid Response, and emergency numbers. The Member Services representative also asks questions to identify any current or ongoing health needs the member may have—including chronic conditions, special health needs, and/or pregnancy. These needs are communicated to AmeriHealth Caritas Iowa's Integrated Care Management and/or Bright Start maternity management teams for further health assessment and care coordination.

Identifying Member Needs through the New Member Assessment

AmeriHealth Caritas Iowa considers the New Member Assessment a critical component of fully understanding members' health needs. Data collected through the assessment enables us to triage members into appropriate components of our Integrated Care Management program. The assessment asks members to identify the services—both clinical and non-clinical—they are receiving as well as their current providers. By capturing this information before claims data or data from the relinquishing health plan/program is received, AmeriHealth Caritas Iowa can begin coordinating care immediately for members whose health needs are time sensitive.

For members with special health needs, accessing the care they need may rely on specialized transportation services. Identifying these members as soon as possible may help prevent disruption in care by transitioning them to AmeriHealth Caritas Iowa's non-emergency medical transportation vendor.

Due to the critical role it plays in care coordination during the transition period, AmeriHealth Caritas Iowa uses a number of outreach methods to connect with members and complete the New Member Assessment. A hardcopy of the New Member Assessment is included in the welcome packet, and Member Services representatives can walk through the assessment with the member during the welcome call. Members may also fill out the assessment electronically through AmeriHealth Caritas Iowa's Member Portal. Ongoing outreach attempts are made, even after the transition period, to engage members who do not have a completed assessment on record. For example, when members call the plan, their records are screened to identify whether they have completed the assessment; if they have not, they are encouraged to do so during the call.

Respecting Member Privacy while Transferring Medical Records

When AmeriHealth Caritas Iowa forwards a copy of the member's medical records to the receiving health plan, we ensure that the member's privacy is protected consistent with federal and state confidentiality requirements, including protections in the Health Insurance Portability and Accountability Act (HIPAA) and

45 CFR Parts 160 and 164. AmeriHealth Caritas Iowa maintains policies and procedures to ensure confidentiality is protected.

We understand that some protected health information is sensitive; therefore, AmeriHealth Caritas Iowa reserves the right to deny access to sensitive information, such as information about sexually transmitted diseases (STDs), HIV-related information, mental health records, substance abuse records, and/or genetic testing. Members (or their representatives) will be asked to sign and date a release form before AmeriHealth Caritas Iowa releases these records to another party.

3.4. Coordination with Medicare

1. Describe your proposed approach and strategies for coordinating care for duals (members with both Medicare and Medicaid coverage).

AmeriHealth Caritas Iowa will work with members to maximize their available benefits. We waive authorization for Medicare covered services provided by a Medicare provider and pay our co-insurance. We educate the staff on Medicare benefits available to members so that we can assist the members to maximize their benefits.

We will provide ongoing care management support, including individual care management assessment and plan of care for members with Medicare in collaboration with other care managers involved or we will be the sole care manager if none exists for the member

We will ensure that others involved in the member's care are aware of services/benefits available through Medicaid that may not be covered by Medicare.

We will pay the member-responsibility section of Medicare cross-over claims. For Medicare services that are covered by AmeriHealth Caritas Iowa, AmeriHealth Caritas Iowa will pay, up to the AmeriHealth Caritas Iowa contracted rate, the lesser of:

- The difference between the AmeriHealth Caritas Iowa contracted rate and the amount paid by Medicare.
- The amount of the applicable coinsurance, deductible and/or co-payment.

In addition our claims processing system tracks non-covered and exhausted benefits, to minimize the administrative burden to providers. Non-covered and exhausted benefits are services which have been deemed as not payable by the Primary Insurance Carrier based on the member's plan. Once Third Party Resource has been sufficiently documented as exhausted or non-covered, the provider is not required to submit an explanation of benefits along with the claim, which is processed as primary.

Our claims platform, Facets® will be configured to meet the specific coordination of benefits (COB) payment guidelines for the state. In any given month, we currently process approximately 175,000 COB claims through our claims platform.

In addition, accumulators can also be set in Facets to do the following:

- Track benefits by either dollar amount or number of visits (counter).
- Track benefits at the member or family level.
- Identify accumulator buckets for all members of a specific product.
- Track accumulations by a specified amount of time (yearly or by lifetime).
- Track the amount of money spent or saved through COB.

2. Explain how your staff will be trained to assist dual-eligible members with questions about benefits, appeals, grievances, and other topics where Medicare and Medicaid policies may differ.

AmeriHealth Caritas' training process begins with our recruitment strategy, which is geared to identify candidates with the necessary upfront competency, including computer proficiency and people skills, to provide high-quality customer service to our member's. Every associate must demonstrate these abilities to move forward with the interview process. New hires undergo six weeks of extensive in-class training and instruction about the health plan's program-specific benefits, as well as the demographics and geographical resources of the areas covered by the health plan. While training topics differ among categories of staff, there is a fixed curriculum that must include:

- Patient privacy and confidentiality, HIPAA and corporate compliance.
- Fraud, waste, and abuse training.
- Diversity and cultural sensitivity.
- Employee code of conduct.
- Medicaid basics/program overview.
- Dual Eligible/Medicare overview.

Each department also has Job Specific Training Plans. These cover fundamental health care and customer service topics, as appropriate to job functions, which may include:

- Complaint and grievance processes.
- Continuity of care and relapse prevention.
- Coordinating care for member's with complex care needs.
- Corporate compliance and fraud and abuse.
- Member eligibility.
- Health care terminology.
- Identifying emergencies and how to respond to them.
- Information management systems and core technology tools.
- Integrated care management.
- Member-focused service.
- Recovery and resiliency.
- Soft skills and providing superior customer service.

Department management, in cooperation with the Human Resources Department, is responsible for facilitating staff training. Training is provided by experienced staff, key stakeholders, and external experts, as appropriate, as well as with the use of interactive online training tools.

Call Center of Excellence Training

The call center's number one priority will be to provide prompt, professional, and courteous customer service to members and their representatives. To ensure this high level of service, call center staff training will emphasize that all callers should be treated with dignity and respect, and privacy and confidentiality are top priority. They will also be coached on AmeriHealth Caritas Iowa's services, departments, and key contacts so they are prepared to connect each member call to the appropriate internal resources. Additional topics covered by the comprehensive call center training program include:

- State Medicaid and federal Medicare regulations
- Customer service soft skills, phone etiquette, and professionalism, especially when working with members with special needs
- Active listening, call documentation, and verifying member understanding before call conclusion
- Culturally and Linguistically Appropriate Services (CLAS) standards and serving members with limited English proficiency (LEP), focusing on:
 - a) Understanding cultural competency and how culture affects communication.
 - b) Promoting awareness of cultural values and beliefs.
 - c) The Plan's Cultural Competency Initiative.
- Using TTY (teletypewriter)/TDD (telecommunication device for the deaf) services.

AmeriHealth Caritas Iowa recognizes that engaging members in their preferred languages is critical to our ability to effectively coordinate their care and connect them to the services they may need. To provide a high level of culturally and linguistically sensitive care, we will ensure that the call center is equipped to meet the needs of Iowa population.

Prior to independently taking live telephone calls, new call center associates are required to participate in phone lab training sessions and side-by-side training with experienced representatives. These sessions are hands-on, with new employees taking calls from members and providers with the assistance of their trainers. Throughout the formal training program, new associates are required to complete skill-based assessments, and on completion of formal training, new associates are required to pass an exam that evaluates their general and module-specific knowledge and that assesses their readiness to begin their job functions. If needed, refresher training is scheduled to ensure every associate has the knowledge they need.

Grievance and Appeal Training

Associates of AmeriHealth Caritas Iowa who perform grievance and appeal reviews will be required to undergo rigorous orientation and clinical training to ensure they can make informed and impartial determinations. Each associate will also be required to perform responsibilities consistent with his/her training, education, licensure, certification, and applicable state and federal laws.

Claim Processing Training

The eleven week claim processing training program is broken into three modules, allowing new associates to learn to process one type of claim at a time. These modules are:

1. Medical Claim Processing.
2. Hospital Claim Processing.
3. Coordination of Benefits.

As each module of the training program concludes, new associates begin processing that claim type in the production environment. A random sample (between five and 30 percent) of claims processed that day by each new associate is audited for early identification and correction of training needs. This daily auditing will last for three weeks after the Medical Claim Processing module, and for two weeks following the Hospital and COB modules. Based on capacity, the quality auditors will review any errors with the associates two to three times per week and with the trainer/supervisor at least once per week. The quality scores achieved for each associate serve as a performance management tool for the trainer and the claims management team.

Social Services Expert Unit

As detailed in our response in Section 8.1, our Social Services Expert unit coordinates the delivery of physical and behavioral clinical care with essential social services like housing, food, education, recreation, and employment with the expectation of helping members who have complex dual-benefit navigation needs. These different sectors, working along with local community involvement, can strive to promote and advocate for better coordination as a way to maximize impact on the health outcomes of individuals and communities. Coordination efforts can be directed toward improving access to and linkages of services, reducing the fragmentation and duplication of services, and increasing the individual's experience of care.

AmeriHealth Caritas Iowa will implement a dedicated Iowa Social Services Expert unit staffed with individuals who have skills that include community development, public policy and social service sector work.

PerformCARE

Peer Support Authorization Request

(Must be submitted and approved by PerformCare prior to service initiation)

Member: _____		Person Completing Form: _____	
Member DOB: _____		Provider Name/Address: _____	
SS#: _____		or MAID# (10 digits): _____	
Member's Current Address: _____		Member Phone: _____	
Release of Information for PerformCare: <input type="checkbox"/> Yes <input type="checkbox"/> No Check One: <input type="checkbox"/> Initial <input type="checkbox"/> Continued Service <input type="checkbox"/> Discharge			
<input type="checkbox"/> Recovery focused Individual Service Plan - must be attached for all continued service requests			
CPT Code: H0038 1 year Max 3600 Units Start/Discharge Date Requested: _____			

Admission Guidelines:

Recommending Physician / Psychologist / CRNP / PA: _____	
Date of Recommendation (must be within 60 days of receipt of request): _____	
Reason for Referral: <input type="checkbox"/> Education <input type="checkbox"/> Vocational <input type="checkbox"/> Social <input type="checkbox"/> Self Maintenance	
Describe Functional Impairment: _____	

ADULT PRIORITY GROUP

<p>1. Must meet age from this section to continue.</p> <p><input type="checkbox"/> Age >= 18</p>	<p><input type="checkbox"/> 2. Has met the standards for involuntary treatment (as defined in Chapter 5100 Regulations – Mental Health Procedures) within 12 months preceding the assessment is automatically assigned to the high priority group. <i>(if this box is checked, stop here, meets priority group standard and qualifies for peer support)</i></p>
<p>3. Axis I Specify Qualifying Diagnosis: _____</p> <p>295.xx Schizophrenia 296.xx major affective disorder 298.9x psychotic disorder NOS 301.83 borderline personality disorder</p> <p><i>(If Adult Priority Group is not applicable, Member is not considered to meet state definition of priority group. Refer to exception request process if applicable)</i></p>	

Must meet one of the following A, B or C. Check the criteria within the column that meets the standard:

<p><input type="checkbox"/> A Treatment History</p>	<p><input type="checkbox"/> Current Residence in or discharge from a state mental hospital within past 2 years</p> <p><input type="checkbox"/> Two admissions to community or correctional inpatient psychiatric units or crisis residential services totaling 20 or more days within the past two years</p> <p><input type="checkbox"/> Five or more face to face contacts with walk in or mobile crisis or emergency services within the past two years</p> <p><input type="checkbox"/> One or more years of continuous attendance in a community mental health or prison psychiatric service (at least one unit of service per quarter) within the past two years</p> <p><input type="checkbox"/> History of sporadic course of treatment as evidenced by at least three missed appointments within the past six months, inability or unwillingness to maintain medication regimen or involuntary commitment to outpatient services</p> <p><input type="checkbox"/> One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician, (eg. Area Agency on Aging) within past two years</p>
<p><input type="checkbox"/> B Functioning Level</p>	<p><input type="checkbox"/> Fill in GAF score _____ <i>Global Assessment of Functioning Scale rating of 50 or below</i></p>
<p><input type="checkbox"/> C Coexisting Condition or Circumstance</p>	<p><input type="checkbox"/> Coexisting Diagnosis <input type="checkbox"/> Psychoactive Substance Use Disorder, <input type="checkbox"/> Mental Retardation, HIV/AIDS, Sensory, Development and/or Physical Disability (check if SA or MR)</p> <p><input type="checkbox"/> Homelessness (sleeping in shelters or places not meant for human habitation, such as cars, parks, sidewalks, or abandoned buildings)</p> <p><input type="checkbox"/> Release from Criminal Detention (applicable categories of release from criminal detention are jail diversion; expiration of sentence or parole; probation or Accelerated Rehabilitation Decision [ARD])</p>

Comments: _____

PerformCare Use Only:	Valid:	Provider Use: <input type="checkbox"/> Please check here if this is being submitted in response to a PerformCare faxed notice.	
D: _____	Pending:	Notice and/or Request Faxed Back to Provider:	
AU: _____	<input type="checkbox"/> IT	Date of Fax: _____	Fax Ref. #: _____
AP: _____	<input type="checkbox"/> CCM	Reason: (see Key-Fax Cover)	
St: _____ Ex: _____ U: _____	<input type="checkbox"/> PR		

PO Box 6600 y Harrisburg, PA 17112

Telephone: 1-888-700-7370 y Fax: 1-888-296-4002

Revised 103/13

Page 1 of 1

**Attachment 3.2.8-A: Example Peer Support Registration Form
(PerformCare is an AmeriHealth Caritas)**

4. Long Term Services and Supports

Please explain how you propose to execute Section 4 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience. Provide any relevant data regarding member or provider satisfaction with MLTSS programs you operate in other states.

Overview

Since 1997, AmeriHealth Caritas Family of Companies (AmeriHealth Caritas) has taken an integrated approach to serving members with complex and chronic needs. AmeriHealth Caritas Iowa is uniquely suited to be Iowa's partner in serving the individuals across the state who receives some form of long-term services and supports (LTSS). AmeriHealth Caritas Iowa will implement a person-centered model designed to address each member's health needs across the entire LTSS population.

We are confident that with AmeriHealth Caritas Iowa's approach, experience, and expertise, we are the right managed care organization (MCO) to help Iowans most efficiently and effectively receive the long-term services and supports they need through person-centered and fully integrated care planning, including physical health, behavioral health and LTSS.

- AmeriHealth Caritas Iowa's LTSS program is founded on a person-centered model that will drive outcomes for the member and the state.
- We will partner with you to ensure effective implementation of this program and care for the Department of Human Services' most needy members.

Focused on Iowa's most pressing needs

Iowa's aging and disability landscape is evolving in response to many challenges that have been evident throughout the state. AmeriHealth Caritas Iowa has a LTSS program to address Iowa's specific needs state.

According to Iowa's 2014 – 2015 state Plan on Aging, 26,092 individuals age 65 and over reside in a nursing facility (NF). This number represents 57 Iowans per 1,000 over the age of 65 compared to 35 per 1,000 nationally. Iowa ranks second in the nation only to North Dakota in the percentage of population in NFs. These drastic numbers suggest room for improvement in providing home and community-based services (HCBS).

This opportunity in LTSS is further confirmed by the level of NF residents with low-care needs. Iowa is fourth in the nation in the proportionate number of NF residents with low-care needs. Twenty-six percent of NF residents are identified as having low-care needs compared to just over 15 percent nationally. This high utilization of NFs suggests that too many Iowans are entering NFs and that strengthening the community-based network is essential to balancing the long-term care system to align with what older Iowans say they want. Most importantly, enhanced HCBS are what Iowans want. Ninety-three percent of Iowans age 50 and over say it is important to be able to stay in their own homes as they age.

Additionally, services such as adult day services, chore and homemaking services, and transportation services that are operated by small, nonprofit organizations are rapidly eroding, are not developing or are no longer available in multiple regions across Iowa. The net result is that if resources are available to purchase a service, the service may not be available in the community. In turn, this forces older Iowans rely on institutional models, such as intermediate care facilities, residential care facilities and assisted living.

To enable individuals to stay in their homes, family caregivers are providing a majority of the direct care to older Iowans living in the community. The Iowa Family Caregiver Program is a tremendous resource to all Iowans. However, due to limited resources, the variety of information and support available is limited, as well.

Iowa is ranked in the second quartile overall on the AARP Long Term Care Score Card and is doing extremely well in several areas. For instance, Iowa ranked fourth in Quality of Life and Quality of Care, first in Nurse Delegation of Health Maintenance Tasks, and ninth in Nursing Home Staff Turnover Rates. Overall, Iowans are very satisfied with their quality of care. Their home care aides can perform all 16 skilled health maintenance tasks and Iowa has a stable workforce in the NF. However, Iowa has opportunities to improve in the following areas: Iowa ranks 51st on the AARP Long Term Care Scorecard in successfully transitioning individuals with a 90+ day stay in a nursing home back into the community; 48th in the supply of home health aides; 41st in nursing home residents with low-care needs; and only seven of every 1,000 eligible Iowans self-direct their own care.

AmeriHealth Iowa has built our LTSS program to address Iowa's specific challenges and believe there are five distinguishing features of AmeriHealth Caritas Iowa's approach:

1. AmeriHealth Caritas Iowa delivers excellence across each of the core elements of a best-in-class LTSS program.
2. AmeriHealth Caritas Iowa's deep understanding of the needs of the different populations served by Iowa Department of Human Service's (DHS') LTSS programs allows us to tailor our processes and programs to the specific needs of each client population.
3. AmeriHealth Caritas Iowa already has spent significant time "on the ground" in Iowa to identify the current needs and ongoing initiatives across the state.
4. AmeriHealth Caritas Iowa will partner with Iowa to further invest in strengthening provider- and community-based delivery systems and enable a smooth transition to managed care.
5. AmeriHealth Caritas Iowa's leadership team brings the experience you should expect in a partner to serve your most vulnerable populations.

In this overview, we introduce each of these features in depth.

1. Best-in-class LTSS program

AmeriHealth Caritas Iowa has a unique set of tools and experience that enable an exceptionally high-quality and cost-effective approach to LTSS. AmeriHealth Caritas has relevant experience with the LTSS population through our Dual Special Needs Plans (D-SNPs) in Pennsylvania and our integrated Medicare Medicaid Plans (MMPs) in South Carolina and Michigan, as well our broad Medicaid experience servicing high-acuity members nationwide.² We adopt a whole-person approach to address distinctive needs and issues of the LTSS population. Similarly, in Iowa, through integration of physical, behavioral, social, medical, and community resources, AmeriHealth Caritas Iowa will address barriers that impact the ability

-
- 2 Dual-eligible members face chronic and often co-occurring physical and behavioral health conditions, as well as complex psychosocial issues including homelessness, addiction and a lack of resources that impact the member's ability to effectively receive and manage their care. These problems lead to higher rates of hospitalizations and emergency room use than average Medicare beneficiaries, along with a greater need for LTSS. Nationally, more than one-third of the dual-eligible population requires a nursing home level of care, about half of whom receive this care in a nursing home, and the other half receive Medicaid-covered personal assistance services in their home.

to self-manage care, coordinate complex care needs, assist with transitions of care, and explain and manage LTSS for the member. Accomplishing these goals will improve health outcomes, increase access to essential services, ensure seamless transitions of care, assure appropriate utilization of services, and increase member satisfaction.

We have a particularly deep understanding of the complex, multidimensional care needs of individuals who are dually eligible. AmeriHealth operates a D-SNP in our southeast and central Pennsylvania markets serving over 3,000 dual eligible members. Additionally, as a result of a series of competitive procurements, AmeriHealth Caritas was selected in 2014 to participate in the Centers for Medicare & Medicaid Services' (CMS') Financial and Administrative Alignment Demonstrations for Dually Eligible beneficiaries in South Carolina and Michigan, both currently serving duals in a capitated financial alignment model. These states have begun voluntary and then passive enrollment of duals for fully integrated Medicaid and Medicare benefits under a three-way contract with CMS and health plans, known as MMPs. Our projected MMP membership is expected to be over 15,000 members, once passive enrollment is complete.

In both of these initiatives, all LTSS benefits are the responsibility of the MMP operated by AmeriHealth Caritas. AmeriHealth Caritas' model of care developed for both of these plans, has been approved by CMS and the respective states, and integrates LTSS with all the beneficiaries' healthcare benefits.

For both states, AmeriHealth Caritas has built distinctive and operational programs to serve dual eligible members, successfully completing comprehensive readiness review processes which entails:

- A comprehensive desk-level review process of policies and procedures, including LTSS operational policies and procedures.
- Medical, pharmacy, LTSS and behavioral health network validation process.
- Onsite readiness review, including demonstration of comprehensive, integrated care management systems and live claims adjudication processing for medical, pharmacy and LTSS claims.
- Approval of a person-centered, integrated care management approach (model of care) for delivery of healthcare, behavioral health and LTSS services, including the scope of services inherent to Medicare beneficiaries who are eligible for Medicaid. This model of care was built on best practices and core operating principles of the Massachusetts Senior Care Options model, a proven approach for delivering integrated care in a financially aligned approach.

Our experience has led to successful programs in both urban and rural areas, as exemplified by our MMP plan in South Carolina which operates in 38 out of 46 counties of the state, most of which have a rural designation.

AmeriHealth Caritas' Rural Experience in South Carolina:

In South Carolina, 25 counties have been designated as rural, and most areas of the state have Health Professional Shortage Area (HPSA) designations. AmeriHealth Caritas' MMP's rural service area consists of 22 of the total 25 rural counties (88 percent).

South Carolina currently has five regional rural health networks dedicated to improving access to healthcare and securing healthcare safety nets. All five rural health networks, which include multiple counties, have a common goal of increasing access to care, strengthening and expanding services to underserved areas, returning healthcare dollars to the local community, improving the cost efficiency of services and maximizing quality of healthcare. AmeriHealth Caritas' MMP affiliate in South Carolina, First Choice VIP Care Plus by Select Health of South Carolina, has fostered contractual relationships with multiple

organizations within each network, which encompasses critical access hospitals, small rural hospitals, federally qualified health centers, rural health clinics, and other community-based safety-net providers.

Since February 2015, when the state of South Carolina began its voluntary enrollment process, First Choice VIP Care Plus has served 273 members (426 members are currently enrolled) residing in South Carolina's rural counties. Passive enrollment into the health plan begins in August 2015, when the majority of the eligibles will be auto-assigned to the participating plans.

1. **High touch model of care.** Built on the foundation of AmeriHealth Caritas' integrated care model (ICM), the program takes a holistic approach that uses a population-based health management program to provide comprehensive care management services and includes assessing social conditions which may affect health or present barriers to independence. Through our fully integrated model and interdisciplinary approach, AmeriHealth Caritas Iowa will provide high-touch, person-centered care focusing on all aspects of a member's well-being. AmeriHealth Caritas Iowa will deliver and coordinate services in a way that blends high-technology stratification and analyses with appropriate levels of individual engagement such as advocacy, communication, problem solving, collaboration, and empowerment. This approach will enable AmeriHealth Caritas Iowa to effectively and efficiently connect a member with the right care at the right time and in the right setting. The model is designed around five key components/guiding principles:
2. **Individualized, relationship-based care.** The model is centered on establishing a positive, supportive relationship between the member and his/her care manager in order to manage his/her health and support activation to change. Each LTSS high risk member is assigned a care manager who serves as the point person for coordinating all aspects of the member's care, in partnership with other members of the team who may also assist with non-clinical activities. The care manager coordinates all care management activities for the member for as long as necessary, through high touch, sustained interventions.
3. **Person-centered, care planning.** Care planning that aligns the member's highest priority issues and preferences identified through the assessment process, with goals and interventions that make the most sense from the member's perspective.
4. **Focus on community-based services.** Utilization of community-based services to avoid or delay institutional-based care and support the member's desire to remain in the HCBS. AmeriHealth Caritas Iowa has met with many key community stakeholder groups, including the executive director of the Iowa Association of Area Agencies on Aging (i4a) in-person and in several telephonic conferences, to begin strategizing how our two organizations can partner to help improve the LTSS delivery system.
5. **Team approach.** An interdisciplinary approach that provides the backbone of care coordination by integrating care across treatments, providers, settings and services.
6. **Family involvement.** Recognition of the importance of caregiver support in the person-centered approach to care, and in enabling members to live a full life in their homes and communities.
7. **Provider collaboration through innovative payment arrangements.** Payment model designs that incent high-quality care and are matched to client needs, in the most appropriate setting for care. We will ensure that providers are aligned financially and share in the goal of achieving the best patient outcomes.
8. **Standardized, integrated health information platform.** An integrated technology platform that aligns the care team and community providers with a member's care management information. This is accomplished in part by using a unified comprehensive platform that can be accessed by providers and

members through a secured portal. The platform links all member data, including demographics, assessments, care plans, member interactions, claims data and reporting. This serves as the basis for members and providers to readily exchange important care data to encourage cooperative care management.

9. **Outcomes accountability.** Instilling accountability for successful program outcomes including standardized reporting metrics to measure specific outcomes, ensuring the entire care management team understands and takes ownership in their respective roles and performing regular monitoring of the program to ensure the program is performing according to established standards. We have experience in outcome accountability from our MMP programs where we are being held accountable for a set of integrated measures and have the systems in place to manage that accountability.

2. Tailored solutions for each of the populations Iowa serves

AmeriHealth Caritas Iowa is deeply committed to serving the unique needs of each individual that receives some form of LTSS. We understand that while much of the populations require similar types of support, the needs of the children and adults with intellectual and developmental disabilities are different from those of the physically disabled, frail elderly and individuals with severe behavioral health conditions.

AmeriHealth Caritas Iowa's Integrated Healthcare Model is designed to provide person-centered care, with a focus on ensuring care and services are delivered in the least-restrictive setting, at a level that meets the member's needs. We will bring our considerable experience managing physical, LTSS and behavioral health services for the most at-risk members to Iowa.

Through Keystone First, AmeriHealth Caritas Iowa's affiliate in Pennsylvania, AmeriHealth Caritas has extensive experience coordinating LTSS. At Keystone First, the Pediatric Shift Care Unit provides support and assistance to medically fragile members less than 21 years of age with complicated healthcare needs, including ventilator dependence. Many of these members would otherwise be institutionalized and all these members receive extensive skilled nursing and other in-home support services. Keystone First coordinates services for significantly more of these members than any of our competitors in Pennsylvania, because of our extensive, inclusive relationships with specialty care providers, including Children's Hospital of Philadelphia. AmeriHealth Caritas has over 1,500 pediatric members for whom we have successfully coordinated in-home, long term support services. Our 30 years of experience providing this level of in-home care allows these high-complexity members to remain at home with their families.

The success of AmeriHealth Caritas Iowa's care management approach is built on several common core elements that are the foundation of the model, regardless of population being served. However, the model is agile enough to adapt components as needed in order to address the unique aspects of the individuals served. The most variable components of the model by population include:

- Makeup of interdisciplinary care team.
- Caseload size.
- Frequency and duration of contact.
- Whether member chooses to self-direct his/her care.

The following drivers have an impact on care delivery focusing on the specific needs of the member and his/her support system, in conjunction with key foundational care delivery components that shape the respective care management program in diverse care settings (per the exhibit below, Exhibit 4.0-A: Drivers of Care Management Needs by Setting).

Driver of Care Management Needs	Impact on Care Management Needs By Setting		
	Community Setting (Non-LTSS Needs)	Community Based LTSS Needs	Nursing Facility/Intermediate Care Facility/ Define Needs
Member/Caregiver Centric Determinants:			
Risk of future inpatient admission, emergency use	Lower	Higher	Higher
Bio-psycho-social complexity	Lower	Higher	Higher
Required healthcare services	Low to moderate complexity	High complexity	High complexity
Caregiver engagement/adequacy of social support	Variable or in tact	Low or variable	Low
Model of Care Determinants:			
Needs assessment	Telephonic or less frequent, face to face contact	Frequent, face-to-face contact	Frequent, face-to-face contact
Care management services	Condition-driven	Complexity-driven	Complexity-driven
Focus	Resolving immediate, presented problem	Resolving pervasive, persistent problems	Resolving pervasive, persistent problems
Duration of effort	Acute/episodic (days/weeks)	Long-term and continuous relationship	Long-term and continuous relationship
Intensity/frequency of contact	Less Frequent (periodic phone calls or visits)	Most frequent (frequent home visits)	More frequent (frequent facility visits)
Relationship	Consultative, coaching	Collaborative, coaching, continuity over time	Collaborative, coaching, continuity over time
Case type	Simple and routine	Systematic and contextual	Systematic and contextual
Caseload size	Large	Smallest	Small
Care team composition	Tailored to meet member needs and can include nutritionist, psychiatrists, etc.		
Skill level of care coordinator	Skilled care coordinators	Highly skilled and experienced care coordinators	Highly skilled and experienced care coordinators

Exhibit 4.0-A: Drivers of Care Management Needs by Setting

3. Understanding of Iowa's needs

AmeriHealth Caritas Iowa began meeting with providers and various stakeholder groups in February 2015 to learn about Iowa's healthcare needs and concerns in order to proactively create a solution, build on the successes and bridge the gaps of the current LTSS system. The AmeriHealth Caritas Iowa team met with a diverse range of provider groups and associations, to further understand the Iowa marketplace and seek the input of Iowans around ways a MCO may help them maintain and improve their overall health and address their LTSS needs.

Key Iowa Stakeholder Meetings	
<p>Aging and disability specific associations and providers</p> <ul style="list-style-type: none"> • Iowa Association of Area Agencies on Aging (i4a). • Leading Age. • Iowa Disability and Aging Advocates (IDAAN). • Arc of Story County. • Mainstream Living. 	<p>Children's and family services</p> <ul style="list-style-type: none"> • Child and Family Policy Center. • Coalition for Child and Family Services. • Iowa Association of Community Action Agencies. • Lutheran Services.
<p>Shelter services</p> <ul style="list-style-type: none"> • Central Iowa Shelter Services. 	<p>Other associations and provider groups</p> <ul style="list-style-type: none"> • Decatur County Community Services. • Iowa Association of Community Providers. • Iowa Medical Society. • Iowa Public Health Association.

Exhibit 4.0-B: Overview of AmeriHealth Caritas Iowa Stakeholder Meetings

AmeriHealth Caritas heard and understands the common concerns echoed from these organizations and will work to mitigate these concerns for the Iowa population, including:

- Lack of in-home care workforce often due to low wages, exemplified by lack of reimbursement for workers to travel long distance in the rural areas. We will explore reimbursement and other arrangements in order to meet access requirements and make sure that home care services are available.
- Ease of placing someone in an institution versus keeping them in the community, exemplified by:
 - A young woman with spinal bifida living in an apartment independently and working nearly full time hit the cap for physical therapy (PT) needed to maintain flexibility and strength. Rather than submitting an exception to the PT cap, her primary care provider (PCP) ordered her to a NF.
 - Transportation issues can lead to members in the community not to receive the services they need (e.g., current broker may not be incentivized to provide rides) exemplified by a woman denied service when she received a ride from a neighbor, claiming she has adequate transportation.
- Perceived administrative barriers on the providers for assisted living facilities, thus making it easier to refer individuals to an institution rather than helping them stay or transition to a home or community-based setting.

Following successful procurement, AmeriHealth Caritas Iowa will convene community stakeholder events in community centers, libraries, senior centers, hospitals and other venues across the state to gain

additional insight into community needs, work to address the issues above and educate the state on AmeriHealth Caritas Iowa.

4. Partner to further strengthen provider- and community-based service offerings and ensure a smooth transition to managed care

Integrating provider- and community-based resources to help members cope with their non-medical issues is essential to ensuring the integrated care team (ICT) provides holistic, person-centered care. For example, the health plan will seek out collaborative relationships with the local Area Agencies on Aging (AAA) which have proven track records of maintaining community partnerships and reputations as trusted resources for older adults and caregivers in surrounding communities. The local AAA's care manager will be embedded as an active and integral member of the health plan's ICT, and will be included in all relevant meetings and member conferences, as determined by member needs. The AAA's can help provide care management support as necessary to fulfill a variety of functions, including:

- Providing comprehensive and integrated care management with the health plan, including participation in the care plan development.
- Coordinating HCBS, such as adult day care, transportation or in-home care.
- Supporting care transition programs that result in seamless transitions for individuals from acute-care settings back to home, which improve member health outcomes and reduce avoidable hospital readmissions.

AmeriHealth Caritas Iowa anticipates developing a relationship on a scope of services with the Area Agency on Aging network through a central standard contract at the Iowa Association of Area Agencies on Aging. The agreement will be tailored to include specific AAA service offerings and the needs in the region in which they operate. The services may include, but will not be limited to:

- **LTSS coordinators** — As part of the health plan's overall care delivery team, LTSS coordinators will complete comprehensive assessments, develop service plans, and coordinate and monitor care through a combination of in-home visits and telephonic contacts.
- **Transition coordinators** — Individuals in this role could be utilized to support members transitioning from hospital to home, hospital to skilled rehab, hospital to assisted living, and skilled rehab to home/residence of independence. This will include collaborating with options counselors who currently work with individuals to transition from an institutional setting to their home/ affordable housing/apartment.
- **LTSS provider network management** — Leverage existing LTSS networks that are organized, credentialed and monitored through the AAA network, as available.
- **Caregiver education and support** — AAA options counseling and family caregiver teams are skilled in member teaching and coaching, and can be a valuable asset at the care team level, as well as in broader community engagement activities.
- **Evidence-based programs** — Availability of a range of evidenced-based programs that can be incorporated into the care delivery process, such as Falls Prevention and Chronic Disease Self-Management programs, among others. Success with these programs support overall member-centric outcomes results.

AmeriHealth Caritas Iowa also understands the move to managed care may displace highly qualified workers from both the public and private sectors providing services in the current LTSS system. AmeriHealth Caritas Iowa will bridge that transition by recruiting locally to fill a variety of positions. When

filled by displaced workers, AmeriHealth Caritas Iowa supports those with local knowledge and experience and provides continuity of care for individuals with LTSS needs currently served the system.

5. Exceptional leadership

AmeriHealth Caritas' LTSS leadership team brings broad-based expertise to the state of Iowa that will help ensure a seamless transition to managed LTSS. Our leadership team includes:

- A former state Secretary of Aging with over 30 years progressive experience as an accomplished healthcare executive in policy, operations, product development and managed care in the LTSS and dual-eligibles arena, including integrated CMS Financial Alignment Demonstrations in two states.
- A Chief Medical Officer for Medicare and Dual-Eligibles with extensive experience serving as Chief Medical Officer for a PACE program providing all Medicare and Medicaid services to dual-eligibles in Philadelphia.
- A former Deputy Director at CMS responsible for administration of and policy development for the national Medicaid HCBS program who also served previously as the Deputy Director for a state Department on Aging.
- An active member of the Managed Care Advisory Council for the National Association of Area Agencies on Aging (N4A) who previously served as Director of an Area Agency on Aging in Washington State, a Director of Long Term Care for an Arizona and Executive Director of a comprehensive human services agency in Arizona.

Conclusion

Our goals and processes are intended to improve member outcomes, but also in a cost-effective manner. With our approach, we expect to deliver to Iowa a program that will provide the needed continuity of care for special populations with long-term needs, improve health and outcomes for these populations over the long-term and save money for both the state and members. Specifically, AmeriHealth Caritas Iowa's managed long-term services and supports (MLTSS) model of care delivers four main drivers of cost savings:

1. Ensuring care is delivered in the right setting with a specific goal of diverting, preventing or avoiding institutional care.
2. Tailoring care provided to care needs, helping prevent deterioration of conditions that may require more services.
3. Delivering effective and efficient use of services (e.g., getting follow-up care after discharge to reduce readmissions).
4. Enhancing coordination with other services, particularly primary and specialty physician care, prescription drug therapy, and behavioral health services.

By providing LTSS in an integrated, coordinated fashion, AmeriHealth Caritas Iowa's program is intended to lower the costs of services, support integrated delivery, prevent hospitalizations and NF admissions, and extend the amount of time beneficiaries can live in their communities, as independently as feasible. Our approach provides comprehensive services, regardless of whether the individual lives in an institutional setting, such as a nursing home, in his or her own home, or in a community residential facility.

AmeriHealth Caritas Iowa understands Iowa's broad vision to use this transition to managed care to leverage creativity and investment in the care and coordination of services for special populations. AmeriHealth Caritas Iowa is an ideal partner to deliver on the state's longstanding commitment to its most

vulnerable citizens, and to serve as a catalyst to deliver on the next generation of improvements in providing the full continuum of LTSS.

4.1 General

1. Explain how you will ensure that individuals are served in the community of their choice and that funding decisions take into account member choice and community-based resources.

While Iowa has made meaningful progress in rebalancing LTSS from an emphasis on institutional care to increased utilization of community-based LTSS, much remains to be done if the state is to realize the promise of the Olmstead decision and to advance individualized options that reflect consumer choice. It is AmeriHealth Caritas' fundamental belief to ensure individuals are served in the least restrictive setting that provides the safest, most appropriate and cost effective environment possible for the member in accordance with the United States Supreme Court's mandate in *Olmstead v.L.C. and E.W* (1999). As Iowa continues to invest in rebalancing initiatives, the state will continue to realize the lasting impact of developing and expanding HCBS alternatives to institutional care.

- On average, community-based long-term care is about one-third the cost of comparable nursing home care, making it an affordable preferred choice for many individuals. ("states seek alternatives to nursing homes," Vestal, stateline.org., 2005).
- Evidence indicates that the cost savings from HCBS manifest in the long run. Over time, states that invest in HCBS experience slower Medicaid expenditure growth than states with low HCBS spending. ("Taking the long view: Investing in Medicaid Home and Community Based Services is Cost-Effective" Mollica. AARP: Insight on the Issues, I26, March 2009.)
- Expansion of HCBS appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings. ("Do Non-institutional Long-Term Care Services Reduce Medicaid Spending? Home and community-based services help people with disabilities stay in their homes while reducing long-term care spending." H. Stephen Kaye, Mitchell P. LaPlante, and Charlene Harrington. Health Affairs 28, no. 1. (Jan/Feb 2009).)

Safest, least restrictive setting: The assessment for members potentially eligible for LTSS enrollment will include an assessment of the individual's ability to have his or her needs met safely and effectively in the community and his/ her preferences for community living. Services are provided in the member's home that has been assessed to be a safe environment by the care manager. The in-home assessment includes a home safety review to evaluate the safety of the environment to support the individual at home.

Care planning: AmeriHealth Caritas Iowa employs a "person-centered" care planning process, which offers members informed choices regarding services, supports, providers and preferences of where members want to receive care. The care manager facilitates these decisions by providing members with information about potential providers of waiver services and assisting members in selecting or changing providers, as requested by the member. For example, Medicaid in Iowa, through the 1915 (c) HCBS Elderly Waiver program, covers many services to help the elderly remain living in their home. These include personal or attendant care, which can be self-directed through the consumer choices option.

Freedom of Choice Acknowledgement: Additionally, during the care planning process, the care manager reviews options for community choices and records the alternative HCBS that were considered by the member on the health plan the health plan's Freedom of Choice form (Attachment 4.1-A), which indicates

that the member meets functional/medical eligibility for LTSS, and requested and received information about the following programs in Iowa, including the Elderly Waiver program, PACE program, Nursing Facility Care and/or other community-based choices.

As specified in the member's service plan prepared by AmeriHealth Caritas Iowa's care manager, the health plan's LTSS service coordinators will work directly with the health plan's contracted HCBS waiver service providers. Using a provider database, the coordinators identify the appropriate HCBS waiver service in the community in which the member wishes to receive service. Once the service is identified, the coordinators will contact the HCBS service providers to ensure they have the capacity to offer service to the member. Using the individual service plan and the provider database, LTSS service coordinators are able to confirm coordination of care among all the member's providers and prevent a duplication of services.

Caregiver support network: Additionally, successful implementation of LTSS services also involves the active participation of the family and/or primary caregiver in the home care program, whose strength, willingness and availability are evaluated by the care manager during the in-home assessment. Participants should have an identified support network system available to them in the event the HCBS provider of direct care services is not able to provide the total number of hours approved and authorized by the health plan. A family member and/or a primary caregiver should be proficient in the tasks necessary to care for the member at home to ensure care is not interrupted. This proficiency requirement may be satisfied by training, as necessary to safely carry out the health plan of treatment and/or by providing direct care to the participant on an ongoing basis. The involvement of the family and/or the primary caregiver helps to ensure a safe home program for the participant.

Funding decisions: Funding decisions consider individual member choice and community-based alternatives within available resources. Funding decisions are taken into account by pricing out the individual service plan so the care manager knows what services are most cost-effective. Using the provider database, the care manager is aware of the costs associated with each member and can consider the cost of each provider when allocating HCBS waiver services. The care manager can pull from a wide range of HCBS waiver service providers to identify the most appropriate and cost-effective provider(s) for each member. Medically necessary waiver services are authorized by the health plan and will assist the waiver participant in remaining safely at home. Authorized services will not exceed limits established by the state in each HCBS waiver.

Community partnerships: As a committed member of the Iowa community, AmeriHealth Caritas Iowa will also establish community partnerships to identify sources of funding that may be used to expand community services offered.

Choice of providers through comprehensive network: AmeriHealth Caritas Iowa is focused on building a network to meet the needs of the populations served and that meets/exceeds standards set by CMS through the Health Service Delivery (HSD) process and other specific provider standards that are available (i.e., LTSS, chemical dependency). AmeriHealth Caritas Iowa will ensure that contracted geographic regions have an adequate diverse provider network so that members enrolled may be served by their provider of choice in the community of their choice. If the access standards are not met or if the actual enrollment exceeds the projected volume, AmeriHealth Caritas Iowa will:

- Enhance the provider network by adding facilities and HCBS providers on a continuous basis.
- Leverage provider system databases, where member and provider enrollment is stored and adjust it annually to increase primary care provider, behavioral health, and HCBS providers.

After meeting with various stakeholders, we learned of some access-to-care gaps in the current system that AmeriHealth Caritas Iowa will address and resolve to the benefit of all. Our approach will ensure that

member's receive the care they need in the community of their choice while maintaining a cost-effective system.

For example, while meeting with an independent living service provider in Iowa, we learned that they had assisted a young woman with spinal bifida living independently on her own. She maintained her own apartment and worked full time. She met her cap on physical therapy which helped maintain her strength and flexibility. Without a regular PT maintenance program, her PCP referred her to a NF.

In these instances, AmeriHealth Caritas Iowa will have the flexibility to provide the services needed to maintain members as described above. Use of HCBS will delay a member's need for an inpatient stay and maintain his /her quality of life at a lower cost than a facility.

Integrated Care Management and Collaboration with Community Based Providers

Mr. S, a resident of a boarding home with unmanaged type-I diabetes, had been in the hospital for a total of 101 days during 15 different visits since the beginning of 2014. Until he actively engaged with AmeriHealth Caritas' care management program, Mr. S averaged only about 6 consecutive days out of the hospital between hospital stays this year.

During the initial health screening, the care management team discovered that Mr. S was living on a fixed income and made poor nutritional choices for an individual with diabetes. Mr. S would purchase a lot of junk food at the beginning of the month, and would eat sparingly later in the month as his funds began to run out. The Care Manager arranged for home delivered meals in collaboration with a community resource that also provides nutritional education. The Care Manager supplied Mr. S with a glucometer and instructed him and boarding home staff on its proper use. The care management team checked on Mr. S. daily in order to monitor his compliance with insulin administration, making adjustments as necessary, in consultation with his PCP and the boarding home staff.

Since his engagement by the care management team at the end of June, Mr. S had only one inpatient hospital stay, and as of December 2014, has not returned to the hospital in 120 consecutive days.

4.2 Level of Care Assessments

1. Describe your ability and process for conducting level of care reassessments and tracking and determining when a reassessment is required.

Overview of Level of Care and Support Assessments Process

The state has articulated the level of care and support assessment responsibilities as follows:

	Responsibility	
	State of Iowa	AmeriHealth Caritas Iowa
Initial Level of Care Assessment for non-members	X	
Level of care assessment for members who may be eligible for LTSS		X
Level of care determination for members who may be eligible for LTSS	X	
Medicaid categorical and financial eligibility determination (members and non-members)	X	
Level of care reassessments (Annual Support Assessment) at least annually and upon change in member's condition		X

Exhibit 4.2-A: Level of Care Assessment Responsibilities

Below describes our process to support the level of care and support assessment processes that will fall within the responsibility of AmeriHealth Caritas Iowa.

Initial identification of members with LTSS needs

The health plan uses an Initial Health Screening (IHS) to identify chronic conditions, unmet healthcare needs and social determinants of health. This tool is administered telephonically (or written if preferred by member) and helps the health plan identify members' risk level, prioritizes members for further assessment and connects beneficiaries to the appropriate Care Management program and interventions

The health plan has ongoing processes to identify members who may be eligible for LTSS, which include:

1. Processing referrals from a member's provider

When a member visits a provider, such as a PCP, specialist or home health nurse, and a health screen is completed, the provider may recognize a change in condition such as weight loss or injury from a fall that will warrant a referral to the health plan for further assessment of LTSS needs. The AmeriHealth Caritas Iowa care manager will complete the appropriate InterRAI tool indicating a need for LTSS and will then coordinate services for the member, which in this case could include home delivered meals and supplements, home safety checks, installation of anti-slip devices, grab bars, etc. The AmeriHealth Caritas Iowa care manager will follow up to ensure that the services were delivered as ordered, that the member was satisfied and his/her health was improving.

2. Processing member self-referrals

A member, friend or family member may recognize a change in a member's condition or status indicating a need for LTSS and contact the AmeriHealth Caritas Iowa care manager to request an LTSS assessment. The AmeriHealth Caritas Iowa care manager will follow a similar process as noted above when a provider makes a referral for LTSS.

3. Receiving hospital Admission notifications

Upon receiving a hospital admission notice, AmeriHealth Caritas Iowa Utilization Management nurse will make an internal referral to the care management team for LTSS following regular and concurrent reviews of hospital admissions with presenting diagnoses and available member records, prior to discharge. The AmeriHealth Caritas Iowa care manager will contact the hospital discharge planner/social worker to begin the pre-discharge process. If a need for LTSS is indicated, the care manager will complete the appropriate InterRAI tool, update the service plan and coordinate services. In this case, services may include a nurse home visit within 48-hours of discharge to complete a home safety check, reconcile medication, and help the member follow up with the primary care provider.

This process is discussed more fully in Section 4.4.3.7.

4. Ongoing review of claims data

Claims data is mined monthly identify to members who may have key diagnosis utilization trends and pharmacy use that together will indicate a potential LTSS need. Such analysis includes:

- **Predictive risk scoring** — Claim data for beneficiaries will be analyzed to determine concurrent and prospective risk levels using diagnostic cost groups (DCGs) Verisk Inc., a population-based system for classification, predictive modeling and risk-adjustment. The predictive risk score will be used to identify those beneficiaries at highest risk for avoidable healthcare episodes. Based on our experience with similar populations, we anticipate that 12 percent of members will fall into the Very High Risk category. These members will receive outreach and assessment for intensive review and monitoring of their plan of care.
- **Gaps in care** — Focused claim analysis will identify beneficiaries for whom there exists no evidence of recommended healthcare services, such as HbA1c testing for beneficiaries with diabetes. The beneficiaries identified will be contacted to help them obtain the missing services.
- **Chronic condition identification** — Monthly analysis of medical and pharmacy claims will identify beneficiaries with diagnoses targeted as high risk conditions.
- **Sentinel event monitoring** — The health plan will maintain a process for reporting and investigating sentinel events, such as an unplanned readmission or a new avoidable serious event.

Initial level of care assessments

For members who have been identified through any of these processes as potentially meeting an institutional level of care and in need of institutional placement or HCBS waiver enrollment, the health plan will conduct the comprehensive level of care assessment using the tool and process approved by the state. The health plan will refer individuals who are identified as potentially eligible for LTSS to the state or its designee for level of care determination, as applicable.

The health plan's care manager performs the multi-dimensional, comprehensive assessment (for Iowa, the health plan will use the designated InterRAI tools) according to the time schedule identified in agreement with the state's requirements. The state has designated the tools that will be used to determine the level

of care and assessed supports needed for individual wishing to access either community supports or facility based care, as described.

Program	AIDS/HIV	Brain Injury	Elderly	Health and Disability	Intellectual Disability	Physical Disability
Assessment	InterRAI	InterRAI	InterRAI	InterRAI	Supports Intensity Scale (SIS)	InterRAI

Exhibit 4.2-B: Overview of Assessment Tools

AmeriHealth Caritas Iowa will use the full suite that is available for each InterRAI instrument required by the state. A fully realized InterRAI assessment "system" consists of:

- A data collection form.
- A user manual.
- Triggers.
- Clinical assessment protocols, or CAPs.
- Status and outcome measures.

As feasible, AmeriHealth Caritas Iowa will intend to embed these triggers and CAPS in our care management system, to support efficient assessment and care planning processes for the care team. The health plan recommends the following timeframe for the initial assessment:

Intervals	Performed	Participants
Initial assessment for non-LTSS members: <ul style="list-style-type: none"> • Completed within 7-14 days of referral, if high risk. • Within 30 days, if moderate risk. • Within 60 days, if low risk. 	<ul style="list-style-type: none"> • In-person with the member at his/her home or place of his/her choice. 	<ul style="list-style-type: none"> • Member and caregiver or other representative identified by member.

Exhibit 4.2-C: Initial Assessment for Non-LTSS Members

The health plan uses an IHS to help identify a member’s initial risk level, which includes identifying chronic conditions, unmet healthcare needs and social determinants of health. This tool is administered telephonically (or written, if preferred by member) and helps the health plan prioritize members for further assessment, and ultimately, connect beneficiaries to the appropriate Care Management program and interventions.

This comprehensive assessment of the member’s needs focuses on the key domains contained in the InterRAI tool set that impact a member’s well-being. The health plan will conduct the comprehensive assessment of individuals wishing to access LTSS services in the members’ home or other non-traditional setting of their choice. Caregivers and family members are included whenever possible. If the health plan is unable to reach a member, or if the individual refuses to meet, the health plan works with the member’s PCP and community service agencies to contact and encourage active involvement with the member.

If a member does not appear to meet enrollment criteria, such as meeting the target population group, the health plan will follow the requirements related to the appearance of ineligibility as stated in the scope of work.

By conducting practical assessments and soliciting member and family input, our care managers can pinpoint various activities of daily life that need enhancement, such as the member’s ability to shop for food, get medications, obtain transportation to appointments, as well as condition management (blood sugar monitoring, antipsychotic medication adherence, etc.).

Care plan and interdisciplinary care team

With this information as a foundation and with guidance from the member, the care manager convenes the interdisciplinary care team (ICT) to formulate an individualized care plan. ICT will include the member, caregiver, family members/representative(s) according to the member’s preference and the member’s PCP. The other members of the team will depend upon the member’s individual care needs and preferences, and can include mental health professionals, chemical dependency treatment providers, social workers, nutritionists/dieticians, direct care workers, pharmacists, peer specialists, and housing representatives. The care manager reviews the assessment results with the team and works together to formulate an individualized care plan responsive to the member’s preferences, needs and goals.

Results of the assessment are documented in the care management information system and used to jointly develop an individualized care plan that articulates the member’s goals, identify and address gaps, and refers member’s for appropriate services. Documentation will identify and communicate patients’ problems, needs and strengths) monitor their condition on an ongoing basis; and record treatment and response to treatment for each participant.

Additionally, once the assessment is completed, the AmeriHealth Caritas Iowa will submit the level of care/support needs assessment to the state in the manner prescribed by DHS. The state will retain all authority for determining Medicaid categorical, financial and level of care eligibility, and enrolling members into a Medicaid eligibility category. The state will notify AmeriHealth Caritas Iowa when a member has been enrolled in NF or intermediate care facility (ICF) for serious mental illness (SMI) and/or intellectual disability, developmental disabilities, or related conditions (collectively abbreviated as "ID"), or 1915(c) HCBS waiver eligibility category and any applicable patient liability amounts and/or waiver budget caps.

Annual support assessments

AmeriHealth Caritas Iowa’s care manager will conduct level of care reassessments in-person, using DHS designated tools, to determine a member’s continued functional eligibility for LTSS (HCBS and NF). These reassessments will occur at least every 12 months.

Intervals	Performed	Participants
Annual	<ul style="list-style-type: none"> • In-person. • At least every 12 months from original initial assessment. 	<ul style="list-style-type: none"> • Member/caregiver. • PCP and care manager.

Exhibit 4.2-E: Annual Support Assessment Overview

The care manager (registered nurse or social worker) will meet with the ICT to consolidate the reassessment findings into the care plan. At least annually, unless triggered sooner, the ICT will reevaluate the health plan of care, including defined outcomes, and make changes as necessary based on the reassessment findings and recommendations.

Reassessments based on trigger events

AmeriHealth Caritas Iowa’s care manager will conduct level of care reassessments in-person, using DHS designated tools, to determine a member’s continued functional eligibility for LTSS (HCBS and NF). These reassessments will occur when the health plan becomes aware that the member’s functional or medical status has changed in a way that may affect level of care eligibility. Examples of triggers that will indicate an earlier reassessment include:

- A transition in care or setting (such as hospital to home; hospital to skilled nursing facility (SNF), rehabilitation facility or ICF/ID, NF, rehabilitation facility or ICF/ID to home).
- Significant change in health or psychosocial status, including change in caregiver status.
- Request for service, when member or his/her designated representative believes that the individual needs to initiate, eliminate or continue a particular service.

AmeriHealth Caritas Iowa understands the final time frames in which reassessments will occur for individuals identified as having a medical or functional status change will be finalized through the procurement and contract negotiation process. The DHS will establish timelines for us to promptly assess the member’s needs and ensure member safety. AmeriHealth Caritas Iowa recommends that LTC level of care (LOC) reassessment is conducted by the health plan every 90 days if an LTSS member resides in the community and every 180 days if member resides in a NF or ICF/ID and that the trigger reassessment take place within seven days of notification of change in member medical or functional status, when such triggers change the risk level to high.

Intervals	Performed	Minimum ICT members involved
LTC LOC reassessment is conducted by the health plan every 90 days if LTSS member resides in community and every 180 days if member resides in a NF or ICF/ID. if change of condition or as requested by member/caregiver/provider, reassessment completed within 7–14 days if member is at high risk of institutionalization.	<ul style="list-style-type: none"> • In-person. • As triggered. • Change in participant status (health or psychosocial). • At the request of the participant or designated representative. 	<ul style="list-style-type: none"> • Member/caregiver. • PCP and care manager. • Other team members actively involved in development or implementation of plan of care.

Exhibit 4.2-D: LOC Reassessments

Tracking reassessments

Through sentinel rules embedded in the health plan’s care management system, AmeriHealth Caritas Iowa is able to track level of care expiration dates to ensure this requirement is met. The rules are set to trigger a reassessment event in the assigned care manager’s queue at an established interval, such as 30 days or 60 days prior to annual anniversary of initial LOC assessment. The assigned care manager is then alerted to the due date of the activity and the care team’s personal care connector (PCC) will begin their outreach to the member to schedule the reassessment. The care manager conducts the reassessment face-to-face wherever the person is residing, be it in the person’s home, NF or ICF/ID. This requirement applies to all members residing in a NF ICF/ID or eligible under a 1915(c) HCBS waiver. The care manager then reviews results with the member and ICT, and documents updates to the member’s care plan as indicated.

Timeline for care pathway

We understand that the time frames in which initial assessments and reassessments for members must occur for individuals identified as having a medical or functional status change will be finalized through the procurement and Contract negotiation process. As a matter of best practice, AmeriHealth Caritas Iowa recommends the time frames below.

Once the assessment is completed, AmeriHealth Caritas Iowa will submit the level of care/support needs assessment to the state in the manner prescribed by DHS. The state will retain all authority for determining Medicaid categorical, financial and level of care eligibility and enrolling members into a Medicaid eligibility category. The state will notify the health plan when a member has been enrolled in NF, ICF/ID or 1915(c) HCBS waiver eligibility category and any applicable patient liability amounts and/or waiver budget caps.

The following table summarizes the health plan’s proposed care pathway timeline and interventions for members that will require LTSS.

Minimum Contact		Level 4 (A and B) (i.e., high-risk LTSS population)
Assessment		
Comprehensive assessment (InterRAI HomeCare tool and other tools as prescribed by the state)	Initial assessment for non-LTSS members: <ul style="list-style-type: none"> • Completed within seven to 14 days of referral, if high risk. • Completed within 30 days, if moderate risk. • Completed within 60 days, if low risk. • Face-to-face visit with the member at his/her home or place of his/her choice. 	
Level of care determination	States retains authority for LOC determination.	
Level of Care Reassessments	LTC LOC reassessment is conducted by the health plan every 90 days if LTSS member resides in community and every 180 days if member resides in a NF or ICF/ID. If change of condition, or as requested by member/caregiver/ provider, reassessment is completed within seven to 14 days, if member is high risk.	
Individualized Care Plan (ICP)		
Individualized care plan- (complete initial)	Within seven to 14 days of assessment.	
Individualized care plan – (continuous monitoring and review)	If in SNF/ALF/ICF/ID: <ul style="list-style-type: none"> • Every 180 days. If in community: <ul style="list-style-type: none"> • Every 90 days. 	

Minimum Contact		Level 4 (A and B) (i.e., high-risk LTSS population)
Ongoing Care Management Interventions		
Face-to-face contact	If in SNF/ALF/ICF/ID: <ul style="list-style-type: none"> Face-to-face visits every 180 days, or sooner if change of condition or member request. If in community: <ul style="list-style-type: none"> Face-to-face visits every 90 days, or sooner if change of condition or member request. 	
Telephonic contact	If in SNF/ALF/ICF/ID: <ul style="list-style-type: none"> Quarterly telephonic outreach when no in-person visit occurs. If in community: <ul style="list-style-type: none"> Monthly telephonic outreach when no in-person visit occurs. 	
Annual Reassessment of Need		
Annual reassessment	Face-to-face reassessment at least annually (every 12 months) at anniversary of enrollment date.	
Individualized care plan updates	Anytime a face-to-face reassessment occurs.	

Exhibit 4.2-F: Minimum Screening, Assessment and Intervention Contact Schedule

2. Propose the approach by which needs assessments will be administered in a conflict-free manner consistent with BIP requirements.

AmeriHealth Caritas Iowa ensures that needs assessments are administered in a conflict-free manner consistent with Balanced Incentive Program (BIP) requirements by ensuring that clinical or non-financial eligibility determination is separated from direct service provision. AmeriHealth Caritas Iowa’s care managers, who are responsible for determining clinical eligibility for services, do so distinctly from the provision of direct services. Furthermore, the health plan’s care managers who evaluate the member’s need for services are not related by blood or marriage to the individual, to any of the individual’s paid caregivers, or to anyone financially responsible for the individual or empowered to make financial or health-related decisions on the member’s behalf.

Additionally, there is strong health plan oversight and quality management to promote consumer-direction. Members are clearly informed by their care managers about their right to appeal decisions about plans of care, eligibility determination and service delivery. Further, members receive written communications (e.g., Member Handbook) describing the process to submit grievances and/or appeals to the health plan for assistance regarding concerns about choice, quality, eligibility determination, service provision and outcomes. AmeriHealth Caritas Iowa tracks and monitors grievances, complaints, appeals and the resulting decisions. Information obtained is used to inform program policy and operations as part of the continuous quality management and oversight system.

If there are circumstances where there is overlap, (for example, if the AmeriHealth Caritas Iowa partners with a AAA or another community-based agency for assessment services), the health plan will ensure appropriate safeguards and firewalls are in place at the AAA or community-based agency so that there is not an incentive to make individuals eligible for services to increase business for their organization. In

partnership arrangements with the AAA's or existing community-based agencies, the health plan will require the following administrative firewalls to mitigate potential conflicts:

1. The agency does not case manage members to whom it provides direct services. Case management is still part of the agency's portfolio of services, but there is no conflict for a given member.
2. The governing structure should be transparent with stakeholder involvement.
3. Staff should not be rewarded or penalized based on care planning results.
4. Case management functions and direct service provision should be located in different departments within the agency or organization.

Eligibility is determined by an entity or organization that has no fiscal relationship to the individual. This separation applies to re-determinations as well as to initial determinations.

3. Propose a timeline in which all assessments shall be completed.

a. Upon initial enrollment with the Bidder:

As discussed fully in Section 4. 4.2.1, AmeriHealth Caritas Iowa will utilize a risk screening methodology to stratify a member risk, in addition to any state available data that can help to establish a risk/priority level for the member. The member's assessment completion date will be determined based upon the risk/priority level. If the risk level is high, the assessment will be completed within seven to 14 days; if the risk level is moderate, the assessment will be completed within 30 days; and if the risk level is low, the assessment will be completed within 60 days. All assessments are conducted face-to-face with the member at his/her home or place of his/her choice.

b. When the Bidder becomes aware of a change in the member's circumstances which necessitates a new assessment

Changes such as a hospitalization, a change in medical condition, a change in activities of daily living (ADL)/Instrumental activities of daily living (IADL), or changes in living arrangement triggers a change in the risk level to high and a new assessment will be completed within 7 to 14 days.

c. At least every twelve (12) months

Upon completion of the initial assessment or a reassessment based on need, a future reassessment date is established in the care management system. Based on workflow processes, a care manager will receive notification of the reassessment due date to ensure the reassessment is completed at least every 12 months in a timely manner.

4. Describe your plan to track and report level of care reassessments.

AmeriHealth Caritas Iowa maintains the ability to track and report on level of care reassessment data, including but not limited to, the date the reassessment was completed.

Tracking level of care reassessments:

Through sentinel rules embedded in AmeriHealth Caritas Iowa's care management system, the health plan is able to track level of care expiration dates to ensure this requirement is met. The rules will be set to trigger a reassessment event in the assigned care manager's queue at an established interval, such as 30 or 60 days prior to annual anniversary of initial assessment. The assigned care manager will then be alerted

to the due date of the activity and the care team's PCC will begin their outreach to the member to schedule the assessment. The care manager will conduct the reassessment face-to-face wherever the person is residing, be it in the person's home, NF or ICF/ID. This requirement applies to all members residing in a NF or ICF/ID or eligible under a 1915(c) HCBS waiver. The care manager will then review results with the Interdisciplinary care team and document updates to the member's care plan as indicated.

We understand that the time frame in which reassessments must occur for individuals identified as having a medical or functional status change will be finalized through the procurement and Contract negotiation process. The DHS will establish timelines which for the contractor to promptly assess the member's needs and ensure member safety. As a matter of best practice, AmeriHealth Caritas Iowa will typically reassess a member who has a change in condition within 7 to 14 days of the triggering event, depending on the event.

Reporting level of care reassessments

Once the reassessment is completed, AmeriHealth Caritas Iowa will submit the required documentation for reassessments which indicate a change in a member's level of care to the state in the time frame and manner prescribed by DHS. Such documentation may include changes in ADL status, medical conditions, living arrangements, and/or support systems.

The health plan's care management system houses reassessment information, including: the date/time stamp for the response to the question, the assessment completion status, care manager responsible, and the current questions and responses and historic responses to questions. Reports on this data are available on a scheduled or ad-hoc basis.

AmeriHealth Caritas Iowa understands that DHS or its designee will have final review and approval authority for any reassessments which indicate a change in the level of care, and AmeriHealth Caritas Iowa will comply with the findings of DHS or its designee in these cases. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care, and AmeriHealth Caritas Iowa will maintain all documentation of the assessment and make it available to DHS upon request.

5. Vendors must work with the state or its designee responsible for implementing the PASRR process. Propose strategies to ensure members receive the specialized services and supports indicated by the PASRR level 2 screening.

Prior to admission to a Medicaid-certified NF and any time there is a significant change in status, members will receive a pre-admission screening and resident review (PASRR) by the state of Iowa or its designee, currently Ascend. AmeriHealth Caritas Iowa intends to work with the state of Iowa and Ascend, which is responsible for implementing the PASRR process and oversight, to ensure PASRR screenings are conducted prior to admission or when there is a significant change in the member's status.

The PASRR process requires that all applicants to Medicaid-certified NFs are given a preliminary assessment (Level I screen) to determine whether they might have mental illness/mental retardation (MI/ID). Those individuals who test affirmatively at Level I are then evaluated in depth (Level II PASRR). The results of this evaluation result in a determination of need, determination of appropriate setting and a set of recommendations for services. The state will not approve admitting a person with SMI or developmental disability to a Medicaid-certified NF unless evaluated to require NF care and unless SMI or ID needs will be met.

The PASRR Level II screen results of current members will be provided to the health plan within 30 days after the members have been assigned to the MCO. PASRR Level II results of newly screened individuals after that

date will be provided to the health plan within 15 days of the end of each month. Once the health plan has received the determination of need status and determination of setting from the state for individuals in need of institutional placement, the health plan's care manager will outreach to the NF to validate that the PASRR screenings were administered in accordance with state and federal requirements. Likewise, when there is a significant change in the member's status, the health plan's care manager will reassess the member for changes in status and during this time and coordinate with the NF to ensure that the PASRR screens were conducted. If not conducted, the health plan's care manager will notify the state or its designee responsible for implementation of the PASRR process (Ascend) so the screenings can be administered.

Additionally, for those members evaluated with the Level II PASRR tool, the set of recommendations for services will be incorporated into the individual's plan of care by the health plan's care manager within seven days. Through the care planning and coordination process, the AmeriHealth Caritas Iowa care manager will be responsible for ensuring that members receive specialized services identified by the process, as many persons with SMI and ID admitted to NFs will need more care for their disability than what nursing homes usually do.

When the Level I screen or Level II assessment determines that the member can be appropriately served in the community and the member has indicated a desire to transition to the community, AmeriHealth Caritas Iowa will work with the member and the NF to transition the individual to community-based services.

If a resident or applicant for admission requires both an NF level of services and specialized services for the mental illness or intellectual disability, the health plan will provide or arrange for the provision of the specialized services needed by the individual while he/he resides in the NF. Specialized service means any type of supplemental care or support the Level II PASRR recommends as necessary for an individual to be appropriately admitted to NF. This can include non-medical supports (e.g., habilitation), or long-term care daily living supports (e.g., cueing). The health plan's care manager, working collaboratively with the NF care planning process, will develop the recommended type of supplemental care, document the service recommendations in the care plan and monitor to ensure services are arranged and provided for the member. The health plan will pull all members identified as requiring specialized services into their utilization review sample and report the results to the state in order to monitor key trends and indicators specified by the state.

DHS remains responsible for specialized services identified through PASRR for all non-members.

4.3 Community-Based Case Management Requirements

1. Describe your proposed model for delivering LTSS care coordination services.

AmeriHealth Caritas Iowa's integrated care model (ICM) is a holistic approach that uses a population-based health management program to provide comprehensive care management services, including LTSS. This fully integrated model will provide customized, person-centered care focusing on all aspects of a member's wellness. Using this interdisciplinary approach, AmeriHealth Caritas Iowa will deliver and coordinate services in a way that blends high-technology stratification and analyses with appropriate levels of individual engagement, such as advocacy, communication, problem solving, collaboration and empowerment. This approach will enable AmeriHealth Caritas Iowa to effectively and efficiently connect a member with the right care at the right time.

Program scope

AmeriHealth Caritas's ICM model promotes matching the member's level of need to an appropriate program of services and support in order to make greater strides in controlling costs and improving the quality of care members will experience. The model is based on a care paradigm that identifies members most at-risk and engages them with intensive care management services. The model also maintains supportive care options for lower-risk members who will require targeted, episodic care management and population health services. To this end, the ICM approach is designed to provide specialized care management services to two broad population targets: complex, high-risk members, and members that require various levels of episodic supportive care management services. Members identified as meeting an institutional level of care and in need of either institutional placement or 1915(c) HCBS waiver enrollment will be considered high-risk members in our risk stratification schema.

Risk stratification groups

The health plan uses a variety of techniques (evidenced-based predictive modeling, data mining, self-referrals and provider referrals) to group members into one of five risk levels from highest to lowest risk. Our stratification methodology is discussed more in-depth in Section 9. Members identified as meeting an institutional level of care and in need of either institutional placement or 1915(c) HCBS waiver enrollment will be considered high-risk members pictured on the right side of the below graphic.

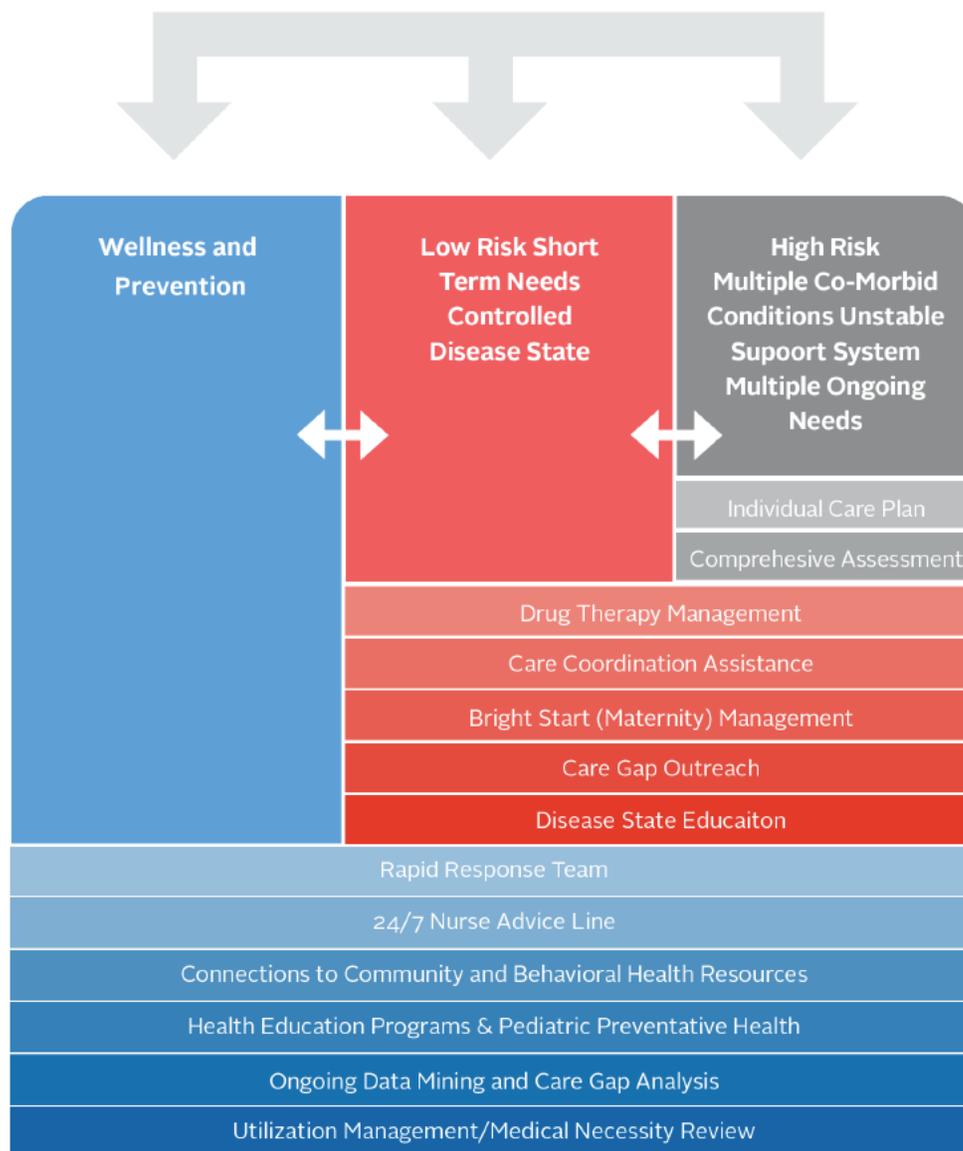


Exhibit 4.3-A: Overview of AmeriHealth Caritas Iowa Risk Stratification

Long-term services and supports (LTSS) members stratified as high risk

In our risk stratification schema, LTSS members are stratified as high risk and supported by the highest intensity of care and specialized services for members. Intensely focusing resources on this costly, high-risk population produces cost savings, improved quality of care and improved quality of life. Examples of LTSS members who would fall in this risk category include:

- Those institutionalized but qualifying to transfer to a home or community setting.
- Members with physical conditions impairing their ability to get care and services away from their living environment.
- Members with advanced illness or needing end of life care.

- Those living in a facility-based setting.
- Non-institutionalized members who qualify for a NF level of care but who are living in the community.
- Members facing imminent loss of their living situation.
- Members with insufficient caregiver arrangements.
- Members with deteriorating mental or physical conditions.

Model of care components

AmeriHealth Caritas' model of care is a person-centered approach that focuses on community relationships, integrating physical and behavioral health, and the socioeconomic status of our members. It also focuses on high-risk recipients characterized by bio psychosocial complexity. Care managers address the root causes that drive poor health, within the context of a long-term working relationship with the member. Our model is built on several key components described below.

High touch interactivity

AmeriHealth Caritas recognizes the importance of proactive, person-to-person interactions with the LTSS population to ensure the success of the integrated care management model. Face-to-face contact is an invaluable component of successful integrated care management programs for individuals with complex health and social needs. Accordingly, we provide a care management approach and proactive strategy that uses person-to-person interactions to build essential trust relationships; effectively communicate needs, expectations, and care instructions; observe subtle changes in and environmental contributors to health status; provide education and socialization; and foster the member's desire and ability to self-direct care.

Our model of care ensures that every member is assigned to a care manager with the skills and expertise most relevant to the members' needs. This includes "high touch," face-to-face opportunities between our care management staff, providers and beneficiaries in several settings:

- Intensive care management services for beneficiaries who have been determined to have the highest needs.
- In-person assessments, conducted for beneficiaries who are "at risk," including those determined to need services by virtue of their living arrangement (e.g., homeless, residential facility), uncontrolled chronic illness; and/or a history of frequent ER use or inpatient admissions.
- Ongoing care management using care managers and LTSS service coordinators who deliver in-person care management to beneficiaries at the highest end of the utilization spectrum.
- Onsite care management for beneficiaries who live in a NF or other residential facility.

The frequency and intensity of contact with the care manager differs by level of care, with more intensive contacts focused on members with the highest needs. The health plan AmeriHealth Caritas Iowa will ensure that high risk members are assigned to an intensive care manager, and that comprehensive care management services are delivered, primarily in-person, with periodic follow-up in-person and by phone, as approved by the state. These Intensive care managers will have demonstrated competency across the disciplines of physical health, behavioral health, and LTSS. They will be the central point for directing person-centered care and will coordinate services utilizing the appropriate provider(s) from our comprehensive network of physical health, mental health and LTSS.

Team approach and family involvement

AmeriHealth Caritas Iowa's interdisciplinary care team (ICT) will consist of a group of professionals, paraprofessionals, and nonprofessionals who possess the knowledge, skill, and expertise necessary to accurately identify the member's full array of needs, pinpoint appropriate services, and design specialized

programs that are responsive to those identified needs. The ICT will include the member, caregiver, parents/guardians or family members, and member representative(s) according to the member's preference. The other members of the team will depend upon the member's individual care needs and preferences and may include PCPs, mental health professionals, chemical dependency treatment providers, social workers, nutritionists/dieticians, direct care workers, pharmacists, peer specialists, or housing representatives. For example, as indicated by care needs, the ICT will include key leadership roles such as geriatricians, behavioral health specialists, social workers, and other providers who will coordinate care with the PCP to provide an integrated approach to care management. The composition of the ICT may evolve during the continuum of the member's care to reflect and address changes in identified needs. The member's specific needs and desires will be paramount in building a team of individuals to communicate with, advocate for, and support the member in getting care and staying well.

Family Caregivers: Frontline Hero's

“Jerry” 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 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 Jerry to a community agency to determine what type of LTSS will 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, Jerry has successfully been cared for in his home since discharge.

Focus on community based services

Our approach focuses on home and community based services that help delay or avoid institutional based care and support the member's desire to remain in the home and community based setting. Care Coordination is the backbone of successful home and community based services. When it is medically appropriate, AmeriHealth Caritas Iowa will coordinate and provide services to ensure our members are able to reside safely and independently in the community and setting of their choice. Members with complex healthcare needs can be safely maintained at home with the proper services, which could include home delivered meals, and home modifications, such as ramp installations, grab bars, and walk-in shower remodels; homemaking to ensure the member has a clean and safe environment to live; and personal care to assist with ADLs and IADLs, such as grooming, bathing, cueing for eating and medication monitoring. Simple companionship to provide social support is a proven intervention to maintain an individual's sense of well-being and belonging. Adult day care can be a substitute for many of the services noted above and also provide additional socializing with a broader group of peers. All of these services are aimed at keeping members healthy. For example, a member with diabetes can benefit from proper nutrition, skin care, and attending primary care and specialist's appointments. These can help reduce or eliminate an institutional level of care, hospital admissions and re-admissions.

All LTSS members are identified as high risk and receive comprehensive and disease-specific assessments and reassessments, along with the development of goals and an individual plan of care, created with input from the member/caregiver and the physician. The ICM 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, durable medical equipment, dental access, assistance with transportation, identification of and access to specialists and referral and coordination with behavioral health providers or other community resources. The ICM team contains both RNs and social worker care managers.

Person-centered approach

Our approach implements a fully-integrated care management program that maximizes members' independence, living in the setting of their choice, and receiving the necessary services to meet members' needs with a seamless navigation of the health and human service system. The care management program utilizes a person-centered system of care approach that will include high touch, face-to-face opportunities between care managers, LTSS service coordinators and the ICT for members "at risk" who would benefit from care management. The ICT will consist of a group of professionals, paraprofessionals, and non-professionals who possess the knowledge, skill, and expertise necessary to accurately identify the comprehensive array of the member's needs, identify appropriate services, and design specialized programs that are responsive to those needs. The composition of the ICT will vary according to the member's individual care needs.

The program will identify and profile member risk indicators from the start of enrollment and throughout the care delivery process using a variety of tools, including telephonic IHS, comprehensive functional needs assessment prescribed by the state, data mining for care gap identification, and predictive modeling.

Each member will be assigned one lead care manager to coordinate the flow of information and activity of the member's care team, including the PCP/Health Home, specialists, home support services, behavioral health providers, long-term care providers and supporting community organizations. The lead care manager will be responsible for developing the health plan of care under the direction of the member in coordination with the member's designee, PCP and ICT. The health plan of care will focus on the member's strengths and preferences and will include an emergency backup plan for each member to ensure continuity of care if a disruption of ongoing support occurs. Personal goals will be established with the member's input and with a focus on areas identified by the member whenever possible. The health plan of care and its associated goals will be distributed to all members of the ICT to obtain signatures in order to promote consistency in activities and focus in disease management for the member; to identify amount, scope, and intensity of services and interventions; and to provide encouragement and reinforce self-management steps. The lead care manager will also lead the transition team in managing planned and unplanned transitions, if there is not a dedicated transitional care coordinator assigned to a region or facility.

The health plan of care will be updated annually, or sooner, as changes in the member's health status are identified. At a minimum, plan-of-care updates will occur with any transition between healthcare settings (such as a visit to an ER or transfer from an acute care hospital to a skilled facility), and with any change/update to the assessment responses.

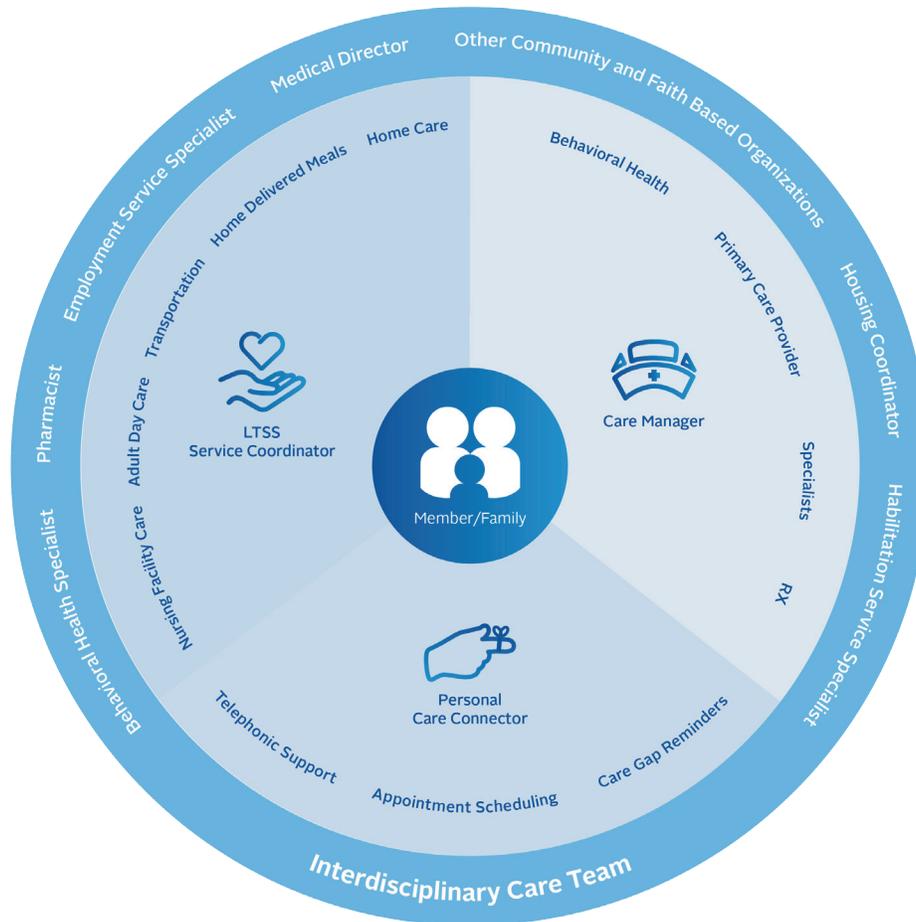


Exhibit 4.3-B: AmeriHealth Caritas LTSS Model of Care

AmeriHealth Caritas Model of Care and Care Team in Action

Mr. A’s initial assessment was completed on January 23, 2015. The initial assessment revealed a 70 year old male who has a 6th grade education, a widower and lives alone. He has no teeth (pulled them himself years ago), cardiac issues and diabetes. Prior to care management, he revealed that, “he has been managing the conditions, but would like to do better.”

A care plan was created with the member that targeted goals related to his health conditions, appointments with the member’s doctor, education regarding the importance of regular doctor visits, healthy lifestyles and care gaps. The member has a scheduled doctor’s appointment in May 2015.

The Care Manager also assessed and educated the member about gum/dental care and the possibility of getting dentures, even if it has been years without teeth. The member was not opposed to the idea of dentures. Since the member had limited dental benefits, the Care Manager asked the LTSS Service Coordinator to research community resources that would possibly assist with free dentures and identified a free dentures program via the Dental Lifeline Network. The LTSS Service Coordinator helped the member apply for the program and when the Care Manager followed up with the member, he informed the Care Manager that he has an appointment for a “denture fitting” in the coming weeks. The Care Connector also helped schedule appointments to address routine tests so that there will be no gaps in care.

2. Propose the required qualifications, experience and training requirements for community-based case managers.

AmeriHealth Caritas Iowa understands that with the implementation of managed care in Iowa, there likely will be highly qualified workers displaced who are currently employed by various government and community-based organizations. This scenario will be an opportunity for AmeriHealth Caritas Iowa to hire local staff and maintain the necessary workforce. Hiring of local, highly qualified individuals will provide AmeriHealth Caritas Iowa with a local knowledge base and will help members seamlessly transition to managed care more seamlessly.

A career with the AmeriHealth Caritas is much more than a job – it is part of a mission to help those less advantaged. For more than 30 years, we have helped people in need get care, stay well, and build healthy communities. Our associates are passionate about helping people and they drive our success. We look for talented leaders, visionaries, and collaborators who want to make a real difference in people's lives.

Care manager

The care manager assists members appropriate for care coordination and case management services in achieving their optimal level of health. The care manager must have relevant experience and education to work with members with complex physical health, behavioral health, LTSS and/or psychosocial needs, and performs the following functions:

1. Provides access to a single point of contact for all questions or inquiries.
2. Conducts assessments with members and/ or care- givers.
3. Develops an individualized care plan (ICP) that is periodically reviewed and updated.
4. Provides disease self-management and coaching.
5. Conducts medication review, including reconciliation during transitions of care setting.
6. Provides periodic monitoring of health, functional and mental status along with pain and fall screening.
7. Ensures the provision of services in the least restrictive setting and transition support across and between specialties and care settings.
8. Connects members to services that promote community living and help to delay or avoid NF placement.
9. Coordinates with social service agencies (e.g., local departments of health, social services and community-based organizations) and the referral of members to state, local and/or other community resources.
10. Collaborates with NFs to promote adoption of evidence-based interventions to reduce avoidable hospitalization, management of chronic conditions, medication optimization, fall and pressure ulcer prevention, and the coordination of services beyond the scope of the NF benefit.

AmeriHealth Caritas Iowa will ensure all care managers hired have and maintain the appropriate credentials, qualifications and training appropriate to serve the needs of our members. Initial onboard training will be offered on a scheduled rotation based on the volume of new staff personnel. Care managers will receive six weeks training that includes classroom learning, systems training and interactive role-playing, including but is not limited to such topics as:

Medical management orientation:

1. Model of care.
2. Benefits overview.
3. Staff roles and responsibilities.

4. Care map overview.
5. Policy and procedures overview:
 - Continuity of care.
 - Transitions of care.
 - Assessment and care planning.
 - Incident management and reporting.
 - Identifying and handling quality of care concerns.
 - Member rights.
6. Multidisciplinary team.
7. Understanding the dual eligible population.
 - Health & aging.
 - Dementia/mental well-being.
 - Behavioral health.
 - Family caregiving.
 - Consumer choice and self-direction.
 - Advanced directives.

Medical management systems training:

1. Jiva system overview guide overview/hands on user practice:
 - Logging into the system/user profile and roles.
 - Overview of the Jiva dashboard.
 - Understanding the icons, widgets, activities and alerts.
 - Building care management episodes.
 - Assessment process.
 - Care planning.
 - Note templates and documentation.

Practice Learning Lab:

1. Case Scenario practice and role Play Topics:
 - Continuity of care.
 - Transitions of care.
 - Long term services and supports.
 - Behavioral health coordination.
 - Assessment process and care planning.
 - Multidisciplinary team.
 - Risk stratification and levels of care.
 - Consumer choice and self-direction.
 - Ongoing monitoring.

Motivational interviewing and member engagement:

1. Introduction to motivational interviewing.
2. Open-ended questions.
3. Introduction to reflective listening.
4. Guiding — eliciting change talk.
5. Choosing — action plan.
6. Bringing It all together.

7. Role play and case scenario practice.
8. Guide to aging and disability community resources:
 - Resource identification.
 - Least restrictive living options.

Field-based training:

1. Community Based care coordination 101.
2. Safety in the community.
3. Supervisor and other team support.

Ongoing training

Mandatory, ongoing training sessions will also be provided on a scheduled basis, (monthly, at a minimum) upon program implementation. AmeriHealth Caritas Iowa will ensure that all training materials are updated as appropriate to reflect any program changes. The below classes are mandatory re-training courses currently provided by AmeriHealth Caritas Iowa to care coordination staff personnel with course completion to be documented within the file of staff personnel. The trainings are a mix of systems and class based. The on-going courses include:

- Development and implementation of back-up plans, emergency plans, and disaster planning.
- Identifying and reporting fraud, waste, and abuse.
- Identifying and reporting abuse, neglect, or exploitation.
- Cultural, senior sensitivity and disability training.
- Critical incident and adverse event reporting.

Additional roles

AmeriHealth Caritas Iowa's LTSS Service coordinator and personal care connector also play pivotal roles in our program.

LTSS service coordinator:

Under the supervision of the care manager, the LTSS service coordinator is responsible for providing direct case management services for older persons and persons with disabilities. The LTSS service coordinator will support with comprehensive assessments of member's needs, including physical health, behavioral health, social services and LTSS. He or she also coordinates treatment with members with potential for high-risk complications and manages members with chronic illnesses, co-morbidities, and/or disabilities to ensure holistic, efficient, and high-quality care and drive better member outcomes. The LTSS service coordinator is a key resource in helping coordinate care for our high-risk, high-need members, and will participate in the same training program as the care managers.

Personal care connector

The personal care connector (PCC) is a high-touch, effective service specialist, responsible for supporting the daily operations of Member Services, Integrated Care Management, and Utilization Management program interventions. The PCC performs in a contact center environment, effectively handling calls from members, providers and other areas. The PCC handles daily routine calls from members and providers in accordance with metric and performance requirements. They identify members with care gaps/HEDIS-related health conditions and assist them in accessing care through plan benefits and community resources. The PCC will handle all in/outbound calls and transactions directly supporting clinical staff and

assigned local teams, provide members with problem resolutions, educational materials and carry out strategies to increase healthcare adherence to reduce barriers to care.

Since the PCCs are such an integral part of our member service strategy and aligned closely with our care team to ensure a seamless experience, we invest significant time in our training program for new PCC recruits. PCCs receive a comprehensive training curriculum covering 39 modules and over 120 hours of classroom training spanning a 4–6 week period, including role-playing with previously recorded call scenarios. Classroom training modules cover topics ranging from the model of service, healthcare literacy, Medicare and Medicaid mastery, CLAS and cultural health, senior sensitivity, product and benefits training, enrollment process, IHS, and customer service systems training, among other topics.

3. Describe your proposed staffing ratio for community-based case managers to members.

The LTSS population is characterized by complex care needs that span medical, behavioral, and social domains. Effective management of these diverse needs can improve health outcomes and cost efficiencies; however, care management can only be effective when the care management team is adequately staffed to support members.

Care Management Team:

The plan's Integrated Care Management (ICM) program will be supported by a core team of (registered nurse (RNs) and social worker care managers, LTSS service connectors, and PCCs. Table 4.3.3-1 illustrates the health plan's anticipated staffing ratios, as well as the anticipated composition of care teams for each level of care.

Each care management team will have a maximum caseload threshold based on caseload acuity. AmeriHealth Caritas Iowa will monitor each team's case demands to ensure that staff has adequate capacity to fully support their members' care and complete interventions in accordance with established time frames. The ratios allow flexibility for adjusting caseloads due to case mix severity, as needed.

Levels of service:

The ICM approach is designed to provide specialized care management services to two broad population targets: complex, high-risk members; and members who require various levels of episodic supportive care management services. All LTSS members are considered high risk.

Care management for these members is characterized by a longer-term relationship with a single care manager who maintains a lower caseload solely dedicated to managing complex, high risk members. Care management services provided to complex, high-risk members are frequent, high touch (face-to-face), and sustained for long periods of time to ensure that members reach optimal stabilization and are moved into a lower risk stratification. Caseloads for care managers are envisioned to be smaller (see Exhibit 4.3-C below), but may vary based on contractual requirements and expectations for outreach activities. Members in these levels have most of their care management services coordinated by a clinical care manager, but as a member progresses toward stabilization and self-management, coordination needs are supported by non-clinical team members (field based LTSS service coordinators and/or telephonic based PCCs) to ensure clinicians on the care team focus on clinical care management activities, including PCP and other key provider interface.

Care Management Program	Risk Level	Level Team Composition	Staffing Ratio
Intensive care management for those in a home base setting	Level B (Intensive care management, HCBS)	2 Care Teams: 800 Members Each Care Team 2 RNs, 4 LTSS service coordinators, 1 PCC	1:38-57
Intensive care management for those in assisted living facility	Level A (Intensive care management, ALF)	2 care teams: 800 members each care team 1 RNs, 2 LTSS service coordinator, .75 personal care connectors	1:106
Intensive care management for those in a NF/ICF/ID	Level A (Intensive care management, NF or ICF/ID)	2 care teams: 800 Members Each care team 2 RN, 1 LTSS service coordinator	1:133*

Exhibit 4.3-C: Care Management Ratios and Team Composition

**Ratios of care managers to members living in NFs or ICF/ID in rural communities may be lower in some regions depending on the number of facilities, geographic proximity to one another and number of members located in the region.*

The ICM program is supported by care managers (RNs and social workers), LTSS service coordinators and non-clinical PCCs with access to additional team members dictated by the member’s needs including behavioral health professionals, pharmacists, and the health plan medical director or designee. The role for each staff member is clearly delineated to assure that all aspects of the ICM program work collaboratively to promote access to quality, medically necessary healthcare services. Roles and responsibilities are documented in the job description document below. (see Exhibit 4.3-D.

AmeriHealth Caritas Iowa’s care managers will be associates of the health plan and located in the health plan’s service area. AmeriHealth Caritas Iowa will employ state licensed clinical staff for persons receiving LTSS. Each staff role is supported by a written job description that identifies the licensure, certification, and experience for staff in that role. The health plan may also explore contracting options with community based agencies for comprehensive assessment activities, as needed. In that instance, assessors would be associates of the respective sub-contractor.

Staff Title Staffing Model	Responsibilities
<p>Medical director</p> <hr/> <p>1:75,000 members</p>	<ul style="list-style-type: none"> • Assist in the development and implementation of medical policy, including recommendations for the Integrated Care Management program. • Provide medical leadership, expertise, and education to the Care Management department including development, implementation and medical interpretation of medical policies and procedures and ICM grand rounds. • Communicate with participating providers during the care management/utilization management process in both outpatient and inpatient settings. • Provide formal communication to practitioners through the provider newsletter, integrating input from the health plan operational areas and the Quality Assurance and Performance Improvement (QAPI) Committee. Educate participating physicians about plan managed care philosophy while functioning as the medical liaison between the physician network and Plan administration. • Intervene and negotiate with attending/consulting physicians in areas of questionable medical necessity, treatment, quality issues, care coordination and discharge planning.
<p>Medical management director</p> <hr/> <p>1 per program</p>	<ul style="list-style-type: none"> • Direct the activities of the Integrated Care Management program and ensuring compliance with regulatory standards. • Prepare annual ICM program evaluation and program description. • Plan, organize and direct the ICM staff in departmental education, training and procedures as they relate to ICM program components. • Ensure implementation of QAPI recommendations and strategies as they relate to the ICM department. • Continue to review and update departmental policies and procedures to increase efficiency and maintain compliance with state regulations and accreditation standards. • Implement UM/ICM collaboration initiatives.
<p>Manager, care management</p> <hr/> <p>1 : 15-20 staff</p>	<ul style="list-style-type: none"> • Plan, organize and direct the development and implementation of the ICM Program. Ensure staff is properly trained, oriented and provided with regular professional development. • Identify opportunities for improvement, both clinical and administrative, and assists the director in the strategic planning processes for these functions. • Coordinate and implement the development of recommended policies and programs. • Coordinate, establish and monitor achievement of departmental goals and objectives. • Responsible for achievement of assigned NCQA standard compliance and compliance with all applicable state and federal laws, as well as achievement of assigned incented health outcomes.

Staff Title Staffing Model	Responsibilities
Care managers registered nurses social workers	<ul style="list-style-type: none"> • Perform comprehensive assessments, address short-term and long-term goals, and develop a plan of care with input from the member/caregiver and physician. • Coordinate care and address various issues including but not limited to: Pharmacy, durable medical equipment (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. • Serves as transition coordinator, if member is identified to transition to another level of care or residential based setting, unless plan has embedded/dedicated care manager at facility who will then assumes this function.
LTSS service coordinators	<ul style="list-style-type: none"> • Provides direct support to the care plan through arrangement and coordination of LTSS services and supports. • In-person engagement with members living in the community. • Act as a touch point for care plan service monitoring and oversight. • Reinforces and provides coaching for achieving care plan goals, including behavior change and condition management education.
Personal care connectors	<ul style="list-style-type: none"> • Collect clinical data utilizing scripted surveys and communicate information to the clinical care manager for interpretation and intervention. • Support care managers in the ICM program by providing administrative support to members, including: appointment scheduling and reminders, health surveys, transportation support, member educational mailings, and other administrative tasks assigned by care managers. • Triage incoming calls and coordinate with care managers when indicated by an urgent needs survey or when care management services are requested.

Exhibit 4.3-D: Key ICM Program Staff

Access to Integrated Care Management staff

Members have access to ICM program staff 24 hours a day, seven days a week through routine business hour coverage, on-call care managers and the 24/.7Nurse Call Line. The normal business hours are 8:00 a.m. to 5:30 p.m. Central Time. ICM services are performed both telephonically and through in-person visits. Care managers communicate with physicians through fax, mail and telephonic outreach. Toll-free telephone and fax numbers are available for members and providers to contact the ICM department. The plan medical director or physician designee is also accessible during business hours, as needed, and on-call after hours.

4. Describe how care coordination services will include ongoing communications with community and natural supports

Community resources

Integrating community resources to support members with non-medical issues is essential to ensuring that the ICT provides holistic, person-centered care. For example, the AmeriHealth Caritas Iowa will seek out collaborative relationships with the local AAAs, which have a proven track record of maintaining community partnerships and a reputation as a trusted resource for older adults and caregivers in

surrounding communities. AmeriHealth Caritas Iowa has met with the i4a and will work towards developing a standard contract for services across all six Iowa AAAs. As a result of our meetings we have secured a signed letter of intent.

AmeriHealth Caritas has replicated a similar collaborative approach with the AAA network in our Financial Alignment Demonstration states. Specifically, AmeriHealth Caritas is participating in the CMS Financial Alignment Demonstration in the state of Michigan, where we have established a collaborative relationship with three AAAs in Wayne and Macomb counties. For members who qualify for the state's HCBS waiver program, the local AAA care manager will be embedded as an active and integral member of the health Plan's ICT and will be included in all relevant meetings and member conferences, as determined by member needs. The AAAs will:

- Assist in providing a range of in-person LTSS assessments, as required by the state.
- Help provide comprehensive and integrated care management with the health plan, including participation in care plan development.
- Coordinate HCBS, such as adult day care, transportation, meals or in-home care.
- Support care transition programs that result in seamless transitions for individuals from acute care settings back to home, which improve member health outcomes and reduce avoidable hospital readmissions.

In addition to care management services, AmeriHealth Caritas partnered with the AAAs in Michigan for several other services and supports, including contract management, credentialing and monitoring of the LTSS provider network and LTSS claims adjudication.

AmeriHealth leaders have worked hand-in-hand with us in crafting a comprehensive plan to serve the dual population, requiring dozens of meetings and hundreds of hours. AmeriHealth understands the contribution that community-based organizations can make in improving the health and well-being of the dual population. They understand the value of the person-centered approach embraced by the aging and disability worlds. They understand that Area Agencies on Aging and their hundreds of service providers are serving the duals population, and function as known and trusted organizations and professionals who understand the needs and wants of this group.

Mary Ablan, Executive Director, Area Agencies on Aging Association of Michigan

AmeriHealth Caritas Iowa has also begun to build relationships with the Community Action Agencies (CAA) through the Iowa Community Action Association. CAA's will be an excellent statewide resource for AmeriHealth Caritas Iowa care managers to refer for community-based services.

- **Low-Income Home Energy Assistance Program (LIHEAP):** This federally funded block grant is designed to aid qualifying households in the payment of a portion of their residential heating costs for the winter heating season. The program's energy crisis intervention components are designed to provide immediate response to alleviate potentially life-threatening situations, and the client education component of the program provides funds for activities that encourage regular utility payments, promote energy awareness and encourage reduction of energy use through energy efficiency, client education and weatherization.
- **Family Development & Self-Sufficiency (FaDSS):** The FaDSS program provides services to Family Investment Program families facing multiple barriers to self-sufficiency. The FaDSS program provides comprehensive in-home services through certified family development -specialists. The FaDSS

program is a nationally recognized model which has demonstrated that it pays off, both in social and economic terms, to invest in high quality intensive services by partnering with families at risk of long-term welfare dependency.

- **Weatherization Assistance Program (WAP):** The Weatherization Assistance Program (WAP) is a federal grant program established to help reduce the heating and cooling costs for low income persons, particularly the elderly, disabled, and children, by improving the energy efficiency of their homes. The WAP has developed from a program that stressed low cost, temporary measures installed by volunteers, to a program that uses trained crews and contractors to install permanent cost-effective measures that address both the building shell and the heating and cooling systems in the dwelling.

Beneficiary and family participation

From our work with dual eligibles, AmeriHealth Caritas has gained an important understanding of the central role caregivers and other natural supports play in helping members stay active and independent in their homes and communities. According to the National Center on Caregiving, most older persons with long-term care needs — 65 percent— rely exclusively on family and friends to provide assistance. Another 30 percent will supplement family care with assistance from paid providers. Care provided by family and friends, mainly women, can determine whether older persons can remain at home. In fact, 50 percent of the elderly who have a long-term care need but no family available to care for them are in NFs, while only seven percent who have a family caregiver are in institutional settings.

To this end, our care model contemplates the active role that caregivers and other natural supports play in the care coordination process, as consented to by the member, including: participation in the assessment process where many times we glean an objective status of the members' health and mental well-being. Caregivers often spend more time with a member than other care team members and are better able to observe day-to-day changes in the member's condition which plays a significant role in coordinating care. With this first hand, real-time knowledge of a member's condition, caregivers know when and what to document and report to the appropriate care team member(s) as needed and during ICT meetings.

Participation in Care Planning

AmeriHealth Caritas Iowa recognizes that when beneficiaries and caregivers are involved directly in their care, they have a greater incentive to comply with the regimens outlined in their individualized care plans (ICPs). Accordingly, AmeriHealth Caritas Iowa will facilitate involvement by gathering information directly from the member and caregiver to identify the key providers and community organizations serving the member, and individuals in the member's support team that he/she wishes to have included in the health plan of care. Some beneficiaries who are elderly, disabled, and committed to living independently may want to include a representative from the Center for Independence. Chronically homeless adults with substance-abuse issues could benefit from involvement with Racial Ethnic Approaches to Community Health, which provides client-centered outreach and case management services to the chemically-dependent transient population.

With a commitment to person- and family-centered care, AmeriHealth Caritas Iowa will incorporate a member-based decision support system to drive both ICP development and communication through a multidisciplinary approach to care management. The ICP, which will focus on the member's strengths, preferences, and goals, will be developed under the direction of the member and in coordination with the members of the ICT, including the member's caregiver(s).

Integrated care team (ICT) process

The member and caregiver will be involved in ICT discussions through participation in ICT meetings and via updates from the care manager. ICT meetings will be held as frequently as needed based on the member's clinical situation and care needs. Meetings may be held telephonically but will ideally be facilitated face-to-face in provider offices or the member's home, as needed and at the member's convenience. Family members are asked to participate in such discussions, if agreed to by the member.

Goals prioritized in the ICP will be established with the member and caregiver's input, and whenever possible, will focus on areas identified and prioritized by the member.

AmeriHealth Caritas Iowa will also employ several outreach strategies designed to keep the member and caregiver involved with the ICT. For example, beneficiaries who have not seen a PCP within the last 12 months will be contacted and encouraged to make an appointment for an annual physical and health check. We will also involve the family member, if present and available, to make sure member goes to PCP. The care team will also facilitate adherence to the ICP. For example, when a provider notifies the care team that a member has missed a scheduled appointment, team staff will contact the member or caregiver to reschedule the appointment and set a reminder in the health plan's system. The team care connector will contact the member or caregiver prior to the next appointment to remind the member and caregiver of the appointment and address any transportation needs or other barriers.

Communicating the Integrated Care Plan (ICP)

To promote consistency and focus, as well as to reinforce self-management steps and provide encouragement, the member's ICP and any follow-up materials will be communicated to all members of the ICT, including caregivers and other natural supports agreed upon by the member. The care manager will document discussions and decisions from ICT meetings summarize results of home health assessments and physical therapy evaluations, and record notes outlining information gathered and actions taken by care team staff, community agencies, and service organizations related to the member's ICP. Additionally, the care manager will incorporate modifications to the ICP, which will evolve over time based on input from the member, his/her various providers and agencies involved in coordinating the member's care. The ICP will be documented in the health plan's information system. The care management team will print a formatted version of the updated ICP that shows goals met, goals in process, barriers, planned interventions, and evaluation timeframes; this document will be shared with the member, caregiver, PCP/health home/medical home, and other members of the ICT. The ICP will be available to providers via our secure Provider Web Portal, and a summary will be sent to beneficiaries and caregivers via fax or mail. Records related to ICT meetings, and the ICP itself, will be included in the member's centralized record and maintained in the health plan's information system according to the record retention policy.

By facilitating the active involvement of beneficiaries, along with useful input from their designated representatives, caregivers, and the wide array of professionals and support organizations involved in providing care, and by providing the mechanism for tracking their ICP, the health plan AmeriHealth Caritas Iowa will deliver holistic, preventive, and recovery-focused care based upon a comprehensive assessment of a member's clinical and non-clinical needs.

5. Describe how internal operations support communication among departments to ensure community-based case managers are aware of issues related to their assigned membership.

Weekly ICT meetings

AmeriHealth Caritas Iowa's internal operations have policies and procedures that support and guide the communication among care managers to ensure they are aware of all member issues. AmeriHealth Caritas Iowa's ICT meetings, held in person or telephonically twice per week, allow care managers to communicate with the member's PCP, caregiver(s), and other providers to discuss, monitor and stay apprised of issues related to the member. As much as possible, the ICT seeks to involve the member as an active participant and solicit their feedback to promote a member-centered collaborative goal-setting process. Participation is welcomed to the degree that the member desires and at his/ her individual comfort level. All ICT interactions with the member are documented in an ICT template and in the AmeriHealth Caritas Iowa's database. ICT meetings cover items including, but not limited to:

LTSS members in a NF or other facility based settings:

- Patterns of recurring falls.
- Incident, injury, or complaint.
- Report of abuse/neglect.
- Frequent hospitalizations.
- Prolonged or significant change in health or functional status.

LTSS members living in the community:

- Change in residence, primary caregiver, or loss of essential social support.
- Significant change in health and/or functional status.
- Loss of mobility.
- An event that significantly increases the perceived risk to the member.
- Member has been referred to Adult Protective Services (APS) because of abuse, neglect or exploitation.
- Members with high utilization or high-cost procedures or drugs.

Care management system

AmeriHealth Caritas Iowa's care management system will support the communication and interconnectivity of information across departments and among team members within the medical management department, so care managers are aware of issues related to their assigned membership. Some examples of such interconnectivity include:

- The care manager's name is stored at the member's data level. Any team member who "touches" the member in the system is aware of their care manager, and likewise, the care manager can view those interfaces from the team member. This becomes essential in the daily interfacing between the UM and CM teams to communicate new admissions, discharges, services or supplies.
- An icon at the member level to communicate to all staff that the member has an active case management episode that includes utilization management alerts.

- For instance, automated rules send an alert to the care manager if the member has an inpatient admission request. This supports the utilization management and case management coordination for discharge and transition planning.
- The system captures and displays care gaps information from our medical economics and analytics departments, which provide alerts to the care manager so they have actionable data upon which to reach out to the member for support and follow-up.

Case study: Care gap system alerts

Bill P. is a 55-year-old male with a history of hypertension and a recent stroke resulting in left leg and arm paralysis. Bill is married and lives with his wife who has never worked and has been helping Bill ambulate through his recent paralysis. The couple often does not have food in their apartment and were recently without heat and hot water. Bill takes four medications daily. Bill has been engaging in the care management program, and an ICP has been developed with identified goals and interventions.

Bill's care manager observed a care gap alert in the care management system: Bill missed a follow-up appointment with his PCP regarding a recent adjustment to his hypertensive medication. The care manager made an outreach call to Bill and learned that he was having difficulty coordinating his transportation to and from the appointment, that he wanted his wife to accompany him as a support, and that he was able to walk only very short distances. The care manager, assisted by a care connector, helped Bill reschedule the appointment and arranged for safe transportation that included his wife as a companion and wheelchair assistance. A reminder was set to contact Bill the day prior to the new appointment to verify that all arrangements were still in place and no new barriers had arisen.

Bill's care plan was adjusted to include the identified transportation goal and additional interventions including caregiver support services and respite for his wife. The care manager also revised Bill's ICP to include reviewing the eligibility requirements for the Iowa Low-Income Home Energy Assistance Program (LIHEAP) with Bill and assisting him with the application process at his local community action agency. Additionally, the care manager reviewed local resources for food supplementation and connected Bill with the one he chose based on geographical location and resonance with his values.

Please see section 9 and 13 to understand how health information technology will foster effective care coordination.

6. Describe strategies to minimize community-based case manager changes and processes to transition care when a member has a change in community-based case managers

AmeriHealth Caritas Iowa will consider many factors in assigning members to the appropriate care manager, including language preference, cultural similarities, and geographic commonalities. Once assigned, we understand that despite best efforts, matches are not always amenable and a change may be required. AmeriHealth Caritas Iowa has policies and procedures in place to facilitate a seamless change to an alternative care manager.

In order to ensure quality and continuity of care for LTSS members, AmeriHealth Caritas Iowa will make every effort to minimize the number of care manager assignment changes. When a change in care manager is initiated it is due to one of the following circumstances:

- Care manager is no longer employed by the Health Plan.

- Care manager has a conflict of interest and cannot serve the member.
- Care manager is on temporary leave from employment of greater than four weeks duration.
- Care manager caseloads must be adjusted due to the size and intensity of the caseload.
- The member moves out of the service area.

AmeriHealth Caritas Iowa is committed to ensuring the member's and caregiver's right to request a change in care manager is protected. AmeriHealth Caritas Iowa will respond to a member's request to change his/her care manager in a timely fashion, (i.e. within 10 days). If AmeriHealth Caritas Iowa cannot accommodate the change, the member and caregiver will be contacted to discuss the issue and review available remedies.

When a new care manager is assigned, he or she will confer with the out-going care manager to review the member's file within five business days if the outgoing care manager is still actively employed with AmeriHealth Caritas Iowa.

The member will be contacted by telephone by the new care manager within three business days of receiving the new assignment to make an introduction and to schedule a transition visit.

The new care manager (and the out-going care manager, when possible) is to attend a face-to-face transition visit with the member (and his/her representative) within 30 days of the care manager change.

A "Change in Care Manager Letter" will be mailed to the member within five business days of the member receiving the introductory telephone call. The letter will include a notification of change, as well as the name and contact information for the new care manager.

A copy of the notification will also be sent to the member's PCP and other LTSS providers.

We minimize care manager changes by assigning members to a care manager with the appropriate skill set to meet the members individualized needs from the start of the care coordination process. This includes taking in to consideration the care managers experience, expertise, knowledge, and training appropriate to meet the needs of the member population, as well as understanding the person-centeredness, cultural competency, disability, accessibility, accommodations, independent living and recovery, and overall wellness. The assignment process also takes into consideration the member's primary language, special communication needs, cognitive and other barriers, and matches care managers with appropriate experience and qualifications, including speaking the member's primary language or who have experience working with members with special communication needs, whenever feasible.

7. Describe your proposed discharge planning process

Overview

A care transition occurs when a member leaves a facility and care is rendered either in the home or another non-hospital based setting. With the proper follow-up care plan, which includes close monitoring during the designated transition period, members can avoid costly facility readmissions and remain safe and independent in their own home or in a community-based setting. Successful care transitions can increase quality of care and generate cost savings by reducing inpatient readmissions and ER visits. Care transitions cost approximately \$500 per month, which, compared to the potential costs of ER utilization or readmission, represents cost savings up to \$15,000 per avoided readmission.

In instances of a post-acute care transition, as described in this section, AmeriHealth Caritas' transitions program focuses on the critical foundational elements adapted from the four pillars of Dr. Eric Coleman's Model of Care Transition Interventions, among other evidenced-based approaches such as Bridge and

BOOST transition programs. We leverage these best practices as well when member transition from a NF or ICF/ID setting to the community, as described further in Sections 4.3.12.5 and 4.3.12.6.

AmeriHealth Caritas Iowa recognizes that effective discharge planning and follow-up plays an important role in helping members avert potentially preventable events and avoidable readmissions. We have developed a formal discharge program that engages key stakeholders while the member is still in the care setting to identify and coordinate the member's post-discharge care needs. AmeriHealth Caritas Iowa coordinates with facility discharge planners, the member's PCP, and needed post-discharge care providers to develop a discharge plan.

The discharge plan details all planned medical, behavioral, and home healthcare services, including transportation and other community that supports the member will need after leaving the hospital. Follow-up appointments are also outlined so that the member's PCP can continue to monitor the member's health during the transition period. AmeriHealth Caritas Iowa communicates with the member's providers throughout this transition to coordinate prior authorization requests, referrals, and medication regimens.

AmeriHealth Caritas Iowa uses a variety of monitoring and outreach methods to follow members post-discharge. Recently discharged members are a priority population for PCCs. We also use in-person outreach and care management teams to follow-up with recently discharged members in their communities.

AmeriHealth Caritas Iowa has policies and procedures to ensure that community-based case managers are actively involved in discharge planning when an LTSS member is hospitalized or served in any other higher level of care for a short period of time. AmeriHealth Caritas Iowa has defined circumstances which require that hospitalized members receive an in-person visit to complete a needs reassessment and an update to the member's plan of care.

Timely and appropriate discharge planning is an essential component of AmeriHealth Caritas Iowa's care coordination process. AmeriHealth Caritas Iowa uses a transition program called Care Transition Services to manage transitions of care between healthcare settings. The goals of the program are to reduce avoidable readmissions, eliminate unnecessary ER visits, ensure members are in safe environments, coordinate any LTSS needed or that are unaddressed, and educate members on how to avoid complications associated with their health condition.

Case Study: Coordinating post-discharge care to transition a member home

“Lee” is a 45-year-old male paraplegic with a colostomy, large sacral decubitus, and bipolar disorder. The health plan’s transition manager met Lee during his hospitalization for wound care following his discharge from prison. Although Lee had a place to go, he did not have a phone, a wheelchair, or furniture for his rented room. Working with the hospital case manager, the health plan’s transition manager arranged for a wheelchair, electric bed, donated furniture, home nursing visits, home health aide visits, and physician appointments. Lee is followed by a care manager for ongoing assessment and intervention.

The Care Transition Services was originally designed to manage the transition from the inpatient acute setting to the home and community based setting. Today, the program also manages transitions from inpatient acute to sub-acute/NF and from sub-acute/NF to home. The foundation of the program focuses on six core components:

- *Physician follow-up – coordinating physician follow-up services following discharge / transition.*
- *Medication management – medication education and self-management and comprehensive medication reconciliation.*
- *Nutrition - meal planning and nutritional education.*
- *Personal health record – patient-centered tool to document key medical, social and healthcare provider information.*
- *Red flags / signs and symptoms – patient, caregiver and family education on healthcare conditions and self-management.*
- *Home and community-based support – identification and coordination of community services (i.e. transportation, housing, utilities assistance)*

The care manager collaborates with the attending physician, the PCP, the member, member’s caregiver, and the facility’s discharge planning staff to facilitate a smooth transition to the appropriate next level of care.

The discharge planning process is initiated with a care transition coach introducing the program to the member, conducting an initial evaluation of the six core components and coordinating with the discharge planning staff. In addition to a needs assessment, patient activation and readmission risk assessments are conducted to ensure a successful transition of care. There may be multiple facility visits with the patient and facility staff until the time of discharge to prepare for the transition. Once discharged, the care transition coach conducts a community visit within two to seven days of discharge to readdress the core components and identify any new risks. During the home visit, the care transition coach will assist in coordinating any existing or ongoing services required for a successful transition. Coordination of services includes consulting with the member’s physicians (PCP and specialists) as well as home health and DME providers as required.

Following the face-to-face community visit, a care manager will conduct follow-up calls weekly for next three weeks to ensure that the member received the necessary services and is progressing well. If a member issue is identified, the care manager will contact the PCP, or other appropriate provider, to ensure that the member’s issues are addressed and resolved.

Establishing discharge plan and coordinating service delivery

Discharge planning is an integral component of the UM) process that is initiated at admission. For LTSS members, there are three times this occurs:

1. Prior to admission, for an elective admission.
2. As a notice of admission after the patient has been admitted for an emergency.
3. When part of discharge expectation is for short term rehabilitation or NF services post-acute care.

The process is designed to keep all parties notified and engaged and to ensure that communication is timely and that any services that are necessary to effectuate discharge from one inpatient setting to another (or to the member's home or another community-based setting) have been secured in advance of discharge.

Hospital discharge planners, PCPs, and specialists are encouraged to contact AmeriHealth Caritas Iowa's UM department for assistance with member discharge. Phone numbers are identified in the Provider Handbook specifically for discharge notification and discharge planning. In addition to notices of admission, AmeriHealth Caritas Iowa will monitor prior authorization and claims data to identify when one of our members has been admitted to an acute-care setting. Our UM nurses perform ongoing, concurrent reviews of the care admitted members receive, as well as outreach to admitted members. Using the diagnosis, length of stay, and reported social supports, AmeriHealth Caritas Iowa will identify the member's potential discharge care needs, and therefore what level of follow-up and care coordination is needed from AmeriHealth Caritas Iowa.

Our discharge coordinator will provide assistance to the members who have the highest risk of readmission. The discharge coordinator actively works with the hospital and other stakeholders to transition the member between care settings. AmeriHealth Caritas Iowa will have ongoing operational meetings with high-volume facilities to monitor our discharge processes and ensure ongoing, effective communication through admission and discharge.

AmeriHealth Caritas Iowa's personal care connector (PCC) team also plays a critical role in supporting members and providers before, during, and after members discharge from acute-care settings. Hospital staff is encouraged to contact the PCC team for assistance in arranging additional services, including home health follow-up, PCP appointment scheduling, or transportation to outpatient care. The PCC team also assists in connecting members to community resources to address needs identified during an ER visit.

Discharge planning process

The discharge program may begin in care management, when a member of the care team is made aware of an upcoming scheduled admission through their on-going interaction with the member. In this case, the care manager refers the ordering provider to the UM department for authorization of the admission and any suggested follow up care post discharge. This is done seamlessly as the same systems platform is used by the care management and utilization management departments. The UM Department enters the case, with notations for the discharge plan and checks the requested service against AmeriHealth Caritas Iowa's medical necessity guidelines (InterQual). This is an automated process and is generally turned around within one to two days but always within fourteen days or as quickly as needed for pre-service requests. Once the services are approved, UM notifies the member, the ordering provider and the PCP. The care manager is notified as soon as the approval is granted so that he or she can work with the member to establish the discharge plan. When possible, this is done in advance of the admission.

More often, the discharge plan begins in Utilization Management when a member is admitted through the Emergency Department. In these cases, the hospital notifies the health plan by telephone, fax and/or provider portal. This service is available seven days a week 24 hours a day. These admissions are entered into the system and reviewed against InterQual criteria within 24 hours of receipt. The member's case is then immediately referred to his/her assigned care manager for discharge planning. If the member does not have a care manager, one will be assigned to assist in the discharge planning and transition. The goal is to engage key stakeholders while the member is still in the care setting to identify and coordinate the member's post-discharge care needs. AmeriHealth Caritas Iowa coordinates with facility discharge planners, the member's primary care provider (PCP), and needed post-discharge care providers to develop a discharge plan.

Discharge Assessment

AmeriHealth Caritas Iowa's UM associates will work with PCPs, specialists, and hospital discharge planners to begin the discharge planning process and take proactive steps to plan the discharge. The process begins with a transition assessment completed by the member's care manager. The assessment focuses on the member's health background, including current and prior healthcare concerns, services received, medication changes, and providers involved in the member's care prior to hospital admission. We also identify the presence (or absence) of family/friend or community supports that would be available to help as the member recovers.

UM associates then coordinate with the hospital discharge planners, attending physician, hospitalists, and appropriate ancillary service providers, to assist in coordinating necessary arrangements for post-discharge care needs. This may include working with the member's support network to ensure that needed home equipment and post-hospitalization services are in place when the member arrives home. This includes coverage and authorizations for any needed home healthcare services, prescription or over-the-counter medications, durable medical equipment, medical supplies, and/or community supports.

Discharge Plan and Checklist

The discharge plan details all planned medical, behavioral, and home healthcare services, including transportation and other community supports that the member will need after leaving the hospital. Follow-up appointments are also outlined so that the member's PCP can continue to monitor the member's health during the transition period. AmeriHealth Caritas Iowa will communicate with the member's providers throughout this transition to coordinate prior authorization requests, referrals, and medication regimens. A checklist is made available to members so they understand the discharge instructions, medication changes and follow-up appointment needed.

©2015 AmeriHealth Caritas - Proprietary



DISCHARGE PREPARATION CHECKLIST

Before I leave the care facility, the following tests should be completed:

<input type="checkbox"/> I have been involved in decisions about what will take place after I leave the facility. <input type="checkbox"/> I understand where I am going after I leave this facility and what will happen to me once I arrive. <input type="checkbox"/> I have the name and phone number of a person I should contact if a problem arise during my transfer. <input type="checkbox"/> I understand what my medications are, how to obtain them and how to take them. <input type="checkbox"/> I understand the potential side effects of my medications and whom I should call if I experience them.	<input type="checkbox"/> I understand how to keep my health problems from becoming worse. <input type="checkbox"/> My doctor or nurse has answered my most important questions prior to leaving the facility. <input type="checkbox"/> My family or someone close to me knows that I am coming home and what I will need once I leave the facility. <input type="checkbox"/> If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment. <input type="checkbox"/> I understand what symptoms I need to watch out for and whom to call should I notice them.
--	--

My Appointments

Appointments/Tests	Date	Address and Phone Number	Who is Taking Me to Appointment
1.			
2.			
3.			

This tool was developed by Dr. Eric Coleman, UCHSC, HCPR, with funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation

©2015 AmeriHealth Caritas - Proprietary

MY MEDICATION LIST		NAME		PAGE ___ OF ___	
		DATE FILLED OUT		PCP	
Drug Name & Strength		When & How Many		How Is It Working?	
		   		You	Provider Response
WHY TAKING?	<input type="checkbox"/> DAILY <input type="checkbox"/> OTHER <input type="checkbox"/> WEEKLY <input type="checkbox"/> AS NEEDED			  	
WHY TAKING?	<input type="checkbox"/> DAILY <input type="checkbox"/> OTHER <input type="checkbox"/> WEEKLY <input type="checkbox"/> AS NEEDED			  	
WHY TAKING?	<input type="checkbox"/> DAILY <input type="checkbox"/> OTHER <input type="checkbox"/> WEEKLY <input type="checkbox"/> AS NEEDED			  	
WHY TAKING?	<input type="checkbox"/> DAILY <input type="checkbox"/> OTHER <input type="checkbox"/> WEEKLY <input type="checkbox"/> AS NEEDED			  	
OTHER NOTES:					
					

Exhibit 4.3-D: Example AmeriHealth Caritas Iowa Discharge Planning Checklist and Medication Reminder Tool

Home Health Services

AmeriHealth Caritas Iowa encourages home healthcare as an important support for members who are discharging from the hospital. The UM department helps coordinate medically necessary home health and home infusion needs with the member's PCP, attending specialist, and the selected home health provider. The member's first six home health visits do not have to be authorized; however, additional visits would require prior authorization.

Home health agencies are required to submit ongoing visit notes and updates so that AmeriHealth Caritas Iowa's UM nurses can ensure the health plan of care is being followed.

Case Study: Coordinating post-discharge care to transition a member home

At 55 years old, “Peggy” was hospitalized due to a joint-replacement infection of her right hip prosthesis. The hospital was concerned about discharging her to a home setting, as the member was not mobile and was not capable of performing self-care activities, including wound care. Additionally, the member had very limited caregiver support, as she lived with her elderly parents who had their own health and functionality limitations. With these combined factors, Peggy was at high risk for poor health maintenance and, consequently, readmission. The hospital was leaning toward transitioning the member to long-term acute care, but she normally provided assistance for her elderly parents, and her absence would jeopardize their health and safety.

AmeriHealth Caritas’ utilization review nurse referred Peggy’s case to our discharge coordinator due to the complexity and risks associated with Peggy’s discharge and her need to transition home. The discharge coordinator stepped in to identify all of Peggy’s care needs and develop a discharge plan that would effectively address them.

After consulting with key stakeholders, the Discharge Coordinator established a plan for Peggy to transfer home with home health services and receive in-home antibiotic therapy for six weeks. The discharge planner coordinated with an infusion company to access the needed medications and supplies. A home health agency that Peggy previously used was engaged to provide the needed skilled nursing care. As a result, Peggy successfully received the care she needed to address her health needs after transitioning home, while also continuing to support her elderly parents.

Post-discharge monitoring

AmeriHealth Caritas Iowa will use a variety of monitoring and outreach methods to follow members post-discharge. Recently discharged members are a priority population and their Care Coordinator will continue to outreach telephonically and in-person, as needed, until the member is stable.

After the member transitions out of the acute-care setting, AmeriHealth Caritas Iowa care managers will call the member to survey the member’s understanding of their discharge plan and determine whether appropriate services are being received. This includes medication reconciliation and understanding of the medication regimen, as well as assistance scheduling any needed non-emergency medical transportation. If home health was not ordered upon discharge, but the post-discharge outreach indicates it may be beneficial, AmeriHealth Caritas Iowa will work with the member to identify a local home health provider and then contact the member’s provider to initiate a referral.

Where there is a concentration of members, AmeriHealth Caritas Iowa will assign transition care coordinators (TCCs) who work solely on care transitions. We also use in-person outreach and care management teams to follow-up with recently discharged members in their communities.

Members with complex discharge needs, or previous readmissions will receive an in-home visit by the nurse care manager and receive weekly follow up to ensure that key transition steps are completed. Weekly follow-up is continued until the nurse care manager determines that the member is stable in the new care setting.

For members at high risk of re-admission or institutionalization, AmeriHealth Caritas Iowa’s care coordinator will conduct face-to-face visits at least once during facility based stay, calling the member within two to three working days of discharge, and conducting a face-to-face visit at the member’s residence or secondary facility within seven days of discharge.

Intervention	Description	Interval
Facility Visit	Face-to-face visit at facility before transition occurs to community setting	One visit
Week One Post Discharge:		
Telephonic Outreach and Home Visit	<p>Telephonic outreach to reinforce the discharge/transition care plan and address any problems or concerns that have arisen since discharge</p> <p>Visit member at residence to:</p> <ul style="list-style-type: none"> Review the post-discharge plan, answer any questions, and address any problems the member is experiencing. Provide support to aid the member in the recovery process and to avoid readmission, including engaging the primary care or mental health provider for continued monitoring. Help the member identify health goals and gain skills in self-care. Review medication use and reconciliation. Review signs and symptoms of red flags. Complete a safety assessment. Review the member's support network and needed community connections. 	<p>Telephonic Outreach: Within 2 to 3 days of discharge</p> <p>Home Visit: Within 2 to 7 days of discharge</p>
Service Coordination	Schedules follow-up appointments, coordinates home and community based services and addresses any barriers to attending appointments or receiving services.	Within 7 days of discharge
Weeks Two-Four Post Discharge:		
Follow-up calls/visits	Outreach call to assess status; in-person visit, as needed.	Weekly contact, or more frequent contact, based on individual need
Ongoing Support:		
ongoing care management	Outreach calls and in-person visits.	After the first four weeks, quarterly in-person visits and monthly calls when no visit occurs. More frequent visits or phone contact may occur based upon individual need.

Exhibit 4.3-E: AmeriHealth Caritas Iowa Post-Discharge Monitoring

Encouraging member engagement

Ensuring that members are engaged in the discharge process is critical to the success of transitions between care environments, especially when members are transitioning back into their homes.

AmeriHealth Caritas Iowa encourages members to follow through on four critical activities after they leave the hospital:

- Following up with their PCP within seven days of discharge.
- Understanding and managing their medication regimens.
- Understanding the signs/symptoms that need to be reported to their provider.
- Understanding and adhering to the discharge instructions, including coordinating services and supports as needed.



200 Stevens Drive
Philadelphia, PA 19113-1570

The information in this notice is available in other languages and formats by calling Member Services at 1-888-991-7200 or 1-888-987-5704 (TTY).

Esta información también se ofrece en otros idiomas y formatos. Llame a Servicios para Miembros al 1-888-991-7200 o al 1-888-987-5704 (TTY).

Muốn đọc thông tin trong thông báo này dưới hình thức và ngôn ngữ khác, xin gọi Ban Dịch Vụ Hội Viên số 1-888-991-7200 hay số dành cho người khiếm thính giác 1-888-987-5704 (TTY).

ព័ត៌មាននៅក្នុងសេចក្តីជូនដំណឹងនេះមានជាភាសាផ្សេងៗទៀត បើអ្នកចង់ទទួលបានព័ត៌មានលម្អិតសូមទូរស័ព្ទលេខ 1-888-991-7200 ឬ 1-888-987-5704 (TTY) បើអ្នកកំចាត់។

Для получения сведений, содержащихся в данном уведомлении, на других языках звоните в Отдел обслуживания по телефону 1-888-991-7200 или 1-888-987-5704 (TTY).

此通知的资料包括其他语言及格式。如需要提供，请致电 1-888-991-7200 或 1-888-987-5704 (TTY) 联系会员服务处。

Date
Member Name
Address

Dear (name of member):

Our records show you were in the hospital. We care about you staying well and out of the hospital. Every day matters during recovery.

Now that you are home, what do you do next?

- Call your doctor to make a follow-up appointment within 7 days of when you left the hospital (or follow-up as your discharge papers say to).
- Fill your prescriptions.
- Take your medicine as the doctor has said to.
- Take a list of your medicines and your discharge papers with you to the doctor.
- For help with rides to the doctor or pharmacy, call the Transportation Line at 1-888-913-0364.

If you need help, please call our discharge Hotline at **1-888-643-0005**.

Exhibit 4.3-F: AmeriHealth Caritas Iowa Post-Discharge Transition Letter

After a member discharges from an acute-care setting, AmeriHealth Caritas Iowa outreaches telephonically to recently discharged members to follow up and provide assistance. 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.

If the member does not understand their discharge instructions or how to comply with them, our Care Management and Rapid Response associates can provide additional guidance. AmeriHealth Caritas Iowa also works with the member to remove any barriers to care, including transportation.

If the assigned care manager identifies assessment, that a recently discharged member may be at high risk for re-admission or institutionalization based on the post-discharge assessment, the member is prioritized for an in-person outreach by the care manager.

During the home visit, the care manager confirms that the member understands his/her discharge plan and discusses the member's discharge instructions, medication regimen adherence, and necessary follow-up care. If new or unmet care needs are identified during the visit, the care manager initiates an in-depth assessment, updated care plan and care coordination support to meet those needs.

Monitoring outcomes

AmeriHealth Caritas Iowa tracks readmissions for a 30-day period. If a member has had to be readmitted to the hospital during the 30-day period, the AmeriHealth Caritas Iowa staff works with the member's PCP and the hospital to develop and implement more intensive preventive measures to eliminate the need for readmission. Readmissions are analyzed to identify any trends or patterns that may exist in diagnosis, physician, procedure, or facility. Results are shared with the facility or provider in order to begin the process of improvement.

Specifically for LTSS members, AmeriHealth Caritas Iowa will track admissions to an institution from the hospital or community, successful discharge from a short term institution stay to the community, and successful discharge from a long-term institution stay to the community.

Post-discharge care of enrollees in remote areas

Members residing in remote or rural areas face additional challenges after discharge. AmeriHealth Caritas Iowa conducts outreach calls to ensure that these members receive all necessary care, including home healthcare, transportation to doctor visits, durable medical equipment, and other healthcare needs. AmeriHealth Caritas Iowa's PCC team works with these members to overcome barriers to health, such as lack of transportation or difficulty in securing medication.

8. Describe your process for monitoring the effectiveness of the community-based case management process. Provide outcomes from similar contracts in other states, if available.

Monitoring the Effectiveness of Community Based Care Management Process

AmeriHealth Caritas Iowa's the health plan model of care will be evaluated annually to measure its effectiveness. The evaluation assesses all aspects of the model including the clinical and service goals. The evaluation includes recommendations for improvement of the model, proposes goals and objectives for the following year, and identifies the resources needed to accomplish the proposed goals and objectives. The health plan collects data to facilitate the model of care evaluation through several mechanisms, including:

- Claim submission (medical, behavioral health, LTSS and pharmacy).
- Authorization review.
- HEDIS data collection and reporting.
- Beneficiary surveys (e.g., Consumer Assessment of Healthcare Providers & Systems [CAHPS] and Health Outcomes Survey [HOS] and; LTSS survey).
- Provider surveys (physician and provider satisfaction).
- Provider workshops.
- Complaint and grievance logging.

The following analyses are conducted as part of the model of care evaluation:

- **Network adequacy (annual)** – GeoAccess analysis to determine the effectiveness of the network in meeting members’ needs. Ratios are calculated separately for the urban and rural counties of the service area. Assessments include separate measures for primary care, behavioral health providers, high-volume specialists, hospitals, and skilled NF. Results are compared against plan access standards. In addition, call center data and out-of-network utilization are assessed to identify more specialized trends.
- **Cultural needs and preferences (annual)** – Beneficiary self-identified language data and interpreter usage reports are assessed to determine threshold languages for plan communications and language needs within the provider network.
- **Chronic care improvement programs (annual)** – Health outcomes and processes associated with the respective clinical guideline, participation rate, and participant and provider satisfaction are evaluated for each Chronic Care Improvement program.
- **Clinical initiatives and indicators (annual)** – Outcome data on various clinical initiatives and indicators, such as BMI measurement, medication monitoring, and fall risk, are collected through a combination of claim data analysis and medical record review. The CMS 5-STAR threshold is used as a performance target, where available.
- **Clinical practice guideline adherence (annual)** – Clinical Practice Guidelines for coronary vascular disease, diabetes, and hypertension are collected through analysis of claim data and medical record review.
- **Patient safety (quarterly)** – Sentinel event review outcomes and member quality-of care concerns are reviewed to identify trends and the need for provider education and/or sanction.
- **Service accessibility (annual)** – Practitioner performance on access standards, member satisfaction with CAHPS elements related to Getting Needed Care and Getting Care Quickly, and the ability of beneficiaries to receive a timely answer to a phone call are assessed to identify the ability of beneficiaries to access care.
- **Service initiatives and indicators (monthly)** – Several services indicators are evaluated to identify opportunities for improvement, including provider call-center performance and timeliness of claim payments. Examples include most frequent reason for calling and average speed of answering.
- **Grievance trends (quarterly)** – Data on the reason and outcome of member grievances is collected and analyzed.
- **Beneficiary satisfaction (annual)** – The CAHPS survey is used to measure member satisfaction with the health plan and the health plan’s providers.
- **Practitioner and provider satisfaction (annual)** – Satisfaction surveys are administered to PCP/Health Homes, high-volume specialists, and hospitals. Satisfaction is measured with several aspects of the Model of Care, including pharmacy services and benefit structure, plan staff responsiveness and specialty availability.

- **Transition management (monthly)** – Data on transition coordination (such as the percent of transitions in which the health plan of care was updated and communicated according to policy; the percent of beneficiaries who were assisted by care managers in finding a place to live if they are not able to go home initially from a hospital or NF; and the percent of beneficiaries with a documented medication reconciliation) are reviewed to identify opportunities to improve performance.
- **Utilization management (monthly)** – Data on health service utilization, clinical condition prevalence, and treatment setting utilization is assessed.
- **Quality improvement project and quality improvement activities (annual)** – Results from Quality Improvement projects and activities are evaluated against the project/activity goals.
- **External oversight (ad hoc)** – Results from external reviews, such as NCQA health plan accreditation, NCQA SNP Structure and Process review, and CMS oversight, are incorporated into the model of care evaluation.

Outcomes measurement

While few uniform quality indicators have been tested and validated that would inform and guide monitoring and quality improvement of managed LTSS, and no national standards exist, various instruments and measures that contain many of the relevant concepts have been developed by several national and state projects to improve LTSS outcomes and quality.

Many of the performance measures in managed LTSS programs are similar to those found in the FFS 1915(c) programs, capturing measures reflecting good practice in assessment, person-centered planning, and safeguards for member health and welfare. Many of the process measures are related to timeliness of screening, assessment, care planning and service delivery, as well as the extent to which defined processes for addressing critical incidents and grievances are followed.

Examples of Process Measures
<ul style="list-style-type: none">• Timeliness of screening/assessment/reassessment (based on state standard).• Timeliness of service plan development (based on state standard).• Timeliness of service initiation (based on state standard).• Timeliness from FEA referral to receipt of consumer-directed services (based on state standard).• Timeliness of care coordinator face-to-face and telephonic contacts.• Care coordinator caseload and staffing ratio.• Percent of complaints received and resolved.• Late/missed visits by service type.• Percent of grievances received and resolved.

Examples of Outcome Measures
<ul style="list-style-type: none"> • Number of episodes of law enforcement involvement. • Number of psychiatric inpatient and ER hospitalizations. • Number of mental health crisis interventions. • Percent in competitive employment. • Percent living in a private residence alone, with spouse or non-relative. • Number of substantiated recipient rights complaints per 100 beneficiaries served. • Increases in: <ul style="list-style-type: none"> • Annual dental exams. • Diabetes management. • Annual gynecological exams. • Community tenure of persons transitioned from NFs. • Number of persons transitioned from NF to community. • Number of persons entering NF. • Potentially preventable readmissions. • Potentially preventable complications.

Exhibit 4.3-G: Example Process and Outcomes Measures

In the dual demonstration projects in which AmeriHealth Caritas is participating, CMS takes steps to ensure that the health and long-term care needs of dual eligible beneficiaries are appropriately met when they are transitioned from FFS to managed care. The agency is requiring states and health plans that are participating in the projects to report individual level quality, cost, enrollment, and utilization data. CMS is also requiring that participating health plans report encounter data and meet certain quality indicators.

AmeriHealth Caritas has robust data collection, analysis and output capabilities. There are 99 total measures we are collecting for our Medicare-Medicaid Plans (MMPs). Subset of these measures that are particularly relevant is listed below.

Source of Measure	Measure	Description	Frequency
CMS	Adults’ access to preventive/ambulatory health services	This measure is used to assess the percentage of members ages 20 to 44 years, 45 to 64 years, and 65 years and older who had an ambulatory or preventive care visit.	1 per year
CMS HOS	Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	1 per year
CMS Part D Review	Part D High Risk Medication	The percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	1 per year

Source of Measure	Measure	Description	Frequency
CMS Part D Review	Part D Medication Adherence for Oral Diabetes Medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	1 per year
CMS/state defined process measure	Assessments	Percent of members with initial assessments completed within required timeframes.	1 per year
CMS/state defined process measure	Beneficiary Governance Board	Establishment of member/ consumer advisory board or inclusion of beneficiaries/ consumers on governance board consistent with contract requirements.	1 per year
CMS/state defined process measure	Discharge follow-up	Percent of members with specified timeframe between hospital discharge to first follow-up visit.	1 per year
CMS/state defined process measure	Individualized Care Plans	Percent of members with care plans by specified time frame.	1 per year
CMS/state defined process measure	Real time hospital admission notifications	Percent of hospital admission notifications occurring within specified timeframe.	1 per year
CMS/state defined process measure	Risk stratification based on LTSS or other factors	Percent of risk stratifications using BH/LTSS data/indicators.	1 per year
CMS/state defined process measure	Self-direction	Percent of care coordinators that have undergone state-based training for supporting self-direction under the Demonstration.	1 per year
State - Specified	Management of urinary incontinence	Percent of members with identified incontinence that have received treatment or documented intervention from a provider.	1 per year
State - Specified	Access to Service	Number and percent of members receiving HCBS like services (as part of capitation) prior to member reaching level of care to be eligible for HCBS.	1 per year
State-specified	Adjudicated Claims, including HCBS Case Management	Percent of adjudicated claims submitted that were paid within the timely filing requirements.	2 per year
State-specified	HCBS Authorization-Non- consumer directed services	Percent of members receiving HCBS who experienced an increase/decrease in the authorization of non-consumer directed HCBS services (each reported separately).	1 per year
State-specified	HCBS Authorization-Respite Care	Percent of members receiving HCBS who experienced an increase/decrease in the authorization of respite hours (each reported separately).	1 per year

Source of Measure	Measure	Description	Frequency
State-specified	Individualized Care Plans	Proportion of members at each risk level (high-, medium-, low-) with an individualized care plan (ICP) developed within specified timeframes compared to total members at each risk level.	Every 30 days
State-specified	Managing Hospital, NF and Community Transitions	Percentage of members who transitioned to and from hospitals, NF and the community. Proportion of those who transitioned to and from hospitals, NF and the community who returned to an (1) institutional setting or (2) community. Percentage of care transitions recorded and transmitted.	1 per year
State-specified	Pharmacy Point of Sale	Number of Rejected Pharmacy Claims with the reason for rejection.	Every 14 days
State-specified	Serious Reportable Events.	Serious Reportable Events include but are not limited to: <ul style="list-style-type: none"> • Deaths (unexpected, suicide, or homicide). • Falls (resulting in death, injury requiring hospitalization, injury that will result in permanent loss of function). • Infectious disease outbreaks. • Pressure ulcers that are unstageable or are Staged III and IV. • Traumatic injuries (including third degree burns over more than (10%) of the body) that result in death, require hospitalization, or result in a loss of function. • Restraints, both chemical and physical, use those results in death, hospitalization, or loss of function. • All elopements in which a members with a documented cognitive deficit is missing for twenty-four (24) hours or more. • Suspected physical, mental or sexual abuse and/or neglect. • Media-related event. Any report of which presents a potential or harmful characterization of the MCO or Demonstration. 	As identified.
State-specified	HCBS Authorization-Personal Care Hours	Percent of members receiving HCBS who experienced an increase/decrease in the authorization of personal care hours (each reported separately).	1 per year
State-specified	HCBS Authorization-Consumer Directed Services	Percent of members receiving HCBS who used consumer directed services	1 per year

Source of Measure	Measure	Description	Frequency
State-specified	HCBS Consumer Satisfaction	Percent of members Receiving HCBS who are satisfied/very satisfied with these services	1 per year
State-Specified	HCBS Plan of Care	Percent of members eligible for HCBS with a waiver service plan with specified timeframes.	1 per year

Exhibit 4.3-H: Sample Subset of MMP Measures

9. Provide proposed strategies for ensuring a seamless transition of LTSS services during program implementation. Include a proposed strategy and timeline within which all members receiving LTSS will receive an in-person visit, an updated needs assessment and service plan. Describe how you will ensure services are not reduced, modified, or terminated in the absence of an up-to-date assessment.

Strategy for Seamless Transition of LTSS Services

A well-thought out approach to the transition from FFS Medicaid to a managed care system for Medicaid beneficiaries who receive LTSS is critical for the overall success of the program. To ensure a well-managed delivery system transition, AmeriHealth Caritas Iowa proposes the following strategies:

Assessment approach

Prioritize the in-person visit and updated needs assessments in the following ways:

- Members with an annual reassessment anniversary date due within 60 days of enrollment effective date.
- If change of condition or status, or at members/family/provider request, or if need identified at welcome call via initial health screen, assess within 7-14 days of notification or request.

All other LTSS members, assessed within 90 – 120 days of enrollment effective date based on geographic region and prioritized based on member needs. LTSS members should be enrolled by geographic regions or waves so care management assessment staff can be deployed by region to obtain operational efficiencies given such a vast rural landscape to the state of Iowa. These regions or waves could mirror the established AAA regional configuration.

To accommodate this approach, the health plan intends to:

- Administer an IHS telephonically through our member services team to prioritize risk, in addition to any state specific risk data that may be made available to the health plan; if the health plan is unsuccessful in reaching a member telephonically, the member will be referred to care management for an in person follow-up contact.
- Geographically deploy staff based on regions of the state for efficiency and best use of resources.
- Administer the comprehensive assessment through a combination of care coordinators who are full time associates of the health plan, as well as contracted associates who are staff members of community partners qualified to perform assessment functions, such as AAAs or local home care agencies). The health plan will hire care management staff as prudent to meet the initial projected startup enrollment, use any excess capacity while ramping up to that number at the beginning to assist

with the assessments, and contract with the community partner agencies to assist in filling gaps in performing comprehensive assessments.

Service planning and coordination

- Once assessments are completed and upon determination that the member’s functional impairment or total health risk warrants care coordination and care management services, the program is offered to the member. Upon consent, the member is enrolled into AmeriHealth Caritas Iowa’s care coordination program and an individualized care plan is developed with the input of the member and/or caregiver to addresses the member’s medical condition, behavioral health, social/ environmental/cultural factors, physical and cognitive functioning, end-of life decisions, existing support system, and functional abilities.
- A state approved tool will be used to complete all assessments.
- The health plan would obtain from the state the member’s existing LTSS service plan. This will be used as a basis for the revised service plan being prepared as a result of the updated needs assessment.
- The care coordinator’s responsibility is to coordinate all care and services that are needed to address the member’s needs. When service needs are identified, the member is given information about the available providers so they can make an informed choice of providers.. The entire care planning process is documented in the case record.
- The care coordinator must verify that medically necessary services are available in the member’s community. If a service is not currently available, the care coordinator must substitute a combination of other services in order to meet the member’s needs until such time as the desired service becomes available. A temporary alternative placement may be needed if services cannot be provided to safely meet the member’s needs.

Timeline:

For all members receiving LTSS, AmeriHealth Caritas Iowa will propose the following timeline for members to receive an in-person visit, an updated needs assessment and service plan:

	Criteria	Proposed Timeline
LTSS Members (Member Receiving LTSS Services)		
In-person Visit	For members with annual reassessment anniversary date due within 60 days of enrollment effective date.	Visit within 45 days of enrollment effective date
In-person Visit	If change of condition or status, or at members/family/provider request, or if need identified at Welcome call via IHS.	Member to be assessed within 7-14 days of request notification
In-person Visit	All other LTSS members, assessed within 90 – 120 days of enrollment based on geographic region (staff will be deployed by region to obtain efficiencies), prioritized based on member needs.	Visit within 90-120 days
Updated needs assessment		At time of in- person visit

	Criteria	Proposed Timeline
Updated service plan		The individualized service plan would be updated within 7 days of in-person visit/assessment
Non- LTSS Members (Newly Identified)		
	All inquiries regarding Medicaid enrollment and initial level of care determination are referred to DHS or its designee in the form and format developed by the state.	

Exhibit 4.3-H: AmeriHealth Caritas Iowa LTSS Member Timeline

Continuity of care

AmeriHealth Caritas Iowa will ensure that members’ LTSS will not be reduced, modified or terminated in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination. AmeriHealth Caritas Iowa will ensure members receiving LTSS will be permitted to see all current providers on their approved service plan, when they initially enroll with the health plan, even on a non-network basis, until a service plan is completed, agreed upon by the member or resolved through the appeals or fair hearing process, and implemented. The health plan will extend the authorization of LTSS from a non-contracted provider as necessary to ensure continuity of care pending the provider’s contracting with the health plan, or the member’s transition to a contract provider. AmeriHealth Caritas Iowa will facilitate a seamless transition to new services and/or providers, as applicable, in the health plan of care developed by the health plan without any disruption in services.

In order to minimize service disruption, AmeriHealth Caritas Iowa will honor the individual’s existing service levels and depending upon the type of service, according to state directives, using any files received from the state of all existing authorized waiver services for the individual member. Providers will be able to use the AmeriHealth Caritas Iowa Provider Web Portal to check member eligibility and benefits, receive referrals and authorizations, and run claims status queries. The Provider Web Portal is simple to use with providers registering online and creating an AmeriHealth Caritas Iowa-specific login and password.

Provider network

For the first year of the contract, AmeriHealth Caritas Iowa offers contracts to all supportive living facilities, and any willing LTSS provider in its service area(s) that renders covered services and meets all applicable state and federal requirements for participation in the Iowa Medicaid program and meets the qualifications of the applicable HCBS waiver. For subsequent years of the contract, the health plan may contract with only those providers that meet the health plan’s established credentialing and quality standards. The health plan will maintain contracts with the HCBS providers that provided at least 80 percent of the FFS services during a defined calendar year. For counties where there is more than one provider of covered services, the health plan will maintain contracts with at least two of such providers, even if one served more than 80 percent of the current members.

If a member enrolls with AmeriHealth Caritas Iowa and is already established with a provider who is not a part of the network, AmeriHealth Caritas Iowa shall make every effort to arrange for the member to continue with the same provider if the member so desires. In this case, the provider would be requested to meet the same qualifications as other providers in the network.

The health plan will offer contracts to member identified independent care providers that are willing to accept the contractual terms and conditions, reimbursement terms and meets the state's and the health plan's credentialing and quality standards. The health plan will maintain a network that includes LTSS providers whose physical locations and services accommodate individuals with physical, behavioral and intellectual/ developmental disabilities.

At the time of enrollment of a member into the health plan, a review of all existing LTSS providers will be completed and compared against the health plan's provider network. The health plan will outreach to all identified in network providers to assist with the transition of the member and to ensure that services will be continued in accordance with the current service plan until a new service plan is created or the current plan is continued by the health plan. Identified out of network providers will be contacted and will be offered the opportunity to contract with the health plan, if the provider declines contracting, a single case agreement for the member will be offered. If the provider declines to become and in network provider and the single case agreement, the health plan will inform the provider that they will still be allowed to see the member during the transition period and a new service plan is created. At the time of the new service plan, AmeriHealth Caritas Iowa will again offer the non-contracted provider the opportunity to contract or sign a single case agreement. If no agreement can be reached the member will be transitioned to an in network provider of his/her choice in a time period that will cause no delay or disruption to the members care.

Provider outreach and education

As part of the provider's orientation process and annual model of care training, a module will be created to educate the provider network on the managed LTSS program that will include:

- History and definition of LTSS waiver services.
- How an Iowa resident applies and qualifies for LTSS waiver services.
- Waiver services available to the AmeriHealth Caritas Iowa member.
- How waiver services can reduce healthcare expenditures by preventing and reducing high dollar medical services.
- How waiver services can improve the member's quality of life which in turn allows them to engage and focus on their healthcare.

Member outreach and education

Education on managed LTSS services and accessing services will be provided by the member's care team including the care manager, LTSS service coordinator, and PCCs and through written materials available in the Member Handbook and plans website. Providing this education upon enrollment and re-enforcing it throughout subsequent visits, re-assessments, and care plan updates will enable the member to more easily navigate through the healthcare system.

Member services readiness

The AmeriHealth Caritas Iowa PCCs will be trained on all managed LTSS plan benefits, services, and access to care rules and expected to educate callers and deliver solutions to customer's questions and concerns. All PCCs are trained to:

1. Understand the dual populations served.
2. Recognize behavioral, cultural and linguistic needs to ensure effective communication.
3. Actively listen to our member's request for what they are saying and what they are not.
4. Orchestrate the proper introductions and warm transfers to the health plan's resources to ensure benefits and services are administered.

We will welcome new members to AmeriHealth Caritas Iowa and collect an IHS, if appropriate. During this call, agents are not just documenting the responses to the questions, but they are listening for care or service gaps and opportunities for the member to maximize their benefits and services of the health plan. For those instances where a simple reminder of available benefits and services is appropriate, our service team will educate on the topic and document the members' response. For those clear instances where there is a gap in care or a more serious need of benefits or services, our service team will orchestrate warm transfer calls to the care managers for proper in-take and assessment. The same approach is applied when calls from providers are received in reference to any of our members.

Performance Measurement for Transition

AmeriHealth Caritas Iowa will prepare and report any required transition performance metrics, in the form and format required by the state, so the state is able to perform its oversight and monitoring of transition implementation.

4.3.12 NF and ICF/IDs

1. Describe proposed strategies for providing care coordination services for residents of NF and ICF/IDs, including the timelines and frequency of in-person visits.

Care coordination strategy for residents of NFs and ICF/IDs

As part of AmeriHealth Caritas Iowa's integrated model of care, a care manager will be assigned to residents of NF (NF) and ICF/IDs. If there is an aggregation of members, either geographically in the same region or a concentration of members in the same NF or cluster of ICF/IDs, a care manager will be dedicated to the region or to the designated facilities. Through the completion of a comprehensive assessment, an individualized care plan is developed. The review of the NF care plan and individualized care plan generated by AmeriHealth Caritas Iowa will ensure that special services indicated by the PASRR assessment are provided.

The health plan of care will be ongoing and updated upon each review. For LTSS, the care manager will perform face-to-face visits to members in a NF and ICF/IDs at least every 180 days and perform telephonic follow-ups on a monthly basis. The face-to-face visits will consist of assessing the following:

- Member's functional status.
- Member's cognitive status.
- Member's behavioral status.
- Medication review.
- If the member wishes to transition to the community.

If at any time the member wishes to transition to the community, the care manager will work with the member to assess and counsel on available options, and to develop a transition plan. Where there is a concentration of members and an assigned transition of care coordinator (TCC) assigned, the TCC will be engaged for further evaluation and assistance in assuring that the proper services and supports are available to assist in this transition. When available we will leverage community-based services. In all cases, the member and his/her designated family or other supports are engaged. The goal is member autonomy and independence in making major life choices. This includes but is not limited to daily activities, activities in the member's physical environment and the ability to have maximum choice over with whom to interact, and what services and supports to engage. During transition, the member may

have very frequent interactions with the Care Coordinator or TCC; this would be designed based upon the individual and can be highly variable.

Timeline and interventions

An overview of interventions and content for members in NF and ICF/IDs is shown in Figure 4.2-F (repeated below). For members in NF and ICF/IDs, we will have an in-person, face-to-face visit at least every 180 days.

Minimum Contact	High-risk LTSS population
Assessment	
Comprehensive Assessment (InterRAI Homecare Tool and other tools as prescribed by state)	Initial Assessment for Non-LTSS Members: <ul style="list-style-type: none"> Completed within 7 – 14 days of referral, if high risk. 30 days, if moderate risk. 60 days, if low risk. Face-to-face visit with the member at his/her home or place of his/her choice.
Level of Care Determination	state retains authority for LOC determination.
Level of Care Reassessments	LTC LOC Reassessment is conducted by the health plan every 90-120 days if LTSS member resides in community and every 180 days if member resides in a NF or ICF/ID; if change of condition or as requested by member/caregiver/provider, reassessment completed within 7 – 14 days, if high risk.
Individualized Care Plan (ICP)	
Individualized Care Plan- Complete Initial	Within 90 days of enrollment.
Individualized Care Plan- Continuous Monitoring and Review	If in SNF/ALF/ICF/ID: every 180 days. If in Community: every 90-120 days.
Ongoing Care Management Interventions	
Face to face Contact	If in SNF/ALF/ICF/ID: Face-to-face visits every 180 days, or sooner if change of condition or member request. If in community: Face-to-face visits every 90-120 days, or sooner if change of condition or member request.
Telephonic Contact	If in SNF/ALF/ICF/ID: Quarterly telephonic outreach when no in-person visit occurs. If in Community: Monthly telephonic outreach when no in-person visit occurs.

Minimum Contact	High-risk LTSS population
Annual Reassessment of Need	
Annual Reassessment	Face-to-face reassessment at least annually (every 12 months) at anniversary of enrollment date.
Individualized Care Plan Updates	Anytime a face-to-face reassessment occurs.

Exhibit 4.2-F: Minimum Screening, Assessment and Intervention Contact Schedule

Targeted Care Coordination Strategies within Skilled NF and ICF/IDs

A disproportionate number of members, particularly those who are dually eligible, live in NF and ICF/IDs, many of whom could be cared for more cost effectively in community settings. There are four main opportunities to optimize health and independence for these members: (1) transition of some members back to the community; (2) optimizing sub-acute stays within SNFs; (3) preventing unnecessary hospitalizations and ER visits for custodial residents of NF and ICF/IDs; and (4) collaborating with ICF/ID card teams. AmeriHealth Caritas is currently implementing these types of care delivery initiatives through our Financial Alignment Demonstration program in the states of South Carolina and Michigan, and as applicable, would be replicated in Iowa.

1) Transition to Home

There is an opportunity to move members residing in NF and ICF/IDs who, with the right set of community services and caregiver support, could cost effectively return to a less restrictive living setting. An in-facility assessment is conducted by the nurse care manager and a determination is made for community transition potential by strongly considering care needs, potential caregiver support, availability of alternative living situations and a cost effectiveness analysis. According to the LTSS Scorecard developed by AARP, the opportunity exists in Iowa to serve an additional 4,085 nursing home residents with low care needs in the community with LTSS; 1,048 more people entering nursing homes would be able to return to the community within 100 days; and 2,885 more people who have been in a nursing home for 90 days or more would be able to move back to the community with LTSS.

Once a member is identified for potential transition, an AmeriHealth care manager is assigned for the duration of the transition process and reviews the member’s situation with the PCP to get approval. The care manager is responsible for organizing all the necessary services and caregiver support and training for a successful return to the community. The care manager in this program will follow each member a minimum of 30 days to ensure services are meeting the member’s needs (See response to Section 4.3.12, Question 5).

Following transition, the member will be assigned to ongoing care management and follow up to reduce future institutionalization risk.

2) Sub-acute Care

NF can present several challenges for cost-effective post-acute care. Facilities may lack the necessary medical coverage to effectively manage sub-acute stays. Medicare fee-for-service (FFS) does little to closely monitor beneficiaries who no longer need skilled level of care. Early discharge planning may be absent leading to evaporation of critical home-based services and support with resultant permanent institutionalization.

AmeriHealth Caritas Iowa proposes as part of its care management program an onsite and regular presence of an nurse care manager (R.N. or N.P.) in facilities with a critical mass of members (see Custodial Management below). The R.N. /N.P. works closely with the collaborating physician to stabilize the member's acute condition and look to rehabilitate where appropriate. The R.N. /N.P. completes a targeted assessment for sub-acute care and initiates a care plan in conjunction with the PCP, facility and family. The member's ICT is available for consultation to the R.N. /N.P.

This close involvement of the R.N. /N.P. strives for several measurable and important outcomes: reduced 30-day readmission to the hospital; optimized Medicare SNF length-of-stay; and improved likelihood of community-based members returning to their previous residence because of effective and timely discharge planning from SNF to home. In addition, this enhanced level of care reduces the need for members to utilize costly and often unnecessary long-term acute care hospital (LTAC) stays. Having a strong SNF-based sub-acute option enables hospital discharge planners and/or Transition Care nurses to bypass LTACs when appropriate as well as refer members to the best SNF units.

3) Custodial Management

Members permanently residing in NF experience up to 50 percent unnecessary hospitalizations because of challenging care environments, lack of advanced care planning, facility financial incentives to trigger a three-day hospital stay, and other factors. Evercare and several other N.P.-based NF programs have demonstrated a 50 percent – 70 percent reduction in hospital stays with improved mortality and a high degree of member satisfaction. AmeriHealth Caritas Iowa would consider placing an onsite R.N. /N.P. in NF or in a region of a NF with a concentration of 100 – 133 members to manage their care. The model would replicate the highly successful Evercare NF program. An R.N. /N.P. would be assigned as the care manager for each member and would collaborate with the PCP to provide preventative and onsite care to minimize hospitalizations and transfers to other care facilities. Key elements of the R.N. /N.P. care plan and approach include:

- Advanced care planning.
- In-facility “pre-acute” care management to avoid hospitalization.
- Medication optimization (e.g., reducing Beer’s list drugs).
- Establishing close partnerships with family and facility staff.

Overall, this multi-faceted program leverages an onsite R.N. /N.P. to achieve care transition, optimal post-acute care and improved care for custodial residents of NF. AmeriHealth Caritas Iowa would leverage existing networks of N.P.s already providing care in facilities in the target markets, and ensure they are managed and trained on the appropriate protocols.

4) ICF/ID collaborative team approach

For members living in ICF/IDs for whom discharge is not possible, AmeriHealth Caritas Iowa care managers will collaborate with the ICF/ID program staff, working to support and not supplant any care management services provided by ICF/ID staff. AmeriHealth Caritas Iowa will ensure each member has a comprehensive assessment of medical, behavioral and medication history along with functional, cognitive and behavioral status review. We will review the members’ supports, such as family, caregivers and others, as well as his/her care team.

Members residing in an ICF/ID will have an assigned care coordinator and an organized ICT. This will usually include professional program staff from the ICF/ID. The team will be made up of individuals relevant to the member’s identified needs and individuals that will support the design and implementation of programs and services sufficient to meet the member’s needs.

AmeriHealth Caritas Iowa's approach to ICF/ID is intended to be collaborative, team effort with ICF/ID staff, with the goal to drive actions and interventions that support the member's maximum independence. The frequency of interventional will be individualized and dependent upon the member's stability. At a minimum, a reassessment will be performed every 180 days.

Aligning financial incentives

Aligning financial incentives is another mechanism that AmeriHealth Caritas Iowa will use to further support care coordination services and enhance care delivery for the residents of NFs and ICF/IDs. AmeriHealth Caritas Iowa will work collaboratively with partner NFs, ICF/IDs and other providers to establish innovative payment mechanisms. This will be part of the contracting process and will include agreed upon quality and performance measures, such as reduced average length of stay (ALOS), reduced hospital admissions and ER visits, and the number of members with specific acuity levels returning to the community with LTSS. Some examples are described below.

Nursing facility initiatives

The health plan will consider offering several NF-specific pay-for-performance opportunities, affording individual providers an opportunity to be recognized financially when they meet or exceed the quality metrics most directly under their control.

The first method can be based on the CMS Five-Star Quality Rating System for NFs. The system features an overall five-star rating based on facility performance on three types of performance measures: health inspections, staffing and quality measures (e.g., percentage of residents with pressure ulcers). A score of five stars means that a facility is "much above average", compared to others in the same state. Facilities that receive one star are rated as "much below average" as compared to others in the same state. The health plan can institute bonus payments to facilities that achieve an overall rating of four or five stars, with a higher payment made to five-star facilities.

Alternatively, the health plan can partner with NFs to implement evidence-based interventions that both improve care and lower costs. The health plan can work with the NF to establish a set of benchmark quality metrics upon which either a bonus payment or a shared savings payment, depending on the arrangement, can be made if the facility meets or exceeds the performance standard within established metrics, and shared savings can be available. Example performance measures include reduction in ER utilization and in avoidable hospital admissions.

Another method can reward NFs that collaborate in the identification and transition back to the community of long-stay residents. The health plan can share a portion of the savings associated with every qualifying resident in a facility that is identified by the facility and transitioned back into the community. To qualify, a member must have resided in the facility for at least six months and must remain in the community after discharge for at least 12 consecutive months.

Residential housing options

The health plan will also consider contracts with assisted living facilities or adult foster homes as an alternative to NF or ICF/ID placements for long-term care members. This includes creating an "intensive or complex" payment tier, with a higher per diem rate, that adequately recognizes or compensates for the special needs of members with medically complex or comorbid conditions.

Clinical staff at the health plan will develop medical necessity criteria for payment of the tier rate. The criteria will be reviewed and approved by the health plan Utilization Management Advisory Committee prior to implementation. Once the new methodology is in place, provider relations representatives

educate providers about the new payment tier and associated criteria. Care managers will target members who might be candidates for placement in a qualifying facility, foster home or ICF/ID.

The intensive tier payment option is design to increase the willingness of assisted living facilities, adult foster home or ICF/IDs providers to accept members with complex conditions. This provides a new placement option for members who otherwise would have remained in or been newly admitted to a NF, thus improving the quality of life for members able to remain in or return to the community.

Taken together, these initiatives provide a complete complex care management solution for the highest-risk Iowans.

2. Describe processes for working with NF and ICF/IDs to coordinate care.

AmeriHealth Caritas Iowa will coordinate and have many touch points with NFs and ICF/IDs including, but not limited to, the health plan's Integrated Care Management and Utilization Management teams:

Integrated Care Management

AmeriHealth Caritas' Integrated Care Management team includes nurses, social workers, clinical pharmacists, behavioral health clinicians, plan medical directors, PCPs, specialists, members, caregivers and/or parents/guardians. The care manager will lead this team and be the primary interface with the NF or ICF/ID. This team works to meet members' needs at all levels in a proactive manner that is designed to maximize health outcomes.

AmeriHealth Caritas takes a member-centric approach that is adaptable to a variety of living and treatment settings. Members, caregivers, parents/guardians participate in care planning, and set reasonable goals or targets for the member and they are assisted in doing this by a care manager.

For those with intellectual/developmental disabilities living in an ICF, a residential-services-based care manager (if available) can serve as the care manager, with support from AmeriHealth Caritas Iowa's care manager, and conduct the comprehensive assessment and coordinate an integrated health management team made up of individuals significant to the member achieving his/her specific goals. The Nursing Home Institutional Program is a partnership between facilities' care teams and the health plan's facility-based care manager, who acts as the accountable care provider for nursing home patients. NFs will be managed through this program as described in Section 4.3.12.1.

Member-centric care requires engagement of the member in care planning. This is best conducted in a place familiar and comfortable to the member. For members living in an ICF or long-term NF, the residential services based care manager or NF based care manager will convene assessment and care planning meetings, usually done in that residence/facility. In addition to the member and the member's family or advocate, this team could include facility staff, habilitative service providers, nurses, social workers, clinical pharmacists, behavioral health clinicians, plan medical directors, PCPs and specialists. The residential-services-based care manager or NF-based care manager leads this team and is the primary interface with the ICF or NF. This team works to meet member's needs at all levels in a proactive manner that is designed to reach the member's goals. AmeriHealth Caritas Iowa will provide a 24/7 Nurse Call Line available to any member of the team, including facility staff who may need after-hours advice.

For members in NFs or ICF/IDs, facility and/or program, staff significant to or working with the member is identified. The integrated care plan is shared with the facility, and conversely, any assessments the facility conducts will be reviewed for possible integration or supplementation of the integrated treatment plan. The NF care manager works with the facility to reduce duplicative processes and to foster better communication. Facility care providers will be invited to be part of the interdisciplinary care team/health

management team. Where appropriate, AmeriHealth Caritas Iowa can work with providers to treat in place and avoid unnecessary admissions.

AmeriHealth Caritas works to partner with members and their families or other supports and, as appropriate, seek out options for community-based housing. Members will be supported to select the least restrictive setting appropriate to their needs and preferences as described in 4.3.12.1.

In the case of a short-term NF stay, AmeriHealth Caritas focuses from the day of admission on the formation of a transition plan. A transition care coordinator (TCC) works with the facility staff. The TCC, who may be the facility-based care manager or another plan resource, takes an active part in the discharge planning to coordinate services, encourage good communication and smooth transition across the residential settings. Making sure that the required supports are all in place prior to discharge and that all members of the care team are aware of the discharge plan helps to ensure a better outcome and reduce unnecessary readmission. The TCC schedules regular follow-ups to check on the member's progress after discharge. The timing of this follow-up is based upon member need and supports, but at minimum, will follow the Program Intervention Map (4.4.2.3 and 4.4.3.1 and 4.3.12.5). After transitioning, the member will be reassessed by his/her care manager and the member's needs and goals are updated and/or adapted in the care plan.

Utilization Management

The Utilization Management team will ensure that our members residing in a NF receive timely and appropriate care (determined to be medically necessary) to maintain and improve their overall health. For services requiring authorization, the TCC or care manager will work with an AmeriHealth Caritas Iowa Utilization Management nurse to ensure that services are checked against the covered benefits and the health plan's Medical Coverage Guideline criteria for medical necessity. This results in the issuance of an authorization number and a written approval that is sent out to the member and the prescribing or authorizing provider. If there is a requested service that is not a covered benefit, the Utilization Management nurse will indicate this to the care manager or TCC who may need to work with the prescriber to identify a reasonable alternative. If the requested service does not meet the coverage criteria due to failure to meet medical necessity, this is reviewed by a medical director before being acted upon. When an ordered service is part of the transition plan and deemed to be uncovered, the TCC will work with member and the prescriber to identify a replacement. In the event that a denial is required, this will be communicated orally, and then a letter will be sent with a clear description of why the request was denied and what coverage or medical necessity criteria were used in the decision. Any initial denial is sent with appeal rights.

For LTSS requiring prior authorization requirements (community-based long-term care services and NF LOC services), the process includes:

- The care coordinator submits the care plan and budget to the UM department for review and approval.
- UM determinations are made by designated UM staff.
- The LTSS UM team will determine if the member meets NF level of care (LOC) criteria based on clinical documentation and the Minimum Data Set assessment (MDS) and preadmission screening and resident review (PASRR) if applicable.
- The service plan cannot be implemented until it has been approved by the UM department.
- The NF LOC and budget will remain in effect for one year or until such time that there is a change in the LOC that requires a reassessment.

3. Describe strategies for coordinating physical health, behavioral health and long-term care needs for residents and improving the health, functional and quality of life outcomes of members.

Holistic approach to care coordination

Long-term care has been historically dominated by the traditional medical model, where the focus is placed primarily on an individual's disease or condition rather than his/her overall needs. However, this model fails to take into account the effect an individual's behavioral health and social supports have on his/her physical health. Long-term care users, in particular, are more likely to require the care of many specialty providers to treat individual conditions, and it is easy for these consumers to see themselves as the sum of their different conditions. Not surprisingly, behavioral health is a substantial need among those who require long-term care services. As a result, AmeriHealth Caritas Iowa's integrated model of care takes a more holistic approach to member care, including social support and behavioral health services in their continuum of care.

Our Integrated Care Management services helps to ensure that beneficiaries with LTSS needs are treated in a holistic manner, meeting the behavioral health needs of people with physical disorders, as well as the physical health needs of people with behavioral health disorders. For individuals with LTSS needs who are residents of NF/ICF/IDs, focal priorities for the health plan will include improving the screening and treatment of mental health problems as part of medical case management services, as well as improving the medical care of individuals with serious mental health problems as part of behavioral health case management services.

AmeriHealth Caritas has established an integrated care management approach that begins by stratifying beneficiaries based on the behavioral health and physical health risks and complexities of the population. This helps to determine the array of services offered to the member with a single point of contact based on each member's needs. Members with high-risk behavioral health needs and no- or low-risk or well-managed physical health needs are assigned a behavioral health clinician as their case manager. Members with high physical health needs and no- or low-risk or well-managed behavioral health needs are assigned a nurse as their care manager. The model uses a collaborative care approach, in that the team is supported by clinicians with various specialties (i.e., mental health, substance use disorders, cardiology, maternity) and levels (Master's-level licensed social workers, registered nurses, licensed psychologists, obstetricians, primary care professionals and psychiatrists). Care managers consult with the various specialists once they have determined all the conditions and issues of their assigned member. This provides the single point of contact for members to address all of their needs holistically.

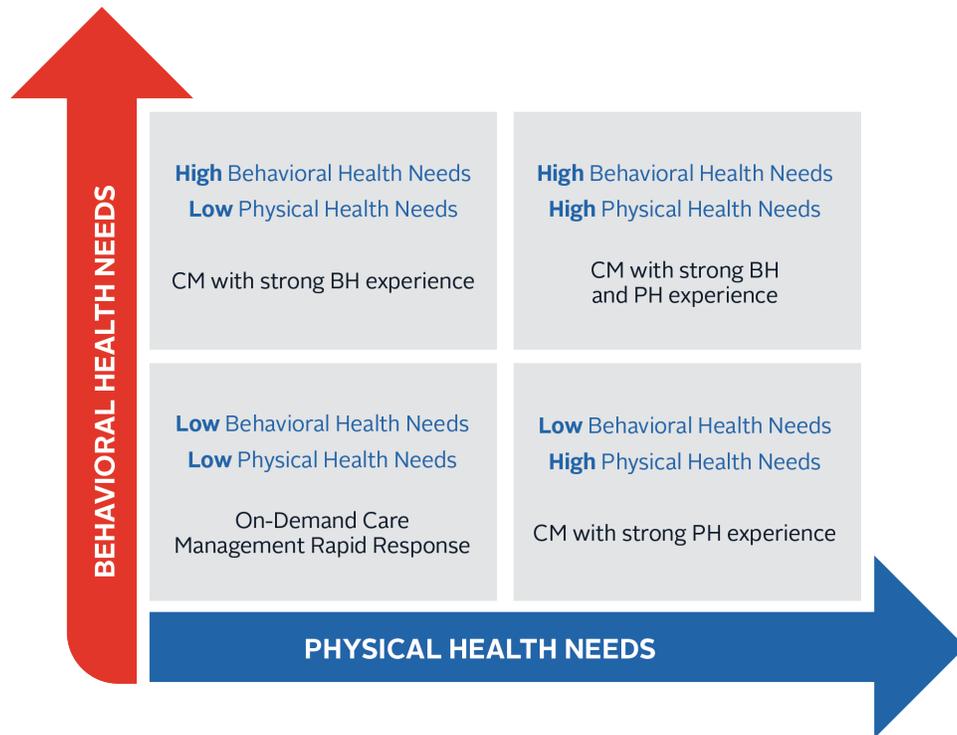


Exhibit 4.3.12-A: Physical Health (PH) and Behavioral Health (BH) Framework
(Note: CM stands for care manager)

There is a continuum of holistic services that will be offered to individuals residing in NF/ICF/IDs with comorbid medical and behavioral health conditions. Collaboration involves the two systems communicating with one another from their respective areas. Co-location brings the two systems to the same physical location, but they remain two separate systems that communicate. Integrated services involve behavioral health and physical health working as one unit, with a singular face to the member supported by all relevant subject matter experts.

Our approach incorporates tested strategies of co-location and need-based resource allocation with additional strategies along the behavioral health-physical health integration continuum (see below). These strategies strengthen existing capabilities and create new ones within the healthcare delivery system to deliver person-centered care that seamlessly addresses a member’s behavioral, physical and pharmacologic needs.

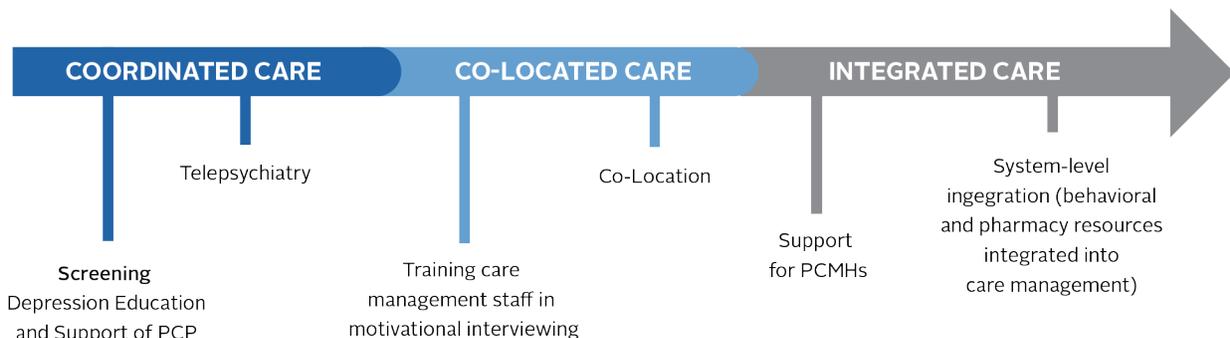


Exhibit 4.3.12-B: Integrated Care Overview

1. **Behavioral health education and support of PCPs**, helping the team manage the behavioral health needs of our members.
2. **Behavioral health telemedicine services (i.e., telepsychiatry)** to deliver psychiatric assessments and care remotely through telecommunications technology, such as videoconferencing.
3. **Co-location** involves integrating behavioral health services into the primary care office, or integrating medical/physical health services into a community mental health clinic, ICF/ID or NF.
4. **Training care management staff in motivational interviewing** is a collaborative engagement method that addresses a member's motivation and commitment toward changing unhealthful behaviors.

Assessment process

LTSS members identified as high risk in the ICM program receive comprehensive and condition-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, the physician(s) and other identified members of the ICT. The ICM 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, dental, LTSS, assistance with transportation, identification of and access to specialists, and referral and coordination with behavioral health providers or other community resources.

Care planning

AmeriHealth Caritas Iowa staff will work with the appropriate long-term care, primary care and mental health providers to develop an integrated care plan for members in need of , physical and mental healthcare coordination. Care managers will also assure that communication between the disciplines, providers and organizations occur routinely for all members with long-term care needs. Care managers will proactively and regularly follow-up on required physical and mental health services, joint treatment planning and provider-to-provider communication to ensure that member needs are continuously reviewed assessed and updated.

Through the use of general screeners and condition-specific assessments, our care managers identify the medical, behavioral health and psychosocial needs of each member in LTSS. This allows the care manager to be the single point of contact for the member when addressing activities of daily life, such as the member's ability to shop for food, get medications, transportation to appointments, desire to obtain a GED, etc., as well as condition management, such as blood sugar monitoring and antipsychotic medication adherence. Our care plans go beyond primary medical diagnosis to address multiple disease states, comorbidities and non-medical aspects of an individual's wellbeing. 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 self-management.
- Psychosocial supports.
- Recovery.

A member defines what recovery is for him/her and the care manager assists the member in developing an individualized service plan, focusing on the member's prioritized needs and desires, and the availability and appropriateness of services and supports. All activity is documented in the member's medical record

in our integrated system that includes utilization management, case management and quality improvement activities for medical and behavioral health, as well as pharmacy data, claims data and gaps in care. This system allows our care managers to get a full picture of each member and share this information when clinically indicated with providers.

Interdisciplinary team approach

Additionally, AmeriHealth Caritas has achieved success in integrating behavioral health services into models of acute and long-term care coordination using an interdisciplinary care team approach. Cases are handled by one care manager, exclusively, who addresses all identified issues with support and consultation from other specialties. This care manager is supported by a team of professionals from multiple specialties, including psychiatrists, psychologists, PCPs, geriatricians, registered nurses, social workers and other medical and non-medical professionals, as needed. There is a single plan of care that addresses all of the members' goals and identified issues.

The designated care manager participates in care plan meetings at the NFs or ICF/IDs. ICT meetings are conducted in order to ensure care planning is well coordinated among the team members for the resident. The team shares the same documentation system to enable complete sharing of information in real-time among utilization management, care management, population health management and quality improvement.

4. Propose institutional diversion strategies and describe successes in other states.

Programs that emphasize community-based services and supports aimed at preventing vulnerable individuals from entering a NF are increasingly important, both for Medicaid beneficiaries and low-income people who are likely to become Medicaid-eligible if they enter a NF. AmeriHealth Caritas' institutional diversion efforts seek to prevent unnecessary NF use by redirecting individuals, when appropriate, to HCBS, by providing long-term care services in the least restrictive setting. Members appropriate for diversion strategies are typically individuals who are at high risk of NF placement and who are currently in the community, hospital or short-term NF.

Member engagement and assessment is the primary strategy AmeriHealth Caritas employs to avoid unnecessary long-term institutional placement. The model of care is built around the goal of member engagement. This begins with member assessment and employs an interdisciplinary care team approach. Members are assessed upon enrollment, when there are certain trigger events, such as an admission or an ER visit for an ambulatory sensitive diagnosis, and at regular intervals based upon projected risk. The assessment helps to stratify members based upon their health needs. All high-risk members are reviewed with consideration to medical conditions, challenges presented by the members' social conditions and limitations in activities of daily living.

The objective of the diversion strategies is to redirect the member's plan of care to decrease SNF admissions or, if admitted, to shorten the ALOS in the NF. AmeriHealth Caritas' three institutional diversion strategies, which are currently being implemented as part of the MMP demonstrations, include the following:

1. Community-based strategy — AmeriHealth Caritas Iowa will focus on maintaining community-based members who are nursing home-eligible but living at home. Key factors as critical in maintaining members in community setting include:

- Timely initiation of services to offer eligible beneficiaries who reside in the community, but are at-risk of being institutionalized, the option of utilizing the timely provision of HCBS waiver services to develop a home program to assist in safely meeting his/her home medical care needs. Our experience shows that members who do not receive HCBS and supports within 30 days of enrollment are at greater risk for institutionalization than members who receive services within this time frame.
- Appropriate service mix increases the amount and intensity of in-home services, so members can safely live in their homes and communities. AmeriHealth Caritas Iowa's robust care coordination and service plan focuses on the needs of the member and reflects the appropriate mix of services and supports based on the members' needs and preferences.
- Proactively work with home health and social service agencies to identify high-risk consumers who are at-risk for NF placement.
- Availability of informal support systems enhances caregiver training and support, so caregivers remain strong and able to sustain the important work of caring for loved ones with chronic and/or disabling conditions. This is essential to maintaining a member in their home and their community. Because of the limited supply of some community-based providers in parts of Iowa (especially in more rural locations), the health plan's care manager will work with the member and family caregivers to ensure that caregivers and other natural supports are well educated and supported through individualized caregiver coaching initiatives.

Case Study: Continence Management program to keep people in their homes

Our care coordinator reports about "Joyce", one of our members, who does not have immediate family in the area. Joyce is on the Waiver program and was receiving aid services five days a week. When our coordinator went to visit Joyce, our coordinator stated that Joyce needed help getting to church on Sundays.

The care coordinator contacted Joyce's case manager and got her approved to receive assistance on Sundays. This member also receives incontinence supplies that she cannot afford on her own.

The Joyce's daughter, who lives out of the area, suggested that she come and live near her. But because the member has the dependable support that she needs from the health plan, Joyce is comfortable and has the independence of staying in her own home.

2. Post-acute care discharge strategy — AmeriHealth Caritas Iowa will assign and/or place care management staff members in key hospitals to enhance this linkage, identify at-risk members and assist in supporting a plan of care to help members transition to the home rather than to a NF or other institutional-based care. Elements of this plan include:

- Meeting with the member and member's family/natural supports to begin identification of LTSS needs before discharge.
- Completing a home visit after discharge to identify LTSS needs.
- Completing medication reconciliation.
- Updating service plan and coordinating LTSS.
- Ensuring the right LTSS is delivered at the right time(s).
- Ensuring the member makes and attends follow-up appointments with the PCP.
- Weekly phone contact for four weeks.

We will also look to partner with key acute care facilities to implement an ER identification initiative. The health plan will work with those acute care facilities where we see significant ER utilization to screen and identify members who may be at risk of a future acute care or NF stays.

In the instance where members who go to ER, are screened and found to be at-risk of admission to an NF, those members will be redirected home with an enhanced care plan rather than to an NF for care. The health plan will be notified of the member's visit by the ER and the member will be referred to the health plan's Care Management team, where the member's assigned care manager will put a service plan in place (within two to three days) that provides the appropriate amount and intensity of in-home services, so the member can safely live in their homes and community.

3. Short-term NF stay strategy — AmeriHealth Caritas Iowa will improve the care coordination and supports for members transitioning from an NF to a community-based setting by providing a member who has a short-term sub-acute NF or skilled nursing facility level of care with the option of returning to and/or remaining in his/her home or home-like setting in the community in lieu of long-term institutionalization. This is achieved by implementing a more proactive home-based service plan for members who enter a NF for a short-term stay to prevent them from becoming longer-term custodial care residents.

5. Propose strategies to identify members who have the ability or desire to transition from a nursing facility or ICF/ID setting to the community. Propose assessment tools, provide a sample transition plan and describe post-transition monitoring processes.

Transition programs attempt to move individuals already in NFs or ICF/IDs into less restrictive community settings, which are generally much less expensive than institutional care. Transition efforts focus on people who live in NFs or ICF/IDs, but who could safely return to live in the community. The overarching goal is to facilitate a safe and timely transition of eligible beneficiaries from a facility to his/her home and community.

For members qualifying for LTSS levels of care, AmeriHealth Caritas Iowa's Complex Care Management program includes a person-centered approach to maximize the member's ability to have his/her needs met safely and effectively in the community. A member defines what recovery is for them and the care manager assists them in developing an individualized service plan, focusing on the member's prioritized needs and desires, and the availability and appropriateness of services and supports. Each service plan includes an emergency backup support and response system to address situations where support services are interrupted or delayed, or member needs change.

AmeriHealth Caritas will be leveraging our experience in serving Medicaid populations (ABD, TANF, dual eligibles) across all of our states to offer a Care Transitions (Transitions) program for Iowa members. AmeriHealth Caritas' Transitions program focuses on the critical foundational elements adapted from the four pillars of Dr. Eric Coleman's Model of Care Transition Interventions, among other evidenced-based approaches including Bridge and BOOST transition programs, which are leveraged for our post-acute care transition efforts as described in Section 4.4.3.7. While primarily focused on post-acute transition, these evidenced based approaches have key transferrable learnings that can be applied in other transitional settings (such as NF/ICF/ID to home). We will focus intensive efforts on members admitted with diagnoses, conditions or psychosocial concerns that will place the member at the highest risk for readmission to the NF or ICF/ID setting.

AmeriHealth Caritas Iowa's Care Transitions program

AmeriHealth Caritas' Transitions program is a high-touch program with a transition coordinator conducting face-to-face visits at least once during a facility-based stay, calling the member within two to three working days of discharge, and conducting a face-to-face visit at the member's residence within seven days of discharge.

For members discharging to or from a skilled nursing facility or ICF/ID, Transitions staff work with the facility's clinical staff to ensure an appropriate discharge planning document is reviewed and approved prior to the member's transfer. The discharge planning document is shared and explained to the member and caregiver by the Transitions representative.

The Transitions staff will use standardized tools to assess the member's risk of re-institutionalization, re-hospitalization or treatment plan non-adherence, and will assist in coordinating the discharge plan, which may include authorizing home care services or assisting the member with after-treatment and therapy services. The face-to-face visit at the member's residence and accompanying telephone calls are designed to provide continuity across the transition to empower members to actively engage in managing their care. The Transitions staff also conducts medication reconciliation, reviews red flags, and provides education regarding initial steps to manage these symptoms and when to contact their provider, and assess the safety of the environment and the member's support network and community supports. The Transitions staff receives training in community resource referrals and will assist the member as needed with items, such as food, transportation and clothing. As the care transition process nears completion, the Transitions staff identifies any ongoing needs and communicates all relevant information to the care manager, who will work with the member and providers to address future needs.

Member identification

The health plan relies on several approaches to identify members who have the ability or desire to transition from a NF or ICF/ID to the community, including:

- **Section Q of MDS.** This includes the results to the question as to whether the resident has expressed an interest in or desire to return to the community.
- **PASARR Level 1 screen.** This includes all individuals who receive a pre-admission review before they entered the NFs, as available.
- **The long-term care ombudsmen.** The health plan will have open communication with the state Long-Term Care Ombudsman program that can be an important source of referrals of individuals who have expressed the desire to transition.
- **NF and ICF/ID staff.** Staff of the NFs and ICF/IDs are also important partners. The health plan will send care management staff into facilities and residences to work with resident members and explore the feasibility of returning to the community. For residents who chose to transition to the community, the staff member will develop a plan and arrange for the necessary services to facilitate the move.
- **Health plan care management staff.** Care managers will conduct face-to-face assessments in the NFs and ICF/IDs at least twice a year and have frequent contact intervals with members in between visits. This frequent and ongoing interface enables the care manager to determine if the member is living in the least restrictive setting desired by the member and his/her caregivers.
- **Family members and other support system.** Referrals made by family members or other representatives of the member who have expressed the desire to transition from a NF or ICF/ID to the community.

Transition process

For every member, the care manager conducts a transition assessment during the initial visit to obtain the member's interest and capacity to transition into the community. If the member expresses a desire to repatriate and appears to have the necessary support systems to ensure great success in the appropriate transition, a TCC, who may be the same care manager or a dedicated TCC if there is sufficient concentration of members in a region or facility, will be assigned to the member to assist in the transition and in coordinating the proper services.

The TCC will outreach to the member, appropriate caregiver, power of attorney (POA), and/or member representative to schedule an initial in-person meeting. During this visit, the TCC conducts a transition assessment, develops repatriation plan of care and initiates the transition of the member from the NF to the community.

The transition assessment will gather additional information about the member's history, health concerns, family and housing situation, and their expressed needs and desires. This information will be collected through a structured interview tool (see Attachment 4.3.12-A: Transition Assessment Tool) that builds upon best practices used by states as part of Money Follows the Person (MFP), CMS Nursing Home Transition Grants, the PASARR Level 1 screen and other valid tools.

The assessment and planning process will ensure that all needed services are identified and arranged accordingly prior to transition. For those persons identified for transition, the transition coordinator assigned will work with the institutional staff, family members and community resources, including those provided through the Medicaid state plan, HCBS waivers, and MFP to effectuate the transition. The process will assure that, prior to the transition, all necessary services and supports are in place for the member to return safely to a community setting, with no interruptions in needed services.

If the member requires assistance in the community to transition safely, the TCC will assist in coordinating LTSS and HCBS. Examples of these services include, but are not limited to, environmental adaptation, chore services, respite care, personal care and transportation services. The TCC will ensure receipt of these services, as appropriate, in order to ensure a safe transition into the community. The member's case will be presented to the ICT to determine the member's ability to live as independently as possible in the community and to ensure an ongoing plan of care is in place to monitor the member after transitioning back to the community.

The health plan's care manager will assume responsibility for ongoing care coordination to assure the health and welfare of the individual. The care manager will make no less than bi-weekly contact with the member during the first 90 days post transition to monitor the member's health and welfare.

©2015 AmeriHealth Caritas - Proprietary

My Transition Service Plan



My Transition Service Plan

Member name	Date of birth	Best phone number	
Mary Jones	2/28/1937	515-765-4321	
Address	City	State	ZIP code
123 Sunny Lane	Des Moines	IA	50309

I was in the nursing facility because:	When:	I want to live:
I fell in the shower and broke my hip and hurt my head	From February 16 2015 – August 23 2015	In my home

My Care Coordinator will:						
	Date	Time	What will happen?			Who?
Visit me in my home	Tuesday August 25 Thursday Sept. 15	10am to 12pm	To see what I may need and order it for me	To teach me about my medication	Talk with me about my next doctor visit	Lynn Rhodes, RN
Call me at home	Every Tuesday until Sept 29; every other Tuesday until December 1	1pm	To be sure I have what I need	To be sure I am getting better	Help me get a ride to my doctor visit	Lynn Rhodes, RN
Get me home delivered meals	Two meals every day until October 1					Molly's Meals
Get me a shower chair	To be delivered on August 25					Neighborhood HomeCare
Have grab bars installed in my bathroom, shower and hallway	Installed by August 31 (At least within seven days of when I get home)					Sam the HandyMan, Inc.

Exhibit 4.3.12-B: Transition Service Plan (Page 1 of 3)

My Transition Service Plan

Have a physical therapist come to my home	Two times per month for three months	To be scheduled	To help me stay strong and flexible			Neighborhood HomeCare
Have a personal care aid come to my home	Four days per week for one month. Then two days per week for two months.	To be scheduled	To help clean my house	To help me take a bath and get dressed	To go to my doctor visits when my daughter can't go with me	Neighborhood HomeCare

I Want To:	My Family Will:
Go back to my church on Sunday's	Visit me every week on Saturday
Work on my puzzles	Take me shopping
Enjoy my cat	Help me with bills

My next doctor visit:	Things I should talk to my doctor about:
With: Dr. Susan Kennedy Address: 411 Laurel St., Des Moines, IA Date: Friday May 15 2015 Time: 9:30am	1. How much it hurts. 2. How long do I take my Naproxen? 3. What I need help with.

My Daily Medication List			Amount to take and when to take			
Name	What it does	How to take	Morning	Noon	Evening	Bedtime
Lisinopril HCTZ (12.5 mg/10mg)	Lowers my blood pressure	With water	1 tablet			
Aledronate (5mg)	Keeps my bones strong	With water	1 tablet			
Coumadin (5mg)	Prevents new blood clots	With water	1 tablet			
Multivitamin	Helps to keep me healthy	With water	1 tablet			

As needed medication			How much and how often
Name	What it does	How to take	
Naproxen	Helps with pain and swelling	With water	One tablet at breakfast

Exhibit 4.3.12-B: Transition Service Plan (Page 2 of 3)

My Transition Service Plan

--	--	--	--

People involved in my care				
PCP name Dr. Susan Kennedy, DO	Address 411 Laurel St., Des Moines, IA 50317	Phone number 515-643-5400		
Primary caregiver Sharon Jones (daughter)	Address 26 Magnolia Rd., Altoona, IA 50009	Phone number 515-789-1234	Emergency contact	
			Yes	No
Team role	Team member	Phone number	Emergency contact	
Care Coordinator	Lynn Rhodes, RN	515-457-2300 ext. 123	Yes	No
Home Health Nurse	Jennifer Brown	515-254-7600	Yes	No
Physical Therapist	Mary Bergeson	515-746-2780	Yes	No
Personal Care Aide	Kristi Pflueger	515-254-7600	Yes	No
	Mary Beth McQueen			
Adult Day Center Coordinator	Clara Rosetti	515-746-9999, ext 321	Yes	No
Fiscal Intermediary	Michael Trinity	515-527-5874	Yes	No

Lynn Rhodes RN 515-457-2300, ext 123
 Care Coordinator Phone number

Mary Jones _____
 Member signature Date

(Legal language for authorized representative)

N/A _____
 Authorized representative name Date

 Relationship to member

Exhibit 4.3.12-B: Transition Service Plan (Page 3 of 3)

Post transition monitoring process

The TCC will provide all care management duties for the member during the transition period (first 30 days post discharge) and until the member is back in the community. Once transitioned back to the community, the TCC will transition the member back to the care manager for ongoing management, if he/she is not the same professional as the care manager. The assigned care manager will continue to monitor the member in the community during the post-transition period. AmeriHealth Caritas' post transition monitoring process is as follows:

Intervention	Description	Interval
Facility Visit	Face-to-face visit at facility before transition occurs to community setting to assess needs and prepare transition plan.	One visit
Week One Post Discharge:		
Telephonic outreach and home visit	<p>Telephonic outreach to reinforce the discharge/transition care plan and address any problems or concerns that have arisen since discharge.</p> <p>Visit member at residence to:</p> <ul style="list-style-type: none"> Review the post-discharge plan, answer any questions and address any problems the member is experiencing. Provide support to aid the member in the recovery process and to avoid readmission, including engaging the primary care or mental health provider for continued monitoring. Help the member identify health goals and gain skills in self-care. Review medication use and reconciliation. Review signs and symptoms of red flags. Complete a safety assessment. Review the member's support network and needed community connections. 	<p>Telephonic outreach within 2 to 3 days of discharge</p> <p>Home visit within 2 to 7 days of discharge</p>
Service coordination	Schedules follow-up appointments, coordinates HCBS and addresses any barriers in attending appointments or receiving services.	Within 7 days of discharge
Weeks Two to Four Post Discharge:		
Follow-up calls/visits	Outreach call to assess status; in-person visit, as needed.	Weekly contact, based on individual need
Weeks Five to 12 Post Discharge:		
Follow-up calls/visits	Outreach call to assess status; in-person visit, as needed.	Bi-weekly contact, based on individual need

Intervention	Description	Interval
Ongoing Support:		
Ongoing care management	Outreach calls and in-person visits.	After the first 12 weeks post discharge, quarterly in-person visits and monthly calls when no visit occurs. More frequent visits or phone contact may occur based upon individual need.

Exhibit 4.3.12-C: Post-transition monitoring

Specific interventions to further facilitate a member’s transition home

Examples of interventions AmeriHealth Caritas Iowa will consider designing to transition members from NFs to community settings include:

- **House call program/home physician program.** AmeriHealth Caritas Iowa can offer in-home physician services to members served in the community. For members transitioning from NFs, the in-home medical providers participate in the discharge planning and visit the member in their home within 24–48 hours upon discharge. This program includes weekly care planning meetings between the medical provider and CM, during which, the CM receives updates on the member’s health status and communicate back to the medical provider in regards to needs-for-services, such as home health and durable medical equipment.
- **SNF care management program.** Described earlier, our facility-based Care Management program reallocates our care management caseloads to assign specific care managers to designated SNFs in order to promote regular face-to-face contact with members in each facility. SNF case managers maintain a regular presence at their assigned facilities, allowing them to develop relationships with the members, speak to their family members and review the member’s chart to identify and address barriers to members living in HCBS settings. The SNF case manager is responsible for developing and coordination the discharge plan to make sure that the member’s needs in the community have been identified and addressed. These case managers are then empowered to arrange for services to meet the unique needs of these members, such as home modification or assisting a family member in becoming the member’s caregiver.
- **Expanded home modifications program.** Implement processes to approve expanded home modification (e.g., ramps, widened doorways) to improve independence for members with accessibility and mobility issues. These modifications allow individuals who will otherwise require NF care to remain in the community.
- **“Welcome Home” transition fund.** This fund helps assist members residing in institutional settings to re-integrate into the community. The fund provides financial assistance to members who have resided in a NF for at least 60 consecutive days, with a one-time authorization of up to \$2,000 per five-year period, to provide assistance in the transition when they have no other source of funds.

6. Describe processes for interacting with the State’s MFP designee and strategies to prevent duplication and fragmentation of care.

Iowa’s Money Follows the Person (MFP) Partnership for Community Integration Project provides opportunities for individuals in Iowa to move out of intermediate care facilities for persons with intellectual disabilities (ICF/ID) and into their own homes in the community of their choice. Individuals living in NFs may also qualify. Grant funds provide funding for the transition services and enhanced

supports needed for the first year after members transition into the community. MFP assistance is available to an individual with a diagnosis of an intellectual disability or brain injury who has lived in an ICF/ID or NF for at least three months. The individual must express an interest moving from the ICF/ID or NF into the community.

AmeriHealth Caritas Iowa will identify and provide the opportunity and supports for members residing in an ICF/ID or NF to safely transition to and reside in a community-based setting based upon the member's goals, preferences and choices. The health plan will look to identify and provide transition support to interested member's through coordinating with Iowa's MFP Demonstration program, Partnership for Community Integration.

Member identification

The target population for the Partnership for Community Integration is individuals with mental retardation and related conditions who are residing in intermediate care facilities for people with intellectual disabilities. Beginning in 2014, people with an intellectual disability or a brain injury who live in a NF also became eligible for MFP. Both adults and children will be eligible for participation. The state historically targeted approximately 56 individuals to be transitioned annually with the support of MFP. Qualified residences are expected to include the family home for some participants. Children may also receive residentially-based community living services if determined appropriate by their transition planning team.

All ICF/ID and NF residents are considered eligible for participation in MFP if they meet the three basic requirements: three months' residency in the ICF/ID or NF, eligible for the intellectual disabilities or BI waiver, and eligibility for Medicaid. Residency and Medicaid eligibility can be confirmed through Iowa Medicaid Enterprise (IME)'s electronic consumer case file system. Medicaid eligibility is routinely handled by DHS Income Maintenance workers.

Assessment and transition of care planning

Proper assessment and transition of care planning is a key factor in coordinating the appropriate needs of a member who is transitioning back to the community. The assignment of a TCC assists the member during this transitional phase. The TCC ensures that the state's approved process to submit a referral to the state's MFP referral system is completed. Once the member is assessed and approved by the MFP transition specialist, the TCC assists with the transition. This ensures that the member's services are appropriate, continuous and are not duplicated.

The TCC will conduct a transition screening that will develop an initial or ongoing plan of care (POC). The POC will include the services that the member requires and confirmation that they are in place. The POC will be ongoing and updated as additional needs arise. The TCC will remain assigned to the member throughout the transitioning period back to the community. Once the member is deemed stable in the community with the appropriate services in place, the member is transferred to a care coordinator for continuous management. The care coordinator will continue to assess and update the POC as necessary to ensure receipt of services and a prevention of duplicate services.

Specifically, AmeriHealth Caritas Iowa will coordinate with Iowa's MFP program transition process as follows:

1. Based on referral of a member as a candidate to return to the community from an ICF/ID or NF, a transition coordinator will conduct outreach to the member to determine his/her desire to explore community-based options.
 - A. Referral sources include:

- i. Identification by a NF through the Minimum Data Set Assessment (MDS) Section Q.
 - ii. Identification by the ICF/IDs residents in their facilities that seem to be good candidates for transition.
 - iii. Self-referral from residents and/or their families/guardians/legal representatives in an ICF/ID or NF that have expressed interest in transitioning to the community.
 - iv. Ongoing screening and reassessment by the health plan, which includes members identified as admitted to the ICF/ID or NF during enrollment and those who have been in an ICF/ID or NF 90 days or longer. Every six months, members are reassessed unless triggered sooner.
 2. The transition coordinator will:
 - A. Provide transition options counseling including the basic information packet explaining the MFP transition program and process.
 - B. Obtain signed consent of the resident, family member or guardian to contact the state's MFP project coordinator, who will then assign a state transition specialist from the MFP program.
 - C. Submit the referral packet documentation to the transition specialist for determination of eligibility for the MFP program.
 - i. Eligibility for the Nursing Home Transition program and RTH is dependent upon:
 - 1) Member's Medicaid eligibility.
 - 2) Member has been in residence of an ICF or NF for at least 90 consecutive days.
 - 3) Eligible for the Intellectual Disability (ID) or Brain Injury (BI) waiver.
 3. The health plan will monitor and initiate review of referrals from ICF/ID and NFs of members who respond to Section Q of the MDS that they are interested in learning more about LTSS in a community-based residence.
 4. If the member is eligible and wishes to transition from the ICF/ID or NF to the community:
 - A. The health plan's transition coordinator will meet with the member to:
 - i. Explore the member's desires, strengths and needs.
 - ii. Learn about circumstances that led to the member's admission to the ICF/ID or NF.
 - iii. Identify factors that may be barriers to a successful transition.
 5. If the member wishes to participate in the MFP program:
 - A. The state is notified, which includes the following enrollment criteria:
 - i. Number of consecutive days of residence in the ICF/ID or NF (requires 90 day NF stay).
 - ii. Medicaid eligibility.
 - iii. Signed consent from the member to participate in MFP.
 - iv. Within three business days of the notification that a resident or family member/representative has expressed interest, the state's transition specialist calls to make an appointment with the consumer/family/guardian to begin the exploration process.
 - v. The state verifies enrollment status for enrollment in the MFP program and notifies the health plan.
 - B. If a member chooses not to transition to the community, the transition coordinator continues to reassess those members who remain in a ICF/ID or NF and have resided in the NF for 90 days or longer, every six months for possible transition.
 - i. The health plan will notify the state if the member, guardian or responsible party determines that an ongoing assessment is not appropriate.
 6. If the member wishes to continue the transition process and can safely live in the community, an interdisciplinary team will be involved in transition, including the health plan's transition coordinator,

the MFP transition specialist, the legal representative, family or friends, ICF/ID or NF staff familiar with the consumer and supportive of his/her choices, a county services coordinator, and other members, as directed by the member.

7. With the member at the center of the health planning process, the interdisciplinary team helps to develop a comprehensive plan that includes:
 - Living preferences.
 - Service plan.
 - Discharge preparation checklist.
 - Medication list for reconciliation.
 - Risk mitigation.
 - Emergency back-up plan (contact names and agencies in case of service disruptions).
 - Date for transition to the community.
 - Whether or not the individual wishes to participate in the Consumer Choices option.
8. Specifically, the state transition specialist will assist the member to identify available community housing programs, opportunities for members to reside in a home or apartment with a caregiver or family member, and/or supportive housing options. Additionally, the specialist will help establish a housing budget and will plan and help arrange for qualified housing for the member.
9. The health plan's transition coordinator will ensure that preparations/plans are completed for the member's transition to the community and will conduct an onsite readiness review at the health planned community residence to verify that:
 - Home modifications are complete.
 - Needed equipment is in place.
 - Transportation arrangements are established.
 - Planned medical and support services are included, as well as arrangement for home delivered meals, as appropriate.
10. Once the transition occurs, the transition coordinator will maintain frequent, intensive contact with the member for the first four weeks post transition, as described in 4.3.12.5.
 - For MFP participants, monthly visits and/or phone contact by the state's transition specialist continues until the state notifies plan of the end date of the MFP participation.
 - A member's transition period may extend beyond 365 days if the member experiences an interruption in his/her community support services due to hospitalization, critical incident or other circumstances.
11. The care plan is revised as necessary to allow the member to reside safely in the home.
 - A. 60 and 30 days prior to the expiration of the consumers demonstration year, the state will provide notification to the health plan that the consumer will be transitioning from the grant-funded services to the ID or BI waiver, and the services to which the consumer will have access under the county system. A targeted case manager will be assigned.
 - B. The transition specialist will meet with the consumer and family or legal representative to complete the consumer satisfaction survey, and ensure compliance with all reporting requirements under MFP.
 - C. The health plan's care team will continue to interface with the member and their family/legal representative, monthly and quarterly, based on the needs of the member.

4.4 1915(c) HCBS Waivers

1. Describe in detail how service plans meeting contractual requirements, state and federal regulations, and all applicable policies, will be developed for each member enrolled in a 1915(c) HCBS waiver

By integrating medical care, behavioral healthcare, and HCBS into a single care management record, AmeriHealth Caritas Iowa will optimize the use of the benefits for which the member qualifies. All medically necessary covered services, regardless of which 1915(c) HCBS waiver in which the member is enrolled, will be provided. AmeriHealth Caritas Iowa has significant experience in providing all of the services associated with any of the current Iowa HCBS waivers.

AmeriHealth Caritas Iowa supports a coordinated care management approach that directly addresses the needs of waiver populations and other recipients receiving care across multiple domains. The integration of HCBS with behavioral health, primary, acute and institutional services will assure that the member receives the right service at the right time and in the right setting. For example, AmeriHealth Caritas is currently responsible for developing service plans in our MMP states that integrate the range of LTSS for members enrolled in the respective HCBS waivers, including, but not limited to:

- All Medicare services (except hospice)
- All Medicaid state plan services (except hospice)
- Behavioral health and substance use disorder services
- Dental services
- Adaptive medical equipment and supplies
- Adult day program
- Assistive technology
- Chores services
- Environmental modifications
- Fiscal intermediary
- Home delivered meals
- Non-medical transportation
- Personal emergency response system
- Preventive nursing services
- Private duty nursing
- Respite care

At the time of enrollment, AmeriHealth Caritas Iowa will assess the member's overall needs across all disciplines and utilize this assessment activity to formulate the building blocks of an integrated plan of care using a logical step-by-step process which includes evaluation of self-reported data, clinical claims data, hospitalization data, LTSS data, and lab and pharmacy utilization data that is incorporated into the member's record to support care coordination. This process will provide targeted care management for those with chronic conditions and/or psychosocial concerns and provide HCBS for members with LTSS needs. AmeriHealth Caritas Iowa will have a dedicated care management teams that focus on continuity of care.

Fundamental to this process is the development of a person-centered plan of care which incorporates the relevant clinical and LTSS data from the assessment process (as described previously) and incorporates the needs, desires and goals expressed by the member, the member's family and relevant caregivers. This person-centered planning process will be conducted in accordance with the new Medicaid HCBS final rule published January 16, 2014. All members of the care management team will be fully trained and knowledgeable about the importance of the person-centered planning process, and that individuals receiving LTSSs through HCBS programs under the 1915(c) Medicaid authorities have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate.

By integrating medical and behavioral healthcare and non-medical supports into a singular domain, AmeriHealth Caritas Iowa will optimize the use of benefits for which the member qualifies, along with additional community-based services that will allow the member to remain independent. The services are approved based on the member's needs and evaluated at timely intervals.

Many of the members will already have sought out HCBS from known and trusted community providers. AmeriHealth Caritas Iowa will interface with existing HCBS providers to encourage them to become part of the network so that members will be able to maintain continuity of care with the providers who are currently providing their services, as well as foster relationships with existing care managers in the development of the care plan.

The use of a Utilization Management team to perform utilization monitoring will ensure contractual requirements are being met.

Policies and procedures, intensive training, system enhancements and in-depth reporting will be instituted to ensure that all state and federal regulations are being met with regard to members enrolled in 1915(c) HCBS waivers.

2. Submit a sample Service Plan

AmeriHealth Caritas Iowa's sample service plan follows.

©2015 AmeriHealth Caritas - Proprietary



My Service Plan

Member name	Date of birth	Best phone number	
Mary Jones	2/28/1937	515-765-4321	
Address	City	State	ZIP code
123 Sunny Lane	Des Moines	IA	50309

People involved in my care

PCP name	Address	Phone number		
Dr. Susan Kennedy, DO	411 Laurel St., Des Moines, IA 50314	515-643-5400		
Primary caregiver Sharon Jones (daughter)	Address 26 Magnolia Rd., Altoona, IA 50009	Phone number 515-789-1234	Emergency contact	
			Yes	No
Team role	Team member	Phone number	Emergency contact	
Community Case Manager	Katie McCalley	515-457-2300 ext. 123	Yes	No
Home Health Nurse	Jennifer Brown	515-254-7600	Yes	No
Adult Day Center Coordinator	Clara Rosetti	515-746-9999, ext 321	Yes	No
Fiscal Intermediary	Michael Trinity	515-527-5874	Yes	No

Services I am directing

Service	How often	Start	End	Provided by	Paid/unpaid	Cost
Home Health Nurse	Once a week	4/20/2015	7/20/2015	Home Care Agency	Paid	\$15.00 Per hour
Home Health Aid	3 times per week	4/20/2015	7/20/2015	Home Care Agency	Paid	\$8.50 per hour
Home Safety Modification	One time	4/20/2015	10/20/2015	Handy Man, Inc	Unpaid	\$350.00
Transportation	3 times per week	4/20/2015	7/20/2015	My Ride, LLC	Paid	No charge

Exhibit 4.3.12-D: AmeriHealth Caritas Iowa Sample Service Plan (1 of 4)

My Service Plan Form

My choices		Currently in place	
Where I live	I want to live in a senior supportive housing community that has activities I like to do.	Yes	No
How I communicate	I always want someone with me when important things about my health are discussed.	Yes	No
The work I do	I want to participate in the crafts work group at my adult day center.	Yes	No
Other	I want to help with the planning of the next holiday party at my residence.	Yes	No

Things I am good at doing
I am good at creating many different kinds of arts and crafts. I am also a good listener to my friends.

Help I need with my health
I do not always understand what my doctor is explaining to me about my health conditions.

Other help that I need
I would like a new rolling walker that has a seat for me to sit on when I get tired.

My goals and time frame (1)		
Goal	I would like to find other help who can go with me to the medical appointments when my daughter is unable to go.	
Resource Community Case Manager	Start date 4/20/2015	Status in process

My goals and time frame (2)		
Goal	I would like a new rolling walker that has a seat for me to sit on when I get tired.	
Resource Primary Care Physician	Start date 4/20/2015	Status In process

Related services							
Service	Frequency	Start	End	Provided by	Paid/unpaid	Cost	Case #
Physical/Occupational Therapy	2 times per week	4/20/2015	7/20/2015	ABC agency	Paid	\$15.00 per hour	135796
Meals on Wheels	2 meals daily	4/20/2015	7/20/2015	Wesley Life	Unpaid	\$3.25 per meal	147225
Adult Day Center	3 days a week	4/20/2015	7/20/2015	Wesley Life	Paid	\$64.00 per day	186822
O2 Concentrator	At bedtime	1/14/2015	6/14/2015	DME, Inc.	Paid	\$325.00 (rental)	299765
Rolling Walker	As needed	4/20/2015	4/20/2016	DME, Inc.	Unpaid	\$89.99	278665

Exhibit 4.3.12-D: AmeriHealth Caritas Iowa Sample Service Plan (2 of 4)

My Service Plan Form

Restriction/limitation to member rights	
Description	Self-administration of medications
Reason	I have a history of forgetting to take my medications and also overdosing on them, which has resulted in ER visits.
Plan to restore rights	Care team will develop a medication dispensing strategy to support Mrs. Jones needs in order to regain this right.

Risk	
My risk	My plan
Falling	<ol style="list-style-type: none"> Continue with physical and occupational therapy 2 times a week on strength training. Remember to lock my walker when I am stationary
Isolation	<ol style="list-style-type: none"> Attend my adult day program 3 times a week Look at residential activities calendar and find activities I would like to do.

Emergency plan					
Health risk assessment	Iowa Comprehensive Assessment				
Identified emergency support crisis response system	<ol style="list-style-type: none"> Alternative Home Care Agency nursing support when self-directed nurse is unavailable. Life Line Medical Alert – Mrs. Jones will activate in the event of a fall or other emergency when appropriate. 				
Emergency backup providers	<table border="1"> <tr> <td>Name</td> <td>Phone number</td> </tr> <tr> <td>Home Care Agency</td> <td>515-254-7600</td> </tr> </table>	Name	Phone number	Home Care Agency	515-254-7600
Name	Phone number				
Home Care Agency	515-254-7600				

Exhibit 4.3.12-D: AmeriHealth Caritas Iowa Sample Service Plan (3 of 4)

My Service Plan Form

Katie McCalley _____ 515-457-2300, ext 123
Care manager Phone number

Mary Jones _____
Member signature Date

(Legal language for authorized representative)

N/A _____
Authorized representative name Date

Relationship to member

Care team member	Signature	Date
Primary Care Physician	Dr. Susan Kennedy, DO	4/20/2015
Daughter	Sharon Jones	4/20/2015
Home Health Nurse	Jennifer Brown	4/20/2015
Adult Day Center Coordinator	Clara Rosetti	4/20/2015

NB-1522-11

Exhibit 4.3.12-D: AmeriHealth Caritas Iowa Sample Service Plan (4 of 4)

3. Describe how member’s expenditures are tracked against any aggregate monthly cost caps.

Built into our LTSS Care Coordination platform is a service plan cost module that will allow AmeriHealth Caritas Iowa to automatically load (such as directly from the state-provided 820/834 transactions) a

member monthly budget or calculate the budget based on administratively defined parameters, such as data risk, waiver code, county of residence and so on. Every member will be loaded with a default budget.

Once the care coordinator begins to build the service plan, he/she will receive a warning message if the service plan is nearing the budget threshold or has exceeded the budget. This will allow the care coordinator to consider alternate services, providers or frequency to stay within the budget limit.

The module also allows staff to view the member expenditure over time, as well as compare the members cost to other members across the health plan continuum. By understanding the cause and effect of the member's services over time, new strategies can be put in place to prevent or mitigate the impact to the budget. This data also allows the care coordinators the capability to collaborate on their successful methods that allow them to stay within the budget.

Examples of AmeriHealth Caritas Iowa operational tools to support tracking member expenditures

Claim adjudication service rules limits

Service rules help the system adjudicate payment based on several parameters. A Service ID may have multiple service rules applied to it. A service rule establishes the calculation method of the service, the claims processing edits to be applied and amounts, and service tiers. At a high level, system configuration will determine how services will be priced.

Limits

The limit rules are used to define each benefit limitation or stop loss (out of pocket maximum) applicable. Each limit rule can be applicable to the selected benefit types based on amounts paid or allowed, on the number of services paid, applied during a plan year or over the member's lifetime. A limit is a dollar amount or number of counters that, once reached, will result in no further benefits being reimbursed. Limits can be established which apply to all services or only to selected services or related diagnoses. Limits can be at the member level or the family level and can be based on a dollar amount or a number of counters.

4. Describe proposed methods for monitoring the provision of services identified on a member's service plan.

AmeriHealth Caritas uses a variety of mechanisms to monitor the provision and quality of services identified on a member's service plan. These methods include:

1. Ensuring providers meet credentialing standards.
2. Conducting service audits including verification of service receipt.
3. Soliciting member feedback, including how members participate in quality oversight.
4. Using MLTSS dashboards to monitor and measure performance.
5. Monitoring relationships with local programs.

1. Ensuring providers meet credentialing standards

The health plan will ensure that facilities providing LTSS will meet licensing, certification and qualifications set forth by the state of Iowa. For community-based LTSS services, if credentialing standards do not exist for these services, the health plan will establish criteria for each of these including, but not limited to:

- Verifying that appropriate state or local licensure or certification, where applicable, is in place and active. AmeriHealth Caritas Iowa's Contract and Credentialing staff will verify, at minimum:
 - Current, unrestricted state license, if entity is licensed.
 - Current, active, unrestricted Medicaid ID number.
 - Individual National Provider Identification (NPI) number and group NPI number.
 - Certificate of liability insurance.
 - Current insurance coverage.
- Requiring the agency to verify that their associates are not listed in any excluded individuals/entities system within the Office of the Inspector General (OIG).
- Monthly monitoring of providers' Medicaid sanction status through OIG's List of Excluded Individuals, Entities Database and the General Services Administration.
- Good standing with the Better Business Bureau (rating of B or higher).
- Monitoring complaints received.

2. Conducting service audits including verification of service receipt

Care Team Monitoring

Care managers play a key role for quality assurance in all programs. In addition to developing service plans and arranging for and ensuring that providers delivered services, case managers monitor the quality of services, respond to complaints, and take action when necessary. At a minimum during monthly member contacts and face-to-face meetings care managers will discuss the services being delivered to the member to:

- a. Ensure the member is satisfied.
- b. Ensure no gaps in care have occurred.
- c. See if the member wants/needs a change in provider.
- d. See if the member wants/needs a change in the services and frequency of services.
- e. Ensure any issues related to delivery of services have been resolved.

Verifying Service Delivery

Verifying the delivery of HCBS LTSS services is a critical component of oversight due to the vulnerability of populations served. Late or missed visits, especially those that provide assistance in essential every day activities, place the member at potential risk of poor outcomes, and will activate corrective action of the provider by the health plan if service delivery is late or missed.

As stated in Section 13, we will work with providers, members and advocacy groups to develop a process to ensure that HCBS are provided based on the health plan of care and that services meet the needs of the member. Ideally, the solution will involve technology to track the service providers' whereabouts along with a confirmation from the member that the worker did provide the medically necessary services prescribed in the health plan of care. If technology is not an option, a paper process will be developed. Our UM and quality management programs will provide additional oversight through review of clinical information provided in authorization requests and medical record audits.

Supervisory Audits

The Manager of the Care Management team will also conduct quarterly audits of a selected subset of service providers to ensure ongoing quality service delivery.

Claims and Authorization Analysis

AmeriHealth Caritas will verify service receipt against what was authorized in the service plan by comparing whether members receive the services identified in their service plans. Through a continuous feedback loop that populates claims data back into care management platform, the system generates profiles and alerts to the care manager that highlight gaps in care based on care plan interventions tied to services that have no corresponding billing activity.

3. Soliciting member feedback including how members participate in quality oversight

Member Satisfaction

AmeriHealth Caritas Iowa will measure member satisfaction specifically focusing on the member's experience of care and quality of life in a number of ways. Utilizing the Consumer Assessment of Healthcare Providers and Systems for MA plans (CAHPS®-MA), the health plan will ask beneficiaries to rate their experience by answering questions regarding how well doctors communicate and other providers, including LTSS providers communicate, getting care and services quickly and without delays, health information and customer service, and overall rating of quality of care and quality of life. The health plan will also conduct annual in-home consumer satisfaction surveys with a random sample of at least 10 percent of LTSS members. AmeriHealth Caritas staff will go into beneficiaries' homes and ask a series of questions related to in-home worker skills, timeliness, and continuity, as well as the care managers' treatment of and relationship to members.

The health plan will also monitor topics of member calls and aggregate data on the reason for each call and any expressions of dissatisfaction. Daily and weekly monitoring of member service interactions will provide insight into the issues and concerns raised by beneficiaries. Additionally, the health plan may initiate directed outreach campaigns to beneficiaries through the care management team to focus on a particular issue or concern that may be trending within the health plan data. The health plan will analyze information regarding member satisfaction gathered from all of these sources in order to implement improvements specifically responsive to areas that beneficiaries have identified.

Member Oversight

AmeriHealth Caritas Iowa will convene a LTSS Member Advisory committee to provide feedback to the health plan on its MLTSS operations. The health plan will engage members by having them serve on the MCOs' Advisory committee, which will meet quarterly and report its findings into the Quality Committee of the overall plan.

4. Using MLTSS dashboards to monitor and measure performance

Monthly dashboards of key indicators are compiled and monitored to analyze key trends in service utilization, costs, satisfaction and other metrics specified by the state. Complaints, grievances, and appeals will be tracked monthly to provide additional data on areas of member dissatisfaction, thorough Appeals and Grievances monitoring process as discussed in Section 8.

5. Monitoring Relationships with Local Programs

Community resource usage is part of the internal quality audit tool we use to monitor our performance. AmeriHealth Caritas Iowa will monitor our relationships with local safety net organizations through satisfaction surveys, agency liaison and care manager feedback, monitoring of grievance and appeals, and tracking participation in Interagency Team meetings. The results are reviewed by the training team and the care manager. Follow up, additional training and subsequent monitoring occurs with the individual staff

member and/or team. This information is reported to the Quality Assurance Performance Improvement Committee (QAPIC), which, upon identification of gaps in service and coordination, develops and implements interventions or corrective action plans to improve service and outcomes. We recognize that identifying and correcting problems early and in a sustainable way is very important to the success of the integrated program.

5. Describe in detail your proposed strategy for implementing the Consumer Choices Option, including how Support Broker and financial management services (FMS) will be implemented.

AmeriHealth Caritas Iowa will work with experienced local partners, such as the Aging and Disability Resource Centers, Area Agencies on Aging, Independent Living Centers, and agencies that provide Support Brokerage Services, to ensure that services continue to be provided with minimum disruption to existing members and that new members have a positive experience.

Following completion of the member approved service plan, the AmeriHealth assigned care coordinator will review the service options with the member that will best meet the member's needs and in the least restrictive setting available. The Consumer Choices Option will be one of the services offered and will be included in the Freedom of Choice form reviewed and signed by the member and care coordinator. This service will be explained in detail for the member and will include written materials explaining the program in the member's language of choice. Information will include:

- How the program works.
- The member's rights and responsibilities.
- List of DHS approved Independent Support Brokers in the member's county.
- The health plan's financial management services provider.

Self-Assessment

The member will be asked to complete a Consumer Choices Option self-assessment. Completion of this assessment as well as the comprehensive assessment completed by the AmeriHealth Caritas Iowa assigned care coordinator will determine member/representative ability and willingness to self-direct.

Independent Support Broker (ISB)

Care Coordination is a critical function within the Consumer Choices Options because it ensures that care is coordinated across settings and types of care. Unlike the Support Broker who serves at the discretion of the member, the care coordinator is an associate of the health plan.

AmeriHealth Caritas Iowa will ensure that before services begin each ISB meets Iowa DHS minimum requirements through successful completion of the following:

- ISB Modules 1-4 and Quiz.
- Successfully complete a budget scenario.
- Register for and attend Module 5, a live webinar.
- Complete Mandatory Reporter Training.
- Successfully pass a background check.

AmeriHealth Caritas Iowa will have policies and procedures in place to ensure that Support Broker functions are not duplicative of care coordinator activities and functions. AmeriHealth Caritas Iowa will be responsible for the enrollment, ongoing training and oversight of the Support Brokers. The care coordinator

will ensure that the Independent Support Broker is performing its tasks according to established policies and procedures and will ensure that the care of the member is coordinated with its Acute Care Providers. Also, as needed when the member needs to transition care across settings the care coordinator will assist to facilitate and reduce the risk of the transition.

Once a member chooses an Independent Support Broker (ISB), this person will be part of the member's interdisciplinary care team. The ISB will assist the member in developing a budget, associate hiring and problem resolution. The role of the Support Broker in assisting the member is to arrange for and manage LTSS. The Support Broker will assist the member or representative in developing a back-up plan for self-directed benefits that adequately identifies how the member or representative will address situations when a scheduled provider is not available or fails to show up as scheduled. AmeriHealth Caritas Iowa will maintain a copy of the back-up plan in the member's file. The adequacy of the back-up plan will be assessed at least annually and any time there are changes in services or providers. The Support Broker serves at the pleasure of the member.

The ISB will meet with the member at a time and location that meets the member's needs to develop a budget and coordinate services that align with the approved care plan. The services will only include those approved in the Iowa Medicaid plan; services that meet the member's need to remain safe and independent in the least restrictive setting; and performed by credentialed/qualified service providers of the member's choice. The ISB will submit the service plan to the AmeriHealth care coordinator for authorization and recording in the member's electronic health record. The ISB and AmeriHealth care coordinator will have at a minimum one contact monthly to ensure the health plan continues to meet the member's needs.

Once a care plan is in place, AmeriHealth Caritas Iowa with the support of the Broker prepares a single service contract for services needed by the members under Consumer Choice. AmeriHealth Caritas Iowa ensures and verifies the provider's qualifications and obtains a signature on all service agreements.

AmeriHealth Caritas Iowa will ensure that the Support Broker develops a back-up plan for self-directed benefits that adequately identifies how the member will address situations when a scheduled provider is not available or fails to show up as scheduled. AmeriHealth Caritas Iowa will maintain a copy of the back-up plan in the member's file. The adequacy of the back-up plan shall be assessed annually and at any time there is a change in services or providers.

Financial Management Services (FMS)

AmeriHealth Caritas Iowa's financial management services agent will work with the member on managing the approved funds, monitor expenses against the budget, provide associate packets and training on the associate-employer relationship, and perform associate background checks. The third party interfaced fiscal intermediary will be responsible for completing all the required associate background checks and setting the care worker up as an associate of the member for payroll management and taxation purposes. The care worker will be advised of all appropriate work rules and regulations. Each worker that the member selects is responsible for completing online timesheets and attesting to their completion of services. Completed timesheets are approved by the member and routed in batch to the Fiscal Intermediary for payroll processing.

Currently, Veridian Fiscal Solutions serves as the Financial Management Service (FMS) for the Consumer Choices Option (CCO) program. As the FMS, Veridian Fiscal Solutions will receive and disburse funds on behalf of the CCO member.

Veridian will at a minimum be responsible for:

- Processing semi-monthly payroll for services provided and AmeriHealth Caritas Iowa approved budget expenses.
- Withholding and filing all employer payroll taxes for the CCO member.
- Issuing monthly statements.
- Submitting budget items requiring approval from AmeriHealth Caritas Iowa on behalf of CCO members.

Veridian also offers the following services:

- Web time entry.
- Direct deposit.
- Online statements.
- Electronic tax statements.

Use of technology to support members utilizing home care aids and direct care workers

AmeriHealth Caritas is evaluating technology solutions, such as MySupport to enhance our systems for those who self-direct their care. MySupport is a web-based consumer friendly source to match direct care workers with older adults and individuals with disabilities. The technology also is a real-time communication solution for members and their caregivers. Members submit their care needs, schedules and other personal preferences along with a schedule of needed services. Matching caregivers respond and services begin. Caregiver's timesheets are exported electronically and the tool can also track/verify delivery of services.

6. Provide a sample of the following tools and forms related to the Consumer Choices Option:

a. Self-assessment tool for members seeking to self-direct service;

Please refer to Exhibit 4.3.12-E: AmeriHealth Caritas Iowa Self-Assessment Form.

A. Informed consent contract; and

Please refer to Exhibit 4.3.12-F: AmeriHealth Caritas Iowa Informed Consent and Risk Agreement.

c. Risk Agreement.

Please refer to Exhibit 4.3.12-F: AmeriHealth Caritas Iowa Informed Consent and Risk Agreement.

©2015 AmeriHealth Caritas - Proprietary



AmeriHealth Caritas
Iowa

Self Assessment Form

The following questions and considerations are to help you decide if Self Directed Care is right for you.

1. In Self Directed Care you will decide what tasks and services are most important to you. What supports and services do you need and/or want? (i.e., homemaking, transportation, personal care, chore services, etc.)
2. In Self Direction, you will select the people who will provide these services/supports for you. How will you find people to provide the services? Do you currently have anyone in mind?
3. Will you personally train the people who will work for you, or will you need help training them?
4. Are you comfortable supervising your workers even if they are friends or relatives?

Yes No
5. Are you comfortable expressing your likes and dislikes to your workers?

Yes No
6. If you are unhappy with your worker how will you handle it? What if the worker is a relative?

Exhibit 4.3.12-E: AmeriHealth Caritas Iowa Self-Assessment Form (1 of 2)

Self Assessment Form (continued)

7. In Self Direction, you will be working within an approved monthly budget amount. How will you keep track of your expenses?

8. Your Care Manager can help you learn how to find workers and how to train your workers and other employer related skills. Will you like this type of assistance?

Yes No

9. Your Care Manager can provide you with information on how to manage your budget. Would you like to receive this type of assistance?

Yes No, thank you. I can manage my own budget.

10. Your family and/or friends can assist you in making decisions about your care if you would like. Do you want to appoint someone to be your representative and to make these decisions for you?

Yes
If yes, who? _____
 No, thank you. I would like to make these decisions on my own.

11. What (if any) other types of training and or assistance do you feel you may need help with?

NB-1522-11

Exhibit 4.3.12-E: AmeriHealth Caritas Iowa Self-Assessment Form (2 of 2)



AmeriHealth Caritas of Iowa
**Home- and Community-Based Services
Consumer Choices Option
Informed Consent and Risk Agreement**

I, _____, choose to participate in the Consumer Choices Option.
Consumer

I understand that my participation in the Consumer Choices Option is completely voluntary. If I decide that the Consumer Choices Option is not right for me, I understand that I may withdraw from the Consumer Choices Option and receive the services for which I am eligible for under the traditional home- and community-based waiver services. I will not be penalized in any way. I will not lose any benefits to which I am entitled and I will not have to be placed on a waiting list.

(Initial to show you have read and understood the above information.)

I will receive a monthly budget in the amount \$_____ to buy services and make other purchases related to my long-term care needs. I understand that I will choose personal care services, community and employment supports and services, and other goods and services that will best meet my needs and are cost effective. I understand that there is an approved list of services and supports that I may purchase from and if I choose a service or support not on the approved list, I will have to seek approval from my AmeriHealth Caritas care manager before purchasing. I understand that I will choose who provides my services, they do not need to be a Medicaid provider, and I will be the employer of record for employees I hire. I understand that by hiring my own employees I accept the risk associated with being an employer. I understand that I will be required to work with an independent support broker of my choosing. I will develop an individual budget with my independent support broker.

I understand that I will also be required to work with a Financial Management Services provider that will be responsible for issuing payment to my employees and for my purchases from my individual budget funds. I understand that if I overspend my budget and no longer have funds in my Individual budget, I am personally responsible to pay my employees and to pay for my purchases. I understand that I am legally required to pay employer-related taxes for the employees I hire. My individual budget must be used to pay for the employer-related taxes. My individual budget must be used to pay for the Financial Management Services fees and the independent support broker's fees. The Financial Management Services will pay for the employer-related taxes, the Financial Management Service fees and independent support broker fees from my individual budget on my behalf.

Exhibit 4.3.12-F: AmeriHealth Caritas Iowa Informed Consent and Risk Agreement (1 of 2)

I will get help from my independent support broker in making sure the budget is being used correctly. I understand that if I misuse my individual budget, I may be transferred back to the traditional home- and community-based Medicaid services for which I am eligible. I understand that I cannot purchase room and board, childcare, and personal entertainment items with my budget.

(Initial to show you have read and understood the above information.)

I understand that I will be responsible for signing all my employees' time cards and by doing so I am verifying that my employees did work the hours claimed on the time card to provide services for me. I understand that signing an employee time card which contains false information about hours worked, may make me a party to Medicaid fraud and legal action could occur.

(Initial to show you have read and understood the above information.)

I have read and understood this consent form. I understand that I get to keep a copy of this consent form.

Consumer's Signature

Date Signed

If applicable, Guardian's Signature

Date Signed

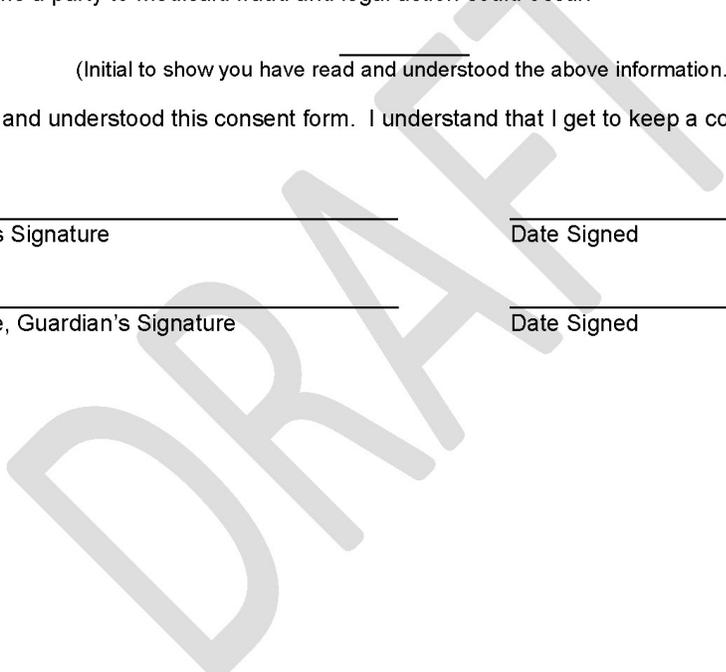


Exhibit 4.3.12-F: AmeriHealth Caritas Iowa Informed Consent and Risk Agreement (2 of 2)

7. Describe your approach for monitoring the quality of service delivery and the health, safety and welfare of members participating in the Consumer Choices Option

Building off the framework described in question 4; AmeriHealth Caritas Iowa will ensure the quality of service delivery and the health, safety and welfare of members participating in the Consumer Choices Option through both the design of its approach to consumer directed services and through its oversight.

Design:

AmeriHealth Caritas Iowa will ensure that members and providers participating in the consumer-directed option experience a well-designed program with appropriate supports, including:

1. Information and supports to participating members about their rights and responsibilities.
2. Access to a registry of qualified providers of services and supports who meet established credentials, including but not limited to no known convictions of abuse, neglect, or exploitation of a person, or misuse or abuse of state or federal assistance programs, and no known felony convictions.
3. Regular, periodic training for attendants/providers to assure quality services and supports.
4. A strong, person-centered approach to service planning.
5. A strong Financial Management Entity to provide the administrative support to consumers with regard to payroll, taxes, worker compensation and other federal and state requirements.
6. Regular access to a care coordinator and an Ombudsman to identify and address unmet needs and resolution of service and quality issues.
7. Regular periodic opportunities, at least annually, to provide feedback to AmeriHealth Caritas Iowa on the member's experience of care, through an annual member survey.

Oversight and Monitoring:

AmeriHealth Caritas Iowa will assure the quality of the services/supports provided to members in the Consumer Choices Option through its inclusion in the overall quality management/improvement program. The QM/QI program will build on Iowa's existing QM/QI program for the HCBS waiver program and will ensure that plans of care are person-centered, built on the identified needs of consumers, and include the consumer's identified goals; that providers meet established credentials, and that mechanisms are in place to identify gaps in services and supports that may jeopardize individual health and welfare.

These oversight mechanisms will include:

1. Member satisfaction

- A. The health plan will measure member satisfaction in a number of ways. Utilizing the Consumer Assessment of Healthcare Providers and Systems for MA plans (CAHPS®-MA) and the Iowa Participant Experience Survey (PES) tool annually, the health plan will ask beneficiaries to rate their experience by answering questions regarding how well doctors communicate with other providers, including LTSS providers, getting care and services quickly and without delays, health information and customer service, and overall rating of quality of care and quality of life.
- B. The health plan will monitor topics of member calls and aggregate data on the reason for each call and any expressions of dissatisfaction. Daily and weekly monitoring of member service interactions will provide insight into the issues and concerns raised by beneficiaries.

- C. The health plan may initiate directed outreach campaigns to beneficiaries through the care management team to focus on a particular issue or concern that may be trending within the health plan data.
- D. The health plan will analyze information regarding member satisfaction gathered from all of these sources in order to implement improvements specifically responsive to areas that beneficiaries have identified.

2. Oversight of Independent Providers

- E. Inclusion of regular feedback from members as to the performance of selected providers.
- F. Monitoring the “hire/fire rate” (turnover rates) of Independent Providers. In a consumer-directed program, consumers have the authority to hire and fire their workers (independent provider) and that authority is essential in achieving a large component of quality assurance.
- G. Ensuring that before services begin each Independent Support Broker (ISB) meets Iowa DHS minimum requirements through successful completion of the following:
 - i. ISB Modules 1-4 and Quiz.
 - ii. Successfully complete a budget scenario.
 - iii. Register for and attend Module 5, a live webinar.
 - iv. Complete Mandatory Reporter Training.
 - v. Successfully pass a background check.

3. Care coordinator interventions: AmeriHealth care coordinator will have (at a minimum) one contact per month with the ISB and the member to:

- H. Ensure the member is satisfied.
- I. Ensure the member’s needs are being met.
- J. Ensure no gaps in care have occurred.
- K. Determine if the member wants/needs a change in provider.
- L. Determine if the member wants/needs a change in the services and frequency of services.
- M. Resolve any issues related to delivery of services.
- N. To confirm the ISB will submit the service plan to the AmeriHealth Caritas Iowa care coordinator for review, authorization and recording in the member’s electronic health record.

4. Technology Solutions

- O. Electronic Visit Verification technology integration: The AmeriHealth Caritas Iowa system not only authorizes LTSS service provision but also schedules the day and time of home visits as well. We plan to leverage interfaced with major EVV Vendors, to allow the AmeriHealth Caritas Iowa system to be aware of a service provider “no show” quickly and notify the care manager or covering care coordination staff in real-time to execute the member’s back-up plan.
- P. Through a continuous feedback loop that populates claims data back into care management platform, the system generates profiles and alerts to the care manager that highlight gaps in care based care plan interventions tied to services that have no corresponding billing activity. The Financial Management Entity will be included in this feedback loop to assure appropriate billing by attendants/providers and appropriate withholding of employer/ associate taxes for consumer-directing members.

5. Appeals and Grievances monitoring

- Q. Complaints, grievances, and appeals will be tracked monthly to provide additional data on areas of member dissatisfaction.
- R. Thorough Appeals and Grievances monitoring process as discussed in Section 8.

6. Additional quality measures AmeriHealth Caritas Iowa will monitor include:

- S. Participant enrollment and disenrollment figures.
- T. Information on the effectiveness of ISB and FMS (Fiscal Management Services) support.
- U. Expenditure rates and information on the kinds of services purchased.

Clinical quality measures such as critical incidents, emergency department visits, and hospitalization.

©2015 AmeriHealth Caritas - Proprietary

Attachment 4.1-A: Freedom of Choice Form

AmeriHealth Caritas

FREEDOM OF CHOICE FORM

Name (Last, First, Middle): _____

Address: _____ Phone number: _____

I have been informed that I may be eligible for home and community-based services (HCBS).

I know that enrollment in a home and community-based program is up to me.

I have been informed what services I may be able to get and my rights and responsibilities under each service.

Based on the information that has been presented to me, I want to [check one]:

- Receive HCBS such as Waiver Program [Specify Waiver] where available.
 - i. Receive services in a nursing facility.
 - ii. Receive services in an Intermediate Care Facility/Other Related Conditions (ICF/ORC).
- Receive PACE services.
- Receive no services.

If I choose to receive HCBS, I know that I have the right to pick the agency that will provide each of my HCBS services from among the enrolled HCBS providers in my health plan.

I know that I may change my Care Coordinator at any time, if I am not satisfied.

I know that the Health Plan will review the list of available HCBS providers with me.

For all applicants to complete:

This form was thoroughly discussed with _____

Participant/Representative

by _____ by means of _____

Name of Plan Care Coordinator (e.g., Translator, American Sign Language, Written, oral)

Applicant/Representative's Signature

Date

Care Coordinator Signature

Date

©2015 AmeriHealth Caritas – Proprietary

4.3.12-A: Transition Assessment Tool



AmeriHealth Caritas
Iowa

Transition Assessment Tool

Member Information

Last Name:	First Name:	MI:
Address:		
City:	State:	Zip Code:
Member ID Number:	Social Security Number:	
Date of Birth:	Marital Status:	

Family Members or Contact Persons

Name:	
Relationship:	Phone:
Name:	
Relationship:	Phone:

This tool is to help us understand what you want to happen, who will be involved, why a different setting would be better, and where you want to go.

How long have you been living here?

.....

.....

Where were you living before you moved here? If it was a hospital, where were you living before that?

.....

.....

How was that working out?

.....

.....

What type of residence were you staying in?

.....

.....

AmeriHealth Caritas Iowa Transition Assessment Tool

Were you living with anyone?

Did they assist you in any way?

Do you have a home or apartment to return to? Who has been taking care of it for you?

Where do you want to live?

Would you prefer an apartment? A single family home? Assisted living center? Or?

What was the reason for your move to the nursing facility or hospital? Was this to be short term or long term?

What type of services and supports did you receive here?

What type of supports and services would you **need** in the community?

What type of supports and services would you **want** in the community?

Have you discussed moving with your family, friends or medical staff? How do you feel about this?

AmeriHealth Caritas Iowa Transition Assessment Tool

What kinds of help will your family and friends give to you when you return to the community? Help with meals? Transportation? Cleaning your house? Shopping and errands? Visiting other family and friends? Paying bills and managing money? Other?

What kinds of help will make the move to your new home easier for you? Help to find housing? Paying for costs to move to your new home? Finding an attendant or room-mate? Moving personal belongings, furniture to your new home? Is there someone that will help do these things?

Do you have family and /or friends in the area that we could contact to help with the move? How often do you see them now?

Do you belong to a church now? When you leave the nursing home, would you like to attend church? A senior center or day care program? Other places for friendship and recreation?

When you leave the nursing home [or ICF/IDD], would you like to volunteer? Work part-time?

Would you like some help to find places to work or volunteer?

Is there any other information that you'd like to share with me to help with your transition to the community? Health info? Financial info? Interests/Desires/Worries?

The information gathered in the face-to-face interview will be supplemented with information from the institutional record regarding the member's financial information, health history, current treatment/therapies/services, and other information that will assist the AmeriHealth Caritas Transitions Coordinator and Care Manager to facilitate a successful transition to the community.

AmeriHealth Caritas Iowa Transition Assessment Tool

Health Status Questions

Use the questions below for a member who has been in the facility for less than 90-days. For a member who has been in the facility longer than 90 days consult with NF or ICF/ID records.

Have you spent the night in a hospital in the last 90 days? YES NO

If yes, do you remember why and how long you were in the hospital? _____

Have you used the emergency room more than once in the last 90 days? YES NO

If yes, do you remember why and did you go home or did you have to stay in the hospital? _____

Do you currently receive Physical or Occupational Therapy? YES NO

If yes, who is your therapist? _____

Do you use oxygen at home? YES NO

Do you currently receive Dialysis? YES NO

Does a nurse, therapist or nurse aide visit you in your home? YES NO

If yes, how many days a week do they come and what help do they give you? _____

Have you had health problems because you cannot get the services you need? YES NO

If yes, how many days a week do they come and what help do they give you? _____

5. Billing and Collections

Please explain how you propose to execute Section 5 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Overview

AmeriHealth Caritas Iowa will operate billing and collections activities in a clear and transparent manner.

AmeriHealth Caritas Iowa is committed to ensuring affordability and access, but understands the role copayments can play in incentivizing responsible member behavior. We feel very comfortable in creating these types of incentivized environments as required.

AmeriHealth Caritas Iowa plans to charge only the copayments that the state requires. Our claim payment engine has full capability to administer the copayments and meet requirements outlined by Iowa.

AmeriHealth Caritas Iowa will comply with all needs stated within this section, including areas not specifically addressed in the questions below.

- AmeriHealth Caritas Iowa's user-friendly interface and bi-directional provider portal supports electronic information exchange, simplifying the billing and collections experience.
- Members and providers can easily check how much each member should be paying, ensuring accurate copayments every time.

5.1 General Provisions

1. Describe your strategy for ensuring total cost sharing does not exceed five percent (5%) of quarterly household income.

AmeriHealth Caritas Iowa will ensure that a member's total cost sharing will not exceed five percent (5%) of his or her quarterly household income. As outlined in the scope of work (SOW), certain populations will have the potential to incur cost sharing responsibility for specific services.

AmeriHealth Caritas Iowa will request the member's household income from the State on a quarterly basis to confirm that a member's cost sharing does not exceed five percent. Our products can handle dynamic cost determinations both at the point of care and during claims processing. We utilize the Facets system for claims processing and adjudication, for pricing methodology and necessary member responsibility logic. We will ensure that Facets keeps a real-time running total of a member's out-of-pocket outlays.

Facets has accumulator functionality that exceeds the SOW requirements. It:

- Tracks benefits by either dollar amount or number of visits (counter).
- Identifies accumulator buckets for all members of a specific product.
- Tracks accumulations by a specified amount of time.
- Tracks the amount of money spent or saved through coordination of benefits (COB).

If at any point in a given quarter, a member's total cost sharing exceeds five percent (5%) of his or her projected household income, a notification will be created in the system. It is important to note that total cost sharing incurred by all members of the household will be included in this calculation. AmeriHealth Caritas Iowa will notify the member and the member's providers that no additional cost sharing payments should be collected for the remainder of the quarter. We will adjust the provider's payment accordingly. Additionally, the provider will be able to call our Provider Services Helpline for telephonic verification or can visit the plan website to check the member's current out-of-pocket responsibility.

2. Describe processes for making information on premium and cost sharing available to both members and providers

Members will be educated upon enrollment through the new member enrollment materials including the Member Handbook, and then on an annual basis, about their premium payment and cost sharing responsibilities. Throughout the year, members will be able to visit our website or call the Member Services Helpline for updates on their premium payment status and progress toward that quarter's out-of-pocket limit. Member Services representatives can also speak to members regarding relevant copay rules and requirements. These avenues will instruct members on related topics, such as the importance of not using the emergency room (ER) for non-emergent care. This information will also be sent to members in the mail.

For providers, we will make sure the general member benefit and copayment schedule is available:

- In the provider manual as a part of the appendix.
- On our plan website in the billing section.
- As part of training during provider orientations.
- In a "leave behind" pamphlet in provider and practitioner offices.

Updates to this information will be published in the provider newsletter and posted on the plan website. The provider manual will also be updated annually. It will have guidelines for up-front discussions with members about paying for non-Medicaid covered services, as well as guidelines prohibiting balance billing for services rendered.

Furthermore, we recognize that clearly communicating general member benefits and copay information, while essential, is not enough. We support the ability for the member and provider to access customized real-time information. For example, while the member is at the provider's office, the provider will have the ability, via the provider portal or through the Provider Services Helpline, to verify the member's cost sharing requirement for a given service in real time. We are committed to making sure the provider accurately collects the member's cost sharing responsibility when required.

5.3 Copayments

1. Indicate if you propose to implement State Plan copayments on populations in addition to the Iowa Health and Wellness Plan and hawk-i members.

AmeriHealth Caritas Iowa will not implement State Plan copayments on populations other than the Iowa Health and Wellness Plan and hawk-i members as mandated by the state. Through our experience working with the Medicaid population across the country, we have found that the benefits of copays, such as encouraging responsible use of services, are outweighed by their potential to deter members from seeking

medical care. However, we have seen value in creating incentives for members to encourage them to use medical services other than the ER for non-emergent care. We plan to leverage our past experience and promote this behavior in Iowa. Services such as our 24/7 Nurse Helpline and accessibility of after-hour appointments to see a primary care physician (PCP) provide an alternative to preventable ER use.

2. Describe how exempt populations and services as outlined in Section 5.3.1 and 5.3.2 will not be charged copayments.

We commit to ensuring that exempt populations will never have out-of-pocket responsibilities. We do this by enrolling these populations in a product that our system recognizes to ensure there is never a copay. We will communicate clearly to members that they should not pay copayments regardless of the service. As noted earlier, we will also notify providers through our provider communications and education. In addition, the provider will be able to verify the member's responsibility in real time via the provider portal or through the Provider Services Helpline. We have managed exempt populations and services in many of our affiliate plans without incident, and assure the same for Iowa.

5.4 Patient Liability

1. Describe your proposed methodology for notifying providers of the patient liability amount and paying providers net of the applicable patient liability amount.

AmeriHealth Caritas Iowa will give providers access to real-time information on the member's responsibility. For example, while the member is at the provider's office, the provider will have the ability, via the provider portal or through the Provider Services Helpline, to verify the member's cost sharing requirement for a given service at that very moment. We are committed to notifying the provider about the member's liability at the time of service so it can be collected. AmeriHealth Caritas Iowa will communicate to our providers that if they fail to collect a payment, or choose not to collect the payment, they will be paid net of the applicable member liability amount. Through our Facets claims system and payment methodology, we will ensure that the provider's claim is processed correctly and the net of the member's liability is paid.

5.5 IDPH Sliding Scale

1. Describe how your organization will ensure the IDPH approved sliding fee schedule is implemented among network providers.

Depending on the sliding scale requirements and the information provided to the plan by IDPH, AmeriHealth Caritas Iowa will be able to store the family size and income level information provided, and place the member in the appropriate product that will be able to apply the necessary fee scale for the member to the servicing network provider. Each member's product determines the allowed benefits, and provides a link to network providers. By classifying the members into distinct products, we are able to apply various pricing/payment rules for network providers. The AmeriHealth Caritas Iowa claims payment system has the ability to store multiple fee schedules, and also has the ability to apply factors to these fee schedules in order to ensure appropriate payment for services.

This page intentionally left blank.

6. Provider Network Requirements

Please explain how you propose to execute Section 6 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Overview

AmeriHealth Caritas Iowa is committed to developing a provider network that meets and exceeds all service and access requirements, in order to provide the best quality and access to the members in Iowa.

We understand that providers deliver the quality care that is needed by our members. It has been both our Mission and our privilege to serve the members entrusted to us in the various markets we serve, and we will bring that Mission and commitment to Iowa.

We will demonstrate this promise to the Iowa members by:

- Developing a comprehensive provider network that meets the needs of every member.
- Providing Iowa members with a long-term commitment.
- Forming deep and meaningful relationships with the providers in Iowa.

- Strong provider relationships are the cornerstone of our success in delivering quality, affordable healthcare services and improved health outcomes.
- AmeriHealth Caritas Iowa's use of value-based contracting focuses on improved quality and outcomes and has brought tangible impact to our markets.
- We are committed to building robust networks that ensure access to quality care in the markets we serve.

Developing a comprehensive provider network

In all of the markets served by our family of companies, our networks are the most robust, consistently meeting or exceeding State and National Committee for Quality Assurance (NCQA) requirements for quality and access. It is also our goal to partner with academic teaching hospitals in every market to ensure our members, especially those with special needs, have access to the most up-to-date technology, clinical methods and ideas. AmeriHealth Caritas Family of Companies (AmeriHealth Caritas) is recognized as a leader in Medicaid managed care because of our commitment to ensuring quality through broad open networks that offer wide access to healthcare services. For example, AmeriHealth Caritas' Keystone First plan, located in southeastern Pennsylvania, is contracted with 49 of the available 52 hospitals (11 more than the next closest plan), and includes leading academic and children's hospitals such as the Children's Hospital of Philadelphia (CHOP) and St. Christopher's Hospital, the Hospital of the University of Pennsylvania (HUP) and Temple University Hospital. In Nebraska, AmeriHealth Caritas' subsidiary Arbor Health Plan contracts with Creighton University Medical Center and the University of Nebraska Medical Center, both located in Omaha. In South Carolina, First Choice by Select Health contracts with Medical University of South Carolina (MUSC) in Charleston, and Palmetto Health in Columbia. AmeriHealth Caritas Louisiana contracts with Ochsner Medical Center in New Orleans. Additionally, our plan in Washington, D.C., AmeriHealth Caritas District of Columbia, contracts with Children's National Medical Center, the teaching hospital for the George Washington University School of Medicine. We do not have narrow

network solutions – in fact, our approach is the opposite – and in Iowa we are working to ensure a robust network offering quality, unparalleled access.

Providing Iowa members with a long-term commitment

AmeriHealth Caritas is committed to the members of Iowa. We are a private organization, owned by two (2) nonprofits and driven by our mission. Our number one commitment is to our members, not shareholders. With our wide networks, we support all patients, well and sick alike. As such, we do not walk away from our members or contracts due to financial constraints and we do not let short-term earnings goals affect the States and members we serve. We have always kept our commitments to our members and our providers to ensure robust access to care for all.

Forming deep and meaningful relationships with the providers in Iowa

Forming strong provider relationships is the cornerstone of our success in delivering quality, affordable healthcare services and improved health outcomes. Strong provider partnerships allow us to better serve our members by working more collaboratively with the healthcare community to provide the level of care for which we have become recognized. Our use of value-based contracting practices that focus on improved quality and outcomes are making a difference in every market we serve. With this in mind, we are committed to reaching out to and contracting with providers in a way that is inclusive and positive and that complements and supports Iowa's current goals and initiatives, including the State Innovation Model (SIM), which is intended to transform the healthcare system in Iowa to one that is patient centered, relying strongly on value-based contracting. Our history of provider partnerships, patient centered care and innovative value based reimbursement aligns with Iowa's vision.

In meetings with providers in Iowa, we have stressed all of these basic tenets, and providers have been very receptive. We are certain we will have the same success building innovative partnerships and improving healthcare outcomes here in Iowa that we have achieved elsewhere across the country. Furthermore, we deeply value our relationships with providers, their feedback and their continued collaboration around improving outcomes for the members in Iowa. As such, we have in-place a formal provider grievance process to ensure that all provider voices are heard, issues are resolved and we continue to work with providers to improve our joint performance.

Member satisfaction

Our member satisfaction survey scores in other markets reflect our success in our commitment to our members. We continue to work to find ways to even better serve our members. Our members consistently give their health plans satisfied or very satisfied ratings year after year. For example:

- In 2014, members of First Choice by Select Health in South Carolina gave their health plan a 91 percent satisfaction score overall. Additionally, 86 percent of adults and 92 percent of children in our South Carolina health plan were satisfied with how quickly they can get the care they need.
- Our Keystone First members in southeast Pennsylvania rated their satisfaction with the healthcare they received at 91 percent, and gave an overall rating of 88 percent for their health plan.
- 90 percent of our members in our AmeriHealth Northeast plan in Pennsylvania said they able to get care quickly.
- Additionally, in 2014 the NCQA recognized three (3) of our Medicaid plans – Keystone First, AmeriHealth Caritas Pennsylvania and Select Health of South Carolina. Select Health is number 61 in the rankings. It is ranked 61 of 136 ranked plans or in the top 45% of ranked Medicaid plans.

Additionally, Keystone First and AmeriHealth Caritas Pennsylvania remain among the top three (3) plans in Pennsylvania, and Select Health remains the highest-ranked Medicaid plan in South Carolina.

As a company, we are committed to our members and to the providers who serve them. We understand that it is our providers who deliver the quality care needed by our members. It has been both our Mission and our privilege to serve the members entrusted to us in the various markets we serve, and we will bring that Mission and commitment to Iowa.

AmeriHealth Caritas Iowa will comply with all needs stated within this section, including areas not specifically addressed in the questions below.

6.1 General Provisions

1. Describe how you plan to meet all network composition requirements.

Highest-quality care requires exceptional coordination of care. That coordination begins with collaboration, and AmeriHealth Caritas has worked to develop a strong provider network for Iowa.

AmeriHealth Caritas Iowa has the capacity to serve all populations covered by the Contract. We have been working diligently over the past several months and will continue our efforts to develop a strong, collaborative provider network for our members in Iowa, realizing that the majority of the population is dispersed and that specialty care access is an issue. The primary goals we are executing against follow and are discussed in this section:

- Establish a robust provider network that comprehensively meets and exceeds both required adequacies in the State RFP and Medicaid access standards by late 2015.
- Leverage deep-rooted and earned partnerships with key State/provider stakeholders, priority specialists, primary care providers (PCPs), hospitals and other providers to coordinate access, delivery, communication, management and costs of care across Iowa Medicaid membership.
- Employ provider education and clear incentive programs to emphasize value-based payments and reinforce provider alignment across the State.
- Prioritize ease-of-use to support collaboration with the State, providers and managed care organizations (e.g., credentialing process, claims payment).

Establish a robust provider network that comprehensively meets and exceeds both required adequacies in the State RFP and Medicaid access standards by late 2015

We will focus contracting efforts on traditional primary care and specialty care provider groups, community hospitals and academic teaching hospitals as well as community-based, behavioral health service extenders and long-term services and supports (LTSS) providers to design the network infrastructure that will meet and exceed the needs of the Medicaid population. We will partner with home repair contractors (e.g., carpenters) and other nonclinical servicers to make any necessary and supportive modifications to a member's home — for example: to build a ramp for wheelchair accessibility, or to remove small barriers that may impede member mobility or reduce their ability to live comfortably in their homes. These efforts not only ensure we provide a robust network for members, but ensure members have the support and means available to access the care they need.

Our efforts are concentrated around the following areas:

- Hospitals — (inpatient (IP)/outpatient (OP)).
- Accountable care organizations (ACOs).
- PCPs/federally qualified health center (FQHC)/rural health clinic (RHC).
- Specialists.
- Ancillary service providers.
- LTSS providers.
- Indian health clinics.
- Behavioral health providers (professional and facilities).

Leverage deep-rooted and earned partnerships with key State/provider stakeholders, priority specialists, PCPs, hospitals and other providers to coordinate access, delivery, communication, management and costs of care across Iowa Medicaid membership

Iowa provider associations

We have identified and engaged key health-related stakeholders and provider associations to build a strategy to develop program partnerships that support both providers and members. We have met personally with the following groups and have a number of meetings scheduled for the coming months to continue discussions:

- Iowa Medical Society.
- Iowa Pharmacy Association.
- Iowa Association of Community Providers.
- Iowa Health Care Association and Iowa Center for Assisted Living.
- Iowa Behavioral Health Association.
- Iowa Primary Care Association.
- Leading Age Iowa.
- Iowa Area Association on Aging.

Collaborative activities include association event/conference sponsorships, speaker engagements with thought leaders, panel discussions and hosting provider educational forums to ensure that providers have all the necessary tools to engage their patients. These programs will be coordinated by a multi-disciplinary group led by the Provider Network Management team of AmeriHealth Caritas Iowa.

Iowa Primary Care Association (Iowa PCA) and Iowa Health+: example of AmeriHealth Caritas Iowa's strong collaboration and partnership model

The Iowa Primary Care Association (Iowa PCA) provides technical assistance and training to Iowa community health centers to support their ongoing commitment to provide quality, affordable primary and preventive healthcare to the underserved in Iowa. Many of Iowa PCA member community health centers provide access to medical, dental and behavioral health services. As a result, the Iowa PCA member health centers provide a health home to more than 184,000 individuals.

AmeriHealth Caritas has a long history of collaborating with primary care associations because of their dedication to providing quality, integrated care. In Washington, D.C., the DCPCA Chief Executive Officer had this to say about AmeriHealth Caritas:

“AmeriHealth District of Columbia has invested in the community by establishing a community wellness center, brought innovative engagement approaches to include the use of community health workers, a phone app and using a Member Wellness Advisory Council to fully incorporate member feedback in the development of strategies.”

AmeriHealth Caritas Iowa has had several productive meetings with the CEO and Senior Program Director of the Iowa Primary Care Association and Iowa Health+ to build a collaborative strategy that supports our shared mission to improve access to high-quality care for those who need it most. These organizations have written letters in support of AmeriHealth Caritas Iowa’s entry into the Iowa market and they appreciate our vision of developing true partnerships with providers. Twelve (12) of their community health centers have signed AmeriHealth Caritas Iowa Letters of Intent, which are provided in Tab 5 of our submission.

Our work is focused on a partnership between AmeriHealth Caritas Iowa and Iowa Health+ that will improve the health status of the Iowa Medicaid population and ensure more cost-effective care, while engaging this population to better manage their own health. This is an ideal partnership opportunity; Iowa Health+, as a key safety net provider, understands the specific needs of the Iowa members, while AmeriHealth Caritas brings over 30 years of experience in managing the unique needs of a Medicaid population.

Opportunities for collaboration include:

- Onsite care coordination/care management linked to AmeriHealth Caritas Iowa care managers to ensure coordinated and comprehensive outreach and member/family support.
- Coordinated team approach to managing members through transitions in care.
- Onboarding health risk assessments and health screenings for members.
- Expedited empanelment to medical homes and early outreach to high-risk members.
- Integration of behavioral and physical care.
- Integration of data at the point of care.
- Expansion of practice transformation to medical and health homes.
- Provider accountability for managing the “whole member,” including social determinants and/or barriers to care.
- Shared savings and other value-based payment models that support infrastructure investments at the provider level.

Hospitals

There are 118 hospitals in Iowa (Kaiser, 2012), and two VA hospitals. Iowa has 82 critical access hospitals (Flex Team, 11/2014). We have reached out to 100 percent of the hospitals or hospital systems in Iowa. We will focus our efforts to outreach specifically to the critical access hospitals to understand the needs of these rural hospitals and how we can work together to create a more effective network of providers for the care of the Iowa membership.

Mercy Health Network/ACO

Mercy Health Network is a faith-based nonprofit organization established in 1998 through an operating agreement between Denver-based Catholic Health Initiatives and Novi, Michigan-based Trinity Health. Mercy operates five (5) major medical centers in Iowa, including three (3) hospitals in Des Moines, where Mercy Medical Center's services include the Mercy Cancer Center and a children's center. Mercy Heart Hospital treats both pediatric and adult heart patients and offers central Iowa's only pediatric cardiology and surgery program.

Mercy Health Network's hospitals continue to focus on improving the overall health of Iowa residents through their accountable care organization (ACO) and wellness programs, designed to prevent the onset of chronic diseases. The AmeriHealth Caritas Iowa team has had several discussions with the Mercy leadership team including SVP, Chief Accountable Care Officer, Vice President, Operations and Development, Senior Director, Payer Contract Management, and the Director, Payor Contracting/Product Development. We have begun a dynamic relationship with Mercy Health Network and are in the midst of Contract negotiations, ensuring AmeriHealth Caritas Iowa members will have provider access in their statewide service areas. Both organizations are committed to building a strong relationship with the providers in this integrated delivery system, as well as their overarching ACO, to meet and exceed the needs of Medicaid members in their service areas. From our first conversation we realized that our organizations, both with mission-driven roots, shared the same vision of helping people get access to quality care.

In our most recent meeting, representatives of the two (2) organizations developed a framework for future discussions. We are currently in the process of arranging for another visit by AmeriHealth Caritas Healthcare Analytics and Payment Innovations team to share various value-based contracting models using the AmeriHealth Caritas PerformPlus® program, which is in use across the country with other providers and ACOs. Our two organizations will continue negotiations to help ensure a deep and robust network for Iowa Medicaid members, including an opportunity for collaboration with their robust telemedicine program. We have shared draft contracts with Mercy that are under review by the Senior Director of Payer Contract Management. Given Iowa's close proximity to Nebraska, AmeriHealth Caritas proposes to leverage our affiliate, Arbor Health Plan's full-service Medicaid-only Contract with Mercy Medical Center, Sioux City. AmeriHealth Caritas will use this Contract language as a basis for Iowa Medicaid Contracts with all of Mercy affiliates and will ensure that these agreements are in place by January 1, 2016.

UnityPoint Health/ACO

UnityPoint Health, based in West Des Moines, is an integrated health system and has relationships with more than 280 physician clinics, 32 hospitals in metropolitan and rural communities, and home care services throughout its nine (9) regions. Unity Point's Blank Children's Hospital, with 88 beds, is the only acute care facility in Iowa that is solely dedicated to pediatric care. UnityPoint Health provides care throughout Iowa, and AmeriHealth Caritas Iowa has begun discussions to contract with UnityPoint.

The AmeriHealth Caritas team has had several discussions related to contracting with all UnityPoint-affiliated providers, including value-based Contracts using the AmeriHealth Caritas PerformPlus® program. AmeriHealth Caritas proposes to leverage Arbor Health Plan's (our Nebraska affiliate) relationships to support our presence in the State and help support our ongoing contracting efforts with UnityPoint as Arbor Health Plan has a full-service Medicaid-only contract with St. Luke's Regional Medical Center, Sioux City, Iowa (one of the 10 facilities within Unity Point system). AmeriHealth Caritas will use this Contract language as a basis for Iowa Medicaid Contracts with all of UnityPoint affiliates and will ensure that these agreements are in place by January 1, 2016. Currently, the AmeriHealth Caritas team is in active discussions with the Vice President for Payor Innovation at UnityPoint related to contracting with all

UnityPoint affiliated providers, including value-based contracts using the AmeriHealth Caritas PerformPlus program. AmeriHealth Caritas staff has shared draft provider contracts that are under review by the UnityPoint contracting team.

CHOP is the top children’s hospital in Philadelphia and one of the best children’s hospitals in the world. Given this, we believed it was incredibly important to ensure CHOP was in our network.

“CHOP has been through a number of contracting cycles during that period with AmeriHealth [Caritas]. Although negotiations with providers and managed care organizations sometimes get contentious, CHOP has found AmeriHealth [Caritas] to be fair in the conduct of its business. This applies to all aspects of their operations including: contracting, medical management, membership services and payments.

The [AmeriHealth Caritas] team is dedicated to improving the health status of the members we serve together. In particular, AmeriHealth Caritas has partnered with our organization on many initiatives, including reducing preventable admissions and unnecessary emergency room utilization, family planning services, and coordinating care for our asthmatic and high-risk pediatric membership.”

*Thomas J. Todorow, Executive Vice President, Chief Financial Officer
The Children’s Hospital of Philadelphia*

UnityPoint also operates a statewide ACO, UnityPoint Health Partners, a framework by which physicians, hospitals and other care continuum providers can work together in pursuit of the Triple Aim (i.e., better quality, better patient experience, at an affordable cost). This endeavor is physician-driven and bridges traditional care silos. AmeriHealth Caritas has significant experience working with similar organizations in other States, including MDwise in Indiana, Geisinger Health System in Pennsylvania and Palmetto Health in South Carolina. We are confident our future partnership with ACOs, such as UnityPoint Health Partners and others in Iowa will benefit from our years of experience in supporting ACOs success.

Broadlawns Medical Center

Broadlawns Medical Center (BMC) is the safety-net facility for Polk County and the largest publicly funded hospital in Iowa, with over 1,000 employees, 300 physicians and an 88-member physician staff. The mission of AmeriHealth Caritas Iowa “Helping our members get care, stay well and build healthy communities” and the BMC mission statement are very similar: “working together to build a healthy community through the delivery of accessible, cost effective and high quality patient care.” Given this shared vision, we are confident in our ability to develop a strong relationship that will ensure access at the time of the implementation date.

AmeriHealth Caritas Iowa’s provider network leadership is engaged in active discussions with the CFO of BMC and we have shared our draft provider Contracts for review by their contracting team. We recognize them as a critical care access facility that is dedicated to their community and the patients they serve, and we look forward to working with them to build a collaborative relationship in the future.

“AmeriHealth Caritas’s goal is to develop strategic partnerships and build accessible, flexible health systems across the nation. Moving forward – as healthcare evolves – they will continue [to] keep pace and ensure the greatest level of care at maximum value for members, providers and governments.

As a partner, AmeriHealth Caritas exceeds expectations every day.”

David J. Friel, Vice President, Geisinger Health System

University of Iowa Health Alliance

University of Iowa Hospitals and Clinics (UI Health Care) is Iowa's only comprehensive academic medical center and a regional referral center. UI Hospitals and Clinics and UI Children's Hospital together deliver quality care in collaboration with University of Iowa Physicians, the State's largest multi-specialty medical and surgical group practice composed of faculty physicians of the UI Roy J. J. and Lucille A. Carver College of Medicine. As with other major academic medical centers in our markets, AmeriHealth Caritas Iowa will look forward to collaborating with the University of Iowa Health Care to provide high-quality patient care.

AmeriHealth Caritas Iowa's leadership team met with the Chief Operating Officer of the University of Iowa Health Alliance. We discussed several areas for collaboration in telemedicine and care management. Their team is very interested in learning more about our innovative value-based programs and they shared a number of components that we will consider as we move to the contracting phase. The Alliance has provided a signed LOI to AmeriHealth Caritas. In addition, we facilitated a meeting to discuss opportunities to enhance their telemedicine program to ensure that rural Iowans have access to care. A follow-up meeting with their larger team is planned to build a shared future strategy.

Blank Children's Hospital

Blank Children's Hospital is a very important network provider in Iowa. We have met with the CEO and described our plans for services and partnerships within Iowa. The CEO discussed the need for a true partnership with the selected CMO's around challenges, areas of collaboration and potential solutions. He was interested in learning more about our value-based reimbursement structure and the clinical support systems we offer.

Genesis Medical Center

Genesis Medical Center has a large catchment area and provides services to a wide and diverse population. We met with hospital representatives who discussed the need to contract with providers outside Iowa to help support the current referral patterns. We discussed our current partnership arrangements and the need to work together to improve the health of the Iowa community. They stressed the need to work with providers to identify resources including those in Moline, Illinois and Rock Island.

Provider Councils

AmeriHealth Caritas has provider councils to encourage collaborative efforts and build more effective communication pathways with providers.

- **Integrated Care Provider Council** — Our Integrated Care Provider Council will comprise PCPs, patient-centered medical homes (PCMHs), FQHCs, Indian health centers (IHS), and behavioral health (BH) providers.
- **Integrated Networks Provider Council** — Our Integrated Networks Provider Council would include clinically integrated networks, such as hospitals, integrated health systems and ACOs.

AmeriHealth Caritas Iowa will offer one council for individual practitioners and another council for more integrated networks to allow each of the provider councils to have its own focus on the issues that matter most to the participants and the members they serve. The provider councils can help guide and support health plan administration so it can be more effective in its work, more responsive to local and national concerns, and more closely connected to those it serves. The councils will advise the Market President and leadership of AmeriHealth Caritas Iowa regarding health plan policy and development and program administration. Each council would meet regularly to employ consensus-based decision making, with the

goal of addressing priority concerns, for example, collaborating on initiatives to enhance member medication adherence.

Provider Relations Committees

We encourage provider participation in our quality-related programs. Providers who are interested in participating in one of our Quality Committees may contact Provider Network Operations or their Provider Network Account Executive.

Collaborating with FQHCs through our National Advisory Board

As leaders in healthcare solutions for the underserved, AmeriHealth Caritas believes it is mission-critical to build effective partnerships with FQHCs. Through collaboration with provider organizations, we can focus on our shared goals and values of promoting access to care, preventing disease and building healthy communities. We continue to identify key FQHC partners across the enterprise to collaborate and improve outcomes for members and their families. AmeriHealth Caritas has launched an FQHC National Advisory Board, comprising nationally recognized leaders from provider practices across the country, which would include participants from Iowa. Senior leadership from AmeriHealth Caritas also serves on the advisory board, which provides guidance for the development and implementation of our FQHC quality programs. The Advisory Board meets twice a year, and agenda/discussion items include:

- Value-based contracting strategies and data sharing/transparency.
- Integrated care management.
- Integrated oral care.
- Integrated behavioral healthcare.
- Provider support and tools to improve practice performance and member outcomes.
- Sharing best practices.

We will utilize existing council structure and invite participation to the following groups:

- Priority hospital systems, ACOs, physician organizations.
- Independent physicians, ancillary services, provider associations.
- Strategic partners and statewide alliances.

Employ provider education and clear incentive programs to emphasize value-based payments and reinforce provider alignment across the State

AmeriHealth Caritas Iowa shares the vision for health system transformation as outlined in Iowa's State Health Innovation Plan (SHIP) document. We also agree that transforming the healthcare system from one that is primarily unmanaged care to a system that is value-based, accountable, integrated, and in which data is standardized is an enormous undertaking. Our clinical support team provides services critical to the success of accountable care initiatives, including face-to-face member engagement, care plan development and coordination, identification of gaps in care, community resource connection, member engagement, behavior change coaching, transportation assistance, and other clinical and nonclinical support. Coupled with our innovative payment solutions, our collaborative approach puts the pieces in place for positive patient outcomes and shared ACO success.

As a managed care organization (MCO) that leads the industry in care management and data analytics, AmeriHealth Caritas is able to implement a tailored ACO solution using a multidisciplinary approach based on the unique needs of the State of Iowa.

Maximizing AmeriHealth Caritas Iowa and delivery system strengths

AmeriHealth Caritas Iowa, in alignment with Iowa's strategies for the State Innovation Model (SIM), will partner with local providers to jointly meet accountable care model core capabilities. Providers will share responsibility for clinical integration and partnering with local organizations to link patients to community resources. Providers will be responsible for on-site care coordination activities and will share accountability for improving clinical outcomes and ensuring that patients are treated in the most appropriate setting.

The ability to integrate critical services for Medicaid members is a distinguishing factor for AmeriHealth Caritas Iowa. We are ideally positioned to include physical, behavioral and pharmacy services, as well as incorporation of community-based outreach programs. Together AmeriHealth Caritas Iowa and provider partners will bring critical core competencies to the partnership. It is important to establish, document and regularly review these core capabilities along with related goals and activities and expected outcomes. Another distinguishing factor for AmeriHealth Caritas Iowa is the ability to support provider-level innovation and accountability.

Some provider organizations may lack the infrastructure to design or operationalize an effective strategy to manage global budgets or risk arrangements, especially as it relates to the Medicaid population. AmeriHealth Caritas Iowa will ensure that partner providers have a defined plan for management and distribution of funds, as well as timely information and data exchange, and a plan for routine reporting on results.

Data integration and intelligence is another strength that AmeriHealth Caritas Iowa will bring to partnerships with provider-led ACOs. Provider-led ACOs may need assistance to create an effective platform for capturing and analyzing data, as well as assistance with mining and utilizing the data for effective population health management. The following are key strengths that will make AmeriHealth Caritas Iowa a strong partner for the Iowa Department of Human Services (DHS) and provider-led ACOs:

- Integrated claims and clinical data at point of care.
- Provider dashboards and reporting.
- Data analysis and drilldown.
- Predictive modeling/identification of high-risk populations.
- Platform for documenting and sharing care plans electronically with providers and members.

Accountability and oversight

A key AmeriHealth Caritas Iowa objective will be to increase the likelihood that partner provider ACOs achieve their cost and quality improvement goals by aligning payment incentives and implementing the necessary infrastructure changes.

AmeriHealth Caritas Iowa has core capabilities that will compliment provider partner strengths and create an ACO model that can effectively improve outcomes, control costs and improve the health status of our target populations.

Key elements for all ACO models:

- Leadership and governance.

- Partnering with (all) stakeholders.
- Gain and/or risk-sharing arrangements.
- Data analysis and IT.
- Improving care delivery.
- Quality improvement.



Exhibit 6.1-A: Holistic Value Proposition

Prioritize ease-of-use to support collaboration with the State, providers and managed care organizations (MCOs)

AmeriHealth Caritas simplifies the provider’s administrative processes by offering electronic interface on a variety of processes. From the onboarding process to management of member care, AmeriHealth Caritas provides a secure Provider Portal where information can be exchanged.

AmeriHealth Caritas Iowa offers NaviNet, a secure Provider Portal with multiple resources and interactive functionality to ease the provider’s administrative burden. Through a single sign-on, providers who register with NaviNet can check member eligibility and benefits, submit claims, request prior authorization, check claim status and view member clinical summaries and care gaps. Additionally, AmeriHealth Caritas supports and encourages credentialing through the use of CAQH and electronic claims submission and electronic funds transfer (EFT) through Emdeon. Providers are also encouraged to register for Network News, a free email subscription service through which AmeriHealth Caritas communicates plan information and updates.

In other markets we serve, AmeriHealth Caritas engages other MCOs and the State DHS to discuss common processes, such as credentialing and encounter submissions to establish standardized processes and reduce administrative burden.

2. Describe any counties or areas of the state and any provider types in those areas where you anticipate facing network development challenges. Discuss your mitigation strategies.

From our ongoing conversations with local providers and stakeholders, we have an understanding that there are potential challenges in developing a specialist network (e.g., Dermatology, Oncology, Orthopedics and Psychiatrists) in the State. We have additional tools in place to further identify potential challenges and also mitigate against these hurdles.

While Iowa overall ranks sixth nationally in the number of family and PCPs per population, the State is in short supply of many physician specialists to meet the State's growing needs. Currently, Iowa ranks 44th overall in terms of providing access to direct patient care physicians. Geographically, we also know that there are 86 medically underserved areas in 72 counties, as illustrated on the attached map published by the Iowa Department of Health in 2012.

Federal Medically Underserved Areas and Populations (MUA/Ps)

January 2012

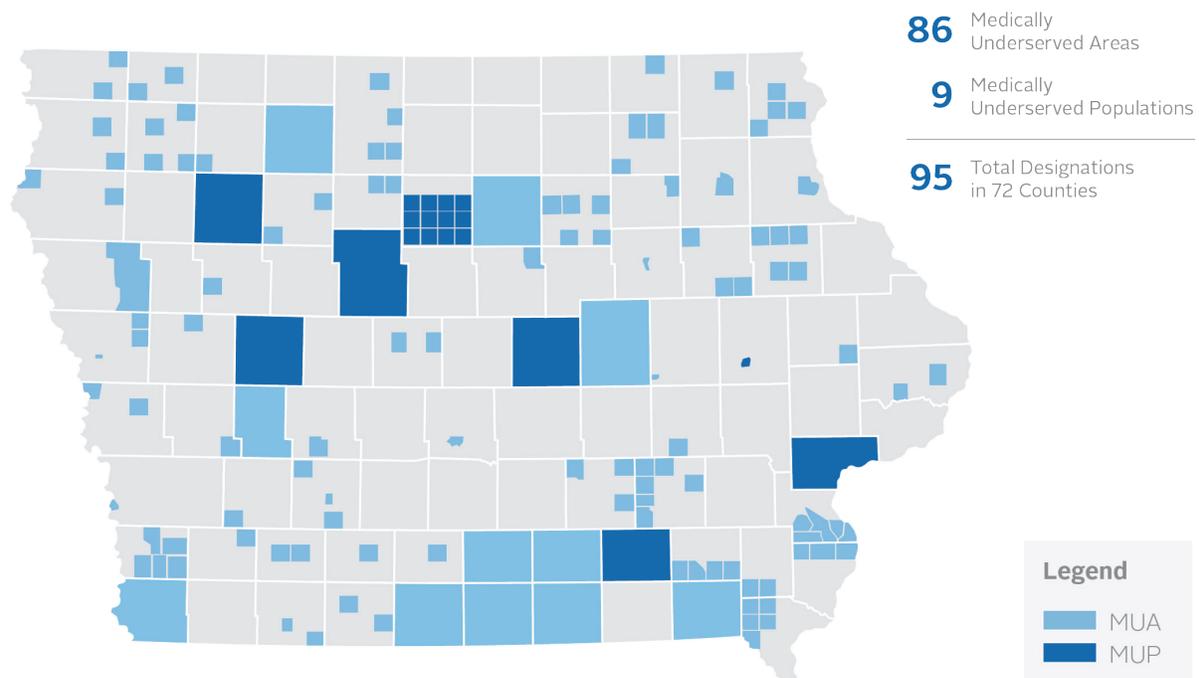


Exhibit 6.1-B: Federal Medically Underserved Areas and Populations³

³ Snapshot of the Medically Underserved Areas & Populations (MUA/P) designations for Iowa as of December 30, 2011.

AmeriHealth Caritas Iowa strategies

AmeriHealth Caritas Iowa has a multi-faceted strategy to proactively identify and address network development challenges.

Reports for identifying gaps:

- **GeoAccess mapping and reports:** AmeriHealth Caritas uses GeoAccess software to map its provider network against where the members live. Our GeoAccess reports analyze availability of all high-volume specialties, including but not limited to primary care, obstetrics and gynecology, ophthalmology, oncology, orthopedics, dermatology, neurology and psychiatry as well as pediatric specialties. Our GeoAccess reports also map hospital access in relation to where the members live.
- **Network adequacy reports:** AmeriHealth Caritas Iowa will generate reports to identify whether the network is meeting access and availability standards, including travel and distance to primary, specialty and hospital care, as well as appointment availability and waiting times.
- **Competitor directory comparison:** AmeriHealth Caritas reviews competitor provider directories to identify practitioners in geographic areas where there is a shortage in our network, and then actively recruits those providers.
- **Additionally, gaps can be reported by members, care givers, advocates, provider groups and care coordinators:** AmeriHealth Caritas tracks all member questions, comments and dissatisfactions and uses member calls related to provider access to develop strategies to mitigate shortages. Additionally, our Provider Network Management (PNM) staff learns from the providers they serve where there are challenges in referring members to in-network specialists. Our PNM staff relies on conversations with their providers to identify quality specialists and follows up on those recommendations. Finally, AmeriHealth Caritas' care coordinators may be in the best position to identify potential network specialists, as they work closely with the members and providers, and understand referral patterns and preferences.

AmeriHealth Caritas Iowa Annual Development Plan

The AmeriHealth Caritas Iowa Provider Network Management (PNM) department has developed and will maintain an annual development plan that ensures the provision of core benefits and services. This plan is critical to us as we work to meet our Mission of helping families get care, stay well and build healthy communities. Our network development plan involves the following steps.

- **Recruiting providers:** AmeriHealth Caritas Iowa is recruiting providers with consideration of the number of Medicaid members, the number and types of providers needed to serve them, and the geographic location of providers and members. We are recruiting providers through multiple avenues to maintain a complete network, as discussed above.
- **Contracting providers:** AmeriHealth Caritas Iowa is contracting with providers in accordance with GeoAccess standards and will develop action plans to overcome network challenges in any areas, including increased outreach, focused recruitment efforts and the execution of single case agreements as needed.
- **Assisting providers:** AmeriHealth Caritas Iowa's PNM team will be a local presence that actively supports providers and members through close relationships, education and frequent on-site visits. The team bridges gaps between the provider and member, ensuring clear communication and effective service delivery. Providers who are new to Medicaid managed care are frequently unsure of what to expect. AmeriHealth Caritas Iowa's experience through our parent organization's history of

serving this population throughout the country will inform and shape the training we offer providers. As we have done in other markets where Medicaid managed care is new, before the program goes live, and for several months thereafter, we will blanket the State with opportunities for providers to attend orientations, workshops and seminars where we discuss AmeriHealth Caritas Iowa's processes and resources. We will also be available upon request to visit provider offices and facilities to offer orientations, workshops and seminars, and make presentations available on the plan website.

Through our discussions with entities like the Iowa Hospital Association, the Iowa Association of Community Providers, we understand their concerns such as denials for ER care, timely payments, need for transportation reimbursement to ensure access, or making it easy to do business with us by using existing credentialing protocols used by Wellmark. We are partnering with these institutions to address these "pain points" and create an outreach program that we can jointly roll out. As we do elsewhere, we will collaborate with other MCOs on these areas to streamline the managed care experience.

We are designing the provider network to reflect the needs and service requirements of AmeriHealth Caritas Iowa's member population. In accordance with 6.1.1, AmeriHealth Caritas Iowa considers the following elements when developing and maintaining its provider network:

- Anticipated maximum number of Medicaid members.
- Expected utilization of services, taking into consideration the characteristics and healthcare needs of the members in the plan.
- Number and types (in terms of training, experience and specialization) of providers required to furnish Medicaid core benefits and services.
- Number of contracted providers who are not accepting new plan members.
- Geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members and whether the location provides physical access for Medicaid members with disabilities.

We will also:

- Ensure the network can support capacity of Iowa Medicaid members.
- Ensure the network provides culturally sensitive care.
- Monitor network compliance with DHS and AmeriHealth Caritas Iowa policies, including the grievance and appeal process, to ensure continuity of member care.
- Continually measure the quality of network services and recalibrate those services as needed to maintain highest quality.
- Provide access to all required services outlined by the Contract and identify the capacity to meet the unmet needs of members, families and communities.
- Actively recruit providers who are significant traditional Medicaid providers to support continuity of care.
- Work within our network to clarify capacity and ensure timeliness of access.

AmeriHealth Caritas multi-faceted mitigation tactics

Mitigation tactic #1: develop partnerships with key provider groups

In areas of known gaps we will identify potential partners to establish satellite or mobile office capabilities to expand into an underserved area. AmeriHealth Caritas Iowa will incentivize providers to fill a particular specialty gap or to provide service to underserved areas in order to exceed current network capabilities and expand the network of care into these areas.

As outlined in the Iowa State Health Innovation Plan (SHIP), the barriers to improved health include challenges related to providing care in a primarily rural state, shortages and unequal distribution of providers, and low reimbursement rates for providers.

As referenced in the Iowa SHIP, the accountable care model will provide an opportunity to transform Iowa Medicaid into a patient-centered system that provides coordinated and integrated care, improves the patient experience of care, achieves better outcomes, aligns Medicaid with other payers, and reduces costs.

AmeriHealth Caritas Iowa looks forward to partnering with existing ACOs in Iowa to develop strong relationships and collaborate with ACOs as partners in their respective regions to enhance care coordination, reduce costs, ensure access and change the overall healthcare system to one focused on outcomes. AmeriHealth Caritas Iowa will collaborate with the ACOs to build upon local and community agencies' strengths and expertise and in ensuring the effectiveness of the medical neighborhood as envisioned in the Iowa SHIP document.

Mitigation tactic #2: utilize home health agencies

Several home health agencies currently provide in-home care for the elderly but there are also some agencies that provide care to the pediatric population. During a meeting with the Iowa Health Care Association, we discussed and support the practicality of PCP and specialty practices having nurse practitioners and other providers on staff to assist in the care of our members in their homes. This reduces the need for transportation, facilitates the care in a member's home, and can be done in coordination with telemedicine for a more robust clinical visit.

Mitigation tactic #3: 24-hour support

To reinforce access and continuation of care, AmeriHealth Caritas Iowa has nursing staff and a physician reviewer on call 24 hours a day, seven (7) days a week. Members or providers can arrange medically necessary tertiary care by calling the toll-free Member Services number or our 24/7 Nurse Call Line to reach the on-call nurse after business hours, on weekends and on holidays. The nurse will facilitate the authorization process, as needed, and if necessary arrange for a care manager to continue to work with the member.

Mitigation tactic #4: Contract in contiguous states

Iowa is bordered by Nebraska to the west, Minnesota to the north, Missouri to the south, and Wisconsin and Illinois to the east.

If a service gap exists/develops that requires the contracting of providers from contiguous States, the AmeriHealth Caritas Iowa's network team will identify the provider type closest in proximity to the deficient service area. We will also research current patterns of care and referral trends and create a network that recognizes providers beyond the State of Iowa that impact the care of the Iowa Medicaid

members. As needed, AmeriHealth Caritas Iowa will contract in Nebraska, Minnesota, Missouri, Wisconsin and Illinois.

Additional AmeriHealth Caritas Iowa solutions to ensure member access to care:

Our mitigation tactics are designed to empower the highest quality of care delivery by providing Iowa Medicaid members with the most comprehensive and best possible access to care. But we also know that sometimes members need more, and we have designed a program of additional innovative strategies and tactics to ensure that all needs can be met.

Solution #1: utilize telemedicine

Developing a comprehensive telemedicine program is a top priority for AmeriHealth Caritas. For the Iowa market, AmeriHealth Caritas will build a telemedicine program, to meet the unique needs of Iowa members, in collaboration with our providers. AmeriHealth Caritas Iowa supports the use of telemedicine to improve access to care for rural populations and will support and enhance current telemedicine offerings in Iowa. The availability of specialties such as Hematology/Oncology, Endocrinology, Cardiology, Infectious Disease, Hepatology, Pulmonology, Gastroenterology, Nephrology and Rheumatology via telemedicine will allow rural patients to receive specialized healthcare, and in many cases continue to be cared for in their own communities.

AmeriHealth Caritas Iowa's objectives for telemedicine include:

- Increasing access to care in rural areas.
- Improving timeliness to diagnosis and treatment planning.
- Improving quality of care.
- Supporting the continued education and retention of rural providers.

A comprehensive telemedicine utilization plan will be submitted to DHS. For a more detailed description of our telemedicine offering, please refer to Section 13.1 of our response.

Solution #2: set up process to utilize out-of-network providers

AmeriHealth Caritas Iowa accommodates services rendered by out-of-network providers through a single-case agreement process. Details around this process are described in section 6.1.11.

Out-of-network providers

If AmeriHealth Caritas Iowa's network is unable to provide medically necessary covered services to a particular member, AmeriHealth Caritas Iowa will identify an out-of-network provider willing to provide the services and will negotiate payment with the provider. Once an out-of-network provider is engaged to provide the service, we will educate the provider on billing guidelines and prior authorization requirements to ensure timely and accurate payment. As part of our communication to the out-of-network provider, we will inform them that the member cannot be billed for the balance of the claim.

AmeriHealth Caritas Iowa will coordinate with out-of-network providers regarding payment of medically necessary services that have been prior authorized. For payment to out-of-network, or nonparticipating providers, the following guidelines apply:

- In the event that needed services are not available from an in-network provider and the member must receive services from an out-of-network provider, AmeriHealth Caritas Iowa will negotiate payment with and reimburse the provider.

- If AmeriHealth Caritas Iowa offers the service through an in-network provider(s), and the member chooses to access the service (i.e., it is not an emergency) from an out-of-network provider, we will inform the out-of-network provider that AmeriHealth Caritas Iowa is not responsible for payment.

Solution #3: mobile care

For primary care we are prepared to incorporate a mobile van for the care of our membership in areas where primary care is lacking and access is an issue. In Indiana we partnered with a local health department to provide mobile vans for western counties – the van went to schools for PCP services, hearing tests and immunizations. For Iowa, mobile vans would be able to provide similar services, but will be ultimately designed to address the most pressing member needs.

Solution #4: transport members (and pay for them to stay) where care is available

When providers are not available in or out-of-network near the member's home, AmeriHealth Caritas Iowa arranges and pays for transportation to appointments. Our Member Services and Rapid Response teams are trained to identify quality transportation vendors and arrange for members to be picked up and brought to appointments, and then returned to their homes.

In some instances a member may require highly specialized care as in the case of a specific transplant. To facilitate excellent outcomes it may be necessary for a member to receive care in an out-of-state hospital that specializes in a specific area of the body or organ. Many of these hospitals are "in network" with our health plans in other States. Our care coordinators identify social services in and around the facility and connect the member with support services, such as the local Ronald McDonald house. We would assist the member and their family member during this time to include transport and housing during the entire transplant process. In some cases, we have arranged multiple flights to the treating facility to include assessment, testing, counseling and the actual procedure.

Solution # 5: experiment with innovative partnerships

Finally, AmeriHealth Caritas Iowa will work with the Iowa provider community to build innovative partnerships to meet the needs of Iowa members. For example, we plan to work with local provider organizations to develop wellness programs and strategies using community health workers. Additionally, we will implement an integrative behavioral health and primary care program which is described in more detail below.

Integration of behavioral health and primary care

We will continue to provide Iowa Medicaid members with meaningful innovations by integrating behavioral health and primary care to reflect a full-spectrum approach to delivery of the next generation of healthcare. In many States, behavioral healthcare is the responsibility of PCPs and other providers. Often, the PCP is caring for the behavioral health needs but doing so in a limited capacity due to their lack of training. This is further complicated because many rural areas lack qualified behavioral health providers such as psychiatrists, psychologists and licensed clinical social workers (LCSWs). If a member is fortunate enough to find a behavioral health specialist, often the appointment times and the ability of the professional to see the patient extends into months rather than days. This further complicates PCP offices, as they are forced to manage medications with which they are unfamiliar, and without the oversight of a psychiatrist for proper medication management.

Our solution to this care is the integration of behavioral healthcare professionals into primary care practices. This strategy enables members to be seen both for medical and behavioral health issues in one

office during a single appointment. We have also introduced the concept of a treatment team in the primary care office, which facilitates a greater understanding of the member's healthcare needs.

This innovation has already proved successful in another market where we identified a high-volume pediatric office that had a large population of members with behavioral health needs. Located in a small, southern and rural town, the physician and two partners were overwhelmed with a large pediatric population with multiple behavioral health issues. Patients were presenting with a variety of medications and the parent was unable to obtain an appointment with a psychiatrist. AmeriHealth Caritas worked with the practice and designed a strategy to address patient and practice needs to facilitate a more robust delivery of care. They were able to provide data of office visits, including frequency and issues. Through the review of the data it was determined a behavioral health professional could benefit the practice. We collaborated in the development of a business plan that outlined pricing for behavioral health services and suggested revenue based on the current volume of patients. The partners met and determined the investment should be made and AmeriHealth Caritas and PerformCare staff assisted to identify and interview professionals for the position.

The practice hired one (1) LCSW and together they continue to treat their patients as a team under one roof. The physicians continue to believe in the model and have introduced the concept to their peers as well.

AmeriHealth Caritas Iowa appreciates that the Iowa DHS has a well-defined and thorough program and structure for integrated health home (IHH) services. The model provides an entire team of professionals to assist with comprehensive care coordination. It recognizes the importance of inclusion of the individual and family, as appropriate, as an equal partner in decision making. Peer support and family support services are included and prioritize care coordination using a whole-person, patient-centered approach to eliminate "silos" and fully integrate care for persons with the highest needs.

AmeriHealth Caritas Iowa will adopt the existing structure and will Contract with existing providers of IHH services. AmeriHealth Caritas Iowa will minimize administrative burden by collaborating with the State and other payers to the extent possible to maintain a standard set of expectations and at a minimum assure compliance with Centers for Medicare & Medicaid Services (CMS) standards. AmeriHealth Caritas Iowa will complete an initial evaluation of gaps in member access to IHH services, as well as implement a process for ongoing evaluation. We will also develop and implement a strategy for ongoing expansion/enrollment of qualified providers.

Additional information on the AmeriHealth Caritas Iowa plan for working with IHH services in Iowa is included in Section 3.2.9.

Revolutionary innovation and technology

We believe that every individual has the right to quality healthcare and services and to benefit from healthcare innovation and technology, regardless of socio-economic status. Collaborating with our state, business and community partners, we work to bridge gaps in healthcare access, innovation and technology for our members. One example of how AmeriHealth Caritas partners with like-minded and innovative organizations to make quality healthcare and services accessible and affordable to every person, is our strategic partnership with Theranos, a nationally recognized, CLIA-certified laboratory that offers services for a complete range of tests from common blood screening panels to specialized testing across all specimen types.

Theranos is working to shape the future of laboratory testing and the way health information is collected, analyzed and communicated in a way that is affordable and available to every person. The process for

utilizing Theranos services is consistent with what providers and patients are accustomed to today, with improvements to enhance the ease of each step, and they have partnered with a leading retail pharmacy to place collection sites within retail stores, bringing access to Theranos' laboratory services through this nationwide pharmacy footprint. We want to make it easier for our members to get the information they need, when they need it, to make important healthcare decisions and develop comprehensive care plans. Theranos allows for easy access and is open early mornings, late evenings, weekends, and holidays to fit everyone's schedule. Theranos' partnership with a national pharmacy chain means that Theranos is well-positioned to meet geo-access requirements in a given state. It also means that there is added convenience for our members who may need to pick up a prescription or other personal needs.

If AmeriHealth Caritas is provided an opportunity to serve the State of Iowa and its Medicaid population, we are committed to leveraging Theranos' revolutionary laboratory platform to ensure members and providers have the information they need to make the best healthcare decisions. We believe that we are the first Medicaid managed care organization in the nation to bring this innovative, evidence-based and customizable solution to our members and providers.

6.1.2 Provider Agreements

1. Describe your process for reviewing and authorizing all network provider contracts.

AmeriHealth Caritas Iowa's network will be developed by contracting with identified providers and groups that fulfill the necessary GeoAccess requirements. AmeriHealth Caritas' Contract Review Committee consists of representatives from our Finance, Legal, Executive Leadership, Network Operations, Medical Management and Network Management departments.

Even though we have utilized a standard Contract, we realize the need to allow for changes within our documents to allow a provider to customize the language to meet their needs and those of their governing bodies. We will review the Contract template with providers and facilitate discussions to answer any questions the provider may have. This helps the provider understand that our philosophical approach to managing successful provider networks begins with thoughtful contracting. It also allows us to understand the provider's needs, systems and approach to how they will manage our members. These initial meetings and discussions help establish expectations from the beginning of the relationship with the provider.

AmeriHealth Caritas Iowa will utilize our Contract Review Committee for reviewing contracts that seek non-standard language and/or rate structures. The committee will meet as needed to quickly address the provider's concerns and expedite the negotiation and execution of the contract. The Contract Review Committee is responsible for providing alternative language and approval of provisions that are outside our standards. The terms agreed to in the meeting will then be communicated by the AmeriHealth Caritas Iowa contractor to the provider.

2. Provide sample provider agreements.

We have provided three provider agreements as attachments within our response. They can be found within Tab 6 of our submission:

- Sample hospital agreement.
- Sample physician agreement.
- Sample ancillary agreement.

3. Indicate if you propose to impose any requirements for exclusivity agreements for quality or payment purposes.

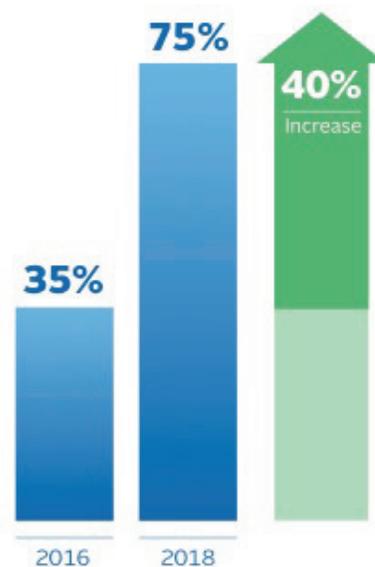
AmeriHealth Caritas wants more than to just become Iowa’s most trusted and valuable healthcare partner. We want to lead Iowa’s evolution into the next generation of healthcare. This cannot be accomplished by exclusive arrangements. Our leadership begins with thoughtful contracting strategies that promote access to healthcare services for all of Iowa’s Medicaid population. That is why we do not typically engage in exclusive arrangements as this often reduces access for others. AmeriHealth Caritas Iowa is new to Iowa, and we have prioritized a seamless transition into the State. Thus, we do not want to disrupt the current referral patterns and treatment options available by entering into exclusive contractual arrangements that limit access for anyone.

It is very important that we are inclusive of all providers, provider types and members. Every State – and every population – is unique, and requires tailored management and strategic collaboration across partners, providers and facilities. We do this by listening to the needs of our providers and members, and offering programs and solutions to meet those unique needs.

4. Propose the percentage of provider contracts that will be consistent with value-based purchasing by January 1, 2018 and specify the percentage annually for each year thereafter. Will you move into value-based purchasing before 2018?

AmeriHealth Caritas Iowa has aligned our goals with CMS goals for transitioning to value-based purchasing. Since we will be building relationships and our experience base in Iowa in 2016, our goal will be to achieve 35 percent in year 1 (2016) and increase to greater than 75 percent by 2018. We are well positioned to meet these goals. Today, 40 percent of AmeriHealth Caritas-covered lives across the markets we serve are already in value-based arrangements. We have been refining value-based arrangements with providers across all of the markets we serve since 2009.

Although some of our competitors may report a higher percentage of their membership is covered by value-based arrangements, comparing their performance against ours may not be a valid contrast. Comparison of health plan membership covered by value-based arrangements should be product-specific – broken down by Medicare, commercial and Medicaid. The 40 percent of AmeriHealth Caritas’ lives in value-based arrangements are Medicaid-only members, who are more medically complex. It is difficult to track targeted outcomes and manage Medicaid value-based arrangements. Our PerformPlus® products are not “one size fits all”; they are designed to address the overall needs of a Medicaid population, while allowing for variations by State and individual provider delivery systems.



AmeriHealth Caritas Iowa’s PerformPlus portfolio of value-based programs are specifically designed to improve the capacity of the health system to deliver high-value care and increase provider accountability for high-need Medicaid populations facing multiple health and social challenges.

The common goal of these programs is to align financial incentives for accountable providers to improve the quality of care and curb costly and avoidable hospitalizations of Medicaid members, particularly those with multiple chronic conditions and behavioral health needs.

AmeriHealth Caritas Iowa value-based purchasing strategy

The AmeriHealth Caritas Iowa strategy aligns well with the goals of the SIM-funded Iowa State Health Care Innovation Plan. AmeriHealth Caritas Iowa has met with several provider-led ACOs in Iowa, such as the UI Healthcare ACO, Mercy ACO and Iowa Health+ and has had positive feedback on the PerformPlus programs that we have shared with them to date. The combination of these AmeriHealth Caritas Iowa programs and the experience of these organized delivery systems should ensure success in meeting Iowa's goals for value-based purchasing, as well as increased provider accountability, improved clinical outcomes and reduced costs of care.

To achieve these goals, AmeriHealth Caritas Iowa is focused on building accountability through collaborative provider partnerships. In recent years, significant progress has been made to advance value-based performance models in the Medicare and commercial health insurance markets; however, the Medicaid managed care market has been slower to adopt this model, due in no small part to Medicaid reimbursement fee schedules. With this challenge in mind, AmeriHealth Caritas created PerformPlus® to partner with State Medicaid agencies, providers and delivery systems to accelerate the adoption of value-based payment models in the Medicaid managed care market.

Iowa's SIM award for their State Innovation Plan creates an ideal environment for a partnership with AmeriHealth Caritas Iowa. Our PerformPlus portfolio is well-positioned to assist Iowa in meeting its goals for a transformative healthcare plan to support integrated care delivery models, establish incentives to move towards value-based purchasing and enhanced quality outcomes, while also reducing the total cost of care for those participating in integrated models.

PerformPlus® is AmeriHealth Caritas's portfolio of value-based incentive programs designed to encourage the "right care" at the "right place." Provider groups, hospitals and integrated delivery systems are rewarded for achieving key performance indicators built around adherence to evidence-based clinical practices and providing cost-effective, appropriate care. Currently, more than 40 percent of our managed care membership receives care from a provider or delivery system that participates in one (1) or more of PerformPlus's value-based programs.

To support provider performance, PerformPlus® provides access to innovative transparency tools that put detailed preventable service activity, care gaps, drug and utilization patterns, clinical population profiles, and other data sets in the hands of participating provider groups and delivery systems to facilitate member care management and physician monitoring. This data sharing is principally accomplished through self-service data mining capabilities and comprehensive dashboards that track each metric, which providers can access through a single sign-on to the AmeriHealth Caritas provider portal.

PerformPlus® programs

PerformPlus® offers a number of programs to engage a variety of providers in achieving accountable care and quality objectives. At the foundation, each program seeks to incentivize wellness and chronic care management and discourage unnecessary or preventable utilization — however, the key performance indicators that drive the incentives are customized to align with each State's unique combination of performance and quality goals, as well as the needs of individual practices.

We use both peer- and trend-based performance metrics to determine incentive payments. PerformPlus® risk-adjusted quality metrics include, but are not limited to:

- Potentially preventable hospital admissions.
- Potentially preventable hospital re-admissions.

- Low-acuity emergency department visits.
- Risk-adjusted actual and expected utilization measures, including ancillary services.
- Neonatal intensive care unit length of stays.
- Obstetric and primary care HEDIS measures.
- Appropriate care measures: the percentage of patients who received recommended treatments based on their clinical condition.

AmeriHealth Caritas Iowa will collaborate with DHS and Iowa's Value-Based Performance Management team to finalize which programs and value-based incentives will be offered to providers. AmeriHealth Caritas currently offers the following PerformPlus® programs in our other markets.

PerformPlus® Shared Savings

AmeriHealth Caritas's signature PerformPlus® Shared Savings program is designed for integrated delivery systems that accept responsibility and accountability for collectively managing a shared population of patients. Based on ACO concepts, Shared Savings arrangements are intended to address the needs of patients in an effective and efficient manner across multiple care settings, eliminating fragmentation and waste in the healthcare system and resulting in better clinical outcomes for the patients served.

Currently, AmeriHealth Caritas has Shared Savings arrangements with partners such as: ACO Pennsylvania (formally Jefferson Health System), Pinnacle Health, Einstein Healthcare Network, Crozer-Keystone Health System, and Temple University Health System in Pennsylvania, and Christus Health System in Louisiana. Another 14 potential new partnerships are currently being negotiated with health systems such as Penn State Hershey Medical Center and Lehigh Health System in Pennsylvania, as well as Palmetto Health and the Medical University of South Carolina in that State.

Access to PerformPlus® dashboards

PerformPlus® provides a variety of Web-based dashboards to participating providers, enabling them to track their progress for each metric.

Clinical stratification (3M)

Partners participating in the PerformPlus® model can access a secure, Web-based dashboard to track their progress for each metric and produce self-service reports and drilldown data mining. The dashboard also allows identification of frequent emergency department utilizers, readmissions, HEDIS results, care gaps, clinical risk and other member-centric data to foster collaboration and meaningful member outreach. Data reports are updated monthly. Our proprietary PerformPlus® dashboard includes all value-based key performance indicators, clinical/risk categorization gaps in care reports and member profiles. Feedback from current PerformPlus® shared savings partners has been exceptional. For example, recent comments by Jefferson Health System and Palmetto Health System were that our organization is more advanced than other Medicaid plans and several large commercial payers as well. Specific examples include the flexibility, level of transparency and actionable information. The PerformPlus programs are not "one size fits all"; they can be flexed to meet the needs of specific markets, member populations and providers. They are designed to afford providers multiple opportunities for success.

A key feature of the dashboard reports is the display of population-level data for all key performance indicators with drilldown capabilities to the facility level, provider level and patient level. These detailed reports equip providers with actionable information to quickly identify performance and utilization trends

and gaps. The breadth of information on these reports enables providers to better manage their contract and be more accountable to delivering high-quality care to their patients.

Currently the data reports are based on administrative claims data. We have recently partnered with a cardiology practice to exchange EMR data as a limited “use case” pilot. As we continue to enhance our dashboard capabilities, we will seek opportunities to incorporate clinical data from EMR or HIEs wherever possible and through our participation in health information exchanges in Philadelphia; Washington, D.C.; and South Carolina, we will receive additional electronic health record “point of service” quality data in the next 12 - 24 months. We are also planning to include authorization data in our monthly dashboard display, to ensure closer to real-time utilization information is available to our provider partners, sometime this year.

Dashboards

The dashboard tool has been deployed to Crozer Health System, Jefferson Health System, Einstein Health System, Pinnacle and Sumter. In addition, dashboards have been developed and are ready to launch for all other health systems and FQHCs currently in negotiation.

Response from both existing and potential shared-savings partners proves AmeriHealth Caritas is a market leader in Medicaid value-based contracting and transparency/technology. A few quotes we have recently received are noted below.

“The Community Partners Program provides us with current, user-friendly data that is easy to access and download. While the program offers a complete incentive, it also provides the tools to do focused patient care management.”

Dr. Lingham, Quality Community Health Centers

“The PerformPlus® Dashboard provides timely information to monitor our performance and manage our patients, including services provided outside our office.”

Susan L. Williams, M.D., President, Crozer-Keystone Physician Partners

Lessons learned

In partnering with Integrated Delivery Systems (IDS) through our innovative dashboard transparency capabilities, we have learned that partnering and collaboration can truly enhance reporting to produce positive outcomes for all. For example, when demonstrating our shared savings dashboard to a top IDS group in the Philadelphia region, a suggestion was made for the member-level ER report to include primary diagnosis as well as the day and time of the ER visit. We were able to utilize this feedback to implement these enhancements for all of our clients. As a result, IDS was able to communicate with their PCPs to determine members who were utilizing the ER for possibly minor services (ear infection) during PCP office hours.

Community Partners Program

The Community Partners Program is a Shared Savings program AmeriHealth Caritas designed for FQHCs in collaboration with the National Association of Community Health Centers (NACHC). The program’s goal is to reward providers for timely, appropriate ambulatory care and positive patient outcomes by focusing on quality metrics that are meaningful to our FQHC partners, such as clinically preventable events.

AmeriHealth Caritas launched the Community Partners program in January 2015 with three (3) FQHCs who serve more than 8,200 members in Pennsylvania and South Carolina. We are currently negotiating with four (4) potential FQHCs in South Carolina and the District of Columbia.

FQHC Providers Currently Participating	FQHC Providers Currently in Discussion
<ul style="list-style-type: none"> • Quality Community Health Care (Pennsylvania) • Spectrum Health Services (Pennsylvania) • Sumter Family Health Center (South Carolina) 	<ul style="list-style-type: none"> • Mary’s Center (District of Columbia) • Care South Carolina, Inc. (South Carolina) • Sandhills Pediatrics (South Carolina) • Palmetto Pediatrics and Adolescent Clinic (South Carolina)

Custom programs

Our advantage is our ability to customize programs based on the needs of the practice. Examples of our customized programs include:

- ACO incentive model (upside only) with Pinnacle Health:
 - Incentive compensation is based on Pinnacle Health’s claim utilization and quality scores.
 - Rewards higher performance with a larger percentage of shared savings.
 - Per-Member Per-Month savings.
 - PCP member attribution based on medical claims.
- Full-risk model with MUSC (proposed – in discussion):
 - Contains minimum and maximum guardrails.
 - Key outcome is a robust methodology of attributing revenue to a health system.

ACO model

ACOs are an increasingly popular approach to achieve the triple aim of improved health, better outcomes and lower per-capita healthcare costs. As a mission-driven managed care organization leading the evolution of the next generation of healthcare, our experience in case management, quality reporting and innovative payment designs position AmeriHealth Caritas as a uniquely qualified leader in Medicaid ACO implementation. The business model of an ACO is to align financial incentives with positive patient outcomes and reduce the total cost of care. Population-based value programs grounded in sound methodology are at the heart of our ACO solutions. Our proven products, dynamic strategies and superior customer service are scalable to any marketplace to achieve accountable care goals, such as higher patient satisfaction, lower healthcare costs, and better health outcomes.

ACOs are not a one-size-fits-all solution. Each implementation must be scaled and fine-tuned to the market. As an MCO leading the industry in care management and data analytics, AmeriHealth Caritas is able to implement a tailored ACO solution using a multidisciplinary approach based on the unique needs of each market. Our multidisciplinary approach with the Analytic Concierge team and a clinical support team organizes complex information to ensure appropriate care is directed to those who need it most.

Our clinical support team provides services critical to the success of accountable care initiatives, including: face-to-face member engagement, care plan development and coordination, appointment scheduling and reminders, identification of gaps in care, community resource connection, member education, behavior

change coaching, transportation assistance, and other clinical and nonclinical support. Coupled with our innovative payment solutions, such as our Population Value Partnership ACO Model, our collaborative approach puts the pieces in place for positive patient outcomes and shared ACO success.

Behavioral health (BH)

Our strategy includes a BH value-based program with the core focus/reward structure centered upon the following:

- Timely follow-up after psychiatric discharge.
- Medication adherence.
- Engagement/treatment.
- Enhanced communication between BH and physical health (PH) providers.
- Well-care for the serious mental illness population, which includes screenings for diabetes and well-care visits.
- Innovative dashboarding/transparency tools.

When it comes to BH, a client's success is rarely the result of the work done by one (1) doctor or the effectiveness of one (1) procedure. It is a complete spectrum of care that offers the best chance of health and full participation in society for people suffering from behavioral issues ranging from alcoholism to depression to schizophrenia. Patients have the best outcomes when there is a seamless interaction between emergency care, inpatient treatment, outpatient facilities and social support networks. Unfortunately, the typical payment structure for BH providers is based on services provided, so payment comes per individual treatment session or doctor's appointment. This is a structure that doesn't encourage the continuum of care that may best suit these patients.

Evaluation and quality metrics focus on performance in areas such as psychiatric and therapy follow-up, engagement rate, client retention, community treatment, education and medication management. A special focus has been placed on timely follow-ups post-discharge from an inpatient level of care and proactive engagement following a new outpatient admission. Lastly, to prevent admissions to an inpatient level of care, clients need to have consistent treatment regimens. Clients who are considered to be at risk are less likely to have a preventable readmission to an inpatient level of care if they are actively engaged in community-based services (such as case management).

6.1.3 Provider Credentialing

1. Describe your credentialing process.

Ensuring that our members receive the highest-quality care begins with our credentialing process. We are strongly committed to establishing credentials — including re-credentialing — for best-quality practitioners and organizational providers. Credentialing of the Iowa network is centrally performed by AmeriHealth Caritas Health Plan (ACHP), supported by its sister company, Keystone First Health Plan, which is accredited by the NCQA as a "credentials verification organization." ACHP utilizes a systematic method developed through our experience across the nation to assess practitioner and organizational provider applicants against our rigorous credentialing standards, with the goal of determining their ability to treat our Medicaid enrollees and become a participating provider. Our credentialing and re-credentialing processes are fully compliant with all applicable federal and State regulations.

Categories of providers subject to credentialing

ACHP follows NCQA standards for initial credentialing and re-credentialing processes and timelines. Practitioner types subject to credentialing review and approval include the following:

Medical Doctor (M.D.)	Doctor of Osteopathic Medicine (D.O.)
Doctor of Dental Surgery (D.D.S.)	Doctor of Dental Medicine (D.M.D.)
Doctor of Podiatric Medicine (D.P.M.)	Doctor of Chiropractic (D.C.)
Doctor of Psychology (Psy.D.)	Physical Therapist (P.T.)
Occupational Therapist (O.T.)	Speech Therapist (S.T.)
Advanced Practice Registered Nurse (A.P.R.N.)	Certified Registered Nurse Anesthetist (C.R.N.A.)
Family Nurse Practitioner (F.N.P.)	Physician Assistant (P.A.)
Certified Nurse Midwife (C.N.M.)	Optometrist (O.D.)

Organizational providers subject to credentialing review and approval include hospitals, home health agencies, skilled nursing facilities, durable medical equipment (DME), dialysis centers, nursing homes, free-standing surgical centers, free-standing radiology centers and LTSS providers.

Our associates review and evaluate the qualifications of each of the above noted practitioners and organizational providers. Participation is determined by meeting the requirements of licensure, certification, education, malpractice history, work history, professional standing, service availability, Medicaid and accessibility as well as conformity to ACHP’s credentialing requirements. Practitioners and providers are re-credentialed at least every three (3) years.

Credentialing timeliness

ACHP will ensure that 90 percent of practitioners and providers applying for network provider status will be credentialed within 30 calendar days of receipt of a “complete” (all requirements satisfied) application, with 100 percent being credentialed within 45 days of receipt of a complete application. The Credentialing Software will track the date all information was received from the practitioner or provider to begin tracking the turnaround time. Written communication to the practitioner or provider will determine the end of the credentialing process.

2. Describe methods to streamline the provider credentialing process.

ACHP utilizes the CAQH application for providers applying for network participation, which helps streamline the credentialing and re-credentialing processes. The Credentialing Software also allows the associates to verify board certification and licensure directly through the system, which saves time from having to retrieve these documents directly through the websites. Ongoing monitoring also occurs monthly automatically through the Credentialing Software to ensure licensure remains current and in good standing. These automated processes allow ACHP to process the complete applications within the time frames noted above.

3. Describe your plans for performing criminal history and abuse checks and assuring all network providers hold current licensure as applicable.

ACHP will utilize the Iowa State Medical Board website to ensure all network providers' licenses are active at the time of credentialing and again at re-credentialing. The License Expiration Monitoring Module (LEMM) in the Credentialing Software also monitors each provider's license on a monthly basis. Criminal history checks will be performed at the time of credentialing and again at re-credentialing through the National Practitioner Data Bank (NPDB) and OIG's sanction and exclusions database. LTSS providers who are not employees of a provider agency or licensed/accredited by a board that conducts background checks will have criminal background and child and dependent adult abuse background checks conducted at the time of credentialing and again at re-credentialing through a State Criminal Background check agency.

4. Describe your plans for ensuring non-licensed providers are appropriately educated, trained, qualified and competent.

ACHP ensures that all providers not requiring licensure are appropriately educated, trained, qualified and competent through the primary source verification process. ACHP verifies their highest level of education and training through the practitioner's training institutions. The NPDB, Office of Inspector General (OIG) website and System for Award Management (SAM) website are also queried for any sanction activity or restrictions. ACHP also ensures the provider is appropriately insured to perform the functions of his or her specialty.

Non-licensed LTSS providers will be put through a credentialing process that will include submission of an application to participate, curriculum vitae, Medicaid number and/or individual/group NPI as required, and current certificate of insurance. The Credentialing department will perform primary source verification of the Medicaid number; sanction activity through the OIG and EPLS; and administrative and statutory exclusions through the System for Award Management (SAM). Background checks will also be conducted for the individuals applying for credentialing. This will ensure that the non-licensed LTSS providers are appropriately educated, trained, qualified and competent to perform their job responsibilities.

AmeriHealth Caritas has policies and procedures for credentialing LTSS providers from other markets in which we do business, which will be modified to meet Iowa requirements. Training for LTSS providers will include, but not be limited to training on the Medicaid program, covered benefits and services, credentialing and contracting requirements, billing guidelines and instructions and how to contact AmeriHealth Caritas Iowa with questions or concerns. We understand that many of these LTSS service providers have never provided services in the healthcare arena; therefore we are committed to providing them with the highest quality of customer service.

The Network Management team will be tasked with providing initial and ongoing orientation of providers. This orientation/review includes at a minimum:

- Claims submission process.
- Authorization process.
- Cultural competencies.
- Language/translation services.
- Health plan expectations of providers.
- Access requirements.

6.1.4 Cultural Competence

1. Describe your plans for ensuring the delivery of services in a culturally competent manner.

AmeriHealth Caritas Iowa will demonstrate its organizational commitment and priority to providing high-quality and culturally sensitive care to its members. AmeriHealth Caritas Iowa's organizational framework includes ensuring all AmeriHealth Caritas Iowa associates and providers within the network deliver culturally appropriate care, which is care delivered by a provider who can relate to the member and provide care with sensitivity, understanding and respect for the member's culture. Our organizational framework consists of four (4) pillars that meet the needs of a culturally and linguistically diverse population which includes:

Promoting Culturally Competent Services

AmeriHealth Caritas Iowa complies with the Department of Health and Human Services Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) Standards. CLAS Standards are federal guidelines that impact members, providers and employees in two (2) key areas:

- Cultural competence, such as language assistance and an awareness of cultural differences between the healthcare provider and member.
- Health literacy, including the ability to communicate with members in clear, concise language they can understand, no matter what language they speak.

Organizations such as ours who embrace CLAS Standards can advance health equity, improve quality of care and make strides toward eliminating healthcare disparities by providing a blueprint for delivering appropriate services. These standards form the basis of our CLAS Committee, and our strategic plan is updated annually with goals based on these standards.

Our CLAS Committee meets quarterly to review successes and consider improvements in helping members receive the care they need. Committee members review every CLAS-related member complaint each quarter to consider whether systemic adjustments are necessary. The committee also sets goals. Supporting program descriptions, strategic plans and evaluation criteria are adopted annually to steer initiatives that improve our cultural competence. This year, the CLAS Committee plans to begin reviewing member HEDIS data; the data will be stratified by race, ethnicity and language to reveal any disparities that need to be addressed.

Delivering Culturally Competent Services to members

We strive to ensure that we meet the needs of our limited English proficiency members. We provide language translation services to members and collect race, ethnicity and language data directly from members.

Limited English proficiency

It is important for AmeriHealth Caritas Iowa to understand and absorb the language needs expressed by our members. However, effective communication is never one-sided, and we want to ensure we have a two (2)-way communication loop with our members. To achieve this goal, we utilize the services of Language Services Associates (LSA), which facilitates the communication with members in more than 200 languages. We also collect race, ethnicity and language data directly from members during routine calls.

We monitor the language line to identify emerging trends; through our annual Language Access Services survey, we survey a sampling of members, providers and internal associates to gain feedback on the provision of our language services.

In 2014, AmeriHealth Caritas:

- Provided nearly 44,000 language translations.
- Completed a total of nearly 623,000 minutes or 10,383 hours of translation services.
- Spent nearly \$582,000 to meet our members' language needs.
- Identified the top translation services are for the following languages: Spanish, Arabic, Vietnamese and Mandarin-Chinese.

Race, ethnicity, language (R/E/L) data collection

Each plan routinely analyzes health outcomes for race, language and ethnic subpopulations. Through this analysis, we identified that both member and provider R/E/L data in our systems was insufficient. Most of our data used the Office of Budget Management (OMB) classifications for race and ethnicity, which do not adequately address many populations. For example, using the OMB classification, a recent immigrant from Jordan is in the same "Asian" category as a second-generation Chinese-American. Accurate R/E/L data is necessary to understand the composition of the membership and network, and helps to identify actionable healthcare disparities.

To improve this deficiency, AmeriHealth Caritas invested in system enhancements and changes to staff protocols to allow for independent and specific R/E/L data capture, storage and retrieval. Since a high percentage of members' R/E/L data found on the States' enrollment files are incomplete and or inaccurate, it was determined that a mechanism was needed to obtain R/E/L data directly from the member and provider.

During the new health plan orientation call, and at other touch points with the Member Service and Care Management team, members are directly asked about what languages they prefer to use in medical contexts (for reading and speaking), as well as their race and ethnicity. Data obtained directly from the member is added to our information systems so that it is accessible for ongoing communication with the member, as well as reporting. While the updated information takes precedence in our future contacts with the member, we do not overwrite the data received from the State.

Providers are surveyed for their R/E/L data to determine the network's cultural responsiveness as culturally competency is a necessary component of a high-quality healthcare system. Provider network language capacity is analyzed against our membership in each area annually to ensure we are meeting the language needs of our members. In areas with opportunities, Provider Network Management implements a plan to address any gaps or identified needs.

Health Equities Council

To ensure that culturally competent care is reflected in the vision, goals and mission of our company, AmeriHealth Caritas created a Health Equities Council (HEC). The Health Equities Council is an enterprise-wide council made up of various departments that seeks to address and reduce racial and ethnic disparities identified in members. The HEC implemented several programs to improve awareness and knowledge for all AmeriHealth Caritas associates, including an annual Health Equity and Cultural Competency Training course. A score of 80 percent or higher is required to pass this annual training, which demonstrates knowledge gains in cultural competency. The HEC schedules regular, nationally recognized speakers to keep cultural competency current in the organization. A National Minority Health Month

Campaign kicks off every April to educate associates and increase awareness of the cultural diversity of the members served. To celebrate cultural diversity and awareness, associates with cultural backgrounds similar to our racial and ethnic minority members, are invited to join a panel to share their experiences on honoring cultural beliefs, attitudes towards health and healthcare, and communication styles that meet the needs of diverse members.

NCQA Multicultural Healthcare Distinction Award

Three (3) AmeriHealth Caritas Iowa affiliate plans in South Carolina and Pennsylvania were among the first in the nation to adopt the NCQA's Multicultural Healthcare Distinction standards. Since becoming Early Adopters in 2010, Select Health of South Carolina, AmeriHealth Caritas Pennsylvania and Keystone First have consecutively maintained their accreditation status – one (1) awarded to an elite group of health plans that demonstrate excellence in tailoring programs and services to meet the unique needs of a diverse membership. This “meet members where they are” approach is the hallmark of our business.

To earn the Multicultural Healthcare Distinction, each health plan must pass a rigorous examination of NCQA standards in the following areas:

- Race/E/L data collection.
- Access and availability of language services.
- Practitioner network cultural responsiveness.
- CLAS programs.
- Reducing healthcare disparities.
- Fostering interpersonal communication styles in providers

CLAS coordinators work with provider network to ensure education and training in cultural competency by providing in person in-service orientations, lunch and learns or training in provider offices. Providers are also given links to cultural competency resources, which provide overviews and tutorials on culturally appropriate and sensitive communication methods with diverse members. These resources include the Office of Minority Health's Think Cultural Health Physician Guide to Cultural Competency. This training provides free CME credits in cultural competency. These resources will be listed on the AmeriHealth Caritas Iowa Provider Portal. AmeriHealth Caritas Iowa will also offer brochures about CLAS, cultural competency and health literacy on the plan website, with contact information for plan staff to assist providers.

Launching to link cultural competent provider network and health disparities

In 2015 AmeriHealth Caritas will launch Culturally Competent Training to over 22,000 providers in our networks on the American College of Cardiology and American Heart Association cardiovascular disease treatment guidelines. We are weaving culturally competent themes throughout the clinical guidelines training, as these providers serve some of the most diverse populations. Free CMEs will be offered to all providers who complete this training. This program will also provide education and awareness to members on their 10-year cardiovascular risk, along with prevention and wellness strategies to live healthier lives.

6.1.6 Provider Relations and Communications

1. Describe your provider relations and communications strategy.

AmeriHealth Caritas has a rich history of partnering with providers, and a strong track record of effective provider relations and communication across the States in which AmeriHealth Caritas operates. AmeriHealth Caritas provider networks in the markets we serve are stable or growing. We are proud to say we retain providers in our networks, and continue to grow networks through innovative partnerships and our reputation for quality service.

AmeriHealth Caritas has a multi-faceted approach to provider relations and communication. AmeriHealth Caritas provides a full orientation program for all new providers and communicates regularly with established network providers. Topical provider communication and initiatives are distributed via fax blast, e-lert and posted online for expediency. Past communications are archived on the Provider Portal for our providers' reference and convenience.

Components of our standard education and training program are on-site orientations for newly contracted providers, routine site visits, provider workshops, welcome packets, the Provider Manual, newsletters and the plan website. Recently in our southeastern Pennsylvania market, over 100 providers attended an office manager seminar. Topics discussed included impacting HEDIS measures, surveying the providers on their preferred communication methods and the quality of our plan website, an ICD10 Q and A and our upcoming testing approach, claims-related topics such as NDC and COB billing guidelines, paper claim submission, and how to avoid denials. The providers had an opportunity to meet their account executives, the network medical director and community outreach staff. Feedback from the attendees was extremely positive.

In addition to initial education and training, AmeriHealth Caritas supports providers continually by keeping them abreast of new information. Provider Network Management (PNM) account executives develop and maintain high-touch relationships with provider offices to ensure their informational needs are heard, addressed and resolved. We offer ongoing provider training in multiple formats to support best practices, quality improvement and State-driven initiatives. To ensure effectiveness, we request provider feedback via surveys and office manager seminars on educational offerings and adjust accordingly.

As mentioned earlier, we have already begun to build provider relations in Iowa and will continue to do so – opening the doors to communication to understand their concerns and begin what we are confident will be longstanding partnerships.

Providers know we support them

You are the only rep who has actually come to our facility and asked if there are any problems or concerns. You are also the only one who has sent any emails to me and asked how your company was doing and what could be done to improve. As the site administrator, I appreciate the little extra you give us trying to make our partnership in providing healthcare a successful one.

Thanks again,

Brad, Open Air MRI

I have been doing credentialing here at Highland Clinic for 15 years. There are some MCO contacts/representatives in which I have experienced a "working relationship" that DOES NOT work. My working

relationship with Lorie Emmons has always been a positive experience for me. Before Lorie I was challenged to get answers that I needed from Bayou Health. Since my working relationship with Lorie began I can attest that I rest easy when it comes to relying on her for any issues or concerns that may come up.

Becky Smith, Credentialing Specialist, Highland Clinic, APMC

2. Describe your policies and procedures to maintain communication with and provide information to providers.

AmeriHealth Caritas Iowa ensures providers are constantly informed of requirements and standards, and uses several methods to educate and communicate with providers. Our process includes communicating through documents such as the Provider Manual, provider Contracts and the provider newsletter, complemented by frequent and routine site visits, as well as initial and ongoing in-person training sessions. As also discussed in the following response, the plan website will also offer a critical medium for communication. The goal is to ensure providers have a clear understanding of expectations placed on them as an AmeriHealth Caritas Iowa network provider.

AmeriHealth Caritas Iowa will provide and maintain a written program manual for use by our provider network. The manual will be made available electronically, and in hard copy (upon a provider's request) to all network providers, without cost.

The AmeriHealth Caritas Iowa Provider Manual will include all components required by the State as outlined in the scope of work (SOW) and information beyond the requirements, such as:

1. Iowa High Quality Healthcare Initiative Covered Services.
2. Member Eligibility Categories.
3. Medical Necessity Standards and Practice Guidelines.
4. Role of the Medical Home.
5. Link to the NCQA and Joint Commission Websites.
6. Emergency Service Responsibilities.
7. EPSDT Benefits.
8. Prior Authorization, Pre-Certification and Referral Procedures.
9. Practice Protocols (including guidelines pertaining to the treatment of chronic and complex conditions).
10. Physical Health and Behavioral Health Coordination (including the requirement for BH providers to send status reports to PCPs and for PCPs to send status reports to members' BH providers).
11. Provider Complaint System Policies and Procedures (including, but not limited to, specific instructions for contacting the supplier's provider services staff to file a complaint and which individual(s) have the authority to review a complaint).
12. Policies and Procedures for the Provider Grievance and Appeals Process.
13. Member Grievance System (including the member's right to a State administrative law hearing, the time frames and requirements, the availability of assistance in filing, the toll-free numbers and the member's right to request continuation of benefits while utilizing the grievance system).
14. Credentialing and Re-credentialing.
15. Link to the DHS Website.

16. Iowa Value-Based Purchasing Program.
17. Transition of Care Planning.
18. Care Coordination Policies.
19. Protocol for Encounter Claims Element Reporting/Records.
20. Medical Records Standards.
21. Claims Submission Protocols and Standards (including instructions and all information necessary for a clean or complete claim).
22. Payment Policies.
23. The Supplier's Cultural Competency Plan.
24. Members' Rights and Responsibilities.
25. Other Provider or Subcontractor Responsibilities.

3. Describe your plan to develop a provider website and describe the kinds of information you will make available to providers in this format.

The AmeriHealth Caritas Iowa website will contain critical resources and access to tools providers need to succeed. The plan website also will be accessible via mobile-friendly format, as well as via tablet and i-Pad. Not only will critical information be available, but tools to help providers communicate with health plan care coordinators, track their performance and receive training. Information posted in the Provider Center will be consistently updated, and include topics included but not limited to:

- **Reference materials:** provider manual, reference guides, EFT and EDI guidance, claims filing instructions, clinical practice guidelines and provider credentialing.
- **Program information:** Care management resources, Let Us Know program, PCMH resources, EPSDT, cultural competency and language services.
- **Training:** Provider orientation and CME webinars.
- **Plan access:** Account executive and Provider Services contact information.

- **Communications:** Topical notices (i.e., ICD-10, newsletters, archived notices).
- **Online Provider Directory.**
- **Provider forms:** prior authorization request, demographic change form, transportation request, obstetrical needs assessment, DME request, supply request.

The NaviNet Provider Portal promotes convenient access to information

Our secure Provider Portal, NaviNet, will be accessible through our website and will enable easy access to information, maximizing efficiency and encouraging collaboration among our providers. We have multiple secure provider portals that we successfully use across our markets, but we chose NaviNet because it is in wide use throughout Iowa, already linking providers to Aetna and CIGNA. In addition, the system links to our care managers to ensure our physicians have the vital information they need to provide the best, coordinated care for our members.

As a multi-payer portal, NaviNet allows providers to log in once and access information from multiple plans. NaviNet also grants providers secure access to request and customize reports that help them manage the health of their patient populations. Providers can build customized reports on key metrics, patient data or outcomes related to pay-for-performance programs through filters and sorting. AmeriHealth Caritas Iowa will offer access to all the standard transactions through NaviNet, including real-time eligibility and benefits and claim status, electronic prior authorization requests via JIVA, care gap notifications and reporting, claims status inquiry, as well as links to important administrative information. This resource allows providers access to information at their convenience, whether using desktop, mobile or tablet devices.

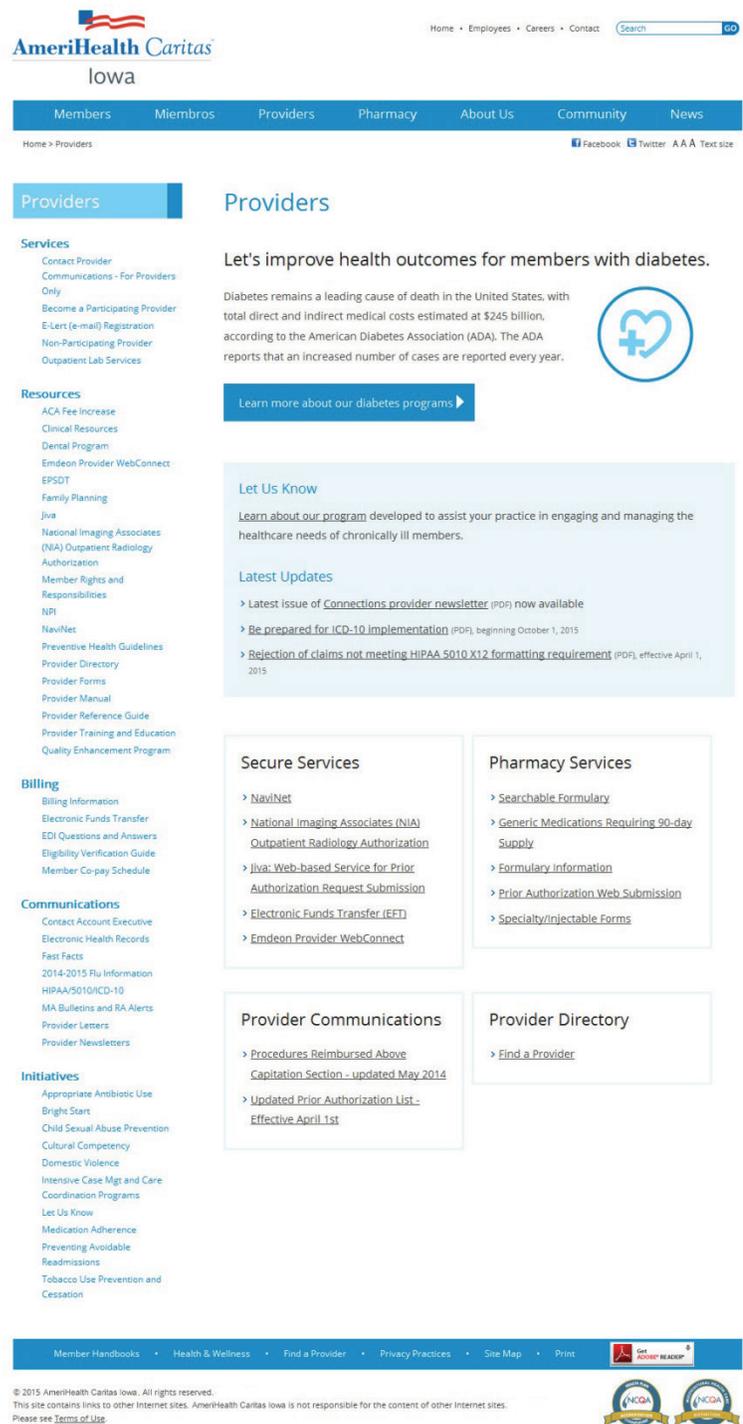
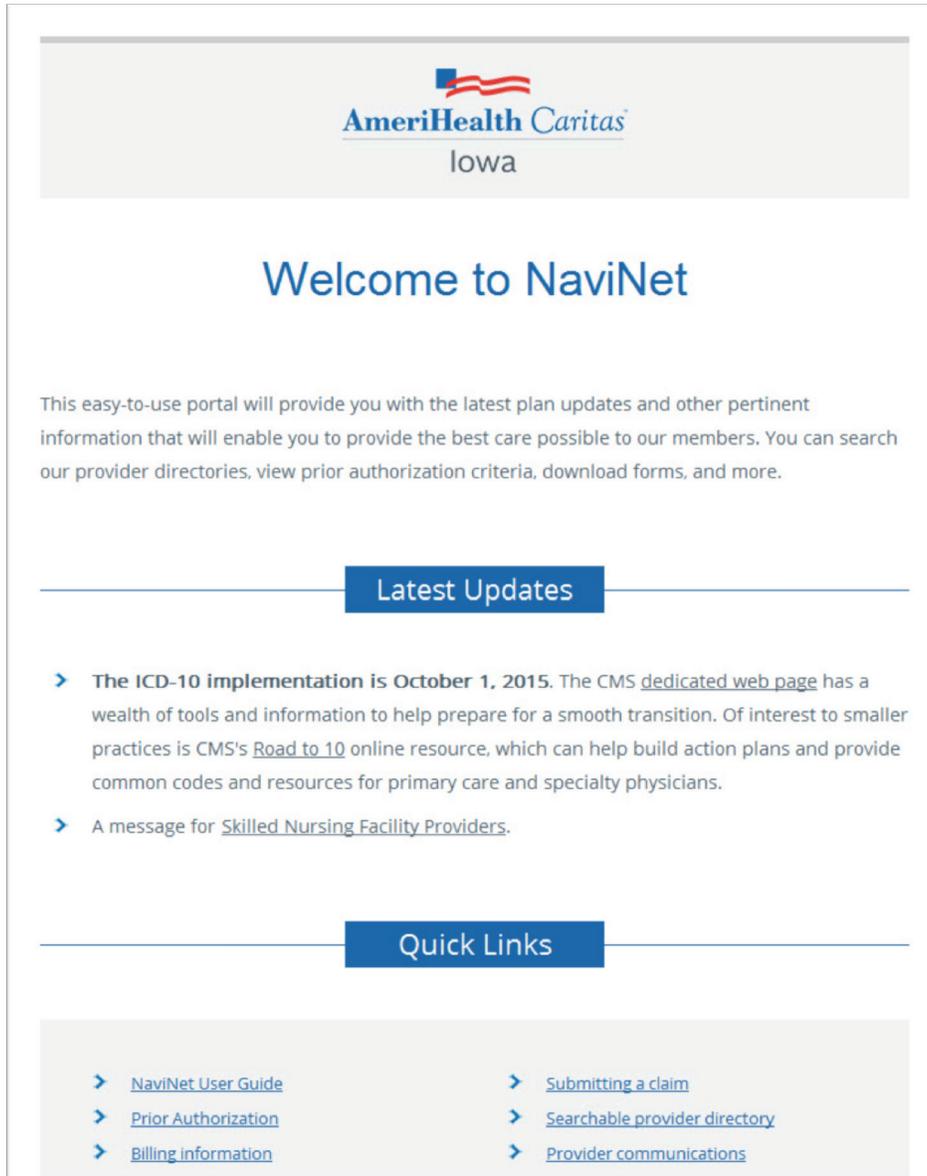


Exhibit 6.1.6-A: AmeriHealth Caritas Iowa provider portal





Welcome to NaviNet

This easy-to-use portal will provide you with the latest plan updates and other pertinent information that will enable you to provide the best care possible to our members. You can search our provider directories, view prior authorization criteria, download forms, and more.

Latest Updates

- > **The ICD-10 implementation is October 1, 2015.** The CMS [dedicated web page](#) has a wealth of tools and information to help prepare for a smooth transition. Of interest to smaller practices is CMS's [Road to 10](#) online resource, which can help build action plans and provide common codes and resources for primary care and specialty physicians.
- > A message for [Skilled Nursing Facility Providers](#).

Quick Links

- > [NaviNet User Guide](#)
- > [Submitting a claim](#)
- > [Prior Authorization](#)
- > [Searchable provider directory](#)
- > [Billing information](#)
- > [Provider communications](#)

Exhibit 6.1.6-B: AmeriHealth Caritas Iowa NaviNet Portal

Delivering useful reference resources to our valued providers

Billing and claims training information will be available on-demand to providers via the provider section of the AmeriHealth Caritas Iowa website, as well as through the Provider Manual, which also covers referral and prior authorization requirements (both of which can impact claims payment). A detailed claims filing instructions booklet is available online that includes sample claim forms, field requirements and common reasons for claims rejection. Hard copies can also be made available to the provider upon request.

Other topics included in the plan website will include:

- Timely filing guidance.
- EDI questions and answers.

- Eligibility verification guide.
- EFT sign-up instructions.
- Billing guidance notifications or coding requirements (for example, NCCI edits).

This information will be reviewed in depth with new providers, and all information available for providers through the website will be reviewed and updated on a regular basis. Providers will be directed to the AmeriHealth Caritas Iowa website to enable them at their convenience to become familiar with the broad range of educational topics we offer. In addition, providers will always be able to contact their assigned Provider Network Management account executive for education, follow-up questions and concerns.

The AmeriHealth Caritas Iowa Provider Manual will be available electronically on the AmeriHealth Caritas Iowa website and can be downloaded by those who prefer a hard copy version.

Providers are often concerned about prior authorization requirements. AmeriHealth Caritas Iowa will detail the prior authorization requirements during all new provider orientations, and continue to reinforce the prior authorization processes during regularly scheduled and provider-requested visits.

Additionally, AmeriHealth Caritas Iowa will provide education related to billing requirements during routine site visits and provider workshops held in the community. The AmeriHealth Caritas Iowa Provider Network Management staff will conduct provider trainings and seminars on a variety of topics to address the needs of our providers across the State. For example, we will review benefits, eligibility verification and online provider resources. In addition, we can offer assistance with the establishment of electronic claim submission and/or EFT as needed. Changes and updates to plan processes and policies will also be included in these workshops, and via regular provider fax communications, and incorporated into the provider manual.

4. Describe your plans for the provider services helpline, including the process you will utilize to answer, route, track and report calls and inquiries.

Setting high goals for provider satisfaction and respectfully resolving provider inquiries and grievances

AmeriHealth Caritas is committed to provider satisfaction, and a major factor contributing to provider satisfaction is to respond promptly to a provider's question or request, and pay claims accurately and quickly. However, there are times when claims are not paid, or the health plan does not respond as the provider expects. In those cases, AmeriHealth Caritas has implemented efficient processes to intake and resolve a provider's inquiry, complaint, grievance or appeal long before the provider feels the need to escalate his or her concern to the State. Although we are committed to resolving provider issues without the need to involve DHS, AmeriHealth Caritas Iowa's process to resolve provider inquiries, grievances and appeals will be completely transparent and open to DHS, and we will share reports and outcomes regularly.

The Contact Center of Excellence (CCOE) Provider Services helpline operates Monday through Friday 7:30 a.m. to 6:00 p.m. Central Time and will be staffed with Provider Services representatives trained to address Iowa-specific provider issues including eligibility, enrollment verification, routine billing questions, claims status, prior authorization requests and requests for documents. During off hours, providers will be able to leave messages and as well will be alerted to the process for obtaining emergency prior authorizations.

The Provider Services staff is also specially trained to resolve provider complaints, such as dissatisfaction with a plan policy and claims payment issues or questions. Setting us apart from most other health plans,

our specialized team has the ability to route calls to our Provider Claims Services unit to research and resolve common claims payment issues over the phone.

Providing a forum for provider grievances

AmeriHealth Caritas Iowa's objective is to assure smooth transactions and interactions with our Provider Network community. We will promptly and respectfully address any verbal or written complaint from a provider and will resolve complaints without delay. Understanding that providers may interact with multiple staff from AmeriHealth Caritas Iowa, all staff will be trained to review concerns and forward to the appropriate person and/or department to document the concern and assist in a resolution. Providers are encouraged to try and resolve their concerns by calling their Provider account executive or AmeriHealth Caritas Iowa's Provider Services department.

Call routing

AmeriHealth Caritas' Automatic Call Distributor (ACD) system is preset to direct calls based on a hierarchy of skill sets or expertise necessary to appropriately handle calls and resolve caller issues. The ACD is a telephone facility that manages incoming calls and routes them based on the number called and an associated database of handling instructions.

Within our system, an Interactive Voice Response (IVR) is used to support automated, self-service call routing for providers to obtain answers to questions such as member eligibility or claim status (as examples).

The automated routing begins tracking in-bound calls at the point at which the provider selects between various options. Once the selection is made, the calls are queued and routed to the next free phone line in each skill set. Information tracked for each call includes call waiting time, off phone time, hold time, abandon time and other data.

Tracking

All calls to the Provider Services line are documented and recorded for tracking and monitoring. While the majority of provider inquiries can be resolved during the call and without follow-up, our automated workflow application ensures that issues needing follow-up are routed to appropriate departments and tracked through to resolution. Provider Services representatives are trained to escalate complaints or issues of a significant nature, such as those impacting member access to care, to ensure expeditious and complete resolution.

All communication, research, subsequent action and documentation associated with provider issues, including those received outside of AmeriHealth Caritas Iowa's formal dispute process, will be managed through our workflow database. Maintaining all of this information in an indexed central location enables accessibility as needed by various internal departments involved in resolving a provider issue. The tracking database is also utilized to generate internal reports that assist in monitoring activity to ensure that issues are resolved within established time frames, as well as identifying any issue trends. Trends are reviewed to determine what improvements can be made to address any underlying problems.

If the provider is not satisfied with the resolution presented, the provider may proceed through AmeriHealth Caritas Iowa's formal complaint process. Although providers may file a formal claims dispute in writing, they may also access information, ask questions and request investigation of a problem or potential issue through a variety of other venues. Our goal is to answer questions immediately and accurately to resolve problems before they become formal disputes or complaints. Once providers have

submitted these inquiries and requests for information, we monitor progress and final resolution through EXP MACCESS, our workflow tool. EXP MACCESS is an imaging-based operations management, workflow management, enterprise content management and customer service solution that has been standardized for managed healthcare organizations.

Real-time monitoring

A dedicated in-house Workforce Management team will use Verint to monitor individual and department performance measures, including the following individual and departmental goals:

- Individual goals:
 - Real-time adherence.
 - Total average handle time.
 - Average hold time.
 - Off-the-phone time.
- Department goals:
 - Answer 80 percent of calls within 30 seconds.

Monitoring our quality to ensure our effectiveness to providers

Monitoring of representatives is necessary to assess whether there are areas of concern regarding courtesy, accuracy, consistency and completeness. Every supervisor is required to monitor calls for representatives on a daily, weekly and monthly basis. Each supervisor has the capability through their desk phone to listen in on calls throughout the day. This allows the supervisor to provide real-time feedback and coach representatives as needed, all while ensuring optimal attention for the provider and avoiding frustration or escalation.

In addition, on a monthly basis the CCOE and AmeriHealth Caritas Iowa executive staff complete call sample calibration monitoring. This monthly activity provides the local executive staff with the opportunity to monitor a random sample of provider calls. The calibration exercise allows the CCOE and AmeriHealth Caritas Iowa staff to provide feedback on call quality and the accuracy of information provided by representatives, and also to inflect Iowa background and information. This collaborative activity will also provide the AmeriHealth Caritas Iowa team the opportunity to hear firsthand the drivers and concerns expressed by providers to the CCOE. This information is invaluable to AmeriHealth Caritas in developing informational materials, provider education and outreach programs, and policies and procedures geared toward the expressed needs of providers.

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

The Quality department provides feedback regularly to representatives and verifies that the calls were appropriately handled in the following areas:

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

Based on the quality scores, the supervisor will create an individual action plan for the representative. If trends are identified, the training department is engaged to provide refresher training. Quality grades are part of the Provider Services representative's monthly feedback as well as their annual appraisal. The supervisor meets with every representative at least three (3) times a month or as needed to review their quality scores and address any issues. AmeriHealth Caritas Iowa will submit Provider Services quality criteria and protocols to DHS for review and approval annually.

Quality is also checked and assured through surveys conducted with providers by a third party. These random-sample surveys capture the topic discussed on the call, the provider's level of satisfaction with the results of the call and any additional comments the provider gives.

CCOE supervisors receive four (4) daily updates with such metrics as average speed of answer (ASA) and average handle time (AHT). They will review the updates and make immediate staff adjustments in the event that a target is trending off goal. Offline, supervisors coach staff to ensure they have the skills and resources necessary for providing high-quality customer service.

The metrics yielded from this monitoring process are favorable. For example, statistics for 2014 performance for the CCOE for AmeriHealth Caritas Louisiana show an average speed of answer (ASA) for Provider Services calls of 11 seconds and an average abandon rate for AmeriHealth Caritas Louisiana provider-related calls of 1.5 percent. Independent auditors have assessed calls to Provider Services at a year-to-date score of 98.3 percent for quality and accuracy. For Provider Claims Services, the ASA is 8 seconds, average abandon rate is 0.7 percent and call quality scored a 98.8 percent. This performance demonstrates our success in meeting our goals and outperforming State requirements, a feat we will replicate for Iowa.

Our processes, technology and experience give us the ability and agility to meet and exceed all contractual service-level goals. These processes allow us to identify and quickly correct service performance issues using intraday performance reports (30-minute interval). For example, when call volume exceeds the forecast and available staff capacity, overflow calls are routed to Provider Services staff in additional CCOEs.

I wanted to take a minute and recognize the outstanding work of one of your employees and acknowledge all the hard work and dedication she provides in assisting my department.

Just about a year ago Haley Smith began participating on our monthly calls to have Physician Billing issues at Children's Hospital resolved. Since that time she has played a key role in addressing issues as they arise and works diligently within her power to have them resolved. I am delighted to work closely with someone with such aspiration to resolve problems; she is truly an asset to your company.

April Lopez, Children's Hospital of New Orleans, Physician Billing, Patient Accounts Coordinator

5. Describe your provider training plans

AmeriHealth Caritas Iowa offers comprehensive provider training for multiple topics in multiple formats; from on-boarding training to specialized medical home training. We also offer our providers ongoing opportunities to earn CME credits and view training reference guides for important systems such as NaviNet, the secure Provider Portal and Jiva, our secure prior authorization portal. Our account executives visit provider offices regularly to cover topics such as billing and claims, member outreach programs, and provider roles and responsibilities. The account executives dedicate at least one (1) visit annually for a comprehensive overview of plan processes, procedures and special programs. All of these resources are also made available on the plan website, and providers are encouraged to make use of the many resources available on the portal.

Training customized to the Iowa market

Providers who are new to Medicaid managed care are frequently unsure of what to expect. AmeriHealth Caritas Iowa's experience through our parent organization's history of serving this population throughout the country will inform and shape the training we offer providers. As we have done in other markets where Medicaid managed care is new, before the program goes live, and for several months thereafter, we will blanket the State with opportunities for providers to attend orientations, workshops and seminars where we discuss AmeriHealth Caritas Iowa's processes and resources. We will also be available upon request to visit provider offices and facilities to offer orientations, workshops and seminars, and make presentations available on the plan website.

Whether workshops are offered on-site in the provider's office, or in the community, our training staff consists of account executives, care management and operations staff to ensure all aspects of the provider's interaction with the health plan is covered. Plan resource materials will be available for providers to take back to their practices, including the provider manual, reference guide and copies of the orientation materials. We also arrange webinars on various topics such as NaviNet and Jiva training, or any other topic of interest to the provider. AmeriHealth Caritas Iowa is committed to innovating its training tools and approach. As such, we have launched online interactive provider training modules on various topics of importance to providers — not only program requirements and changes, but also quality initiatives, best practices, PCMHs and other topics that support improved efficiency and better outcomes. AmeriHealth Caritas Iowa offers timely training and education on any topic of interest identified through provider requests, State or federal regulation, or analysis of trends in the marketplace.

Key requirements addressed in provider training

On an ongoing basis after the program is launched, AmeriHealth Caritas Iowa will schedule provider orientation visits within 30 days of placing a newly contracted provider or provider group, and

continuously upon request. Key educational components in the initial new provider orientation will include:

- AmeriHealth Caritas Iowa overview.
- Iowa Medicaid program policies (including updates and changes).
- Physician requirements and programs.
- Verifying member eligibility.
- Utilization management.
- Integrated care management (ICM) care coordination.
- Confidentiality requirements.
- Marketing requirements, including acceptable and prohibited practices.
- Benefits coverage.
- Referrals and authorizations.
- Claims filing guidelines, including appeals.
- Access and availability standards.
- Provider Contact Center services.
- NaviNet Provider Portal use and instructions.
- Quality Improvement Program.
- Credentialing.
- PCMH transformation.
- LTSS provider roles and responsibilities.
- BH and PH integration.
- Provider rights and responsibilities.
- Member rights and responsibilities.
- Provider complaint system and claims dispute process
- Grievances and appeals.
- Regulatory provisions.

Training to support traditional LTSS providers

We perform the same training with the LTSS group as with any other provider. Many of the LTSS providers may be unaccustomed to dealing with billing and working with the Medicaid program. Therefore, our LTSS training and orientation is extensive, offering education about the basics of the Iowa Medicaid program, as well as how to interact with AmeriHealth Caritas Iowa. We introduce them to electronic billing through Emdeon and access to member eligibility through the same process. We spend time discussing LTSS provider requirements, and specific billings they will be using based on the type of services they provide. We cover who AmeriHealth Caritas Iowa is, the LTSS eligible member population, and their benefits and exceptions. Additionally, our LTSS providers will need to understand the role of AmeriHealth Caritas Iowa's community-based care manager, and how the care manager helps to connect the member with all needed

services. We are dedicated to helping LTSS providers deliver necessary services so that these members can stay in the community as long as possible.

Training to support medical home transformation

An ongoing effort to build effective medical home partnerships is also an essential element in AmeriHealth Caritas' commitment to deliver better health outcomes. We recognize that transformation to an effective medical model of care requires time, resources and expertise that have not always been readily available to some practices. We offer many resources to help providers achieve, maintain and enhance their medical home status. Our program is detailed in section 6.3.2.C.

Behavioral health (BH) training for physical health (PH) providers

AmeriHealth Caritas has hired clinical trainers who specialize in BH topics to provide a robust education and support program for PH providers. These trainers develop condition-specific tool kits that include guidance on assessing, diagnosing, managing and referring for services. The tool kits are then personalized for each market to include plan-specific resources, such as the disease management programs offered, as well as community resources and referral pathways. Account executives in each market are also trained to support their providers in BH issues. The depression/PHQ-9 tool-kit has been developed and is being used currently to train PCPs and pediatricians. There are plans to develop anxiety and substance use disorders tool kits in 2015.

AmeriHealth Caritas has participated in the Screening, Brief Intervention and Referral to Treatment (SBIRT) program in South Carolina Medicaid, targeting OBs and pregnant women. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

This program can be implemented with additional physical health providers and can be refined to address BH conditions as well.

Evaluating the effectiveness of provider training

We evaluate the effectiveness of these training sessions by requesting feedback from the provider. We are committed to constantly improving our training sessions and making the sessions a worthwhile endeavor for the provider and the provider staff. We have a form that we request the provider complete at the end of each session. The responses are reviewed by the Director of Provider Network Management for determining the topic of the training sessions. We also conduct provider surveys to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing and claims reimbursement.

The 2014, the Provider/Practitioner Satisfaction Survey found that 80 percent of providers would recommend AmeriHealth Caritas health plans to other practices/providers and their patients; a similar proportion agree that AmeriHealth Caritas takes their input and recommendations seriously.

A compelling measure of the success of our ongoing outreach to providers is the informal feedback we receive from them. We have found providers to be appreciative of the relationships established by our Provider Network Management and Operations departments; their hands on, proactive approach to supporting providers, hearing their concerns and resolving their issues ensures an effective partnership in care delivery.

Provider Network Management (PNM) account executives

In addition, each provider is assigned a PNM account executive as a resource for ongoing support. The PNM account executive performance goals require that account executives complete eight (8) visits per week in addition to any special project that they may be working on. These visits are based upon the following provider visit policies:

Provider type	Frequency of visits
PCPs with panels > 500	Monthly
PCPs with panels < 500	Quarterly
Specialist and ancillary providers	Quarterly
Hospitals and facilities	Quarterly

Exhibit 6.1.6-A: PNM account executive visit policy

PNM account executives educate providers on our quality programs, administrative or program changes, and other topics as requested by the provider. This enhanced provider support increases overall satisfaction and promotes an opportunity for us to engage with the provider on initiatives that improve quality outcomes. Provider visits serve as an effective communication vehicle for both parties because we use their feedback to continuously improve our services.

6.1.8 Notification of Provider Disenrollment

1. Describe procedures for ensuring continuity of care and communication with members when a provider disenrolls.

AmeriHealth Caritas Iowa cultivates strong relationships with network providers

Through our high-touch approach with members, AmeriHealth Caritas Iowa is committed to ensuring the highest and smoothest continuity of care and clear communication when a provider disenrolls. Continuation of care is provided for members with open active treatment plans if a provider managing their care is terminated from the network (either by AmeriHealth Caritas Iowa or of the provider’s own volition unless termination is for quality or exclusion reasons). That said, AmeriHealth Caritas Iowa will actively work with members to identify acceptable alternative participating providers to transition their care when necessary. As part of continuity planning, members with open treatment plans may continue to

receive services with the exiting provider (with exiting provider agreement) until such time as treatment is completed or 90 days whichever comes first.

AmeriHealth Caritas Iowa may authorize ongoing care from nonparticipating providers, beyond the end date of the previous authorization or the continuity of care period, if there is not sufficient expertise or access within the regional network to provide appropriate care to the member. In those situations, a single case contract may be negotiated, documenting the approved services, duration and payment in writing.

AmeriHealth Caritas Iowa will employ proactive strategies to foster strong relationships with network providers, offer support, ensure mutually beneficial relationship, and avoid loss of providers. We support members in effectively accessing care, keeping appointments, valuing preventive care to reduce no-shows and increase engagement, which in turn reduces burden on providers and can improve member health. PNM account executives form strong relationships with providers and office staff, offer education, and answer questions. This active and supportive partnership with our network providers sets us apart, and we work to address potential problems before they become issues that could lead to termination.

Provider Network Management team delivers local support

AmeriHealth Caritas Iowa will utilize a staff of PNM account executives who live and work in Iowa, understand the local landscape, and often have already established relationships with providers and health systems. This extensive experience within the community, combined with an affiliation with and firsthand knowledge of the communities in which they serve, gives them a distinct advantage in identifying and mitigating concerns on a pre-emptive basis, before they become issues. Account executives will contact and visit providers regularly to educate them on:

- Medicaid and the Iowa Families programs.
- Preventive services and health education resources.
- AmeriHealth Caritas Iowa programs and campaigns.
- Provider workshops and training opportunities.

Provider Network Operations team

The Provider Network Operations team provides assistance in the resolution of provider complaints or issues. When providers identify issues or concerns, account executives record this information in an internal database that the Network Operations team accesses for centralized tracking and resolution. The database system has the functionality to route issues between departments as needed, track issues to ensure adherence to established turnaround times, and report activity and trends.

Once issues are researched and the course of action required for resolution is determined, the assigned department coordinates and tracks all activity related to resolution of the submitted issue. Activities required for resolution vary but may include a request to modify existing processes or rules utilized by operational areas, or education of internal staff or providers regarding a plan policy, process or contractual arrangement. The tracking database is also utilized to generate internal reports that assist in monitoring activity to ensure that issues are resolved within established time frames, as well as spot any issue trends. Identified trends are reviewed to determine what improvements can be made to address any underlying problems. This focused attention on provider needs is another way AmeriHealth Caritas Iowa seeks to listen to and meet provider needs and prevent unnecessary termination from the network.

Provider Contract termination is guided by ethical decision-making process

Caring for our members and being where they are so they can access care is of paramount importance to AmeriHealth Caritas and AmeriHealth Caritas Iowa. Our organization exists to provide quality and accessible healthcare services to our members and is driven by our mission to help people get care, stay well and build healthy communities. Any decision the organization makes must be guided by this mission and by our values, which are advocacy, care of the poor, compassion, competence, dignity, diversity, hospitality and stewardship.

We view healthcare decisions as much more than convenient business conclusions. Sometimes the decision making process can be as simple as evaluating how a decision sustains our values. Often, however, decisions involve complex choices that affect a large internal and external community. Prior to deciding to terminate any provider Contract that will have a significant impact on stakeholders, including members, community entities and business operations. AmeriHealth Caritas thoughtfully considers all aspects of the termination by employing principals outlined in our Ethical Decision Making policy. Our leadership team developed the Ethical Decision Making Tool to ensure that every decision made within the organization results in choices that advance our mission and values. When deciding to terminate key provider contracts or numerous provider contracts, we take steps to assure proper communication and consideration of the impact of terminating and to assure that all perspectives have been considered.

Such decision-making is approached in three (3) phases:

- Preparation.
- Decision-Making.
- Implementation.

The Preparation Phase includes consideration of the number of individuals potentially impacted by the decision, as well as the duration and depth of the impact. Our organizational values, commitments and strategic direction are also considered during this phase. This is also when we take care to consider who else will be affected by our decision, including members, providers and the community. We also seek to identify who would have insight into the decision at hand and its implications.

During the Decision-Making Phase, we establish a decision-making group with responsibility and authority to make the decision. During this phase we gather information and data, establish priorities, develop options and listen to viewpoints to gain consensus on a final decision.

In the Implementation Phase, we assign accountabilities and build a plan for monitoring and reporting with measurable outcomes, as well as a plan to communicate key messages and methods to the community of concern. These plans will connect to the larger meaning and purpose. This process ensures that decisions are made with careful consideration of the impact to our members and the community at large.

When the decision has been made to terminate a Contract, the following processes represent implementation of the decision.

Collaborative and compliant relationship with State partner

AmeriHealth Caritas Iowa will notify DHS as soon as we suspect any significant changes to the provider network or, if applicable, to any subcontractors' provider network, according to the State's definition of significant change. AmeriHealth Caritas Iowa values an open, transparent and compliant relationship and will adhere to requirements.

Assisting members with provider transitions and membership supports

The process will begin no later than 120 days before the termination effective date in order to meet contractual requirements for member and provider notification. Further, early identification of members with special needs and early outreach to all affected members enable the arrangement of appropriate, quality alternative healthcare services without disruption to the members or to the provider network.

AmeriHealth Caritas Iowa will convene the contingency team and create a work plan that clearly defines who is responsible for each task and the required time frame. Data is pulled to create member mailing lists, physician lists, special needs/continuation of care lists/GeoAccess maps and more, as described below:

- Key community, legislative leaders and providers are contacted to provide progress updates, identify and mitigate vulnerabilities for the community to facilitate a smooth transition.
- We identify all providers and practitioners owned (employees of the health system) by the health system/hospital being terminated.
- A critical component is to identify healthcare access issues caused by facility and provider termination through a GeoAccess to Care Survey.
- AmeriHealth Caritas Iowa develops strategies to mitigate access to care issues (e.g., recruitment of additional providers and practitioners to fill gaps in care).
- AmeriHealth Caritas Iowa believes it is important to identify members who received healthcare services from a terminating facility or practitioner within the past 12 months or whose PCP is terminating.
- Member and provider notification letters and related materials are drafted and appropriate State approvals are sought.
- We draft scripts for associates who will be outreaching to and receiving calls from affected members.
- We create a member retention strategy and identify and outreach to physicians to whom members will be transitioned.
- We ensure a smooth transition by identifying those members with special needs or who will have continuity of care issues for immediate outreach.

We begin member notification and outreach not less than 45 days prior to the termination, or within 15 days of receipt of the provider termination notice. Notification strategies include:

- Letters.
- Phone calls.
- On hold messages.
- Automated (and interactive) phone calls.
- Special effort is made to contact members with special needs so that the healthcare services they receive can continue without interruption. Members with special needs receive repeated phone calls until our case managers have successfully transitioned or arranged for continuation of their care.

Alternative providers and practitioners are actively recruited by the PNM team to ensure the termination does not have a lasting impact on access to care for our members.

Systems that assist with transitions

Continuation of care will be provided for members with open active treatment plans if a provider managing their care is terminated from the network (either by AmeriHealth Caritas Iowa or of their own volition unless termination is for quality or exclusion reasons). AmeriHealth Caritas Iowa will actively work with members to identify acceptable alternative participating providers to transition their care. As part of continuity planning, members with open treatment plans may continue to receive services with the exiting provider (with exiting provider agreement) until such time as treatment is completed or 90 days whichever comes first.

AmeriHealth Caritas Iowa may authorize ongoing care from nonparticipating providers, beyond the end date of the previous authorization or the continuity of care period, if there is not sufficient expertise or access within the regional network to provide appropriate care to the member. In those situations, a single case contract may be negotiated, documenting the approved services, duration and payment in writing.

The Member Clinical Summary clearly communicates member needs for continuous care

AmeriHealth Caritas Iowa enables network providers to quickly and easily review member history, and needs, facilitating the member's transition between providers and supporting continuity of care. AmeriHealth Caritas Iowa's Member Clinical Summary provides a snapshot of the member's recent prescription history, chronic conditions, inpatient admissions, emergency room visits and office visits. The Member Clinical Summary also includes the member's demographic information, open authorizations and identified gaps in care. This clinical summary can be printed and sent to the new providers to allow for additional coordination of the member's needs.

The summary will be accessible through AmeriHealth Caritas Iowa's Provider Portal, which also enables providers to build customized reports from the member information stored in our core claims administration and clinical care management platforms. The Member Clinical Summary, and the other available or customized reports, can be printed or downloaded in CCD or Excel CSV formats, which can then be uploaded into providers' electronic health record (EHR) systems.

Ensuring continuity of care for members through systems and policies

Built-in safeguards for continuity of care in the individualized care plan

Healthcare is not an industry to us; it is an obligation. It's an opportunity for a "next generation" of healthier people and promises fulfilled. As part of this, we build in safeguards to ensure the continuity of care in individualized care plans. Holistic treatment plans include regular monitoring, member education, coordination of needed services, focused care management support and enrollment in a disease management program. Care plans for members with special or complex health needs also include assessments and interventions that focus on caregiver support. Centralized access ensures members' needs are available for all involved in providing care. For example, transition plans involve many AmeriHealth Caritas associates and functional areas.

Interdisciplinary and collaborative support for member care from the Care Management, Utilization Management, Rapid Response and Member Services teams

The Care Management, Utilization Management, Rapid Response and Member Services teams work closely and collaboratively to share information on member needs and care and ensure members are supported in understanding and accessing the care they need. Representatives serving members on these teams identify needs and share information to ensure members in need of specialty healthcare are

referred appropriately for services and assisted in scheduling appointments and overcoming barriers to care including the need for transportation and other supports. They monitor members with complex health conditions or comorbidities to identify gaps in care and evaluate treatment adherence and progress. They follow established procedures to collaborate with members, facility staff and providers to plan discharges and other transitions in care so that appropriate steps are taken to safeguard members' health and quality of life.

Community Outreach team supports members with transitions

A supplemental source of support to members is our Community Outreach team. The Community Outreach team is available to educate members on navigating healthcare system, assist with scheduling appointments, remind members of their appointments and the importance of keeping them, and resolve barriers to care to ensure appointments are kept. This value-added service ensures that the member has an appointment that is conducive to his or her schedule and that the member is aware of the date and time of the appointment.

The Community Outreach team also is available to provide member education directly to members. Through direct contact with the member, the Community Outreach team can assist members in remedying any issues they may be experiencing and educate the member in effectively navigating the healthcare system. The Community Outreach team supports both the provider and the member and facilitates clear communication between the parties.

This background exhibits itself in a meaningful way for members and providers. The Community Outreach team acts as the feet on the street and engages the Provider Network Management account executive as soon as they become aware of a potential access issue. The Community Outreach team is another mechanism to ensure that clear lines of communication exist between member and providers.

AmeriHealth Caritas Iowa uses out-of-network providers as needed to address gaps

Single-case agreement process

If services are unavailable or cannot be performed by an in-network provider, the PNM team makes same-day contact with out-of-network providers to begin the negotiation process, which is completed in three (3) to seven (7) days. During this time, the AmeriHealth Caritas Iowa UM department will be engaged to ensure that a prior authorization is in place and claims related to services will be processed and reimbursed accordingly.

Ongoing engagement to ensure claims processing and reimbursement often results in a contractual relationship

Mirroring our practice of personal interaction with in-network providers, AmeriHealth Caritas Iowa will keep in close contact with out-of-network providers during this process to ensure smooth delivery and payment of services. The relationship our account executive develops with the provider through this engagement often forms the foundation for a successful contractual relationship, thus mitigating gaps and strengthening our provider network. In fact, in our Louisiana affiliate, this streamlined methodology for ensuring continuity of care for members and payment for providers through the single-case agreement process resulted in the successful re-entry of Ochsner Health System into the AmeriHealth Caritas Louisiana provider network, as described below.

Case study in retaining provider systems: Ochsner Health System

Building great relationships with providers often takes time and requires meeting challenges along the way. This was the case with AmeriHealth Caritas Louisiana's relationship with Ochsner Health System (Ochsner), a large provider system in the southeastern region.

"Ochsner leaders said they would like to keep the door open for future participation but did not feel that the partnership was working at the time," said Rebecca Engelman, Executive Director of AmeriHealth Caritas Louisiana. Engelman, along with Sherry Wilkerson, Director of PNM, went to work with their AmeriHealth Caritas Louisiana teams to ensure a smooth and precise termination process.

Using single-case agreements, the team proposed a plan that would allow several hundred members to remain in the Ochsner system for OB/GYN, transplants and other services.

"If possible, we wanted impacted members to continue in established treatment plans at Ochsner and remain with the doctors who were currently treating them," Wilkerson said. "Continuity of care was important, as well as our ongoing quest to avoid gaps in care that may occur when member care is transferred."

The Ochsner providers agreed to the plan and were impressed with this approach. AmeriHealth Caritas Louisiana worked with its managed care team to provide the best care for our members still engaged with Ochsner over the past year. In this way, the partnership continued.

At a meeting earlier this year, Ochsner leaders indicated they were ready to Contract again with AmeriHealth Caritas Louisiana.

Credentialing oversight began, and the provider relationship resumed. Through this relationship, AmeriHealth Caritas Louisiana members have access to southeast Louisiana's largest nonprofit, academic, multi-specialty, healthcare delivery system: nine (9) hospitals, 40 multispecialty health centers and more than 900 physicians in over 90 medical specialties.

Responding to impact if the loss is in a geographic area where providers of the same provider type are not available

AmeriHealth Caritas Iowa recognizes the disruption that occurs to member continuity of care when a provider terminates. It is especially critical when the termination creates an access gap. In cases where a provider termination results in access issues, we use several methods to mitigate the service gap. Routine and ongoing recruiting by PNM occurs using the following sources:

- AmeriHealth Caritas' network manager and Enclarity data lists.
- Competitor directory searches.
- Iowa Medical Association member directories.
- Web searches for specific Iowa providers.
- Provider referrals used by existing hospital and physicians in the area.
- Identify and recruit/add nurse practitioners and PAs in the area.
- Border hospital and practice support, if appropriate.
- Telemedicine provider/site opportunities.

- Long-term efforts to identify available providers within medical school and hospital residency programs.
- Long-term efforts to collaborate or broker practice and clinic development utilizing supervising residency physicians and available clinic space or now closed facilities.
- During the initial stages of preparing to enter the Iowa market and begin building a provider network with coverage to meet member needs, we assembled a list of all border hospitals that are within 30 - 45 miles of an Iowa border. We looked at the services offered by the facilities in border areas to make sure would meet member needs for care (e.g., ER, OB, psychiatric or acute care).

AmeriHealth Caritas Iowa will use creative strategies to mitigate provider shortages

When necessary, AmeriHealth Caritas Iowa will design an agreement with an out-of-network provider to see members and address needs on an interim basis. Our ongoing contact with the provider, support through any issues, and attention to timely payment often result in these agreements serving as a bridge to bring the provider into our network.

Mobile units are one of several alternatives offered to maintain access to care following the termination of a large provider group or hospital system. AmeriHealth Caritas Iowa will offer services through mobile units to truly reach members where they are as needs are identified. Our affiliate MDwise offers a mobile van program that coordinates with schools to offer day-time coverage for screenings and routine to some urgent care needs.

Telemedicine is another alternative if available in the specific area needed while recruitment of providers is underway. We will also work with existing providers in the area, in specialties that mirror the specialties lost in the termination, to inform and collaborate on short-term ways they might offer special clinic services or longer/weekend hours to provide for urgent care needs until additional providers are added.

Article: "MDwise Funds Mobile Health Center to Deliver Services to Children in Area Schools"

VERMILLION-PARKE – Vermillion-Parke Community Health Center's (VPCHC) mobile School-Based Health Center is slated to open in August 2012. The mobile health center will help to reduce healthcare disparities, enhance continuity of care and empower the area's homeless and vulnerable populations to become more self-sustaining.

The project received a federal school-based capital grant in August 2011 as part of the Patient Protection and Affordable Care Act. Recently, the project received additional funding that will pay for equipment that will aid in the delivery of essential medical services to children attending any school within the five (5) Parke and Vermillion County school corporations. By identifying and addressing health problems that may negatively affect the learning process, this mobile clinic will help children stay in school and succeed.

"This additional funding will further allow this mobile health clinic to provide much-needed services to the schools in our community," said Elizabeth Burrows, CEO of Vermillion-Parke Community Health Center.

"Ensuring proper healthcare for children in the Vermillion-Parke region is of great importance to us," said Dr. Caroline Carney Doebbeling, medical director for MDwise, one of the organizations that helped to provide this additional funding. "By providing this additional funding, we are helping parents achieve peace of mind knowing that their children have the ability to receive necessary healthcare services through this mobile health clinic. We're excited to have the opportunity to be a part of this important initiative."

School-based health centers (SBHCs) were first created in the late 1970s in Dallas as a way to provide basic healthcare to medically underserved children and adolescents. SBHCs improve students' overall health and wellness through health screenings, education and disease prevention activities. According to the 2007 - 2008 survey conducted by the National Assembly on School-Based Health Care, there are an estimated 1,910 SBHCs nationwide, and 34 in Indiana alone.

The Vermillion-Parke School-Based Health Center is being made possible through collaboration between MDwise Hoosier Alliance, Union Hospital Health Group and Union Hospital Clinton.

6.1.9 Medical Records

1. Describe your process for transmitting and storing medical data, including the use of technology and controls to ensure confidentiality of, and access to, medical records.

AmeriHealth Caritas has policies, procedures and contractual requirements for participating provider medical records content and documentation that are in compliance with the provisions of Iowa Admin. Code 441 Chapter 79.3. Our policies and procedures are communicated to network providers in the provider manual, and reinforced during initial orientation site visits. Our provider manual includes the following requirements related to maintaining complete, accurate and secure patient medical records.

Medical records of network providers are to be maintained in a manner that is current, detailed, organized and permits for effective and confidential patient care and quality review. Provider offices are to have an organized medical record filing system that facilitates access, availability, confidentiality and organization of records at all times.

AmeriHealth Caritas Iowa providers are required by Contract to make medical records accessible to the Iowa DHS, the Iowa Department of Health (DOH), the United States Department of Health and Human Services (HHS), CMS and/or the Office of the Inspector General (OIG), and their respective designees, to conduct fraud, abuse, waste and/or quality improvement activities.

Providers must follow the medical record standards outlined below, for each member's medical record, as appropriate:

- Elements in the medical record are organized in a consistent manner and the records must be kept secure.
- Patient's name or identification number is on each page of record.
- All entries are dated and legible.
- All entries are initialed or signed by the author.
- Personal and biographical data are included in the record.
- Current and past medical history and age-appropriate physical exam are documented and include serious accidents, operations and illnesses.
- Allergies and adverse reactions are prominently listed or noted as "none" or "NKA."
- Information regarding personal habits, such as smoking and history of alcohol use and substance abuse (or lack thereof), is recorded when pertinent to proposed care and/or risk screening.
- An updated problem list is maintained.

- There is documentation of discussions of a living will or advance directives for each member.
- Patient's chief complaint or purpose for visit is clearly documented.
- Clinical assessment and/or physical findings are recorded.
- Appropriate working diagnoses or medical impressions are recorded.
- Plans of action/treatment are consistent with diagnosis.
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Follow-up instructions and time frame for follow-up or the next visit are recorded, as appropriate.
- Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the practitioner and updated, as needed.
- Healthcare education provided to patients, family members or designated caregivers is noted in the record and periodically updated, as appropriate.
- Screening and preventive care practices are in accordance with the health plan's Preventive Health Guidelines.
- An immunization record is up to date (for members 21 years and under) or an appropriate history has been made in the medical record (for adults).
- Requests for consultations are documented in writing and are consistent with clinical assessment/physical findings.
- Laboratory and other studies ordered, as appropriate, are documented in writing.
- Laboratory and diagnostic reports reflect practitioner review, documented in writing.
- Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented in writing.
- There is written evidence of continuity and coordination of care between primary and specialty care practitioners or other providers.

Generating and securely transmitting HIPAA-compliant files

AmeriHealth Caritas understands that member medical data is also shared with the health plan for many healthcare operational processes. As such, AmeriHealth Caritas securely exchanges inbound and outbound HIPAA-compliant files and other health information data through secure file transfer protocols (SFTP) or secure virtual private networks (VPNs) with Medicaid entities in 13 states for more than 3 million active members. This includes the following ASCX12N transaction and response files.

- Batch transaction types:
 - 820 Premium payment.
 - 834 Benefit enrollment and maintenance.
 - 835 Healthcare claim payment/advice.
 - 837I Healthcare claims (institutional).
 - 837P Healthcare claims (professional).

- 837D Healthcare claim (dental).
- 277CA Healthcare claims acknowledgment.
- Online transaction types.
 - 270/271 Healthcare eligibility benefit inquiry and response.
 - 276/277 Healthcare claim status and request and response.
 - 278/278 Services review inquiry.
 - 278/278 review response.

AmeriHealth Caritas Iowa will be ready to support these transactions.

AmeriHealth Caritas uses IBM Standards Processing Engine (SPE) and IBM Websphere Transformation Extender (WTX) to validate and compliance check incoming and outgoing EDI X12 transaction sets up to WEDI/SNIP level 6. SPE enables us to:

- Process increasing volumes and regulatory complexity associated with U.S. healthcare messaging.
- Build healthcare solutions for HIPAA, health insurance exchanges and reporting requirements.
- Apply ready-to-execute templates and compliance validation for ASC X12N transaction sets.
- Transform inbound data from any format to ASC X12N formats and transform outbound data from ASCX 12N formats to any format leveraging WTX.

Applications that process data and generate transaction files are built to comply with all HIPAA-based standard code sets, including:

- Logical Observation Identifier Names and Codes (LOINC).
- Health Care Financing Administration Common Procedural Coding System (HCPCS).
- Home Infusion EDI Coalition (HEIC) Product Codes.
- National Drug Code (NDC).
- National Council for Prescription Drug Programs (NCPDP).
- International Classification of Diseases (ICD-9 and ICD-10).
- American Dental Association Current Dental Terminology (CDT-4).
- Diagnosis Related Group (DRG).
- Claim Adjustment Reason Codes.
- Remittance Remarks Codes.

AmeriHealth Caritas Iowa will work with Iowa State representatives during the implementation and readiness phase to incorporate any Iowa-specific code sets into our systems and processes.

Storage

Electronic records are retained on AmeriHealth Caritas' computer systems for 10 years. Thereafter, the electronic record in question is retained in magnetic media and stored off-site for the balance of the applicable retention period, in accordance with the Infrastructure Delivery Back-Up Policy, Policy No. 144.007. In accordance with 18 U.S.C. §1519, no records subject to a suspension of retention schedule shall be altered, mutilated, destroyed, concealed, covered up or falsified in any way.

Technology controls

AmeriHealth Caritas Iowa will leverage the information systems used by AmeriHealth Caritas to support the Iowa Contract. Our information system successfully maintains and protects electronic protected health information (EPHI) so it can only be accessed by authorized people and processes, is not inappropriately altered or destroyed, and is available when needed. Access to our data is restricted through administrative controls (identity management), technical protections (backups, encryption and blocking unauthorized access), and physical safeguards (hardware protections and intrusion).

Our systems fully comply with both the HIPAA Privacy and Security Rules, and our DMZ topology provides additional security by separating public Internet connectivity from private business partners' connectivity. The Internet-facing DMZ supports secured FTP connections, including SFTP, FTPS, HTTPS/S, SCP2 and FIPS 140-2 validated cryptography.

AmeriHealth Caritas is also compliant with the Operating Rules established in the Patient Protection and Affordable Care Act for Eligibility and Claim Status (Phase 1) as well as EFTs and electronic remittance advices (ERAs) (Phase 2). Subcontractors who interact with EPHI or personally identifiable information (PII) are required to maintain the same levels of compliance. AmeriHealth Caritas secured the services of a nationally recognized consulting firm in September 2014 to assess whether AmeriHealth Caritas was in full compliance with all electronic transactions impacted by the most recent Operating Rules. Written attestation of the results can be provided upon request. AmeriHealth Caritas Iowa will maintain compliance with any new HIPAA standards to protect the privacy and identities of Iowa residents.

Safeguarding systems through access and identity management

AmeriHealth Caritas Iowa's access controls will be built on AmeriHealth Caritas' comprehensive Information Security policies. AmeriHealth Caritas protects all confidential information, including PHI and PII, through a layered Access Management program managed by our dedicated Identity Management team. A layered security approach provides a greater level of protection by eliminating the possibility that defeating a single control would provide unauthorized access to confidential information. The Information Security team maintains an extensive suite of policies, procedures, and processes to protect our Members' information, all of which center on the minimum-necessary rule and are reviewed regularly. Access to viewing and modifying information is restricted to those who "need to know," and all modifications made are tracked through audit trails.

Managing role-based access profiles to support data and network integrity

The Identity Management team, overseen by the Chief Information Security Officer (CISO), reviews and monitors all access authorization requests. Each request must detail the justification for access and include management approval. Access profiles are reviewed at least annually by a combination of Information Security, Internal Audit and Corporate Compliance teams. Information Security disables or deletes access profiles to support network integrity depending on certain activities or statuses, such as inactivity and termination. Access is disabled and then deleted for inactive users, and immediately revoked for associates who are terminated.

All associates are trained on HIPAA compliance and the minimum necessary rule, as well as other information security topics, including phishing. AmeriHealth Caritas has also implemented an enterprise-wide User Awareness Campaign to educate employees on various information security topics each month.

Role-based access profiles will be used and managed to restrict associates and business partners to accessing the minimum necessary information needed to complete a task, keeping confidential and

protected information on a need-to-know basis and providing members with as much privacy and security as possible.

Audit trails and unauthorized modification

Associates and business partners are restricted to view-only information access unless there is a demonstrable need to modify system information. Audit trails are created in accordance with Federal, State, and Contract requirements to track modifications to system information, including the originating user/device end-point, as well as time and date stamps. AmeriHealth Caritas maintains audit trails for at least seven (7) years. Security mechanisms have been implemented to prevent overwriting and unauthorized modification of audit trails, and automated tools are used to identify suspicious activity, including intrusion attempts.

All user access is monitored 24/7/365. Technical limits on unauthorized access attempts are configured to automatically lock and alert.

Authorized representatives

AmeriHealth Caritas has established defined processes to request and provision access needs, as required, to meet the needs of our clients. Access will be provisioned based on the principal of "least privilege."

Intrusion detection and prevention

The AmeriHealth Caritas Information Security team continuously monitors public-facing entry points and devices residing on the AmeriHealth Caritas network. A robust combination of monitoring and intervention technologies are used to secure the network, including Orion's NetFlow Traffic Analyzer, which captures flow data from continuous streams of network traffic and quantifies exactly how the corporate network is being used, by whom and for what purpose. Other technologies used include:

- **Intrusion detection system (IDS)** — Inspects all network traffic to detect and report suspicious activity.
- **Intrusion prevention system (IPS)** — Inspects all network traffic and takes immediate action if malicious activity is detected.
- **Websense** — Enforces Internet access allow/deny lists to reduce exposure to Web threats.
- **LogRhythm** — Security Information and Event Management (SIEM) software leveraged to correlate logs across security, network and application devices enabling detection of more sophisticated security threats.
- **Aladdin MobilePASS** — Our two-factor authentication solution that leverages Cisco security appliances. Two-factor authentication combines both something you have (a secure code on a device that changes once per minute) with something you know (a hard-guessable password) to ensure secure external access to the AmeriHealth Caritas network.
- **Symantec data loss prevention (DLP)** — A tool that monitors data patterns and keywords, as well as diagnostic algorithms to detect PHI or PII at risk of being sent through an unsecured connection. Users are instead directed to a secure email server to ensure data is protected.

Authentication of access profiles is handled by Aladdin, our two (2)-factor authentication solution, leveraging Cisco security appliances. This model ensures continued support for external access to the AmeriHealth Caritas network.

We also leverage a data loss prevention tool that monitors data patterns and keywords, as well as diagnostic algorithms to detect PHI and PII that is at risk of being sent through an unsecured connection. Users are instead directed to a secure email server to ensure data are protected.

Alerts are immediately sent to key personnel when there is an unexpected change to an environment and/or logical configuration within our networks so they can begin investigating and mitigating the potential threat. In addition to alerting key personnel, our systems automatically react to anomalous or malicious network traffic by blocking the suspicious activity.

All new Internet-facing applications undergo both code review and penetration testing prior to deployment. Existing Internet-facing applications are periodically code-reviewed and penetration-tested.

6.1.10 Availability of Services

1. Describe your plans to ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid members.

Office hours and appointment availability standards

Participating providers must offer hours of operation that are equal to or greater than the hours of operation offered to any other patient under commercial or any other insurance carrier. To ensure adherence to the appointment availability standards as defined below, per CMS and Iowa requirements, AmeriHealth Caritas Iowa will routinely monitor providers against these standards through the initial and annual site visit reviews and member complaints.

Appointment availability and access standards are expressed to providers via the Provider Manual, during new provider orientation and through regular site visits. Compliance with these standards is monitored regularly for PCPs, specialists, hospitals and ancillary providers through an annual survey conducted by a third-party entity. Gaps are identified through provider site visits, member grievances, interdepartmental communication and regular “mystery shopper” surveys. Appointment availability issues are handled in an expedient manner with direct communication with respective providers, related to findings and contractual requirements. Appointment no-shows and late arrivals can result in providers having limited appointment availability. AmeriHealth Caritas Iowa helps to reduce these occurrences by assisting provider offices with in-office scheduling and reminder calls to our members.

AmeriHealth Caritas Iowa will ensure that network providers have an appointment system for medically necessary covered benefits and services and/or expanded benefits that is in accordance with prevailing medical community standards as specified below:

- Routine care: within six (6) weeks of the member request.
- Non-urgent sick care: same day or within 72 hours of the member request.
- Urgent care: same day or within 24 hours of the member request.
- Emergent care: immediately upon member presentation at the service delivery site.
- Maternity care:
 - First trimester: within 14 days of the request.
 - Second trimester: within seven (7) days of the request.

- Third trimester: within three (3) days of the request.
- High risk: within three (3) days of identification of high risk or immediately for an emergent situation.
- To offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid fee-for-service if the provider serves only Medicaid members.
- To be available 24 hours a day, seven (7) days a week, when medically necessary.

Figure 6.1.10-A: General appointment availability

Provider type	Appointment type	Availability standards
PCP	Emergency care	24 hours per day, seven (7) days per week
	Urgent, symptomatic care	Same day, or within one (1) calendar day
	Non-urgent, symptomatic care	Within two (2) days
	Non-symptomatic (well or preventive) care	Within one (1) week to 30 calendar days
High-volume specialists (cardiologist, oncologist, ophthalmologists, orthopedic surgeons, general surgeons, pulmonologists, otolaryngologists, gastroenterologists and specialists in PH and rehabilitation)	Routine	Within 30 calendar days

Figure 6.1.10-B: Behavioral health appointment availability

Provider type	Appointment type	Availability standards
BH providers	Emergency	Within 15 minutes of presenting
	Mobile crisis	Within one (1) hour
	Urgent	Within one (1) hour of presentation or 24 hours after phone contact
	Persistent symptoms	48 hours
	Initial behavioral Health Intake Assessment	Within 14 calendar days of the request or 10 working days of the request
	Routine BH services (in follow-up to intake assessment and upon determination)	Within 14 to 28 calendar days of the request
	Substance abuse and pregnancy	Within 48 hours of seeking care

Provider type	Appointment type	Availability standards
	Chemical dependency assessment/intravenous drug users	Within 14 calendar days of the request, or 120 days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made
	Follow-up to inpatient care	Within seven (7) calendar days of discharge

Access to after-hours care/on-call requirements

Members must have access to quality, comprehensive healthcare services 24 hours a day, seven (7) days a week. We understand how after-hours access to care can mean the difference between a PCP appointment and a visit to the emergency room. Providers must have either an answering machine or an answering service for members after hours. The after-hours coverage must be accessible using the medical office's daytime phone number. The health plan will monitor access to after-hours care by conducting an annual survey of PCP offices after normal business hours.

- The answering service must forward calls to the provider or on-call provider, or instruct the member that the provider will contact the member within 30 minutes.
- When an answering machine is used after hours, the answering machine must provide the member with a process for reaching a provider after hours.
- For emergent issues, both the answering service and answering machine must direct the member to call 911 or go to the nearest emergency room.

Case study in Louisiana:

The results of our 2013 annual audit of appointment availability showed an overall PCP appointment availability compliance rate of 81.3 percent. Additionally, we audited 10 percent of the highest-volume specialty practices in the network. The compliance rate for specialists was found to be higher, at 91 percent.

To mitigate the PCP compliance rate of 81.3 percent, account executives initiated a campaign to provide education to primary care offices that encourages providers to take advantage of AmeriHealth Caritas Louisiana member outreach staff. The outreach staff educates members on no-shows and missed appointments, and provides assistance with appointment-setting, as these areas contribute to delayed appointments and accessibility issues.

Testimonial from a provider in Louisiana: "Bradford [an AmeriHealth Caritas Louisiana care connector] has been very helpful at the Goodwood location. He has always had a very welcoming demeanor. Bradford has personally assisted my clinic with two families with a history of repeat missed appointments. He called them to see what the issues were on their end in an attempt to fix the problem. He has also educated me on AmeriHealth Caritas and what the plan offers."

Manager, Pediatric Academic Clinic, Our Lady of the Lake Physician Group

AmeriHealth Caritas Iowa is committed to identifying and removing barriers to care for our members and will not execute a Contract with a provider with the intent of allowing or permitting him or her to

implement barriers to care. If AmeriHealth Caritas Iowa becomes aware of the failure of any of its existing providers to allow full access to care, we will take action to correct this within 30 calendar days. AmeriHealth Caritas Iowa understands that failure to do so is considered by DHS a breach of Contract provisions and requirements.

Ongoing monitoring activities include:

- Regularly scheduled provider office visits.
- An annual provider after-hours and availability survey.
- An annual appointment availability survey.
- Quarterly scheduled after-hours and appointment availability “Mystery Shopper” surveys.
- Member grievance and/or provider complaint investigation and resolution.
- Corrective Action Plan requirements and follow-up.

The Network Management Plan includes provisions for member grievances and/or provider complaints regarding network access and availability requirements or non-compliance with AmeriHealth Caritas Iowa policies and procedures.

Member complaints and grievances against a provider are investigated and followed up by the PNM department. The area account executive contacts the respective provider’s office and obtains the history of the event(s) expressed by the member. The account executive then logs the provider’s statement into an electronic service form that is routed to the Member Services department. The Member Services department follows up with the member to discuss the outcome of the provider outreach and finalizes the member complaint or grievance by formal letter of response.

6.1.11 Provider Compliance

1. Describe procedures for ensuring network providers comply with all access requirements and for monitoring providers for compliance.

The Network Management Plan includes provisions for member grievances and/or provider complaints regarding network access and availability requirements or noncompliance with AmeriHealth Caritas Iowa policies and procedures.

Ongoing monitoring activities include:

- Regularly scheduled provider office visits.
- An annual provider after-hours and availability survey.
- An annual appointment availability survey.
- Quarterly scheduled after-hours and appointment availability “Mystery Shopper” surveys.
- Member grievance and/or provider complaint investigation and resolution.
- Corrective Action Plan requirements and follow-up.

Member complaints and grievances against a provider are investigated and followed up by the PNM department. The area account executive contacts the respective provider’s office and obtains the history of the event(s) expressed by the member. The account executive then logs the provider’s statement into

an electronic service form that is routed to the Member Services department. The Member Service department follows up with the member to discuss the outcome of the provider outreach and finalizes the member complaint or grievance by formal letter of response.

Grievances and complaints

AmeriHealth Caritas Iowa is committed to identifying and removing barriers to care for our members and will not execute a Contract with a provider with the intent of allowing or permitting him or her to implement barriers to care. If AmeriHealth Caritas Iowa becomes aware of the failure of any of its existing providers to allow full access to care, we will take action to correct this within 30 calendar days.

AmeriHealth Caritas Iowa understands that failure to do so is considered by DHS a breach of Contract provisions and requirements.

Ensuring adherence to standards

Once we have identified that a provider is noncompliant with availability and wait-time standards, we will work aggressively and collaboratively to bring the provider back into compliance. Providers who are found to be noncompliant are reported on the QM Report with a tracking number, summary description of the issue and any follow-up or actions planned or taken by AmeriHealth Caritas Iowa. The noncompliant providers will be carried over on subsequent quarterly reports until final resolution of the issue; these provider offices are automatically included in the sample pool for the next monitoring session.

Providers who are noncompliant with any of the standards are notified of our findings and educated regarding the standards. The assigned PNM account executive is actively involved in helping the provider initiate solutions for meeting compliance. The account executives schedule another monitoring event, either an on-site visit to monitor office wait times, a “Mystery Shopper” call to check appointment availability or an after-hours call to verify ability to reach a physician. Offices found to be noncompliant in the follow-up monitoring are required to create and implement a corrective action plan. The PNM account executive monitors the implementation of any corrective action. Results of all monitoring activities are combined with phone access performance to create a global picture of access and availability. The access and availability findings are reported to the Quality of Service Committee (QSC), a subcommittee of the Quality Assessment Performance Improvement Committee (QAPIC), for review, identification of opportunities, prioritization and planning. Final results and recommendations are reviewed by the QAPIC.

Our PNM account executives 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” and to correctly identify urgent care and walk-in clinics, providing urgent/walk-in care site information to our nurse helpline, Member Services and Rapid Response departments.

We also work closely with our PCP network to identify those that offer several “unscheduled” appointments throughout the day. This process has provided our Rapid Response team an easy way to resolve immediate member appointment needs. One group is offering our members urgent care appointments by leaving each physician unscheduled slots of time available for these appointments each hour.

Case study: resolving non-adherence to after-hours performance standards

In most cases, providers are willing to become compliant once they are notified that they are not meeting a contractual requirement. The example below demonstrates how we worked with a provider office to resolve non-adherence and to support their care of our members. This example demonstrates our desire to collaborate with our providers to resolve contractual issues with the appropriate information and provider assistance.

Resolving noncompliance: provider after-hours performance

*During the course of our annual after-hours availability audit, we identified a rural provider's office with a member panel size of 400, primarily devoted to pediatric care that **did not offer an option for patients to contact them after regular business hours**. This provider was not in compliance with access to care standards, specifically practitioner after-hours performance.*

A site visit was held with the office and the required compliance standards were discussed. Office staff verbalized understanding of their contractual requirements and requested assistance with back-up coverage. The PNM account executive shared with the provider office existing processes and suggested recording a message that would meet the contractual requirements. The provider office updated the recording to improve access to care and support their patients. A follow-up after-hours call verified that the office had become compliant with the access standards.

2. Describe emergency/contingency plans in the event a large provider is unable to provide needed services.

Systems that assist with transitions

Continuity of care will be provided for members with open active treatment plans if a provider managing their care is unable to complete the plan of care for the members. AmeriHealth Caritas Iowa will actively work with members to identify acceptable alternative participating providers to transition their care. Through AmeriHealth Caritas Iowa's policy for continuity planning, members with open treatment plans can continue to receive services with the exiting provider (with exiting provider agreement) until such time as treatment is completed or 90 days, whichever comes first. However, if the provider is unable to complete the treatment plan for various reasons (e.g., the provider dies, moves or is sanctioned, or a natural disaster renders the provider inaccessible), AmeriHealth Caritas Iowa's contingency policies can be customized to meet the members' needs. As discussed in section 6.1.8 re: utilizing non-par providers to mitigate network shortages, AmeriHealth Caritas Iowa will keep in close contact with out-of-network providers during the member continuity period to ensure smooth delivery and payment of services. The relationship an account executive develops with the provider through this engagement often forms the foundation for a successful contractual relationship, thus mitigating gaps and strengthening our provider network.

Assisting members with provider transitions and membership supports

As soon as AmeriHealth Caritas Iowa learns that a provider is unable to deliver services, AmeriHealth Caritas Iowa's contingency plan will go into effect. The process will begin immediately. It is critical to identify members with special needs early, and to promptly begin outreach to all affected members to arrange appropriate, quality alternative healthcare services without disruption to the members or to the provider network.

AmeriHealth Caritas Iowa will convene the contingency team and create a work plan that clearly defines who is responsible for each task and the required time frame. Data are pulled to create member mailing lists, physician lists, special needs/continuation of care lists/GeoAccess maps and more, as described below:

- Identify all of the members potentially impacted by the service stoppage. Identify those members with special needs or who will have continuity of care issues for immediate outreach.

- Identify all providers and practitioners included in the service stoppage.
- Key community, legislative leaders, Iowa DHS and providers are contacted to provide progress updates, identify and mitigate vulnerabilities for the community to facilitate a smooth transition.
- We identify alternative community practitioners and providers who can immediately provide services to members displaced by the service stoppage.
- A critical component is to identify healthcare access issues caused by facility and practitioner termination through a GeoAccess to Care Survey.
- AmeriHealth Caritas Iowa develops strategies to mitigate access to care issues (e.g., recruitment of additional providers and practitioners to fill gaps in care).
- We draft member and provider notification letters and related materials and seek appropriate State approvals.
- We draft scripts for associates who will be outreaching to and receiving calls from affected members.
- We create a member retention strategy, and identify and outreach to physicians to whom members will be transitioned.

Members who contact the plan with concerns about care that has been interrupted will be assigned a care manager immediately who will assist the member with transition. Health plan-initiated member notification and outreach will begin in not less than 5 days, or as required by State. Notification strategies include:

- Letters.
- Phone calls.
- On hold messages.
- Automated (and interactive) phone calls.
- Special effort is made to contact members with special needs so that the healthcare services they receive can continue without interruption. Members with special needs receive repeated phone calls until our case managers have successfully transitioned or arranged for continuation of their care.

Alternative providers and practitioners are actively recruited by the Network Management team to ensure the termination does not have a lasting impact on access to care for our members.

Ensuring continuity of care for members through systems and policies

AmeriHealth Caritas Iowa uses out-of-network providers as needed to address gaps

If services are unavailable or cannot be performed by an in-network provider, or if transition to another provider disrupt a member's treatment plan, the PNM team makes same-day contact with out-of-network providers to begin the negotiation process, which is completed in three (3) to seven (7) days. During this time, the AmeriHealth Caritas Iowa UM department will ensure that a prior authorization is in place and claims related to services will be processed and reimbursed accordingly.

AmeriHealth Caritas Iowa may authorize ongoing care from nonparticipating providers, beyond the end date of the previous authorization or the continuity of care period, if there is not sufficient expertise or access within the regional network to provide appropriate care to the member. In those situations, a single case Contract may be negotiated, documenting the approved services, duration and payment in writing.

The Member Clinical Summary clearly communicates member needs for continuous care

AmeriHealth Caritas Iowa has a tool to assist providers who take over treatment of members who are in an ongoing course of treatment. The Member Clinical Summary will be provided to the new provider to enable him or her to quickly and easily review member history and needs. This will facilitate the member's transition between providers and support continuity of care. AmeriHealth Caritas Iowa's Member Clinical Summary provides a snapshot of the member's recent prescription history, chronic conditions, inpatient admissions, emergency room visits and office visits. The Member Clinical Summary also includes the member's demographic information, open authorizations and identified gaps in care. This clinical summary will be printed and sent to the new providers to allow for additional coordination of the member's needs. AmeriHealth Caritas Iowa's care managers and Medical Director will also be available to discuss the treatment plan with the new provider.

Member Outreach team supports members with transitions

A supplemental source of support to members transitioning to new providers is our Member Outreach team. The Member Outreach team is available to educate members on navigating the healthcare system, assist with scheduling appointments, remind members of their appointments and the importance of keeping them, and resolve barriers to care to ensure appointments are kept. This value-added service ensures that the member has an appointment conducive to the member's schedule and that the member is aware of the date and time of the appointment.

6.2 Network Development and Adequacy

1. Describe in detail your plans to develop and maintain a comprehensive provider network, including goals and tasks and the qualifications and experience of the staff members who will be responsible for meeting network development goals.

Our dedicated Network Development team features seasoned contractors and staff with more than 100 combined years of experience in healthcare management, provider contracting, provider training, recruitment, and collaboration in and with State agencies. The team will consist of a Vice President of Network Management, two (2) Directors of Network Management, two (2) Behavioral Health Contractors and a contracting team comprising four (4) contractors.

We will do three (3) key things: recruit providers, Contract with them and assist them.

- **Recruiting providers:** AmeriHealth Caritas Iowa recruits providers with consideration for the number of Medicaid members, the number and types of providers needed to serve them, and the geographic locations of providers and members. We recruit providers through multiple avenues to maintain a complete network.
- **Contracting providers:** AmeriHealth Caritas Iowa contracts providers in accordance with GeoAccess standards and develops action plans to overcome network challenges in any areas, including increased outreach, focused recruitment efforts and the execution of single case agreements as needed.
- **Assisting providers:** AmeriHealth Caritas Iowa's PNM team is a local presence that actively supports providers and members through close relationships, education and frequent on-site visits. The team bridges gaps between the provider and member, ensuring clear communication and effective service delivery.

Provider recruitment

We check with other affiliate plans in AmeriHealth Caritas to see if we have existing Contracts or relationships with any border hospitals. For Iowa, we checked with our Nebraska affiliate, Arbor Health Plan, to identify the hospitals in their network that are near the Iowa-Nebraska border.

AmeriHealth Caritas Iowa examines referral trends and pattern of care access trends (if available) to determine which hospitals are serving a large number of Iowa Medicaid members. We research the ownership of hospitals to determine whether they are corporately owned and whether we might have a national Contract with them through AmeriHealth Caritas. Large groups such as HCA, Tenet and CHS are already in affiliate health plan networks. This prompts a discussion about the best approach for incorporating local facilities through our established relationship elsewhere.

We survey:

- Current contracted rates.
- Current contact person they have a relationship with.
- Recommendations on that hospital as a network provider.
- Areas of concern or challenge with that facility.

Depending on the results of above, we determine which hospitals should be recruited, prioritizing the list according to member and access needs. Initial contact is made to those determined to best meet needs based on usage patterns and access to membership volume. We will continue to augment our network based on results of GeoAccess mapping and member need.

Steps taken to identify and recruit external providers include:

- Ongoing outreach to increase participation, to include three (3) documented attempts.
- Face-to-face provider meetings to engage key providers.
- Provider association outreach and collaboration.
- Community recommendations through the AmeriHealth Caritas Iowa Member Advisory Council (MAC).
- Physician recommendations through the AmeriHealth Caritas Iowa Quality of Clinical Care Committee.
- Physician-initiated outreach.
- Through the AmeriHealth Caritas Iowa website, a provider can submit an inquiry to register interest in contracting with AmeriHealth Caritas Iowa; a PNM account executive then contacts the provider to initiate contracting.
- Through the AmeriHealth Caritas Iowa Provider Services Call Unit, a provider can initiate account executive contracting outreach.

Statewide considerations and action steps

AmeriHealth Caritas Iowa develops strong relationships with providers who have not historically accepted Medicaid, as the willingness to accept Medicaid as a payer has proven to be a barrier in many areas of the State. Our local PNM account executives are an integral resource in encouraging provider participation in Medicaid. Account executives establish a presence with potential network providers through frequent in-office visits and attendance at trade and association events. Through these encounters, they educate providers who are unfamiliar with the program and answer questions about serving the population. They

are able to address many of the underlying reasons for reluctance to participation. Account executives explain the resources AmeriHealth Caritas Iowa offers to support providers in effectively serving our members. Our supportive strategies include efforts to educate members on the importance of preventive care and regular well-exams — but they reach beyond education and include practical steps, such as assisting members in scheduling appointments and removing barriers to keeping appointments by coordinating appointment reminders, transportation and child care.

To increase network participation, AmeriHealth Caritas Iowa also reaches out to new graduates seeking to build their practice. We participate in residency programs to reach these providers.

To ensure network adequacy, we will monitor the following standards quarterly, utilizing GeoAccess reporting for members.

PCPs (serving members 21 and older):

- Ratio: One (1) PCP*: 1,500 members (*family practice, general practice, internal medicine, OB/GYN, osteopath, clinic, FQHC, APRN or subspecialist as applicable).
- Distance: Two (2) PCPs within 30 miles of residences for 90 percent of members in an urban service area. One (1) PCP within 60 miles of residences for 90 percent of members in a non-urban service area.

Pediatric or pediatric-qualified providers (serving members through age 20):

- Ratio: One (1) pediatric PCP*: 1,000 members through age 20 (*family practice, general practice or physician who is qualified to provide pediatric services).
- Distance: Two (2) pediatric PCPs within 30 miles of residences for 90 percent of members in an urban service area. One (1) pediatric PCP within 60 miles of residences for 90 percent of members in a non-urban service area.

Obstetric providers:

- Ratio: One (1) obstetric provider: 1,000 members.
- Distance: Two (2) obstetric providers within 30 miles of residences for 90 percent of members in an urban service area. One (1) obstetric provider within 60 miles of residences for 90 percent of members in a non-urban service area.

Other high-volume specialty care providers:

- Ratio: One (1) cardiologist: 1,500 members.
- Distance: One (1) cardiologist within 60 miles or one (1) hour of travel time of residences for 90 percent of members in the service area.

- Ratio: One (1) oncologist: 1,500 members.
- Distance: One (1) oncologist within 60 miles or one (1) hour of travel time of residences for 90 percent of members in the service area.

- Ratio: One (1) ophthalmologist: 1,500 members.
- Distance: One (1) ophthalmologist within 60 miles or one (1) hour of travel time of residences for 90 percent of members in the service area.

- Ratio: One (1) orthopedic surgeon: 1,500 members.
- Distance: One (1) orthopedic surgeon within 60 miles or one (1) hour of travel time of residences for 90 percent of members in the service area.

- Ratio: One (1) general surgery provider: 1,500 members.
- Distance: One (1) general surgery provider within 60 miles or one (1) hour of travel time of residences for 90 percent of members in the service area.

- Ratio: One (1) gastroenterologist: 1,500 members.
- Distance: One (1) gastroenterologist within 60 miles or one (1) hour of travel time of residences for 90 percent of members in the service area.

- Ratio: One (1) pulmonologist: 1,500 members.
- DISTANCE: One (1) pulmonologist within 60 miles or one (1) hour of travel time of residences for 90 percent of members in the service area.

- Ratio: One (1) otolaryngologist: 1,500 members.
- Distance: One (1) otolaryngologist within 60 miles or one (1) hour of travel time of residences for 90 percent of members in the service area.

- Ratio: One (1) physical medicine/rehabilitation provider: 1,500 members.
- Distance: One (1) physical medicine/rehabilitation provider within 60 miles or one (1) hour of travel time of residences for 90 percent of members in the service area.

Hospitals:

- One (1) hospital provider within 10 miles of residences for 90 percent of members in urban and non-urban service areas.

BH service sites:

- One (1) BH service site within 10 miles of residences for 90 percent of members in urban service areas.
- One (1) BH service site within 25 miles of residences for 90 percent of members in non-urban service areas.

Chemical dependency treatment facilities:

- One (1) chemical dependency treatment facility within 10 miles of residences for 90 percent of members in urban service areas. One (1) chemical dependency treatment facility within 25 miles of residences for 90 percent of members in non-urban service areas.

Pharmacy providers:

- One (1) pharmacy within 10 miles of residences for 90 percent of members in urban service areas. One (1) pharmacy within 25 miles of residences for 90 percent of members in non-urban service areas.

LTSS providers:

- Skilled nursing facilities (SNFs): Sufficient in numbers to allow 90 percent of members to move into an SNF within 20 miles of their location of choice within the service area.
- Residential services: Sufficient in numbers to allow 90 percent of members residential placement within one (1) week of referral/request and to have the choice of three (3) residential options within at least two (2) residential licensed categories in a 10-mile radius for urban service areas and a 25-mile radius for non-urban service areas.
- The percentage of specialty designations for residential service providers must be a proportionate to the number of members with diagnoses that would require specialty placement (i.e., BH, dementia or developmental disability).
- In-home personal care: Sufficient in numbers to allow 90 percent of members to receive services within five (5) business days of referral and to allow members a choice between at least two (2) different providers for each of the services they qualify to receive.
- Other LTSS providers: Sufficient in numbers to include at least two (2) of each provider type in the service area or sufficient to allow members to receive services within 10 business days of referral in the most appropriate setting.

2. Describe your strategies for provider outreach and contracting in rural areas.

We have met with the Iowa Primary Care Association on numerous occasions and have begun working with this group to help identify issues in the delivery of care in rural areas. We are discussing potential resources currently available in these counties and how we may be able to work together to enhance the number of providers and bring more services into these counties through telemedicine, satellite offices or mobile clinics. AmeriHealth Caritas Iowa is also sponsoring and attending the Heartland Rural Physician Alliance conference. Here, we look to engage rural health professionals to gain a deeper understanding of the challenges of providing quality healthcare in the rural setting. We will use learnings from our engagement with the Iowa PCA and Heartland Rural Physician Alliance to guide the development of solutions for these issues.

We will also work with the county offices of the Departments of Public Health to identify the resources and providers they rely on to deliver care. It has been our experience that many times the departments of health have networks of providers they utilize for the medical management of the patients who seek assistance through their offices.

We also work with other communities and community leaders to understand the issues they are experiencing in their counties related to healthcare. This will be a two-prong approach involving our marketing and government relations team as well as the network development team.

Overview of AmeriHealth Caritas Iowa's telemedicine solution

Developing a comprehensive telemedicine program is a top priority for AmeriHealth Caritas. For the Iowa market AmeriHealth Caritas will build a telemedicine program, to meet the unique needs of Iowa members, in collaboration with our providers, specialists and sponsors of existing telemedicine initiatives. Our goal is to develop a telemedicine program that both integrates with and enhances the current Iowa

telemedicine program. Integration into the existing infrastructure and processes will minimize the impact to providers while improving members' access to care and driving positive outcomes. AmeriHealth Caritas has met with providers and key stakeholders to better understand the provider and member needs regarding telemedicine solutions and will continue to refine our telemedicine offering through implementation of the Iowa High Quality Healthcare Initiative.

We have met with the University of Iowa and plan to leverage their expertise, technology and extensive network of specialists, providers and health partners to implement a robust telemedicine solution. We recognize the success and value that University of Iowa brings to the Iowa High Quality Healthcare Initiative and will work with them to integrate with their telemedicine solution for our members and providers. AmeriHealth Caritas will also work with other telemedicine sponsors in Iowa (e.g., Mercy Health Network) to fully integrate and leverage their offerings, including infrastructure built for telepsychiatry services.

AmeriHealth Caritas is also developing innovative telemedicine services that improve access to care, reduce costs for members and providers, and improve outcomes. Through this offering we can provide enhanced services and innovative approaches to telemedicine, which further extends access to care for members and promotes collaboration among providers. These enhanced services would augment (not duplicate) the current capabilities available through existing telemedicine providers and would be developed in conjunction with them. For more detail on AmeriHealth Caritas Iowa's telemedicine solution, please refer to section 13.1.

3. Detail any way in which you propose to limit members to in-network providers.

Members will be assigned to in network PCPs. Our use of the PCP model has assured adequate care and better management of the overall health of our members. We will only limit members to in-network providers as we wish to partner with providers who understand the importance of well care and its impact on HEDIS and quality outcomes. Our network development team will create a network to surround the member and the primary care offices with sufficient numbers of facilities, hospitals, ancillary services and specialty care to create a network that will be adequate enough to prevent the need for out-of-network services. In the event it is necessary, we will use a single case agreement with providers we identify to provide care for our membership when an in-network provider is unavailable.

4. Describe your plans to ensure providers do not balance bill its members and plans to work with members to help resolve billing issues.

We provide extensive orientation beyond the contracting phase to address billing procedures. Our contracts speak specifically to the issue regarding balance billing the members. We also reinforce this during the initial orientation and subsequent office visits with the providers. If a member has any issues with bills, our Member Services team will work with the member to identify appropriate responsibilities of the member to pay a claim. If it is discovered a member has been inappropriately billed it will prompt a visit by the PNM team with the offending provider. Many times it has been an oversight by the office staff and, once we identify the issue, the provider quickly resolves the current bill and any future billings as well.

6.3 Requirements by Provider Type

1. Indicate if you will use a primary care provider (PCP) model of care delivery

AmeriHealth Caritas Iowa will use a PCP model of care and attach members to specific PCPs via provider selection by the member, where other family members are assigned, current provider relationship established in AmeriHealth Caritas Iowa records, and through auto-assignment based on geographic location.

2. If a PCP model will be utilized, describe the following:

A. Physician types eligible to serve as a PCP.

The following specialties are eligible to serve as PCPs/medical homes for AmeriHealth Caritas Iowa members:

- Family practice (FP).
- Internal medicine (IM).
- Pediatrician (Ped).
- General practice (GP).
- In addition, female members typically have direct access to obstetricians/gynecologists (OB/GYNs).

B. Any panel size limits or requirements.

AmeriHealth Caritas Iowa does not anticipate the need for panel size limits or requirements for PCPs.

C. Proposed policies and procedures to link members to PCPs.

Connecting members to PCPs/medical homes

AmeriHealth Caritas believes and evidence supports that a holistic approach to care will serve as a catalyst for improving quality and reducing utilization and related costs. As of January 1, 2015, 24 percent of AmeriHealth Caritas members were attributed to a recognized medical home. Our goal is to have 30 percent of membership across our markets connected to a certified medical home by 2016. Recent studies suggest that full medical home transformation and longevity with the same medical home yield the most positive results. Respondents in a recent study by the Patient-Centered Primary Care Collaborative (PCPCC) reported favorable improvements in overall cost, utilization, quality outcomes, patient access and patient satisfaction. A recent analysis done for our Pennsylvania affiliate's PCMH pilot program shows statistically superior performance for select HEDIS rates for the NCQA/pilot group and increased E&M services relative to the control group. Additional results show a favorable trend and relativities for ambulatory care sensitive conditions and potentially preventable readmissions, which should result in a decrease in related costs.

Other key factors to achieving improvements in cost and quality include a primary focus on medical home transformation rather than recognition, an on-site care coordinator and meaningful financial incentives.

Medical home practices in the AmeriHealth Caritas Iowa network will be connected to and work closely with medical and behavioral healthcare managers. Members will be best served by this fully integrated system of care that coordinates medical and behavioral health services.

AmeriHealth Caritas Iowa will provide resources to help medical home practices work with Members. We will require them to provide the following comprehensive primary care functions and will fully support them to do so.

Responsibilities of PCPs

- A PCP will be assigned as a medical home to coordinate holistic care for members and serve as a primary point of care coordination. AmeriHealth Caritas Iowa will ensure members are assigned to their preferred PCP, based on member selection, prior relationship, and cultural and linguistic appropriateness.
- A PCP will be required to provide preventive screenings, EPSDT components and initial health screenings.
- An effective medical home will serve as the member's "GPS" to guide them through a confusing and sometimes fragmented delivery system.
- Since healthcare needs and emergencies are not restricted to office operating hours, primary care practices will be required to optimize continuity and timely, 24/7 access to care.
- Through care gap reports and programs, we will empower participating primary care practices to proactively assess their patients to determine their needs and provide appropriate and timely chronic and preventive care, including medication management and review. Through coordination with our care managers, providers will develop a personalized plan of care for high-risk patients and use team-based approaches like the integration of behavioral health services into practices to meet patient needs efficiently.
- Primary care practices will be educated to engage patients and their families in decision-making in all aspects of care, including improvements in the system of care. Practices will be encouraged to integrate culturally competent self-management support and the use of decision aids for preference-sensitive conditions into usual care.
- Primary care is the first point of contact for many patients and should be at the center of the patients' experiences with medical care. Practices will work closely with all of a member's other healthcare providers, coordinating and managing care transitions, referrals and information exchange.
- The Practice Quality Improvement team will meet regularly to review data, identify opportunities for improvement, develop plans and monitor progress. Regular status meetings will be held with AmeriHealth Caritas Iowa. The PCP practice will be encouraged to participate in on-site learning collaborative sessions and webinars. The practice will also be asked to contribute at least one (1) best practice for the AmeriHealth Caritas Iowa website.

AmeriHealth Caritas Iowa will ensure that PCPs conduct initial health and screening visits for newly enrolled children and newborns. We will track evidence of screenings through:

- Member Clinical Summary.
- Care Gaps Report.
- HEDIS measures.
- "Mystery shopper" calls.
- Administrative reports.

Supporting medical homes and members:

AmeriHealth Caritas Iowa understands provider offices sometimes face challenges connecting members to appropriate providers for all of their care needs. For example, during a PH examination, a provider may discover that a member is in need of BH or other services. To facilitate this process, we promote our Let Us Know program, which encourages providers to contact our Rapid Response team for assistance with connecting members to the right care to meet their needs. After the member's initial needs are coordinated, the Rapid Response team will connect the member to indicated services and care. The PCP can also ask the Rapid Response team to follow up with the member when treatment changes have been made, such as starting a new medication or changing a medication dose.

Through the “Let Us Know” referral form, providers will be able to send information related to the needs of a member directly to the AmeriHealth Caritas Iowa Rapid Response team. The form allows providers to enter member information, provider information and interventions requested, as well as any additional information. The Let Us Know form will be easily accessible to PCPs through our AmeriHealth Caritas Iowa website. In addition to website access of the form, AmeriHealth Caritas Iowa providers will receive copies of the form in their Welcome Packet and can request copies from their PNM account executive as needed. AmeriHealth Caritas Iowa PNM account executives will reinforce the use of the Let us Know program with PCP offices at each visit.

The story below demonstrates the Let Us Know program at work in an affiliate plan:

A Keystone First provider needed help in getting a member to schedule an appointment to manage her diabetes. According to the provider's office, the member had not returned any outreach on their part to schedule an appointment, nor had she had her blood sugar checked in nearly two (2) years. Through the Let Us Know program, the member was contacted by a health plan care connector.

Through the phone call, the care connector learned two (2) important things: The member had wanted to find a new PCP, and she needed a glucometer — a device used by diabetes patients to measure their blood sugar. The care connector explained to the member that the best way to obtain the glucometer was to meet with her current PCP before changing to a new provider. She agreed. Her appointment was made and kept. She saw her PCP, scheduled another appointment to have her blood work done and received her glucometer.

Partnering with PCPs to ensure members have access to a medical home:

AmeriHealth Caritas Iowa would be pleased to partner with the Iowa Department of Community Health and local PCPs to offer access to quality care coordinated across the healthcare system through the PCMH and/or medical home model. The medical home model of care is our foundation for a value-based strategy of partnering with Iowa providers. We advocate and promote this whole-person approach to care, led by the primary care team, to effect:

- Improved clinical outcomes.
- Better management of utilization and costs.
- Increased member and family engagement in care.
- Personalized, continuing provider-member relationships.
- Whole-person orientation, including BH.
- Coordinated, integrated care for PH and BH across the healthcare delivery system.

- Technological support for providers for population health management, as well as individual member care.
- Enhanced access.
- Payment that rewards performance and added value.

An ongoing effort to build effective medical home partnerships is also an essential element in AmeriHealth Caritas' commitment to deliver better health outcomes. We recognize that transformation to an effective medical model of care requires time, resources and expertise that have not always been readily available to some practices. We offer the following resources to help providers achieve, maintain and enhance their medical home status:

- **Initial support:** AmeriHealth Caritas Iowa is committed to collaborating with providers by sharing best practices, real-world examples, learning opportunities and a roadmap tool with step-by-step guidance to assist in transformation and performance improvement.
- **Ongoing growth:** To encourage continued improvement, AmeriHealth Caritas offers providers frequent education and training on the PCMH program and the progress of the practice toward meeting goals.

In addition, data transparency through an online portal allows providers secure and easy access to:

- **Provider Toolbox:** Our Web-based PCMH microsite gives providers access to our free, online Provider Toolbox of PCMH resources to ensure convenient, flexible, anytime support. The Provider Toolbox includes member engagement materials, topical resources, networking information and opportunities, and community resources, as well as education and implementation tools for providers and their staff. These resources assist with transformation, recognition and ongoing performance improvement.
- Key performance data, organized in a dashboard format and including applicable measures.
- Member gaps in care reporting that uses authorization, medical and pharmacy data to identify when needed services are missing or due.

Ongoing support to foster optimal performance and best practices through continuous quality improvement

AmeriHealth Caritas provides resources to assist our providers with member engagement and care coordination, including BH and community resources. These include our Let Us Know program, Rapid Response teams, Integrated Care Management teams and Community Outreach teams.

AmeriHealth Caritas recognizes the importance of integration of physician and BH services, as well as BH homes for members. Our plan is to engage providers of these services for Iowa in assisting them to become medical and health homes.

Our model focuses on ensuring practices have implemented infrastructure and process changes with an ultimate goal of improved and sustainable outcomes. This continually evolving process will focus on the attributes of the medical home model of care that drive change and will combine those with related financial incentives, actionable data and practice support for transformation. Core attributes, which have been referenced in emerging market literature, include:

- Care coordination.
- Risk-stratified care management.
- Improved access to care.

- Patient and caregiver engagement.
- Ongoing measurement and improvement activities.

The Iowa Primary Care Association (PCA) cites medical home transformation as a top priority and is interested in partnering with AmeriHealth Caritas Iowa to continue expansion of this model of care. Based on our shared priorities, we will investigate positive collaborations to foster maximum provider engagement in medical home transformation and continued performance improvement.

3. If a PCP model is not proposed, describe methods to ensure compliance with 42 CFR 438.208 as described in Section 6.3.1.

A PCP model is proposed.

4. Describe your plan for providing a sufficient network of all provider types outlined in Section 6.3, including timelines and tasks.

Initiate the CPNM new market — business implementation plan’s activities for network build	March 2015
Develop a portfolio of value-based programs and incentives, including accountable care and PCMH models	March 2015
Identify potential strategic partners. Prioritize meetings with these key provider systems and involve marketing team as well.	April 2015
Create initial mailing of LOIs/Contracts	April 2015
Meet with key hospital systems (e.g., Trinity and UnityPoint)	April 2015
Establish contacts with key FQHC and RHC provider groups	May 2015
Identify Indian Health Clinics and develop outreach to these providers	May 2015
Identify LTSS and BH providers and develop outreach to these providers	June 2015
Provider outreach to Contract mailing recipients	June through November 2015
Complete contracting and loading of provider data	November 1, 2015
Create OLPD (online provider) and paper directories, first draft	November 15, 2015

Exhibit 6.3-A: New market activities for provider network

- We will target hospitals, PCP/FQHC/RHC and specialists, focusing on any services included in the hospital contract to include inpatient acute and BH beds, OP services, ancillary services and other services covered by the hospital legal entity. This work will include collecting all provider data required to credential and onboard the provider.
- AmeriHealth Caritas Iowa will focus on DME, freestanding OP/SP/OT therapy clinics, LTSS providers and free-standing BH facilities and practitioners including psychiatrists, psychologists and social workers.

- AmeriHealth Caritas Iowa will identify ACOs and schedule meetings to discuss potential working relationships, collaborations and reimbursement structures.

For BH providers, we will engage the 15 Regional Division of Mental Health and Disability Services (MHDS) CEOs in the development of a sufficient network, and engage the group for their insight into delivery of appropriate services. For additional assistance, we will also engage the regional disability coordinators to establish relationships and warm hand-off to the Medical Management team of AmeriHealth Caritas Iowa. This will assist us in the development of services for the identified population in the RFP.

5. Describe your plans for meeting the requirements regarding Indian Healthcare Providers.

We have identified the following IHS clinics in and around Iowa that could support the care of our members. We will outreach to these providers to understand their current treatment models and care management tools. These meetings reveal current treatment programs, levels of care and resources we may be able to utilize with the care of our members. We are outreaching to the facilities listed below and arranging meetings with the clinic leadership and clinical team.

We will treat IHS providers as in-network, regardless of whether they sign a contract with us. This will ensure that adequate clinics are readily available and allow appropriate access for those members who seek treatment in the IHS clinics. In Nebraska, we have identified that many of the IHS clinics lack resources and require our administrative assistance to help them understand billing processes and the resources available to care for the member. We have implemented quarterly meetings with the IHS clinics in Nebraska, and have developed positive working relationships and partnerships to ensure we meet the needs of the population.

As we have done in Nebraska, we will work with IHS clinics serving our Iowa members to ensure full partnerships by establishing regular joint operating meetings with the clinics to discuss business processes, clinical programs and general issues regarding the care and management of our members. These meetings will be held at least quarterly and will involve network management staff, medical management and operations staff and include reports regarding the claims payment history, innovative payment methodologies based on quality and HEDIS measures and membership lists.

To date, we have relationships with the following IHS clinics in and around Nebraska, and have begun identifying and outreaching to IHS clinics in Iowa.

- Winnebago Hospital.
- Carl T. Curtis Health Education Center.
- Fred Leroy Health and Wellness.
- Santee Health Center.
- Ponca Hills Health & Wellness Center.

Additional IHS clinics to serve Iowa members:

Meskwaki Health Center

1646 305th Street
Tama, IA 52339
(641) 484-4094

Winnebago Hospital

U.S. Highway 77-75
Winnebago, NE 68071
Phone: (402) 878-2231

Indian Hills Clinic

2600 Outer Drive N.
Sioux City, IA 51104
(712) 239-3300

Siouxland Community Health Center

1021 Nebraska Street
Sioux City, IA 51105
(712) 252-2477

Sioux Falls Urban Indian Clinic

711 N. Lake Avenue
Sioux Falls, SD 57104
Phone: (605) 339-0420

This page intentionally left blank.