AmeriHealth Caritas
Iowa

200 Stevens Drive
Philadelphia, PA 19113-1570

May 22, 2015

Carrie Lindgren
Issuing Officer
Iowa Department of Human Services
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114

RE: Iowa High Quality Healthcare Initiative RFP# MED-16-009

Dear Ms. Lindgren,

AmeriHealth Caritas Iowa, Inc. is pleased to submit its response to the RFP for the Iowa High Quality Healthcare Initiative. We recognize that you are taking a bold and ambitious step to improve the health and wellness of the Medicaid population of Iowa and we would be honored to be selected as your partner in ensuring that Iowa Medicaid beneficiaries are not just "healthier" but the "healthiest. "

We believe that AmeriHealth Caritas Iowa is the right partner to help you achieve the objectives set out in this transformational program and deliver the Next Generation of Healthcare. As part of our transmittal letter, we have included an Executive Summary that highlights our capabilities and approach to caring for the whole person through a fully integrated model of care and services and the value we will bring as your partner in improving the overall health and wellness of Iowans.

Medicaid managed care is more than a business to us. It is an ***opportunity*** to serve the least advantaged and make a difference in people's lives. Based upon a mission started thirty-two years ago by a small, community health plan focused on serving the poor, today it is a commitment driven forward by a combination of proven expertise and a focus on holistic care and service. We encourage you to reach out to our references, which include leaders from state Medicaid agencies that have undergone similar transformations, leading provider organizations and other key stakeholders, some of whom are also quoted throughout this letter and our proposal, to better understand first-hand what it is like to partner with AmeriHealth Caritas.

The individual who is authorized to respond to the Department about the confidential nature of certain of the information contained in this proposal is:

Robert Gilman, Esq.
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In submitting this proposal, AmeriHealth Caritas Iowa attests as follows:

- AmeriHealth Caritas Iowa will furnish the services required by Enrollees as promptly as is appropriate, and such services will meet the Department's quality standards.
- AmeriHealth Caritas Iowa confirms that the capitation rates provided will cover all services required by Enrollees, and that AmeriHealth Caritas Iowa will meet the Medical Loss Ratio requirements specified by the Department, as set forth in the Scope of Work.
- AmeriHealth Caritas Iowa acknowledges that liquidated damages may be imposed for our failure to perform under the RFP and any resulting contract with the Department.
- AmeriHealth Caritas Iowa further acknowledges that our contract with the Department will be performance-based, and that accordingly, incentives and disincentives may apply to our performance.

We share your deep commitment to accessible and affordable quality healthcare for every person in Iowa and look forward to the opportunity of further collaborating with the State and our provider and community partners to bridge the gaps in healthcare access, innovation and technology for Iowa Medicaid members.

We would be honored and excited to be a long-term partner with the State of Iowa!

Sincerely,

Paul A. Tufano
Chairman and Chief Executive Officer
AmeriHealth Caritas Family of Companies

Russell Gianforcaro
President
AmeriHealth Caritas Iowa, Inc.

Enclosure: Executive Summary

Executive Summary

AmeriHealth Caritas Will Improve the Lives of Iowa Medicaid Members

AmeriHealth Caritas has been improving the lives of Medicaid members for more than 30 years. Today, we touch the lives of more than 6.6 million individuals in 16 states and the District of Columbia. Our comprehensive, person-centered approach to care is built on a philosophy of compassion and driven by a focus on outcomes. We deliver care that honors the uniqueness of each member while removing barriers to care so that individuals can access the services they need to get well and stay well. Our community-based approach reaches members where they live, empowering them to make lasting changes that improve their health while reducing strains on the healthcare system.

There are several unique circumstances the State is confronting in the Iowa High Quality Healthcare Initiative. Medicaid managed care is new to Iowa, and unlike many other Medicaid managed care programs, will provide comprehensive services to a broad population including TANF/CHIP members and those with complex needs (e.g., long-term care). Iowa also has a large number of Medicaid members located in rural communities that have significant challenges with access to primary, specialty, emergency and behavioral healthcare. Close communication and engagement with members, providers and advocates will be required to ensure a smooth transition and excellent member experience as well as offering new ways of accessing care.

We recognize the State has a number of initiatives underway to improve the health of Iowans including the Chronic Condition Health Homes, Integrated Health Homes for members with severe and persistent mental illness, the State Innovation Model (SIM) for accountable care organization (ACO) development and the Healthiest State Initiative. AmeriHealth Caritas understands the value of these initiatives and recognizes that our tools and programs will complement and help accelerate State initiatives (e.g., enhancing enrollment in Health Homes). We have collaborated on these types of programs in our existing markets and are prepared to do the same in Iowa. In addition, we are pleased to be a sponsor of the 2015 Healthiest State Initiative Annual Meeting in June. We continually strive to engage members in healthy activities and together we will make Iowa the “Healthiest State.”

Delivering the Next Generation of Healthcare

AmeriHealth Caritas has a long and successful history of partnering with states to address their unique and diverse needs and challenges. Our integrated suite of services will exceed the needs of Iowa Medicaid members while also reducing the administrative burden for the State and lowering the costs for healthcare management and delivery. We have built relationships in Iowa with providers, provider associations and community organizations and have worked diligently to better understand the market and the goals of the Department of Human Services (DHS) to prepare for providing Medicaid managed care services in Iowa. We have also established a subsidiary specific to Iowa. AmeriHealth Caritas Iowa will invest in the Iowa marketplace, creating new jobs, facilities and programs that will contribute to the local community and overall economy.

We will bring new ways of engaging members, empowering them with information and providing access to care. Our soon to be announced **strategic partnership with Theranos** will align new technology in laboratory testing with our person-centered approach to proactively inform care plans.

Our investment in Iowa continues with the development of **three, state-of-the-art, Community Wellness Centers, potentially located in Des Moines Cedar Rapids and Sioux City**. We are proud to announce these Community Wellness Centers, which support our mission of helping members get care, stay well and build healthy communities. The Community Wellness Centers will be a resource hub in the community and provide space for new member orientations, community meetings, wellness screenings, care management, doctor appointment scheduling, health education and coordinating social services. In time, these Community Wellness Centers will become an integral part of the fabric of Iowa healthcare and allow the member to strengthen his or her health by providing them with additional tools.

Exhibit 1: AmeriHealth Caritas is Bringing Communities Together in Wellness

AmeriHealth Caritas' work is focused on improving the healthcare of the communities we serve. Our success in these communities is reflected in our ability to understand and build programs that address those needs. Our approach to removing barriers to healthcare and services is a top priority for our family of companies.

Key components of our Next Generation of Healthcare approach are:

- **Person-centered approach to care** — We understand that care is individual and needs are unique. Our care managers work closely with our members to create holistic care plans and adapt interventions to fit our members' health needs, life circumstances and what they value most. Our Integrated Healthcare Management (IHM) model is designed to address not only the physical health needs of our members, but also the broader range of behavioral health, pharmacy, long-term services, social supports and other healthcare needs that influence the member's current and future health. We use a **"no wrong door"** approach, enabling members to access our services, providers and support through traditional avenues (phone calls), as well as advanced technology means (texting, telehealth) and community-based

encounters (in-home visits, community care management, embedded support in provider offices). This person-centered approach connects members to the right care at the right time.

- **Access to care when and where it is needed with a broad network** — Access to care is a fundamental factor in improving health outcomes. While access to care is a common challenge within Medicaid programs, it is especially acute in Iowa, driven in part by limited transportation and physician shortages. By understanding member needs and meeting them wherever they are, AmeriHealth Caritas enables and empowers access to care when and where it is needed. This includes tackling barriers to access to care on multiple fronts. As we have in other markets, we plan to **contract with the major academic medical centers and children's hospitals** so that our members have access to the best clinical care and innovation. We will **deploy mobile units** in physician shortage areas for preventive care and other services, reimburse non-emergency transportation and stay costs for medically necessary services and ensure access to services with out-of-network providers as needed and without additional cost to the member. We will also have a **comprehensive telemedicine and telepsychiatry program** for Iowa, leveraging existing provider platforms and augmenting those resources with our own telehealth solutions. Our South Carolina and Pennsylvania health plans have been **rated the best Medicaid plan for access by their State Medicaid agencies** as a result of our implementation of similar initiatives and we are committed to the same proactive approach in Iowa.

- **Collaborative partnerships with the State, providers and community organizations** — AmeriHealth Caritas is committed to the communities we serve. We are driven by creating stakeholder value to improve the health of our members. We work collaboratively with State and other partners to address the challenges of the rising costs of care, limited access to care and increasing administrative complexities. **Our 30-year relationship with the Commonwealth of Pennsylvania's Medicaid agency through economic "ups and downs"** demonstrates our unparalleled commitment to our state customer partners. In Iowa, we are building a robust provider network throughout the state with priority health systems, the primary care association, Federally Qualified Health Centers (FQHC), behavioral health providers and other specialists.

- **Data-driven results and evidence-based outcomes that are aligned with broader efforts such as the Iowa SIM program** — At AmeriHealth Caritas, we measure success through the good health of our members. Using proven, data-driven identification techniques and engaging members where they live, work and go to school, we are able to reduce avoidable utilization of emergency rooms (ER), reduce care gaps and improve outcomes. Our approach relies on the collection and analysis of data to understand the issues and enact meaningful interventions and programs to support effective management of costs while improving access to care and health outcomes. Our approach is well-aligned with your SIM efforts. For example, AmeriHealth Caritas is well-positioned to adopt the 3M Value Index Score (VIS) currently used in Iowa's SIM as these same metrics are already part of our **PerformPlus®** value-based programs. We have implemented the full 3M platform in Pennsylvania, South Carolina, Louisiana, Indiana, Nebraska and the District of Columbia over the past seven years, and are able to rapidly and accurately deploy this solution, as well as the accompanying value-based programs and transparency portals, in Iowa.

Revolutionary innovations for Iowa

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. Giving our members the same healthcare experience that is available to individuals who are more advantaged reinforces this view and our approach to treat all members with dignity and respect. Everything we do and every decision we make starts with our members in mind and we are committed to investing in our members up front.

One example of how AmeriHealth Caritas partners with like-minded and innovative organizations to make quality healthcare and services accessible to every person is **our new 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. Aided by cutting-edge Theranos technology, **we are taking a 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 establishing comprehensive care plans to drive improvement in health.

If AmeriHealth Caritas Iowa 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 that our members and providers have the information they need to make the best healthcare decisions. **AmeriHealth Caritas Iowa is committing to make the up-front investment in our members starting on "day one" to provide enhanced access to testing to enable proactive dialogue with providers and subsequent comprehensive care plan development.**

We are the first Medicaid managed care organization in the nation to leverage this innovative, evidence-based and customizable solution to drive greater engagement among our members and providers. In the very near future, we expect to publicly announce our strategic partnership with Theranos and intent to bring this innovative solution to all of the markets and Medicaid members we serve.

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. Many laboratory tests are not completed because the testing process can be intimidating (fear factor). Their **revolutionary laboratory service platform** uses dramatically smaller samples than traditional laboratories, with samples collected from both capillary draws (i.e., finger stick) and traditional methods.

Results are returned much faster than industry averages, with the overwhelming majority of results reported within 24 hours of sample collection. Theranos has partnered with a leading retail pharmacy to place collection sites within retail stores, bringing easy access to Theranos' laboratory services through this nationwide pharmacy footprint. The company also provides a detailed level of transparency by publishing its test menus and prices and is committed to reducing the overall cost of care.

It is important that our members and their healthcare providers have the information they need, when they need it, to develop personal healthcare plans and make timely healthcare decisions. Removing barriers to knowledge and access to healthcare and services for those most in need is a top priority for our family of companies. **Our partnership with Theranos is aligned with our mission, consistent with our commitment to offer solutions to assist our clinical partners and supports our forward-thinking approach to developing innovative, evidence-based and customizable solutions for our members, all of which empowers our members to fully engage in their healthcare.**

Excerpted From Fortune magazine, June 30, 2014

"This is about being able to do good," Holmes says… "And it's about being able to change the healthcare system through what we believe this country does so well, which is innovation and creativity and the ability to conceive of technology that can help solve policy challenges."

"Consumerizing this health care experience is a huge element of our mission," Holmes says… "which is access to actionable information at the time it matters."

– Elizabeth Holmes, Chairman, CEO and Founder
Theranos

AmeriHealth Caritas Iowa is dedicated to providing the highest quality of care at maximum value for Iowa Medicaid members, providers and the State of Iowa. We are genuinely excited and expertly suited to partner with DHS to deliver the next generation of care and improve the overall health of the residents of Iowa. Just as we have proven through our partnerships with other states, we are ready and equipped to engage and address the financial, socio-economic and technical challenges that Iowa faces on a daily basis. **By remaining true to our mission, AmeriHealth Caritas has earned a national reputation for helping people get care, stay well and build healthy communities.**

About AmeriHealth Caritas

For more than 30 years, AmeriHealth Caritas has been helping people access the care and services they need to live healthier lives. From our roots as a small managed care organization serving low-income residents of West Philadelphia, AmeriHealth Caritas has grown to become an industry leader. Providing healthcare coverage and services to more than 6.6 million members nationwide, our partnerships and commitment to excellence ensure that our members have the best possible health outcomes through an integrated, cost-effective approach that coordinates physical health, behavioral health, pharmacy, community care, long-term care and social services. We remain committed to leveraging our clinical and business expertise to provide seamless, quality healthcare experiences for our existing and future members.

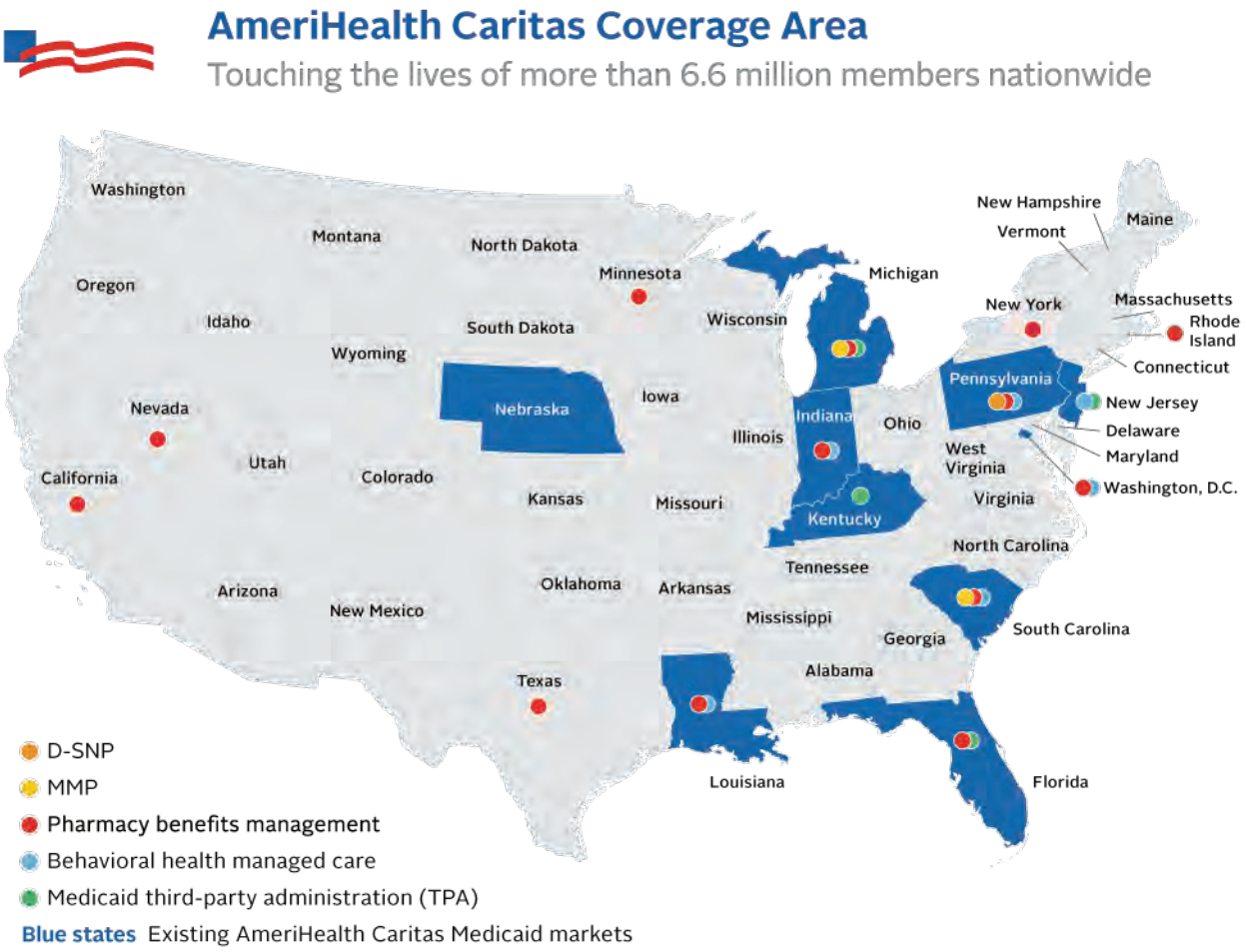


Exhibit 2: AmeriHealth Caritas Coverage Area

AmeriHealth Caritas offers a range of products targeting those most in need and at-risk populations including:

- **Full-risk Medicaid managed care** services with a variety of programs and capabilities to meet the special medical and social needs of underserved populations (Temporary Assistance for Needy Families [TANF], Aged, Blind and Disabled [ABD], foster care and Children's Health Insurance Program [CHIP]).
- **Dual eligible services** with prescription drug coverage and a specialized Medicare Advantage special needs plan (D-SNP) and Medicare Medicaid Plans (MMPs) designed for members enrolled in both Medicare and Medicaid.
- **Behavioral health services** leveraging our wholly owned subsidiary PerformCare®, a full-service behavioral health managed care company that supports members through specialized behavioral health and human services programs in the public and private sectors.
- **Pharmacy services** through our wholly owned subsidiaries PerformRx℠ and PerformSpecialty℠. PerformRx provides innovative, cost-effective pharmacy benefits management services for Medicaid, Medicare and commercial health plans, while PerformSpecialty provides specialty pharmacy solutions to members with complex pharmacy needs. Through a distinctive, high-touch approach, PerformRx and PerformSpecialty partner with health plans to improve member outcomes

and financial performance. PerformRx and PerformSpecialty base their success on a clinical focus that is driven by cutting-edge, proprietary technology and a strong Medication Therapy Management program.

- **Insourced dental** services utilizing an internal team to create and manage dental benefits programs. This allows for the development of value-added integrated programs that add to improved quality outcomes for dental and physical health.
- **Third-Party management and administrative services (TPA)** provided to Medicaid managed care clients in markets across the country, including Indiana, Michigan, Kentucky and New Jersey.
- **Long-term services and supports (LTSS)** programs for members providing an integrated solution across physical health, behavioral health, pharmacy, institutional care, home-based care and social support, that are applied across all our markets, including in our MMPs in South Carolina and Michigan.

AmeriHealth Caritas Family of Companies is a privately held company owned by Independence Blue Cross (southeastern Pennsylvania) and Blue Cross Blue Shield of Michigan. These are two of the leading organizations among the independent non-profit Blue Cross Blue Shield companies. With this ownership structure, we are not influenced by shareholder expectations or near-term earnings pressures. Unlike companies who have exited states and/or provider contracts due to poor short-term financial performance, we are able to take a longer-term view toward performance and service and focus on members and mission and our partnership with the State.

Our Understanding of Iowa

Overall goals for Medicaid Modernization

Iowa Medicaid is the second largest payor in Iowa serving nearly 26 percent of the population in SFY15. With this new Medicaid program, the diverse Medicaid population across 99 counties statewide will be transitioned into a comprehensive managed Medicaid program. This includes over 560,000 members currently enrolled in a number of programs, including the existing Medicaid, *hawk-I* and Iowa Health and Wellness Plan programs. Unlike many other state Medicaid programs which are limited to the TANF/CHIP population, in Iowa members with complex needs, such as ABD, LTC, LTSS and the integration of behavioral health will be included in this program. With this transition, the State aims to improve quality and access, achieve greater accountability for outcomes and create a more predictable and sustainable Medicaid budget for the State of Iowa.

Socio-economic status

AmeriHealth Caritas Iowa understands that socio-economic factors play an important role in access to quality healthcare and the type of programs that are required to improve health status. Some of the key socio-economic factors in Iowa include:

- Iowa is the 11th most rural state in the country, with 36 percent of the population living in rural areas as compared to 19 percent nationally.
- Steady urbanization is underway, with nearly all counties experiencing total population growth being associated with metropolitan areas.
- Iowa's population is predominantly homogeneous, with the balance comprised of ethnic groups including Hispanic/Latino, African-American and Asian.

- Iowa has an aging population, and Iowa ranks 5th nationally in terms of percentage of total population over 65 years.
- Iowa has a lower poverty rate (13 percent below the federal poverty level) and unemployment rate (3.3 percent) than the national averages.

We believe that our depth of experience and innovative approaches will help address the socio-economic determinants of health in Iowa. For example, we recently implemented a **"Health Empowerment Tour"** in Philadelphia, which is designed to engage and educate participating members as well as the wider community on health and wellness issues in a faith-based setting. The goal of the program is to promote health education, health literacy and preventive healthcare in low-income communities. Results of the program include a 13 percent drop in total cholesterol across attendees, a 10 percent drop in blood pressure and an average weight loss of four pounds. 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. **We plan to implement a similar Health Empowerment Tour in Iowa, in conjunction with the goals of the Healthiest State Initiative.**

AmeriHealth Caritas uses a formal **Cultural Competency Program** that has been built upon the 14 national standards for Culturally and Linguistically Appropriate Services (CLAS) as set forth by the United States Department of Health and Human Services. We have a committee dedicated to helping each of our health plans achieve the **National Committee for Quality Assurance** (NCQA) Multicultural Health Care Distinction, a designation that acknowledges Medicaid health plans that meet defined standards in providing culturally competent care. Our goal is for each of our health plans to achieve this designation. Three AmeriHealth Caritas health plans were among the first six Medicaid plans in the country to be awarded this distinction when it was first offered by NCQA in 2011 and each of these health plans has successfully undergone recertification. **We will seek NCQA Multicultural Health Care Distinction for AmeriHealth Caritas Iowa.**

Some of the tools AmeriHealth Caritas will utilize to meet the changing needs of the Iowa Medicaid population include:

- **Race/Ethnicity/Language (REL) data capture.** AmeriHealth Caritas' ability to capture additional REL data, beyond what is available in the state Medicaid system, will enable us to proactively design programs and approaches to meet the needs of Iowa Medicaid members. Our enhanced data collection and language capture features enable us to differentiate between languages spoken and languages read. These technology capabilities will be leveraged to best serve the needs of the market.
- **Focus on health equity.** Like its parent company, AmeriHealth Caritas Iowa will maintain a strong focus on understanding health disparities and improving health equity. AmeriHealth Caritas Iowa will analyze outcomes and utilization rates by REL sub-populations and identify opportunities to create focused interventions and programs. This type of targeted approach and analysis will provide additional insights on how best to interact and care for members.

Health challenges

Some of the important health challenges faced by Iowa Medicaid members include:

- Asthma: High rates of adult hospitalization and ER use, driven by low rates of compliance with medication.
- Behavioral health: Follow-up after hospitalization for mental illness is less than 60 percent, likely due to mental health access challenges.

- Management of chronic diseases such as diabetes: Screening rates among diabetic Medicaid members for Hemoglobin A1C are below the national average.
- High tobacco use with insufficient discussion of cessation medication or strategies: 30-35 percent tobacco use rates, with rates for intervention lower than the national average.
- Balance between institutional and home-based long-term care: Majority of the Medicaid long-term services and supports (LTSS) funds are spent on institutional, not home-based, care.

We deploy programs to address these health challenges across our various markets, with proven outcomes. For example:

- **Asthma:** AmeriHealth Caritas' asthma medication ratio, a standard measure of compliance with treatment, was above the national average for 2014. One health plan scored in the 75th percentile and another health plan in the 90th percentile among Medicaid plans nationally.
- **Behavioral health:** Medication adherence is a critical outcome metric for members with mental illness. For members with schizophrenia who are taking antipsychotic medications, all of our health plans scored in the 75th percentile, with one scoring in the 90th percentile, among Medicaid plans nationally.
- **Chronic conditions, such as diabetes, cardiovascular disease and asthma:** Our blended Integrated Healthcare Management (IHM) model combines case and disease management into a holistic approach that addresses co-morbid conditions, behavioral health needs and social/environmental support needs. Within this program, condition management blue prints detail the priority areas our care managers need to focus on for each co-morbid condition. Evidence-based blue prints are available for areas such as asthma, diabetes, chronic obstructive pulmonary disease (COPD), heart disease, obesity, sickle cell anemia and depression. Through our focus on transition management and connecting members to care, we decreased readmissions for members with these targeted chronic conditions by 11.5 percent in 2014 across our health plan populations.
- **High tobacco use:** We screen all members for tobacco use during the initial health risk assessment and members identified for individual care management during the comprehensive assessment phase. Any member identified as using tobacco is provided with information on tobacco cessation programs, including toll-free QUIT lines, access to counseling and the availability of tobacco cessation medications.
- **Balance between institutional and home-based long-term care:** An example of AmeriHealth Caritas' experience coordinating long-term services and supports is our specialized Pediatric Shift Care Unit, which provides support and assistance to medically fragile members less than 21 years of age with complicated healthcare needs, including ventilator dependence. Because of our specialized unit and relationships with specialty care providers, including Children's Hospital of Philadelphia, all of these members receive extensive skilled nursing and other in-home support services allowing these high-complexity members to remain at home with their families.

Barriers to care and health access

Many of the health challenges described above are due to insufficient access to outpatient care, including primary care, mental health and specialty care. For example:

- There are 86 primary care physicians per 100,000 residents, ranking Iowa 47th in the country.
- According to a 2011 Iowa Medical Society report, Iowa ranks 51st among the 50 states and the District of Columbia in OB-GYN and emergency physician supply.

- In a 2011 Community Needs Assessment, over 40 percent of the counties indicated a lack of transportation as a barrier to accessing health services.
- In the same assessment, 35 percent of counties indicated an unmet need for mental health services.

These access challenges in the broader population can be even more acute for Medicaid members given their lower socio-economic status. Our core belief is that Medicaid members should receive access to quality healthcare regardless of socio-economic status. In all of the markets served by AmeriHealth Caritas, **our networks are broad and inclusive**. It is also our goal to partner with academic teaching hospitals in every market to ensure that our members, especially those with special needs, have access to the most up-to-date technology, clinical pathways and innovations. We will take a similar approach in Iowa, applying strategies to address the unique geographic and access challenges in the State. Examples include:

- Negotiating single case agreements with out-of-network providers for medically necessary covered services.
- Transporting members (and paying for them to stay) where care is available.
- Deploying a mobile van with select services (e.g., immunizations, other primary and specialty preventive care services) for rural access.
- Deploying a telemedicine and tele-psychiatry program.

We have successfully applied many of these strategies in other markets with similar access challenges. For example, in South Carolina, the 2012 Medicaid Health Plans Report Card rates our health plan as having the best access to care among Medicaid plans within South Carolina and in the **top quartile of the National Committee for Quality Assurance** (NCQA) **HEDIS 2013 National Medicaid percentile benchmarks**. Similarly, in Pennsylvania, our health plan received the top scores on access to care and member satisfaction with access.

"AmeriHealth Caritas contracts with some of the largest health systems in Philadelphia, Harrisburg and Allentown, offering its members a comprehensive provider network and access to care. AmeriHealth Caritas also received the best scores overall among health plans, including top scores for access to care and for member satisfaction based on 2014 data."

– Allen W. Fisher, Division Director,
Pennsylvania Medicaid Bureau of Managed Care Operations

Cost of care

We recognize that a significant proportion of Iowa's healthcare costs represent long-term care services with nearly half of Medicaid expenditures for these services. And although approximately 58 percent of the program enrollees are children, they account for only 19 percent of costs, whereas 19 percent are people with disabilities and they account for half of Medicaid expenses. Iowa Medicaid expenditures total over $3.5 billion and the State of Iowa would like to ensure a more sustainable budget going forward:

- The goal is to achieve over $51 million in savings within the first six months of the transition to managed Medicaid.

- More broadly, the Iowa State Health Care Innovation Plan goal is to reduce the rate of growth in healthcare costs for the State as a whole to the Consumer Price Index within three years. The goals of the ACO organization are more aggressive, which includes reducing costs by five to eight percent within three years.

As we describe below, our care management, utilization management and value-based provider partnership programs in Iowa will be tailored to meet these financial goals. We are committed to helping the State of Iowa achieve the proposed financial savings, as we have demonstrated through our achievements in other states. For example, in our Pennsylvania market, while we have approximately 50 percent of the managed Medicaid program enrollment, we manage nearly 80 percent of the highest cost cases, including members needing neonatal intensive-care unit (NICU) care and those with sickle cell disease, hemophilia and Hepatitis C. Our membership in this market has a risk-adjusted rate score that is eight percent higher than the market's average risk score, but we have managed to keep cost trends at or under three percent over the past seven years through strong relationships and innovative value-based arrangements with our provider partners.

Our Strategy and Approach Makes Us the Right Partner

AmeriHealth Caritas Iowa is the right partner for the Iowa Medicaid program. As demonstrated throughout our proposal, AmeriHealth Caritas has the experience, knowledge and skills to partner with DHS to exceed the expectations of Medicaid members in Iowa. Our innovative solutions have proven successful across other states with a similar Medicaid population size and demographics and facing many of the same types of challenges as in Iowa.

Our fully integrated model across physical, behavioral and long-term services and supports aligns closely with the State of Iowa's mission, vision, goals and values, and is based on the following core tenets for the delivery of high-quality accessible healthcare and improving health outcomes for Iowa's Medicaid population:

- Person-centered approach.
- Collaborative partnerships with the State, providers and community organizations.
- Access to care when and where it is needed.
- Data-driven program design and evidence-based outcomes.

Highlights of AmeriHealth Caritas' key strengths and experience, including examples of our approach and the programs we have successfully implemented in other states, are provided below. AmeriHealth Caritas Iowa will leverage and implement these programs to develop targeted solutions to meet the specific needs and improve health outcomes and overall well-being of Iowa's Medicaid members.

Person-centered approach

With 30 years of experience serving Medicaid populations, AmeriHealth Caritas understands the needs of these at-risk populations. We use this knowledge to deliver holistic, person-centered care management through IHM and as embedded partners in the communities we serve. We have learned that being a trusted community partner enables us to better serve our members by connecting them to the right care at the right time.

Iowa Medicaid members face a wide range of socio-economic, educational and other issues. Our innovative approach to serving members identifies and focuses on the unique needs of each individual—

from their physical health to the broader range of behavioral, social support, long-term services and other needs that impact the member's current and future health. Using our robust data analytics, we proactively identify members whose clinical diagnoses and utilization patterns indicate a need for additional support, and then work closely with them to develop comprehensive, person-centered care plans that address their health needs, life circumstances and personal values. Our care managers use active coaching models and adapt care interventions to support healthy outcomes.

Our person-centered approach also includes:

- Engaging, educating and empowering members to actively participate in improving their health outcomes.
- Providing members with the information they need to improve and manage their health through our innovative use of Theranos technology and our next generation member portals.
- Involving members, parents or guardians, care team members, providers, behavioral care providers, social services and community group representatives in the care planning and management process.
- Utilizing community-based services to avoid or delay institutional-based care, supporting members who desire to remain in the home and community-based setting.
- Incentivizing and rewarding healthy member-specific behaviors.

Exhibit 3: Person-Centered Approach

"I have had nearly two years of experience working with AmeriHealth District of Columbia and have found that the company has been a wonderful partner to members, the provider community and my organization. In particular, [they have] invested in the community by establishing a member wellness center, brought innovative member 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. A notable accomplishment is the reduction of 30-day hospital readmissions by 14.8% in 2014 for members with asthma or other chronic health problems. Lastly, they effectively partner with community-based organizations to focus on upstream interventions and prevention."

– Jacqueline C. Bowens, CEO, District of Columbia Primary Care Association

Member willingness to engage in healthy behaviors, including preventive care, chronic condition monitoring and health and wellness activities, is a critical determinant in the success of any program to improve health outcomes. AmeriHealth Caritas Iowa will adapt the engagement strategies and approaches proven successful in other AmeriHealth Caritas markets to the Iowa market in order to reduce ER utilization, reduce care gaps and help members get the care they need. This includes:

- **Identifying members who need hands-on care management support.** We use a variety of techniques, including a risk-adjustment tool, clinically based classification system and a health risk assessment, to measure a population's burden of illness and assign each member to a single, mutually exclusive risk group. Our risk group model enables us to focus the appropriate programs and services based on risk categories and then further refine the plan to address individual needs. We pay special attention to members who fit the classification of "super-utilizer" based on a history of, or a risk for, disproportionate utilization of services and cost.
- **Team-based community care management.** To assist members with unmet chronic disease management needs and a history of frequent preventable inpatient admissions and ER visits, AmeriHealth Caritas Iowa will deploy community-facing teams to help those members navigate the healthcare system and access needed medical, behavioral health and social services. This program has proven especially effective at reducing inpatient admissions and ER visits for the super-utilizer population in other AmeriHealth Caritas markets.
- **Becoming part of the community and investing in the neighborhoods where our members live** to support our philosophy that "we are where our members are." Our staff is hired from the communities they serve, in the neighborhoods in which our members live. In addition to coordinating health events, our community staff work with individual members to engage them in their healthcare, connect them to available community services and assist them with navigating the often-complex healthcare delivery system. AmeriHealth Caritas uses proven, data-driven techniques to guide community-based activities and engage members where they live, work and go to school.

AmeriHealth Caritas also seeks to proactively engage members with long-term physical and behavioral health needs through targeted care management programs. Our LTSS program for Iowa is based on extensive experience with dual eligibles in our Medicaid programs across multiple states, including our D-SNP in Pennsylvania and our dual eligible demonstrations (MMPs) in South Carolina and Michigan. Our program is led by staff with decades of leadership experience from federal (CMS), state (Department on Aging), community and managed care settings (local Area Agencies on Aging).

We take a whole-person approach to address the unique needs and issues of the LTSS population. To do this, our dedicated care managers serve as a single point-of-contact and integrate physical, behavioral, social, medical, home-based and community-based resources. We work with members and caregivers to address barriers that impact the ability to self-manage care, coordinate complex care needs, assist with transitions of care and explain and manage long-term services and supports for the member. Our person-centered care management programs will improve health outcomes, increase access to essential services, coordinate transitions of care, ensure appropriate utilization of services and increase member satisfaction.

"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' Pennsylvania health plan, 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.

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. 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.

We will work with DHS to apply existing programs to the Iowa market as well as collaborate with DHS on adapting programs or developing new, innovative solutions to address Iowa-specific challenges. The following are examples of select programs and initiatives that support our holistic, person-centered approach and that we will tailor and implement in Iowa:

Program	Description	Iowa Need Addressed	Experience from Other States
Member Incentive CARE Card	Wellness incentive program designed to encourage members to pursue preventive health services and maintain an ongoing relationship with their PCP, OB-GYN and primary care dentist with the intent to reduce reliance on the ER for primary care services. Members earn monetary incentives on a debit card upon completion of targeted services and receipt of a valid claim for these services. Rewards are redeemable at specific "merchant classes" such as grocery stores and pharmacies.	Under-utilization of preventive and primary care.	AmeriHealth Caritas has used member incentive programs in all of our markets to engage members in healthy behaviors and preventive care. We have seen increased engagement as demonstrated in improved HEDIS scores across our health plans.

Program	Description	Iowa Need Addressed	Experience from Other States
Prenatal Incentives	Prenatal incentives program providing financial and support incentives that encourage pregnant members to start their prenatal care in the first trimester and to keep all of their scheduled prenatal appointments. Additional incentives are provided for pregnancies that meet particular delivery and post-partum requirements.	High incidence of low birth weight infants.	From 2012 to 2013, our South Carolina Select health plan's rate for low birth weight infants was over 4% lower than the March of Dimes rate for the State of South Carolina.
Community Care Management Team (CCMT)	The CCMT provides high-touch, face-to-face engagement through a community-based team of nurses and social and community health worker to help members navigate and increase access to medical, behavioral health and social services. The program supports the development of member self-management skills through encouragement and coaching for chronic disease management. AmeriHealth Caritas currently has CCMTs in Philadelphia, PA; Chester, PA; Charleston, SC; and Baton Rouge, LA.	Under-utilization of primary and preventive care. High ER usage. High mortality rates from HIV, heart disease, diabetes, etc.	Program-wide, early results from year one of the program demonstrated a more than 10% decrease in claims costs and a 25% decrease in inpatient admissions from the targeted membership population.
Public Housing Assistance (PHA) and Shelter System Collaboration	The PHA and Shelter System collaboration provides health screenings and health information to members who reside in PHA sites and shelters through on-site events and activities. This includes educating members on how to use the health plan and reduce gaps in care. Members are screened for total cholesterol, HDL, LDL, triglycerides, glucose, HbA1c, blood pressure, height/weight, dental and BMI	High poverty rates driving care gaps.	In 2014, our Keystone First health plan in Pennsylvania enabled screenings for members who resided in PHA sites and homeless shelters.

Program	Description	Iowa Need Addressed	Experience from Other States
Welcome Home Transition Program	Nurse practitioner-based program providing in-home visits and follow-up contacts for 30-60 day period to ensure smooth transition of dual eligible members from an acute care setting to home with the goal of preventing hospital readmissions or institutionalization.	Improved care transitions and coordination for complex populations.	Underway in Philadelphia with early experience showing high customer satisfaction; improved communication across providers and care teams; lower readmissions; and early identification of members at risk of institutionalization for further intervention by the care team.
Jump Start Back to School	Our Select Health of South Carolina health plan, along with partnering agencies, holds Jump Start Back to School events featuring free back-to-school information, health screenings, children's activities and backpacks with school supplies. The goal is to help members and families prepare for a safe, healthy and successful school year. Bilingual staff and interpretation services are available for attendees with limited English proficiency.	Under-utilization of primary and preventive care. Unmet needs for primary care, mental health services and dental care.	Select Health has partnered with more than 45 community organizations to conduct Jump Start Back to School events. 3,732 in attendance with 60% being current members. 1,304 attendees were preregistered members with care gaps. 1,003 children were set up with follow-up visits for well-child, dental and vision.
Cavity Free Kids	The Cavity-Free Kids program provides oral health education and training programs for providers, preschoolers and their families. Through early childhood education programs, Cavity-Free Kids works to incorporate information and understanding about the importance of dental care into children's daily lives and as a consequence, change behaviors and attitudes.	Under-utilization of primary and preventive care.	In Pennsylvania, 28 Cavity Free Kids presentations were conducted across 35 counties with over 1,000 participants in attendance.

Program	Description	Iowa Need Addressed	Experience from Other States
Mental Health First Aid	A public education program that introduces participants to risk factors and warning signs of mental illness, builds understanding of their impact and provides an overview of common supports. This 8-hour course uses role-playing and simulations to demonstrate how to offer initial help in a mental health crisis and connect persons to the appropriate professional, peer, social and self-help care.	Lack of timely recognition of those in a mental health crisis.	Initial rollout and outcomes data collection underway.

Exhibit 4: Examples of AmeriHealth Caritas' Person-Centered Approach

"I love this [Community Care Management] program. The collaboration between Keystone First and St. Christopher's Center for the Urban Child represents everything that health care COULD and SHOULD be. Through sharing data, resources and best practices, we are hoping to close the care gaps for our most vulnerable children with asthma. The energy and willingness to innovate on the payer side has reinvigorated my faith in the US healthcare delivery system. We are hoping to standardize, publish and replicate this model for others to learn from us."

– Katie McPeak, M.D., Medical Director, Center for Child and Adolescent Health, St. Christopher's Hospital for Children, Philadelphia, PA

Collaborative partnerships with the State, providers and community organizations

AmeriHealth Caritas is a mission-focused organization, driven by creating stakeholder value. Part of our strategy includes becoming an integral part of the fabric of the communities we serve. We are committed to building the health and trust of our communities and working collaboratively with state and community partners to address the truly complex challenges of the rising costs of care, increasing issues with access to care and escalating administrative complexities. We take pride in our national presence and are able to leverage key lessons and efficiencies from serving multiple Medicaid markets. To make a difference in the communities we serve, we approach each market locally and each member individually.

AmeriHealth Caritas is committed to attracting and keeping a talented workforce that reflects the diversity of the communities where we live and work. We recruit locally for key positions so that our health plan associates can relate to members with an instinctive understanding of the circumstances and conditions unique to the area. In 2013, AmeriHealth Caritas was presented a **HIRE Award** from Innovate+Educate for using creative methods to discover talent, promote diversity, develop a work-ready talent pipeline and bridge the opportunity divide. AmeriHealth Caritas Iowa will continue this philosophy and approach when hiring and staffing for AmeriHealth Caritas Iowa.

Our ability to sustain long-term programs stems from our willingness to do the right thing for our members and State partners, even if there may be a negative financial impact for us. For example, in a specific Pennsylvania market that covers close to 600,000 Medicaid participants, the Pennsylvania

Department of Human Services (DHS) experienced access-to-care issues with certain managed care organizations (MCOs) in the market. Over the past seven years, certain MCOs terminated multiple hospital and health system contracts as well as FQHC relationships in order to sculpt their network, ostensibly to manage costs. As a result of one health system termination, AmeriHealth Caritas gained 15,000 members over a two-month period, many of whom with high risk scores. To maintain access to care with their long-standing physicians, AmeriHealth Caritas, in partnership with the Pennsylvania DHS and the impacted providers, accepted all of these members via an expedited transfer and became engaged in managing their care.

Developing a robust and inclusive provider network – AmeriHealth Caritas is recognized as a leader in ensuring quality through broad open networks that offer wide access to healthcare services. For example:

- In Pennsylvania, Keystone First health plan, located in southeastern Pennsylvania, has contracts with 49 of the available 52 hospitals (11 more than the next closest health plan) including leading academic and children's hospitals such as the Children's Hospital of Philadelphia (CHOP), St. Christopher's Hospital for Children, Hospital of the University of Pennsylvania (HUP), Geisinger Health System and Temple University Hospital.
- In Nebraska, Arbor health plan has contracts with Creighton University Medical Center and the University of Nebraska Medical Center, both located in Omaha.
- In South Carolina, First Choice health plan by Select Health has contracts with Medical University of South Carolina (MUSC) in Charleston and Palmetto Health in Columbia.
- In Louisiana, AmeriHealth Caritas Louisiana has contracts with Our Lady of the Lake Health System, Ochsner Medical Center, Tulane University, CHRISTUS Health System and Louisiana State University (LSU).
- In Washington, D.C., AmeriHealth Caritas District of Columbia, has contracts with Children's National Health System, the teaching hospital for the George Washington University School of Medicine.

In Iowa we are working to ensure a robust network offering quality and unparalleled access including active contract discussions with leading provider entities, including:

- UnityPoint Health.
- Mercy Health Network.
- Broadlawns Medical Center.
- University of Iowa Health Alliance.

Providing quality health care — We build strong relationships with providers to deliver accessible, high-quality care. We understand the importance of giving our providers the necessary tools, incentives and access to programs to participate in our network and promote engagement, improve health outcomes and increase transparency and ease of administration. AmeriHealth Caritas builds strong and dependable provider partnerships and commits to them through value-based incentive programs, timely and accurate payment of claims and realistic provider reimbursement rates. Over 1,200 AmeriHealth Caritas providers in Pennsylvania, Louisiana, South Carolina and the District of Columbia currently participate in our incentive programs. We are discussing an array of potential programs with Iowa providers, including ACOs, shared savings and value-based payment models, in line with Iowa's SIM objectives.

"AmeriHealth Caritas understands that a successful managed care program depends on a true collaboration with all providers of care. Providers can count on AmeriHealth Caritas to: ensure access for members through robust provider networks and telemedicine strategies for rural populations; collaborate closely with hospitals, primary care physicians, specialists and other providers; deliver value by conveying the information needed to improve patient care; and offer shared-savings incentives that promote better outcomes and accountable care."

– David Friel, Vice President, Geisinger Health System

Establishing community partnerships — AmeriHealth Caritas Iowa is deeply committed to partnering with the State, providers and community resources to provide access to needed healthcare services. Integrating into the communities we serve is a key success factor in developing a relationship and establishing trust. To achieve this in Iowa, we are building community partnerships throughout the State with organizations like the Iowa Association of Community Providers, Iowa Association of Area Agencies on Aging (i4a) and the Iowa Community Action Association.

Our collaborative community partnership approach also includes:

- Participation in and promotion of community events to conduct health screenings for our members.
- Collaboration with local businesses, e.g., grocery stores such as HyVee, to provide members with convenient access to key health screenings and incent healthy behaviors.
- Partnerships with schools having concentrations of low-income students to provide school supplies.
- Donations of time from our associates who volunteer to support school and other events in their local communities.

We also have extensive experience delivering creative solutions, such as our work with FQHCs to provide "one stop shopping" for medical and dental care or our Community Wellness Centers in South Carolina and the District of Columbia, to meet the needs of our members and the surrounding communities.

"Select Health is passionate about serving the community, making life better for children and helping nonprofit organizations with missions that align with that passion. This company stands out as one whose culture is caring and making a difference."

– Barbara A. Bond, Executive Director and CEO,
Ronald McDonald House Charities of Charleston

Examples of our programs and initiatives that are targeted to leverage and enhance collaborative partnerships are provided below. We will tailor and implement these programs in Iowa:

Program	Description	Iowa Need Addressed	Experience from Other States
Community Wellness Center	Our Select Health South Carolina health plan established our FirstChoice Community Center to connect members to community resources and plan benefits, providing a broad range of services on site including: • Benefit Bank. • FirstChoice Community Educators. • HEDIS screenings. • Free notary services. • Free health and community events. • Education programs. In November 2014, our District of Columbia health plan opened its first Community Wellness Center as an extension of its outreach, care management and wellness strategies.	Under-utilization of primary and preventive care. Disparities in health and healthcare access based on race and ethnicity.	The FirstChoice Community Center has served over 14,000 people since 2010. The majority of these (60%) are Select Health members. Over 40 partnering agencies utilize the center. Over 1,000 children received health screenings and follow-up appointments. Over 5,900 children got a better start for the school year through education programs. Over 2,000 families received assistance with applications for other social services.
Healthy Hoops®	Healthy Hoops is a trademarked innovative childhood asthma and obesity management program. Approved by the National Committee for Quality Assurance (NCQA), Healthy Hoops uses basketball as a platform to teach children with asthma and their families, how to manage their condition through proper nutrition, exercise and the appropriate medication use.	Prevalence of childhood asthma and childhood obesity.	Over the past 13 years, Healthy Hoops has served over 10,000 families in Pennsylvania, South Carolina, Indiana, District of Columbia and Kentucky markets. The program has demonstrated decreases in inpatient and ER utilization, an increase in the use of prevention inhalers and a decrease in the use of rescue medications.

Program	Description	Iowa Need Addressed	Experience from Other States
Health Empowerment Tour	The Health Empowerment Tour is designed to engage and educate participating members and the wider community on health and wellness in a faith-based setting. The goal of the program is to promote health education, health literacy and preventive healthcare. Consisting of six weeks 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.	Disparities in health and healthcare access.	In a recent roll-out through our Keystone First health plan, there was a 13% drop in total cholesterol and a 10% drop in overall blood pressure among participants and an average weight loss of four pounds. In addition, participants increased their awareness of nutrition content in foods and willingness to try healthier foods. Over 24% of participants lost weight.
Community Baby Showers	An engaging and fun way to introduce pregnant moms to the Bright Start® program. Provide risk assessments to determine individual care needs, conduct dental screenings for pregnant moms and deliver parenting preparation courses.	High incidence of low birth weight infants.	In 2014, more than 120 pregnant women attended Community Baby Showers hosted by one of our Pennsylvania health plans; 38% of these members also received dental screenings.
"Try the Y" Program	Collaboration between AmeriHealth Caritas' Nebraska affiliate and community YMCAs to offer a 90-day trial period at no cost to members to expose members to healthier lifestyles and provide them with access to health and wellness facilities they otherwise might not be able to afford.	Disparities in health and healthcare access. High death rates from diabetes and heart disease. High percentage of Iowa residents who are overweight or obese.	In 2014, our Nebraska health plan's program engaged 182 total households, 646 total individuals, and generated 2,179 total YMCA visits.

Program	Description	Iowa Need Addressed	Experience from Other States
FQHC "Community Partners Program"	Aligns incentives and engages physicians in shared goal of positive patient outcomes and economic stewardship; Web-based provider dashboard promotes transparency, collaboration and self-service reporting. Members to receive "one stop shop" for medical and dental care in a single visit through FQHC partnerships as many Iowa Medicaid members receive medical services at FQHCs.	Increase dental preventive care services.	In 2014, Keystone First's program included 27 FQHC screening events, resulting in 219 dental screens and 95 adolescent wellness screenings.
Centering Partnerships	Program is to help pregnant women develop a support group with other women of similar gestational age.	High incidence of low birth weight infants.	At our Select Health plan in South Carolina, a key provider partner study by Dr. Amy Picklesimer, Greenville Health System OB-GYN Center, determined the rate of preterm delivery at 37 weeks gestational age for women in Centering group care was 7.9% compared to 12.7% for women in traditional care and the rate of preterm delivery at 32 weeks gestational age was 1.3% for women in group care compared to 3.1% for women in traditional care.

Exhibit 5: Examples of AmeriHealth Caritas' Collaborative Partnerships

Access to care

Access to care is fundamental to improving health outcomes. It is also one of the biggest challenges that the Medicaid population faces in receiving timely and quality healthcare. By putting people at the center of healthcare, understanding their needs and meeting them wherever they are, AmeriHealth Caritas enables access to care when and where it is needed. Our multi-pronged approach to providing and expanding access to care in Iowa will include the following:

- **Transportation** — Providing transportation services for members to access healthcare at provider facilities, including member transportation support and coordination.

- **Mobile health vans** — Bringing healthcare to members through the use of mobile healthcare service vans; we will offer maternity and dental care to members through mobile units in targeted areas with access issues. These mobile service units will function as primary care locations offering primary care and dental follow-up. We will develop additional programs and expand geographical reach, as we determine the specific areas of need in the specialist provider community.
- **Data analytics** — Using advanced data analytics and geo-access tools to establish and maintain a strong provider network with the right number and types of providers located where they are needed.
- **Language** — Assessing member demographics such as language needs and including providers with the required language skills in our network, as well as providing translation services for more unique language needs.
- **Contact Center of Excellence (CCOE)** — Utilizing our CCOE staff to coordinate member transportation needs and facilitate the scheduling of member appointments with providers and connect members to social support resources; these teams provide 24-hour access.
- **Telehealth** — Providing remote access via telehealth options for members who cannot access on-site care. AmeriHealth Caritas Iowa will partner with leading provider organizations on their established telehealth programs to provide greater access services to Iowa Medicaid members. We will also partner with an industry-leading telemedicine company to provide member access to primary care and specialty providers, including behavioral health, via video and phone.
- **Telemonitoring** — Providing telemonitoring services including home biometric monitoring. This will be used as part of managing a member's care plan to incorporate real-time data. We will implement a congestive heart failure telemonitoring program in Iowa in the first year of operation.
- **Mobile technology** — Employing mobile technology to provide real-time on-demand member access to benefits information, medication history, ID cards, provider directory with geo-location tools, PCP information as well as sending reminders to address potential gaps in care.
- **Community Care Management** — Teams that extend care management into the community. Teams are deployed to communities that have a concentrated number of high-risk members, including those who have complex care needs. These members are often times difficult to engage through telephonic care management, access care primarily through emergency services, or are frequently admitted to inpatient settings.
- **Integration of access to physical and behavioral health services –** As we have done in other states, we will work with providers to support real or virtual integration of care. For example, in another market, we supported PCPs in identifying unmet behavioral health needs, developing a business plan and hiring a Licensed Clinical Social Worker to provide psychiatric services in that location.
- **Community Wellness Centers** — Establishing three state-of-the-art Community Wellness Centers in Iowa, potentially in Des Moines, Cedar Rapids and Sioux City, where many members reside. The Community Wellness Centers will be used to promote our mission to help members get care, stay well and build healthy communities. The centers will be a resource hub in the community and provide space for new member orientations, community meetings, wellness screenings, care management, doctor appointment scheduling, health education and coordinated social services.

AmeriHealth Caritas has been highly effective in reducing or overcoming these barriers to accessing care in the other Medicaid markets we serve. AmeriHealth Caritas Iowa will employ all of these strategies in Iowa to improve access to care for Iowa Medicaid members.

"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 and Chief Financial Officer, The Children's Hospital of Philadelphia

Examples of programs and initiatives implemented in other states that provide and enhance access to care are provided below. We will tailor and implement these programs in Iowa:

Program	Description	Iowa Need Addressed	Experience from Other States
Community Outreach Solutions (COS) Program	Our COS teams identify, locate and visit hard-to-reach, high-risk members, developing a critical link between the medical delivery system and individuals where they live. COS associates live and work in targeted geographic areas where there are a high number of chronically ill members who are not well connected to the care system. These teams know the local ecosystem for social services and help members sort through complex and competing needs.	Under-utilization of primary and preventive care. Unmet needs for primary care, mental health services and dental care.	In AmeriHealth Caritas' Pennsylvania, Nebraska and District of Columbia Health Plans, we have increased member engagement and access to care. In 2014, we went to our hardest to reach members in Pennsylvania and reached the following membership: • 15,383 total home visits attempted with 30% contacted. • 1,929 appointments made, with 50% PCP appointments confirmed.

Program	Description	Iowa Need Addressed	Experience from Other States
Transition Home Visit Program	Home visit by a licensed therapist after a behavioral health hospitalization. Disease education, validation of contact information, needs assessment, and establishment of regular outpatient follow up care are the primary areas of focus.	Access to and follow up with outpatient behavioral health services.	Seven-day follow up after hospitalization rates increased from 22% to over 50% within the first year of implementation and results have been sustained.
Non-Emergency Transportation (NEMT) Services	Our comprehensive non-emergency transportation program focuses on helping members get safely to and from appointments, especially when a lack of transportation resources presents a barrier to care. This includes the coordination of non-emergency transportation services as well as free transportation to doctor's visits.	Under-utilization of primary and preventive care. Limited access to care.	In other state Medicaid programs for which NEMT is a covered service, AmeriHealth Caritas has delivered efficient transportation to members through an established process that includes determining the best transportation method, monitoring standards and measuring quality.
Free Cell Phone Program	Our Voxiva/Tracfone initiative dispenses free mobile phones to our members. With text reminders, through Text4Babies, Text4Kids and Text4Health (adult health program), our members can opt into these programs for free.	Under-utilization of primary and preventive care. Unmet needs for primary care, mental health services and dental care. Limited access to dental care.	Deployed in our AmeriHealth Caritas District of Columbia, Louisiana and Pennsylvania health plans, we have dispensed 30,000 free phones to our members and are receiving text messages through our texting programs.

Exhibit 6: Examples of AmeriHealth Caritas Programs that Increase Access to Care

"In the areas of access, cost and quality, AmeriHealth Caritas Louisiana's performance has been key in helping our Bayou Health program demonstrate early success. They have developed or tailored their programs to our members' needs, which vary significantly by geographic region with the state."

– Ruth Kennedy, Medicaid Director,
State of Louisiana, Department of Health and Hospitals

Data-driven results and evidence-based outcomes

For over 30 years, AmeriHealth Caritas has consistently improved clinical outcomes and the quality of care for the Medicaid population across the numerous states we serve. We understand the importance of identifying and supporting a robust set of programs to achieve better outcomes driven by program goals and initiatives.

Our Quality Assessment Performance Improvement (QAPI) infrastructure, coupled with our **PerformPlus** value-based contracting portfolio, is used to identify and implement interventions to achieve targets set for identified performance measures. We build a high-value strategy that improves access through engagement of members and communities; outcomes by reducing healthcare disparities; quality of care through meaningful partnerships and networks; and savings through implementing best practices. We accomplish this through:

- **Utilizing data to evaluate and improve care management and care coordination —** Our data analytics capabilities have enabled us to identify and enrich how we interact with providers and support our members in the management and coordination of their care. We use data to identify and evaluate a variety of programs including incentive, value-based performance 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, achieving targeted quality outcome measures and providing cost-effective, appropriate care. We continually refine our programs and approach with revised targeted measures to align with the goals of our Medicaid Agency stakeholders and anticipate successfully employing these programs in Iowa.
- **Sharing data through platforms and technology for providers, members, families, contact centers and care managers —** Our extensive data collection and analytic capabilities, coupled with our proven methods of information delivery, allow providers and members to access the information they need when they need it. Providers have access to extensive dashboards through our **Quality Enhancement Program (QEP)** and **PerformPlus** dashboards. Our systems also provide alerts on evidence-based care recommendations when a member's record is accessed in our secure **Provider Portal**, allowing the provider to address gaps in care together with the member. For members, our secure **Member Portal** and our custom mobile application provide ongoing health and wellness reminders, as well as prompts for important activities such as HgbA1c monitoring for diabetes and refill reminders for medications. Our contact centers, including Member Services and Care Management, have access to the same alerts and data, allowing for collaboration of care and closure of care gaps. These tools enable members to take control of their health, providing support and coaching to facilitate desired actions.
- **Sophisticated information exchange and analytics driving member and provider engagement —** AmeriHealth Caritas has invested in critical areas related to Health Insurance Exchanges (HIEs) to capture and utilize member information, enhancing our ability to integrate key information with our care management applications and providing access to more and better data for decision-making and member support.

Examples of how AmeriHealth Caritas shares data to drive improved outcomes are reflected in some of our programs described below, all of which will be tailored and implemented in Iowa:

Program	Description	Iowa Need Addressed	Experience from Other States
PerformPlus Value-based Programs	Reward program for physicians for timely, appropriate ambulatory care and positive patient outcomes; utilizing peer and trend based measurements, including HEDIS measures, to determine outcomes and link to rewards. Reimbursement incentives based on performance for closing gaps in care for agreed-upon HEDIS and other quality metrics, including: • High-quality and cost-effective care. • Member service and convenience. • Accurate and complete health data. Program feature is an industry-leading, web-based PerformPlus dashboard Portal with monthly performance reporting and drill-down capability that engages providers and provides full transparency.	Quality of care. Under-utilization of primary and preventive care.	More than 40% of our managed care membership across all markets receives care from a provider that participates in one or more of the PerformPlus value-based programs. Early results of our Shared Savings partnerships resulted in the following improvements: • 8.6% decrease in Potentially Preventable Admissions. • 2.3% decrease in Potentially Preventable Readmissions. • 50% key quality indicators have improved by an average of 7%.

Exhibit 7: AmeriHealth Caritas' Data-Driven Programs

"IowaHealth+ greatly appreciates AmeriHealth's vision for working in partnership with Iowa's providers to improve the quality of care delivered to the Medicaid populations and values the support of the patient-centered health home model and need to invest in the primary care delivery system. We also want to recognize AmeriHealth's understanding and willingness to work to streamline processes and protocols in order to assist providers in Iowa in efficiently and effectively delivering care to patients (i.e. prior authorization processes, data, reporting and analytic platforms, etc.).

– Theodore J. Boesen Jr., CEO,
IowaHealth+, an FQHC owned Accountable Care Organization

Our Proposed Organization

AmeriHealth Caritas Iowa will partner with DHS early on and make it a priority to help DHS solve the challenge of affordably connecting vulnerable populations with high-quality healthcare. To maximize access to care and services, **AmeriHealth Caritas Iowa will establish a main office in Des Moines and three state-of-the-art Community Wellness Centers throughout the State of Iowa**, potentially in Des Moines, Cedar Rapids and Sioux City. These locations were identified based on population density, percentage of population in poverty, population receiving Medicaid and percentage of adults aged 18 and older who self-report that they receive insufficient social and emotional support all or most of the time. Our local offices and state-of-the-art Community Wellness Centers will be strategically located near ERs and other community services so that we can better serve our members, following our approach of “we are where the members are.”

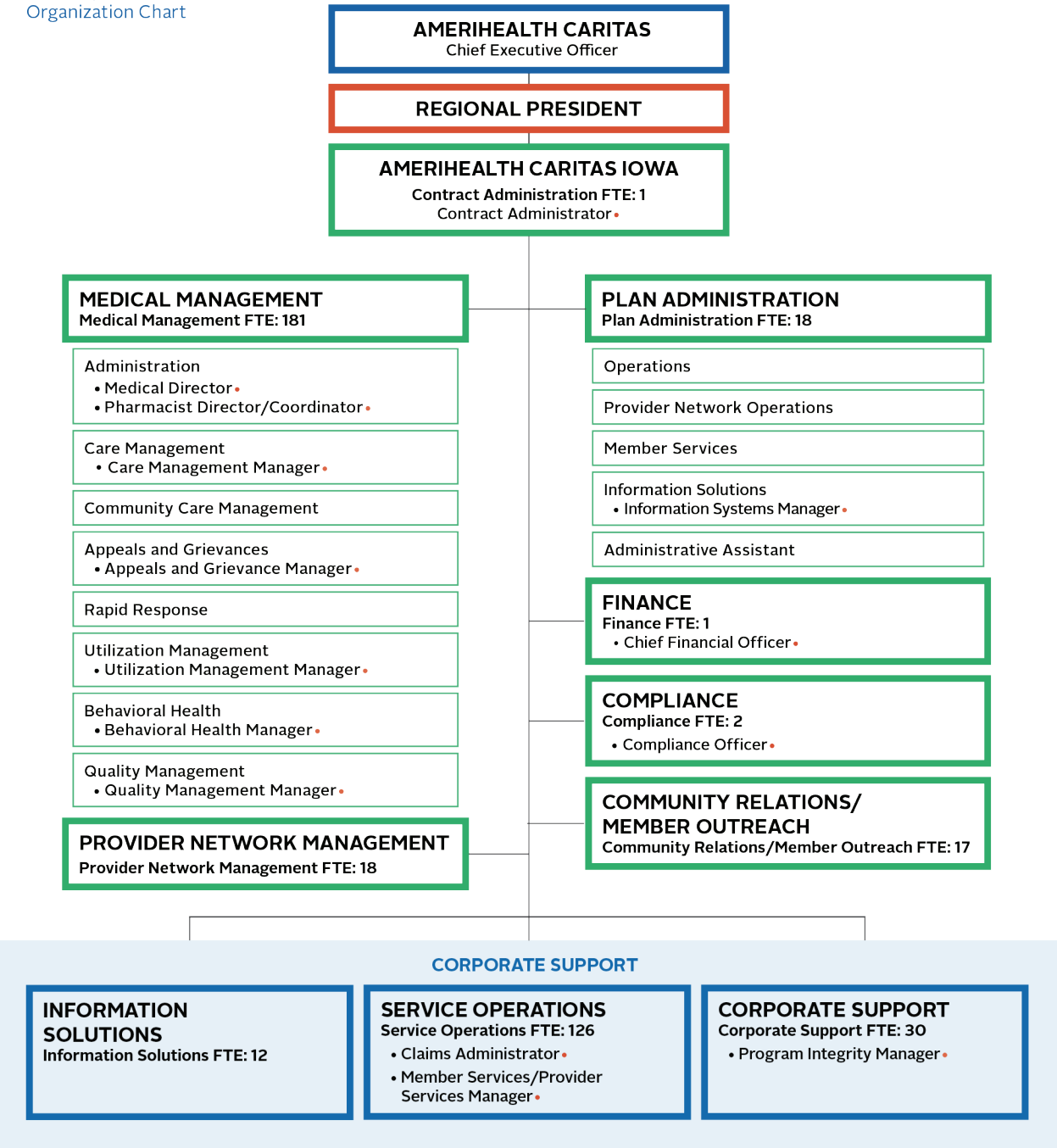
To support the intensive management needs of a brand new managed Medicaid program, AmeriHealth Caritas Iowa expects to commit significant resources to support this contract. We plan to hire over 400 full-time associates and over half of this team will be located in an AmeriHealth Caritas Iowa office or in the field, including Provider Network staff, social services experts, community outreach personnel and community care management teams. The remaining part of this team supporting the health plan will be working in other AmeriHealth Caritas locations outside of Iowa. We will leverage our national resources and operations for functions including customer service, claims processing and pharmacy benefits management to leverage efficiencies associated with shared services due to economies of scale.

AmeriHealth Caritas is not just a name but rather we are residents of and familiar faces in the communities we serve. We will partner with local vendors and organizations to better serve the needs of Iowa Medicaid members. Our strong local presence in Iowa will provide individuals and families with better access to care, education and opportunities.

Our staffing plan addresses the initial implementation for Iowa Medicaid, as well as the ongoing execution of the plan. The pre-implementation staffing model includes those positions that will establish network adequacy, medical management, project management and human resources support to get the health plan up and running as rapidly and effectively as possible. Our post-implementation staffing model supports the long-term vision for the health plan and includes all functions necessary to ensure we provide a "high-touch" experience for the member as we help them get care and stay well. Our staffing model includes positions that truly reflect that “care is the heart of our work”.

The following exhibit provides an overview of the proposed AmeriHealth Caritas Iowa organizational structure. Key staff will be 100 percent dedicated to the Iowa implementation once the award is announced. We have positioned ourselves to hire candidates from our talent pipeline quickly as this will help to ensure a seamless transition.

Post-Implementation Organization Chart



• Indicates required role

Exhibit 8: AmeriHealth Caritas Iowa Organizational Chart

Conclusion

AmeriHealth Caritas has a long and successful history of partnering with states to address their unique needs and challenges. We bring a mission-focused approach in our work to improve the healthcare of the communities we serve. Our innovative programs and solutions will provide the highest quality of care and significant value for Iowa Medicaid members and the State.

AmeriHealth Caritas Iowa and the Iowa DHS have a shared vision for the next generation of Iowa's Medicaid program. Everything we do and every decision we make starts with our members in mind and we are committed to giving our members the best healthcare experience possible. Through our holistic person-centered approach to healthcare and services, collaborative partnerships with DHS, providers and communities and an intense focus on increasing access to care, we will remove barriers to healthcare and services for those most in need and deliver better health outcomes.

AmeriHealth Caritas Iowa is the right choice for Iowa. We would be honored to be your partner for the Iowa Medicaid program.

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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, 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.

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 unparalled access, focusing on seamless care coordination, and leveraging the strength and success of current Iowa Department of Human Services (DHS) iniatives, 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.

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.

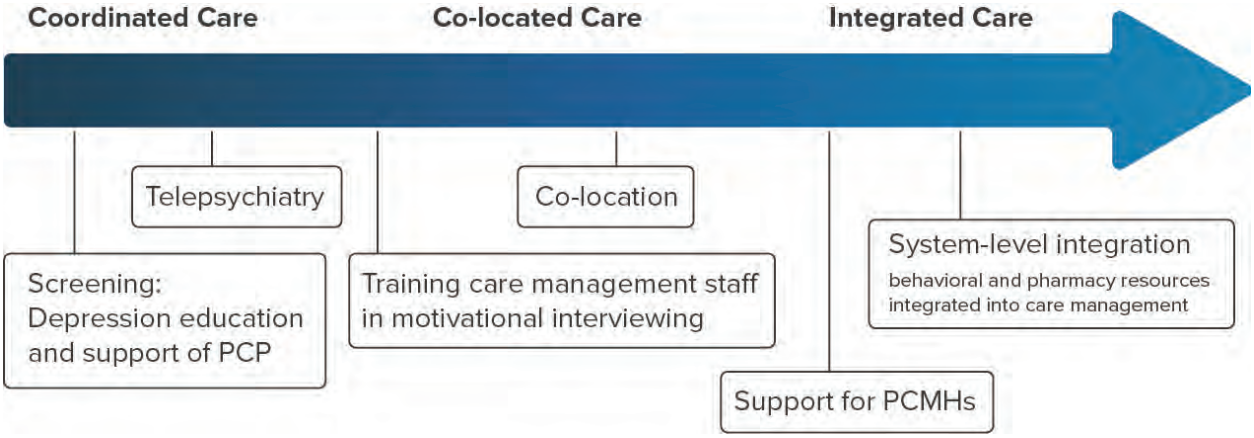
To address the specific elements listed in Section 1.4.2, we believe we have the qualifications in place to meet and exceed the State's needs:

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, arthrogryposis, 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 NCQA 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 then 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 pursed 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 PerformRx℠ 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 $[redacted], investments of $[redacted], total assets of $[redacted] and member equity of $[redacted]. 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.

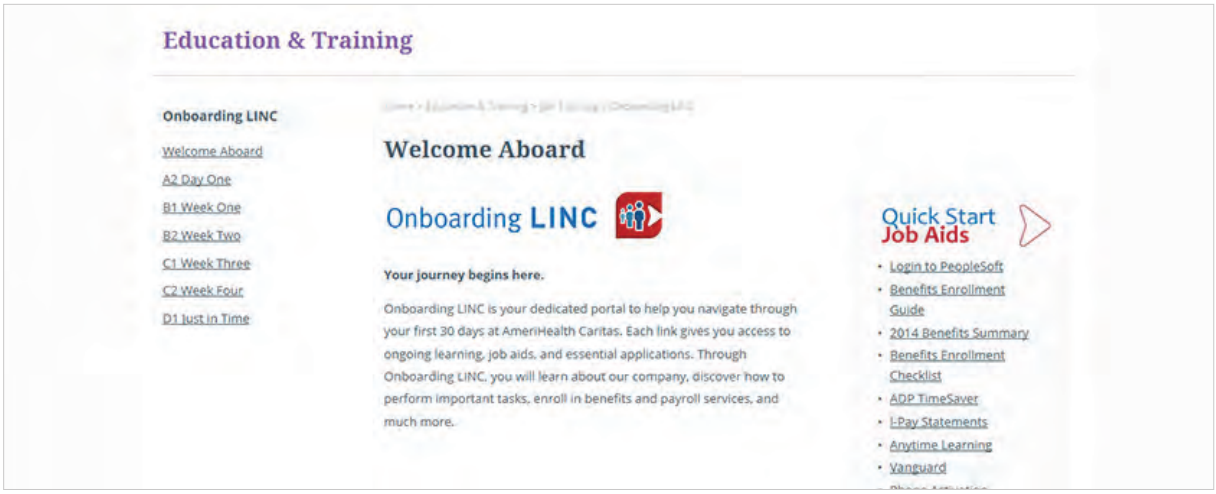


Exhibit 2.9-A: Onboarding training plan

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 MACESS 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 the 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.

Online Help

Select an Online Help File

Contents | Search | Glossary

Search

Type in the word(s) to search for:

newborn

Highlight search results

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Title	Rank
Newborn Enrollment FAQs	1
Newborn Auth Claims - Medical (Pend Queue)	2
Newborn Auth Claims - Hospital (Pend Queue)	3
2013 ACLA/LaCare Updates	4
Inpatient Claims	5
Member Data Issues	6
Resolve	

Newborn Enrollment FAQs

Added 10/24/13 Updated 2/12/15

Question	Answer
How is a newborn enrolled onto AmeriHealth Caritas Louisiana (ACLA)?	• The delivering doctor must report the delivery to Louisiana DHH. If the provider fails to notify the State, the member (mother) must contact **Bayou Health at 1-855-229-6848**. • Once ACLA receives notification from the State of the newborn's eligibility, the newborn will be created in Streamline/Facets.
What is the effective date for a newborn?	The newborn is **retro-effective with ACLA on the DOB**, regardless of when ACLA received notification from the State
Are newborns automatically enrolled into ACLA?	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.
What if the newborn's not in Streamline/Facets?	• 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.

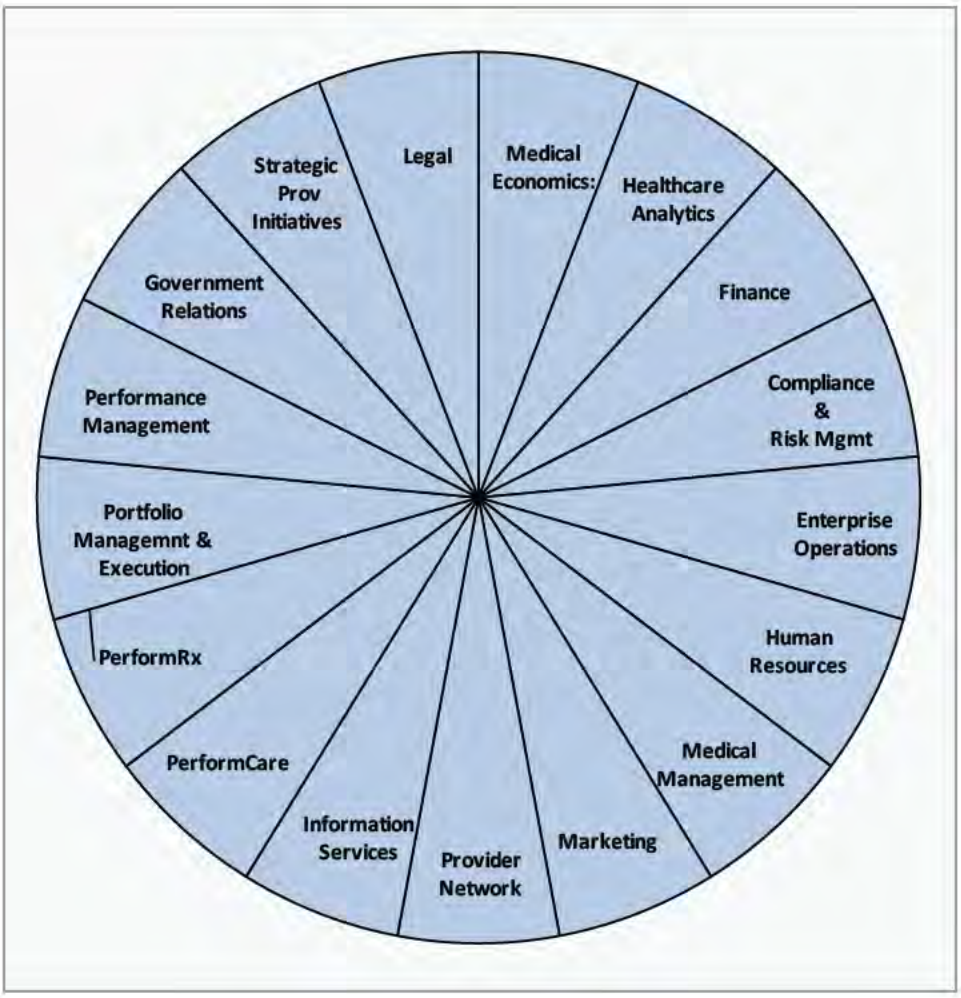

Exhibit 2.14-B: Core Team

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.

- 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.

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.

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**

Is it an emergency?

Yes →

CALL 911 for problems like:

- Chest pain
- Choking
- Poisoning
- Severe wound/heavy bleeding
- Not able to breathe right
- Severe spasms/convulsions
- Loss of speech
- Broken bones
- Severe burns
- Drug overdose
- Sudden loss of feeling or not being able to move
- Severe dizzy spells, fainting or blackouts

I don't know →

Before going to the emergency room:
Please call your doctor or the 24/7 Nurse Call Line at XXX-XXX-XXXX.

No →

Do you need urgent care?

No →

Yes

Call your doctor or the 24/7 Nurse Call Line for problems like:

- Coughing
- Vomiting
- Diarrhea
- Sore throat
- Colds
- Pink eye
- Stomach ache
- Rashes
- Bruises
- Toothache - call your dentist or Member Services if you don't have a dentist.

Call your doctor or the 24/7 Nurse Call Line for problems like:

- Toothache
- Sunburn
- Skin rash
- Sexually Transmitted Disease (STD)
- Earache
- Sprains
- Animal or insect bite
- Fever
- Minor cuts

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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**.

Qúy 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

SAMPLE

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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.

AmeriHealth Caritas Iowa

SAMPLE

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.

The Rapid Response team initiated targeted outreach to these members and the graph reflects the ongoing usage of the Rapid Response team's member monitoring on a monthly basis. Interventions included telephonic outreach, letters to members that were unable to be contacted by telephone, and face to face outreach by the CEOT and CCMT. To date, we have been unable to contact only 12 members, even after community team referrals.

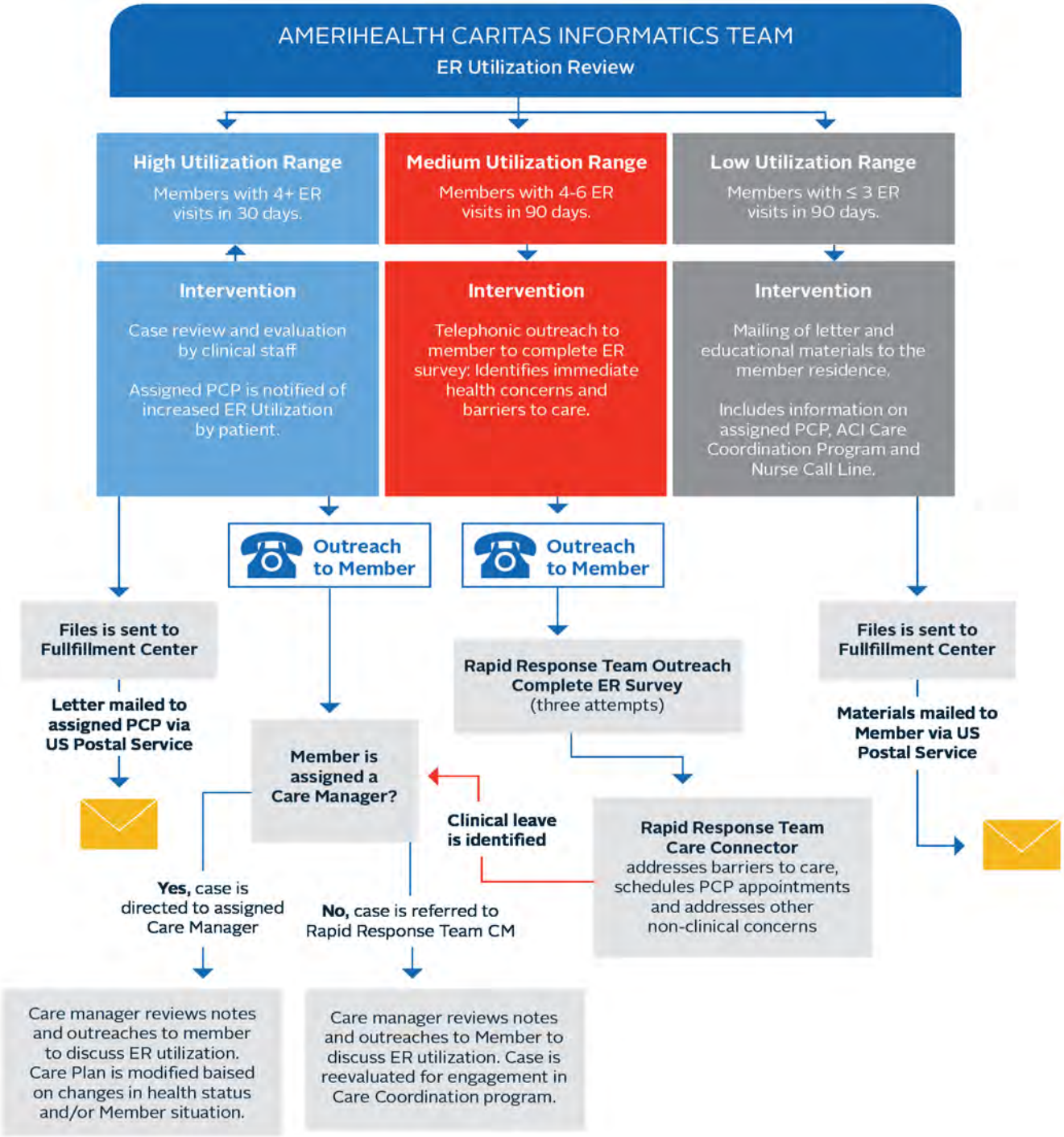

Exhibit 3.2.5-D: ER Utilization Review Process

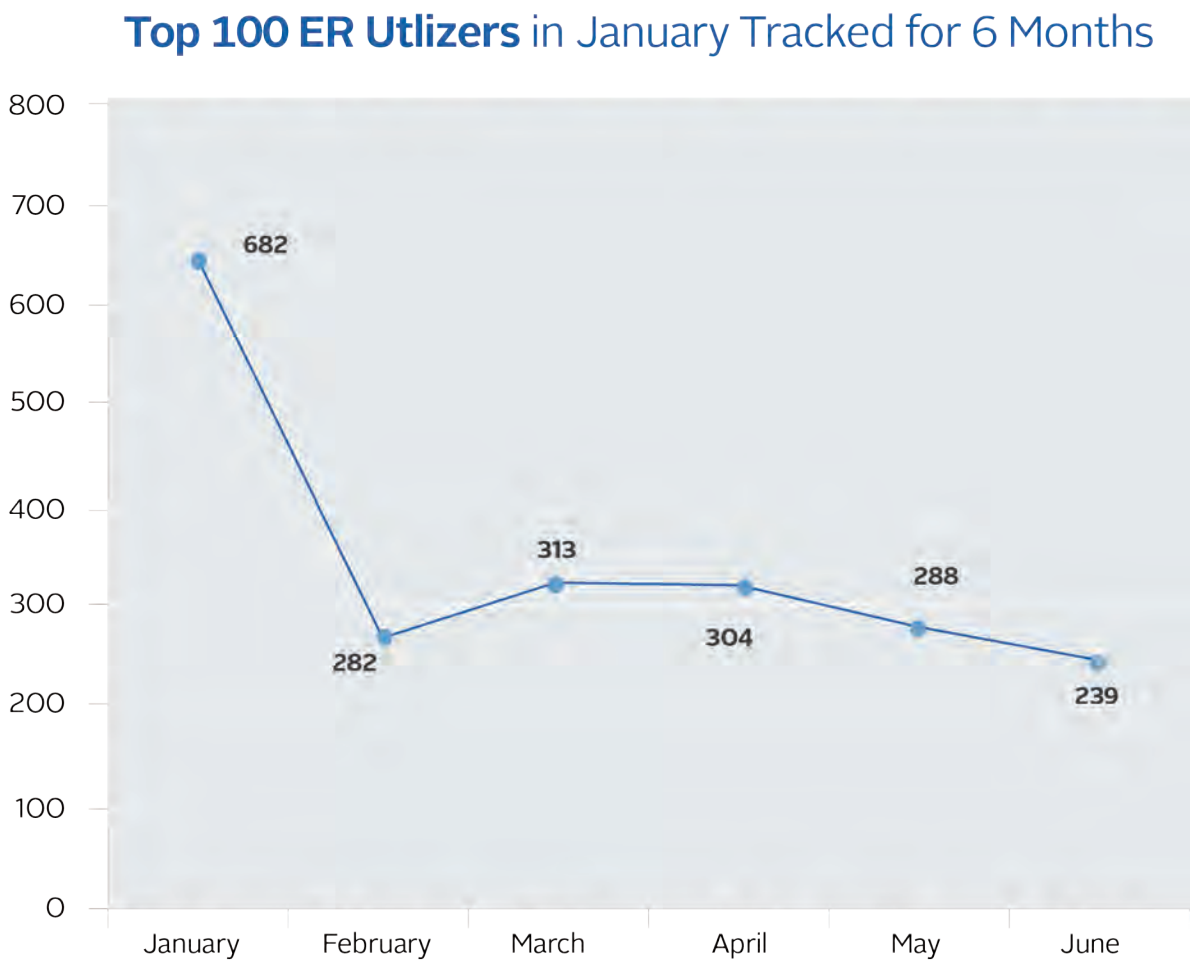

Exhibit 3.2.5-E: ER Utilization Example

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.

PerformRx℠, 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, prospecitive 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 PerformPA℠ 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 prescritions to one precribing physician through a Recipient Restriction program.
- **PerformPA® —** PerformPA® is the HIPAA-compliant web-based system that will be used 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 in 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 wills 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 though 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.

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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 regiments.

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 patters 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 mall. Additionally, this importation 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.

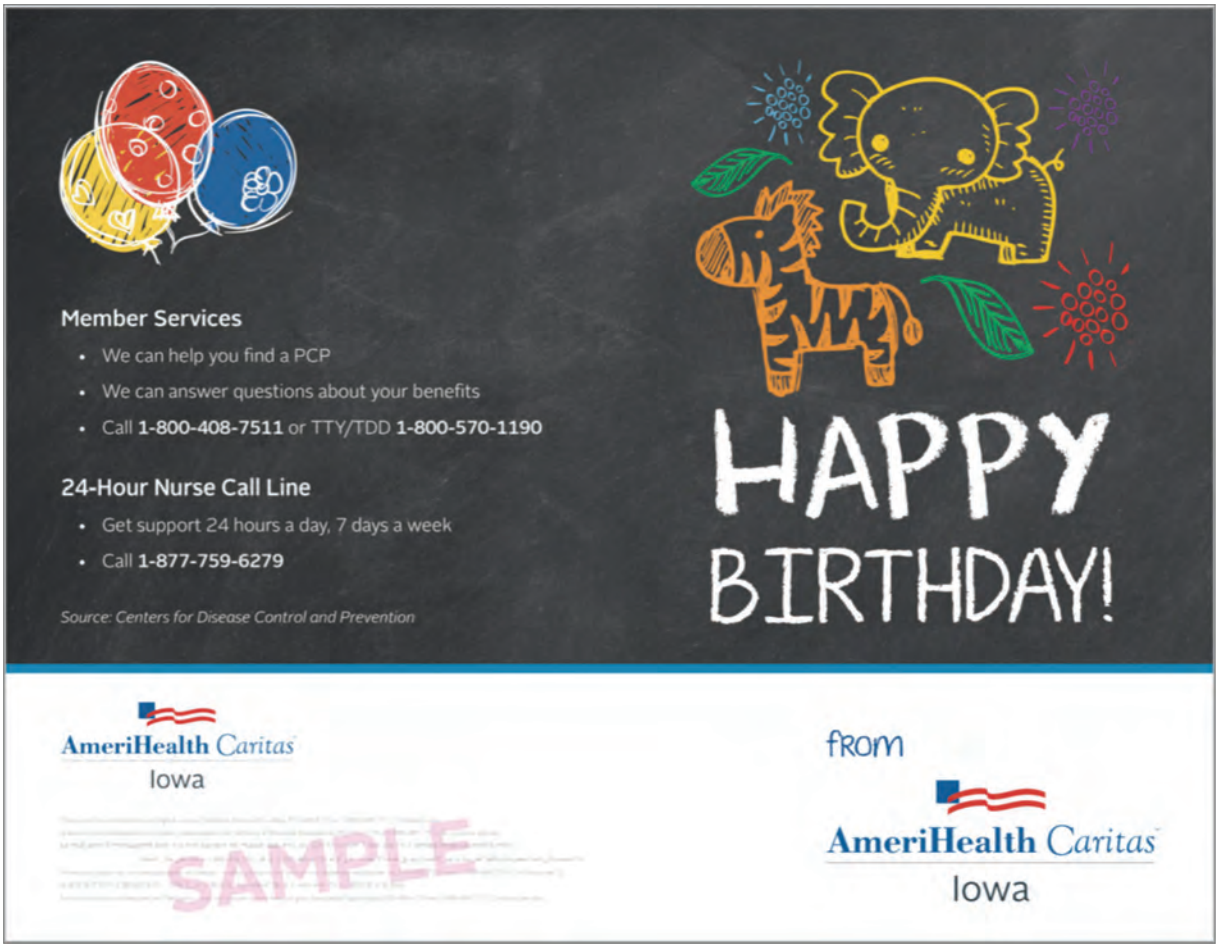


Exhibit 3.2.7.-A: Example AmeriHealth Caritas Iowa Birthday Card

Staying Healthy!

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.

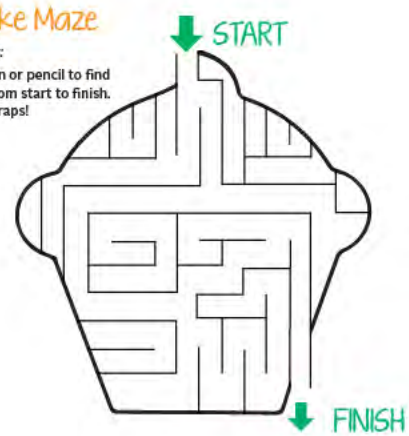
Birthday checklist:

- ☐ 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.

AmeriHealth Caritas Iowa

Use this checklist to keep up with your child's well-child visits.

- ☐ 3 – 5 days.
- ☐ 1 month.
- ☐ 2 months.
- ☐ 4 months.
- ☐ 6 months.
- ☐ 9 months.
- ☐ 12 months.
- ☐ 15 months.
- ☐ 18 months.
- ☐ 24 months.
- ☐ 30 months.
- ☐ Children ages 3 – 21 should have a well-child visit each year.

Rapid Response Team
X-XXX-XXX-XXXX.

PCP name

PCP phone

AmeriHealth Caritas Iowa

Utilice la lista siguiente para asegurarse de que sus niños reciben chequeos médicos aestas edades.

- ☐ 3 – 5 días.
- ☐ 1 mes.
- ☐ 2 meses.
- ☐ 4 meses.
- ☐ 6 meses.
- ☐ 9 meses.
- ☐ 12 meses.
- ☐ 15 meses.
- ☐ 18 meses.
- ☐ 24 meses.
- ☐ 30 meses.
- ☐ Los niños de 3 a 21 años de edad deben de tener una Visita de Bienestar cada año.

Rapid Response Team
X-XXX-XXX-XXXX.

Nombre del médico/PCP

Número de teléfono del médico/PCP

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.

AmeriHealth Caritas
Iowa

200 Stevens Drive
Philadelphia, PA 19113-1570

SAMPLE

September 19, 2014

Head of Household
<Member name>
<Address>
<City, State, ZIP>

Dear Member:

We want to make sure you get the best care for you or your child.

From time to time, we will send you information on health care topics, like the one enclosed.

If you have questions about what you read or if you would like to talk to one of our nurses, please call us at **1-888-643-0005**.

Thank you,

AmeriHealth Caritas Iowa
Rapid Response Team

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:

- ☐ 3 – 5 days.
- ☐ 1 month.
- ☐ 2 months.
- ☐ 4 months.
- ☐ 6 months.
- ☐ 9 months.
- ☐ 12 months.
- ☐ 15 months.
- ☐ 18 months.
- ☐ 24 months.
- ☐ 30 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 qua điện thoại bất kỳ ngôn ngữ nào. 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**.

AmeriHealth Caritas Iowa

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 Start SM 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	• Create a Safety Plan-High Priority Goal • Learn about condition • Improve activities of daily living (ADLs)/Functionality.	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	• Member/caregiver will obtain optimum level of health by participating in self-management of condition(s)-High Priority Goal	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 effects 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 wil 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.

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.

AmeriHealth Caritas Iowa

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**.

AmeriHealth Caritas Iowa

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.

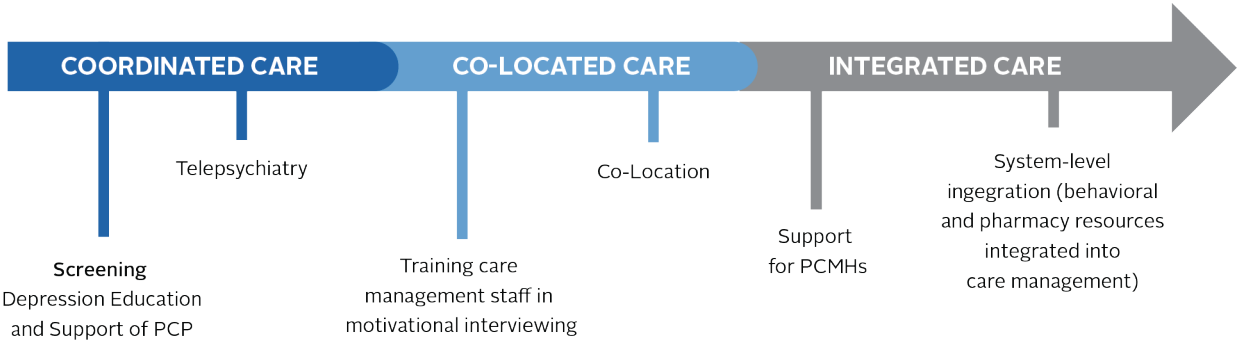


Exhibit 3.2.8-E: AmeriHealth Caritas Care Coordination Overview

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., 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.
4. **Training care management staff in motivational interviewing**, a collaborative engagement method that addresses a member's motivation and commitment toward changing an unhealthful 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-yearold 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 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, a15-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 used 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 that 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: • 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
Enhanced Telehealth Services and Tele-monitoring	Accessed by appointment.	Utilizing existing telehealth infrastructure (e.g. University of Iowa, Mercy Health Network) as well as an AmeriHealth Caritas direct-to-consumer (DTC) platform	Telehealth visits will generate claims captured in our standard encounter reporting process.	Members will be notified through their New Member Welcome Packages, health plan website, and other channels.	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.
Enhanced Care Coordination and Management	Members will be connected with applicable services based on risk profiling and stratification.	AmeriHealth Caritas Iowa Care Management team in conjunction with Member's PCP and other providers as applicable.	Not reported in encounters, but captured in Medical Management care plan and internal reporting.	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 engaged through care management.

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
Member programs: • 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	Members must complete 12 initial gym visits in order to be eligible for free full-year gym membership Benefits Bank available to all Members at designated locations Mission GED available to those members pursuing their GED Other services available through referral by care manager	Gym memberships provided by participating gyms Weight Watchers provided by participating locations Benefit Bank administered by The Benefit Bank, a non-profit organization supporting the social and financial needs of low-income populations	Nutritional counseling will generate claims activity captured in our routine encounter data submission 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 Members receiving financial support for their GED will be tracked via internal reporting	Members will be notified through their New Member Welcome Packages, health plan website, and other channels Members will be identified through case management referral for nutritional counseling and other programs as appropriate	Members may directly access free membership at sponsoring organizations (gyms, Weight Watchers) Nutritional Counseling and Smoking Cessation programs will be accessed via care management referral 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) Mission GED will be accessed via application

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: • 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.

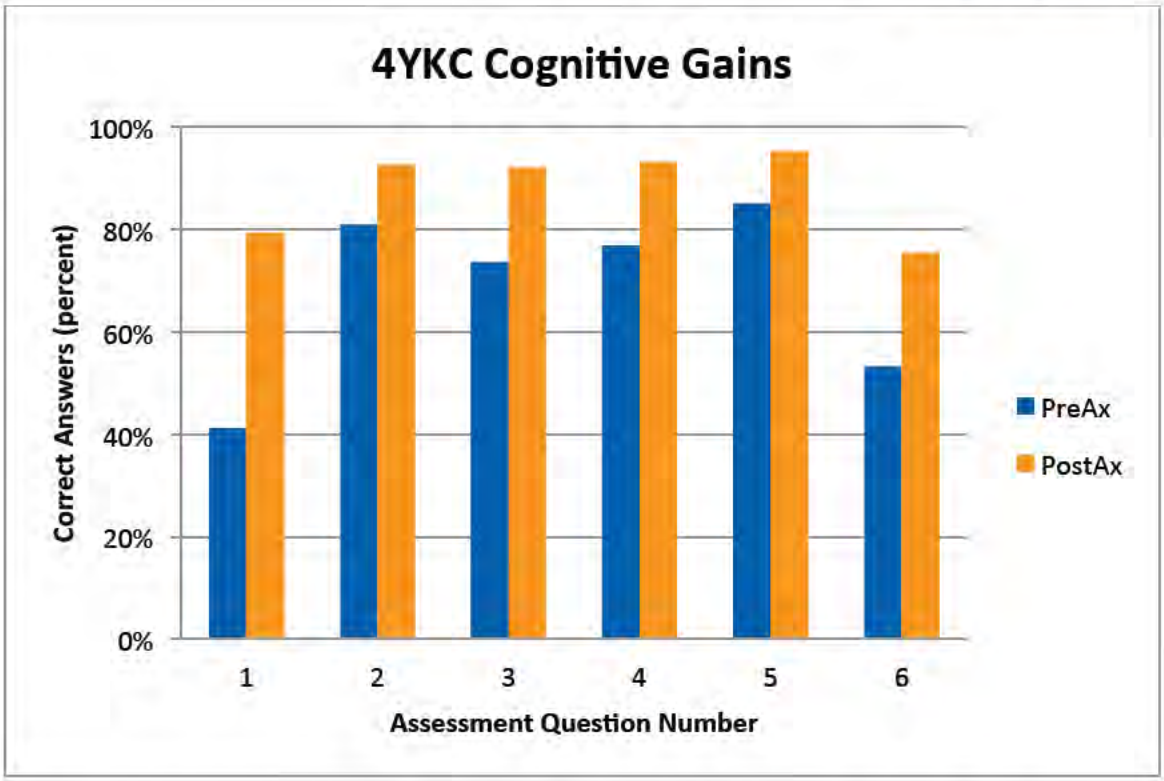
Programs for Children:

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 • 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 • 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.

AmeriHealth Caritas Iowa

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: ☐ Yes ☐ No Check One: ☐ Initial ☐ Continued Service ☐ Discharge

☐ 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: ☐ Education ☐ Vocational ☐ Social ☐ Self Maintenance

Describe Functional Impairment: _____

ADULT PRIORITY GROUP

1. Must meet age from this section to continue. ☐ Age > = 18	☐ 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. *{if this box is checked, stop here, meets priority group standard and qualifies for peer support}*
3. Axis I Specify Qualifying Diagnosis: _____ 295.xx Schizophrenia 296.xx major affective disorder 298.9x psychotic disorder NOS 301.83 borderline personality disorder *{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}*	

Must meet one of the following A, B or C. Check the criteria within the column that meets the standard:

☐ A Treatment History	☐ Current Residence in or discharge from a state mental hospital within past 2 years ☐ Two admissions to community or correctional inpatient psychiatric units or crisis residential services totaling 20 or more days within the past two years ☐ Five or more face to face contacts with walk in or mobile crisis or emergency services within the past two years ☐ 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 ☐ 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 ☐ 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
☐ B Functioning Level	☐ Fill in GAF score_____ *Global Assessment of Functioning Scale rating of 50 or below*
☐ C Coexisting Condition or Circumstance	☐ Coexisting Diagnosis ☐ Psychoactive Substance Use Disorder, ☐ Mental Retardation, HIV/AIDS, Sensory, Development and/or Physical Disability (check if SA or MR) ☐ Homelessness (sleeping in shelters or places not meant for human habitation, such as cars, parks, sidewalks, or abandoned buildings) ☐ 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])

Comments: _____

PerformCare Use Only:	Valid:	Provider Use: ☐ 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:	☐ IT	Date of Fax:	Fax Ref. #:	Reason: (see Key-Fax Cover)
AP:	☐ CCM			
St: Ex: U:	☐ PR			

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Revised 103/13

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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.

- 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.

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.

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 it 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 members 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 choses 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	
Aging and disability specific associations and providers • Iowa Association of Area Agencies on Aging (i4a). • Leading Age. • Iowa Disability and Aging Advocates (IDAAN). • Arc of Story County. • Mainstream Living.	**Children's and family services** • Child and Family Policy Center. • Coalition for Child and Family Services. • Iowa Association of Community Action Agencies. • Lutheran Services.
Shelter services • Central Iowa Shelter Services.	**Other associations and provider groups** • 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 Section4.4.3.7.

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: • Completed within 7-14 days of referral, if high risk. • Within 30 days, if moderate risk. • Within 60 days, if low risk.	• In-person with the member at his/her home or place of his/her choice.	• 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 prioritizes 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 are 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 individuated 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	• In-person. • At least every 12 months from original initial assessment.	• 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.	• In-person. • As triggered. • Change in participant status (health or psychosocial). • At the request of the participant or designated representative.	• 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: • Completed within seven to14 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 to14 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**: • Every 180 days. **If in community**: • 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:** • 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 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.
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 7to 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.

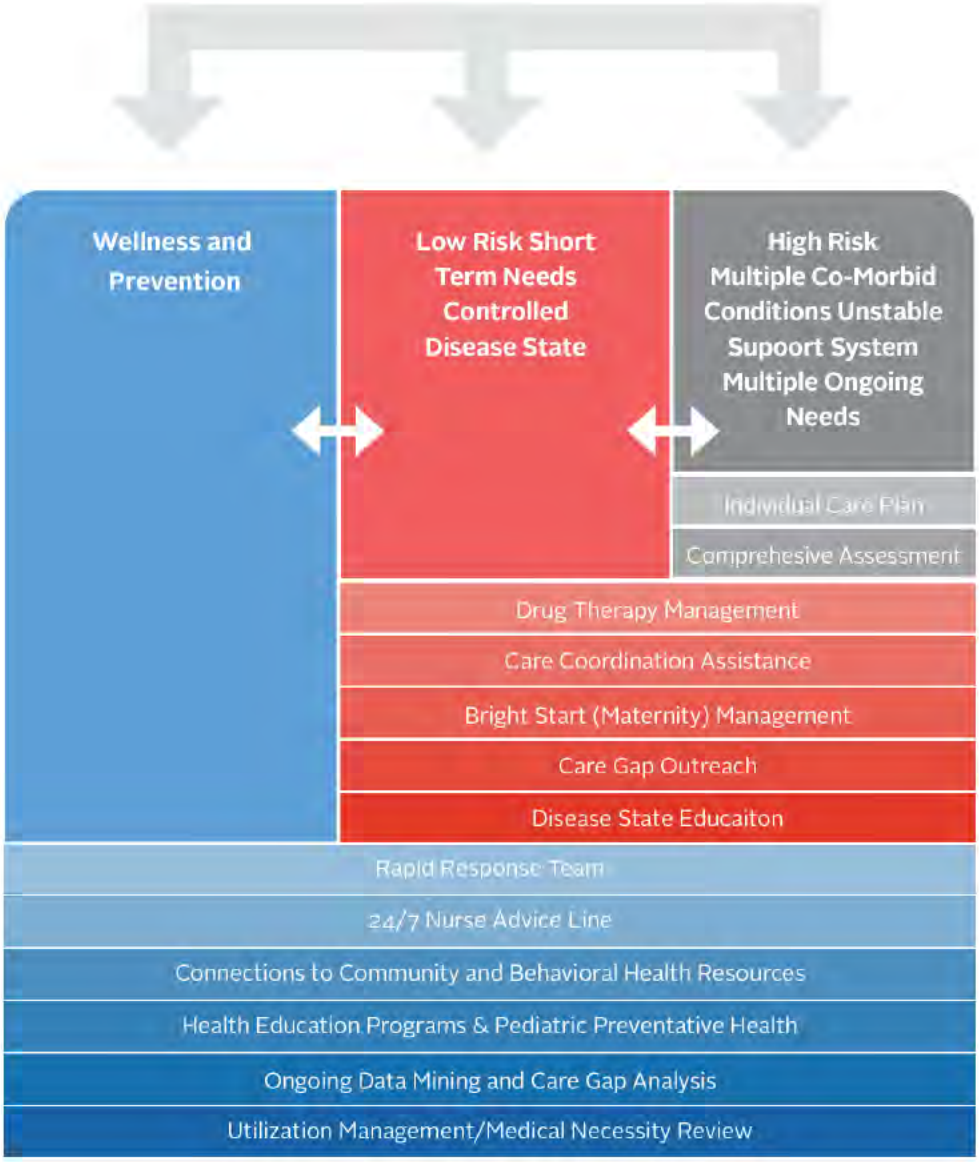

Exhibit 4.3-A: Overview of AmeriHealth Caritas Iowa Risk Stratification

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.

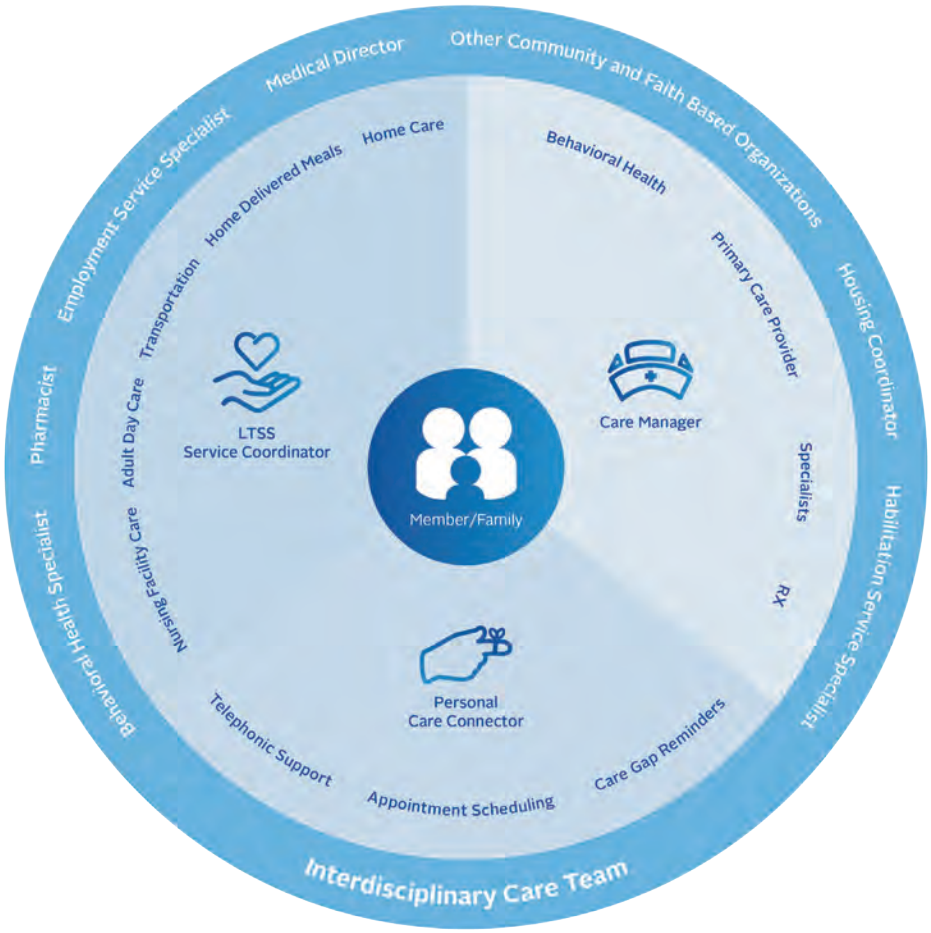

Exhibit 4.3-B: AmeriHealth Caritas LTSS Model of Care

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 mangers.

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
Medical director **1:75,000 members**	• 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.
Medical management director **1 per program**	• 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.
Manager, care management **1 : 15-20 staff**	• 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	• 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	• 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	• 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

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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 mangers 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 manger 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.

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DISCHARGE PREPARATION CHECKLIST

Before I leave the care facility, the following tasts should be completed:

- ☐ I have been involved in decisions about what will take place after I leave the facility.
- ☐ I understand how to keep my health problems from becoming worse.
- ☐ I understand where I am going after I leave this facility and what will happen to me once I arrive.
- ☐ My doctor or nurse has answered my most important questions prior to leaving the facility.
- ☐ I have the name and phone number of a person I should contact if a problem arise during my transfer.
- ☐ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- ☐ I understand what my medications are, how to obtain them and how to take them.
- ☐ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.
- ☐ I understand the potential side effects of my medications and whom I should call if I experience them.
- ☐ 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

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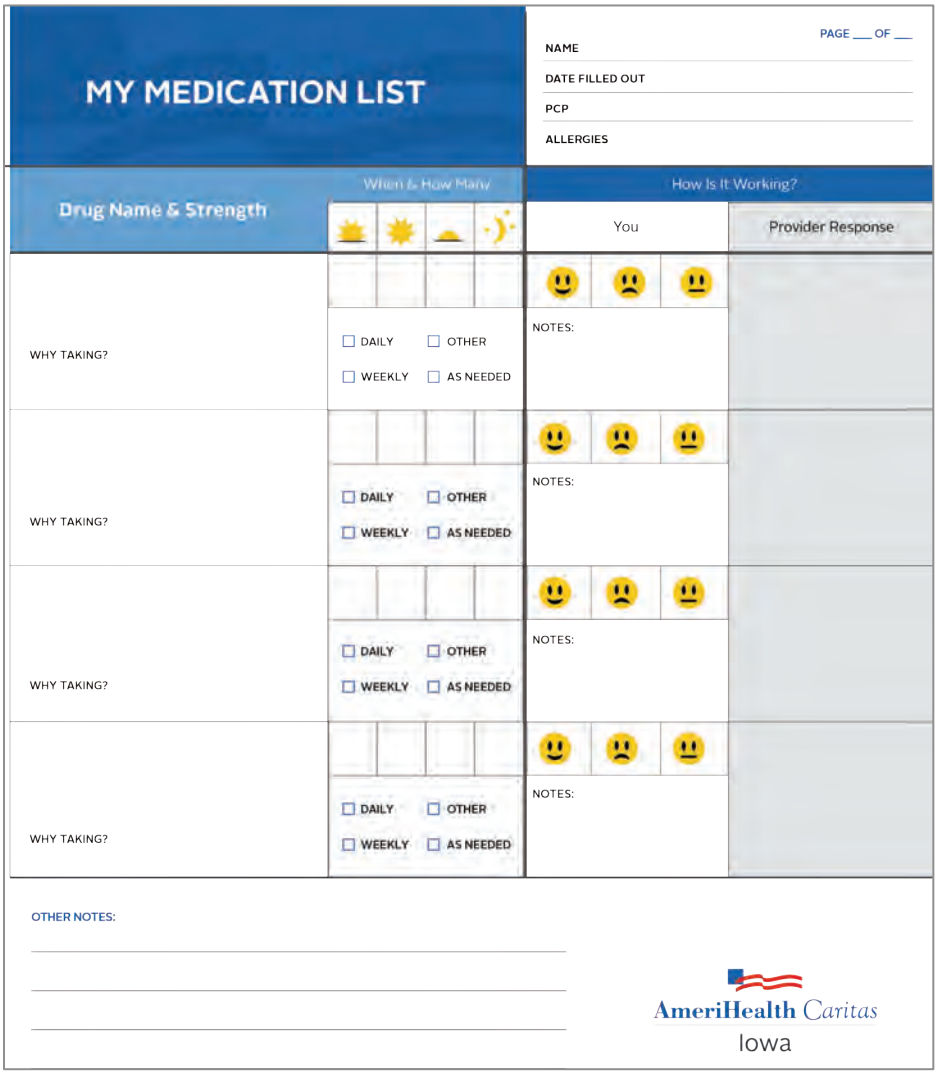

MY MEDICATION LIST

PAGE ___ OF ___

NAME

DATE FILLED OUT

PCP

ALLERGIES

Drug Name & Strength	When & How Many	How Is It Working?	
		You	Provider Response
WHY TAKING?	☐ DAILY ☐ OTHER ☐ WEEKLY ☐ AS NEEDED	NOTES:	
WHY TAKING?	☐ DAILY ☐ OTHER ☐ WEEKLY ☐ AS NEEDED	NOTES:	
WHY TAKING?	☐ DAILY ☐ OTHER ☐ WEEKLY ☐ AS NEEDED	NOTES:	
WHY TAKING?	☐ DAILY ☐ OTHER ☐ WEEKLY ☐ AS NEEDED	NOTES:	

OTHER NOTES:

AmeriHealth Caritas Iowa

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	Telephonic outreach to reinforce the discharge/transition care plan and address any problems or concerns that have arisen since discharge Visit member at residence to: • 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.	Telephonic Outreach: Within 2 to 3 days of discharge Home Visit: Within 2 to 7 days of discharge
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.

AmeriHealth Caritas
Iowa

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).

Để thông tin này có sẵn trong các ngôn ngữ và định dạng khác, vui lòng gọi Dịch Vụ Hội Viên at 1-888-991-7200 o at 1-888-987-5704 (TTY).

Muốn đọc thông tin trong thông báo này dưới ngôn ngữ khác, xin gọi Ban Dịch Vụ Hội Viên at 1-888-991-7200 hay số dành cho người khiếm thính at 1-888-987-5704 (TTY).

ถ้าต้องการรับข้อมูลในประกาศนี้ในภาษาอื่นๆ ให้โทรติดต่อฝ่ายบริการสมาชิกที่หมายเลข 1-888-991-7200 () 1-888-987-5704 (TTY) ได้ตลอดวันนี้ค่ะ

Для получения данной информации в данном уведомлении на других языках позвоните в Отдел обслуживания по телефону 1-888-991-7200 или 1-888-987-5704 (TTY).

非通知的信息以其他语言和格式提供。如需帮助，请致电 1-888-991-7200 或 1-888-987-5704 (TTY) 联系会员服务部。

SAMPLE

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
• 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
• 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: • 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: • 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 mangers 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 is 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: • 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.

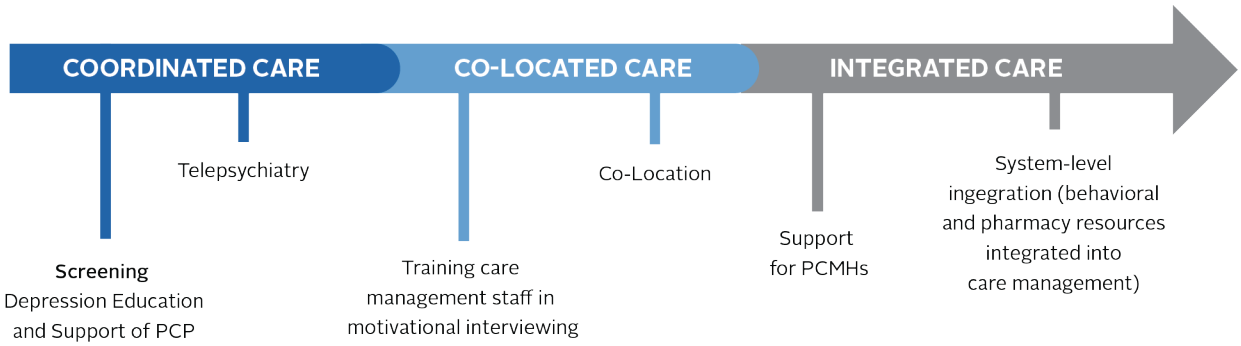

Exhibit 4.3.12-B: Integrated Care Overview

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 individuated 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.

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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.

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My Transition Service Plan

AmeriHealth Caritas Iowa

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 Mary Beth McQueen	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

Lynn Rhodes RN
Care Coordinator

515-457-2300, ext 123
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	Telephonic outreach to reinforce the discharge/transition care plan and address any problems or concerns that have arisen since discharge. Visit member at residence to: • 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.	Telephonic outreach within 2 to 3 days of discharge Home visit within 2 to 7 days of discharge
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.

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AmeriHealth Caritas Iowa

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	Address	Phone number	Emergency contact	
Sharon Jones (daughter)	26 Magnolia Rd., Altoona, IA 50009	515-789-1234	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 restorerights	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	1) Continue with physical and occupational therapy 2 times a week on strength training. 2) Remember to lock my walker when I am stationary
Isolation	1) Attend my adult day program 3 times a week 2) 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 responsesystem	1) Alternative Home Care Agency nursing support when self-directed nurse is unavailable. 2) Life Line Medical Alert – Mrs. Jones will activate in the event of a fall or other emergency when appropriate.	
Emergency backup providers	Name Home Care Agency	Phone number 515-254-7600

Exhibit 4.3.12-D: AmeriHealth Caritas Iowa Sample Service Plan (3 of 4)

My Service Plan Form

Katie McCalley
Care manager

515-457-2300, ext 123
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

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 though 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.

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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

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Exhibit 4.3.12-E: AmeriHealth Caritas Iowa Self-Assessment Form (2 of 2)

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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

DRAFT

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.

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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

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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.

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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.

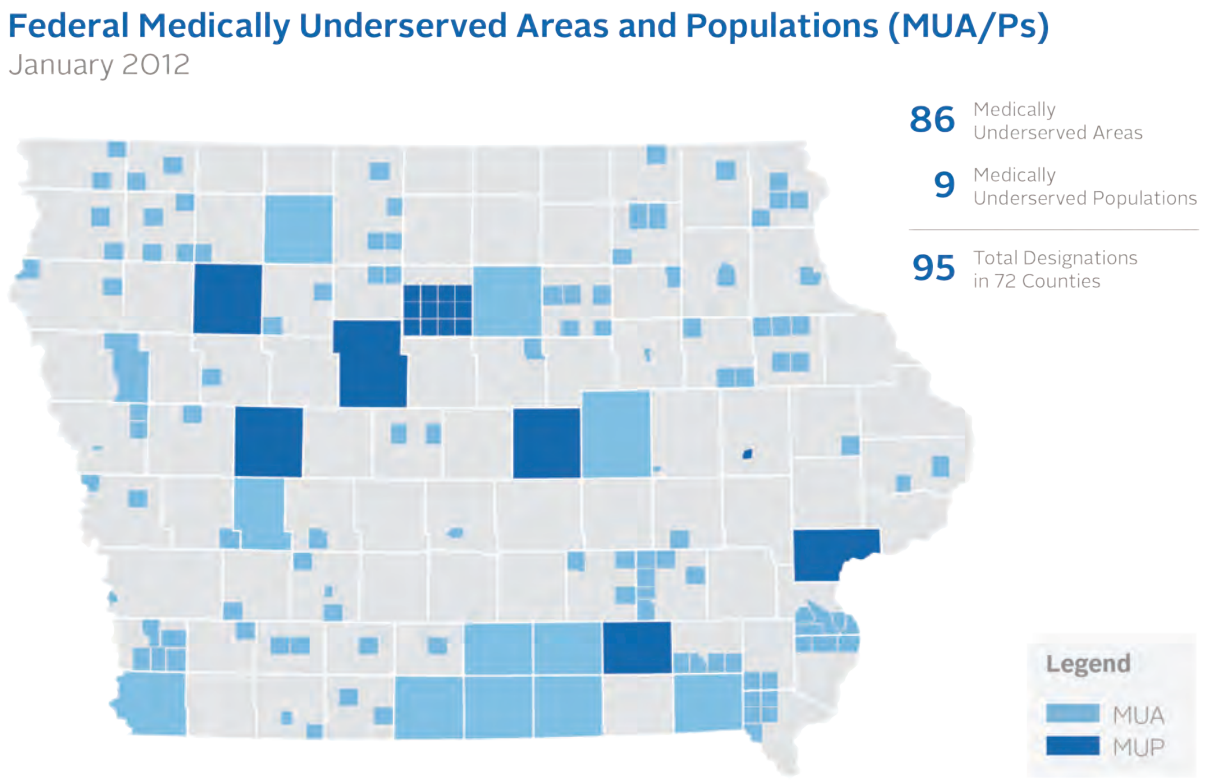


Exhibit 6.1-B: Federal Medically Underserved Areas and Populations[3]

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 then 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.

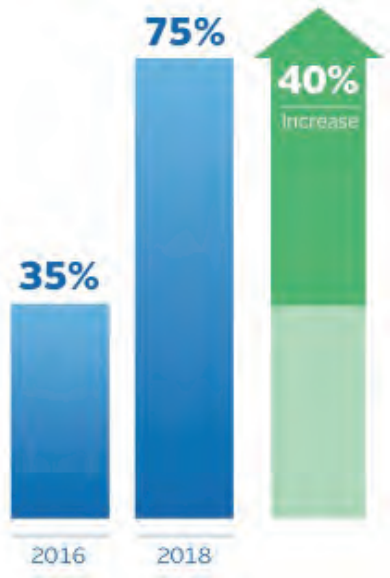
3. Indicate if you propose to impose any requirements for exclusivity agreements for quality or payment purposes.

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.

PerfomPlus® 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
• Quality Community Health Care (Pennsylvania) • Spectrum Health Services (Pennsylvania) • Sumter Family Health Center (South Carolina)	• 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.

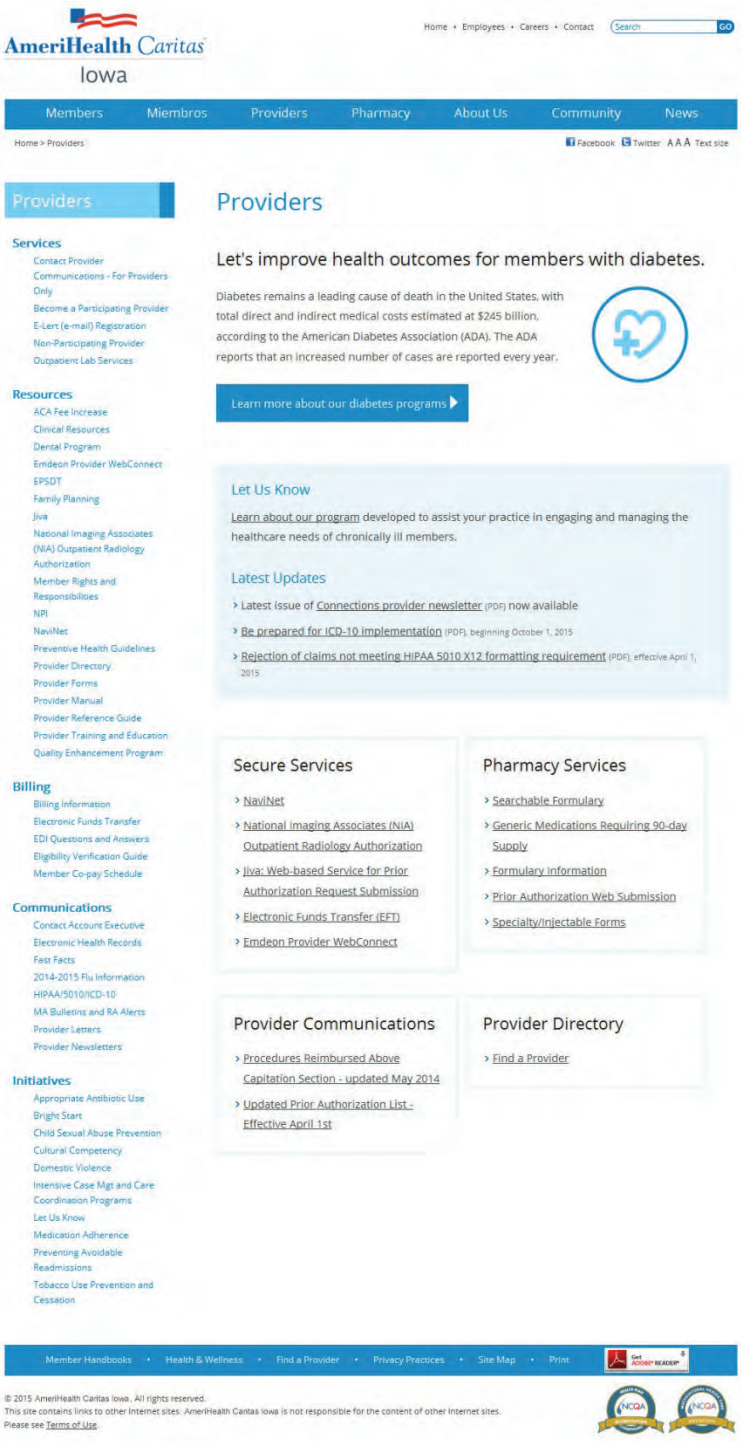


Exhibit 6.1.6-A: AmeriHealth Caritas Iowa provider portal

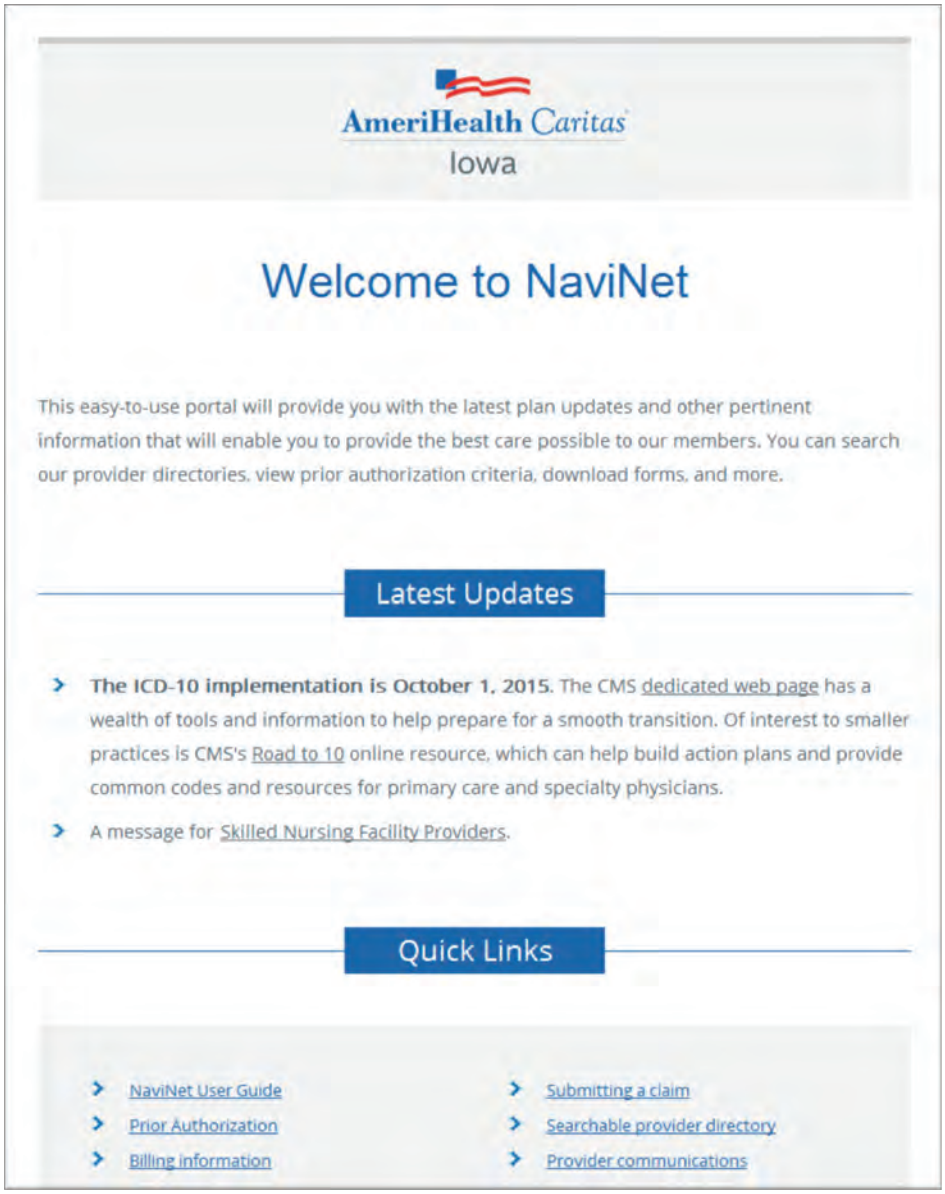


Exhibit 6.1.6-B: AmeriHealth Caritas Iowa NaviNet Portal

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 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 MACESS, our workflow tool. EXP MACESS is an imaging-based operations management, workflow management, enterprise content management and customer service solution that has been standardized for managed healthcare organizations.

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.
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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

Indian Hills Clinic
2600 Outer Drive N.
Sioux City, IA 51104
(712) 239-3300

Sioux Falls Urban Indian Clinic
711 N. Lake Avenue
Sioux Falls, SD 57104
Phone: (605) 339-0420

Winnebago Hospital
U.S. Highway 77-75
Winnebago, NE 68071
Phone: (402) 878-2231

Siouxland Community Health Center
1021 Nebraska Street
Sioux City, IA 51105
(712) 252-2477

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7. Enrollment

Please explain how you propose to execute Section 7 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Overview

AmeriHealth Caritas Iowa is able to meet all Iowa Medicaid enrollment and disenrollment requirements as described in Section 7.

Easy member enrollment and disenrollment plays a critical part in the continuity of care and the ability for the hardest-to-reach populations to have access to quality health care. Our enrollment and disenrollment processes are turn-key, easy to use and fair. We focus on empowering access to all populations, no matter where they are.

We focus on a holistic enrollment approach centered on member rights, cultural awareness and sensitivity, and our commitment to serving all members in all circumstances—resulting in low opt-out rates across the populations we serve.

Members matter most

We deliver the highest-quality healthcare through a culture that prioritizes—above all else—member rights, cultural awareness and sensitivity, and an intractable commitment to serving members wherever they are and whatever their circumstances may be. It is through this commitment that we honor member values, recognize their humanity, respect their worth as individuals, protect their dignity and preserve their right to self-determination.

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

7.4 Member Disenrollment

1. Describe your grievance process for addressing member quality-of-care concerns and member disenrollment after the first ninety (90) days of enrollment.

We treat all member complaints and grievances with the highest level of attention and care. We are a people-to-people organization, dedicated to delivering the absolute highest-possible levels of care and service. To best achieve this goal, we actively encourage members to submit concerns by educating them on the grievance process (see attachment), and we commit ourselves to resolving member concerns expeditiously and to the satisfaction of our members.

Member-initiated complaints and grievances

If members feel their rights have been violated or they feel they are not getting the care, support or attention their health conditions warrant, they have the right to file a formal complaint or grievance. The member may file a complaint or grievance by calling our Contact Center of Excellence's member services department or in writing. The AmeriHealth Caritas Iowa Complaint and Grievance team will actively investigate the issue raised by the member, and work to provide a resolution. The Complaint and Grievance staff will complete an exploration into the matter through the following actions:

- Verifying the service and/or activity of the member during the visit with the service provider.
- Contacting the member to ensure all concerns/issues identified during the initial call are clear and concise.
- Notifying vendors (e.g., transportation) through our Vendor Delegation Oversight team, which acts as a liaison between the vendors and our Complaints and Grievance department (this process is instrumental in ensuring all protocols are being met in accordance with our contractual obligations).
- Documenting and routing all actions to the appropriate areas, and housing the acknowledgment/resolution letters outlining the solution through our workflow management system (EXP application).

AmeriHealth Caritas Iowa gladly provides assistance to members through the entire complaint or grievance process, until the concern is resolved. Our customer service representatives comprise the first point of contact for member grievances. The representatives provide intake for the initial information, which is documented and tracked in our workflow management system and route it to the appropriate area for review. Every single employee who interacts with members is trained in AmeriHealth Caritas Iowa's complaint, grievance and fair-hearing processes, as well as when and how to assist members in using them.

AmeriHealth Caritas Iowa is dedicated to supporting member rights, believing that well-informed members are better able to participate in their own care and make educated judgments about the health choices available to them. We seek to inform members of their lawful rights through a variety of member materials, including the Member Handbook and Member Newsletters, as well as during contact center interactions. See below for sample outreach from our Member Newsletter.

Member-initiated disenrollment

AmeriHealth Caritas Iowa is committed to resolving member concerns and establishing mutually agreeable resolution plans. We view member disenrollment as a measure of last resort. However, when the enrollment broker has considered the member's request and approved the disenrollment, we are committed to making the transition as smooth as possible. We will fully document the disenrollment and maintained the documentation in the member's record. In addition, AmeriHealth Caritas Iowa will continue to provide medically necessary covered services to the member, in accordance with the established treatment plan (if applicable) and standard policies, until the effective date of disenrollment specified by the enrollment broker. If the member is hospitalized at the time of disenrollment or has special health needs, AmeriHealth Caritas Iowa will notify the member's new managed care organization (MCO) of that status. Upon request, AmeriHealth Caritas Iowa will work with the member's new MCO to transfer all appropriate records in a timely manner.

State-initiated disenrollment

When the State deems it necessary to disenroll a member, we will follow similar disenrollment procedures for both member- and contract-initiated requests. AmeriHealth Caritas Iowa will continue to provide medically necessary covered services to the member, in accordance with the established treatment plan (if applicable) and standard policies, until the effective date of disenrollment. If the member is hospitalized at the time of disenrollment or has special health needs, AmeriHealth Caritas Iowa will notify the member's new MCO of that status within five business days of the transition. Upon request, AmeriHealth Caritas Iowa will work with the member's new MCO to transfer all appropriate member records in a timely manner.

Contractor-initiated disenrollment

Disenrollment due to disruption to plan operations

AmeriHealth Caritas Iowa will never disenroll or encourage a member to disenroll because of his or her health care needs or a change in health status. However, we reserve the right to disenroll members who disrupt plan operations to the extent that we can no longer deliver services to them. To date, AmeriHealth Caritas has not encountered a single member who disrupted plan operations to the extent that disenrollment was appropriate. We do have experience serving members who are chronically dissatisfied with care in any setting; are extremely high utilizers of time, energy and resources; and can exhaust the time, patience and willingness of the caretakers or providers trying to help them. Our responsive, person-centered, culturally competent approach during all interactions with our members allows us to serve even these challenging members. For Iowa's Medicaid population, AmeriHealth Caritas Iowa will undertake all steps within our control to ensure member health needs are met in a way that does not disrupt the plan's operations.

Disenrollment due to fraud

We also reserve the right to disenroll a member due to fraudulent activity if the member is convicted of fraud by the State. When potential member fraud is uncovered by an AmeriHealth Caritas Iowa employee, we will collaborate with the State in its investigation into the matter. See Section 12, question 1, for additional detail on our procedures for avoiding, detecting and reporting suspected fraud to the State.

Disenrollment process

AmeriHealth Caritas Iowa will treat involuntary contractor-initiated disenrollment as a last resort. However, in the event AmeriHealth Caritas Iowa must resort to involuntarily disenrolling a member, we will provide written notice to the state that includes the reason(s) for the disenrollment request and specifies the disenrollment request is for the following month. An AmeriHealth Caritas Iowa care manager will complete the disenrollment form with the member's name and ID number, the detailed reason for the request and the interventions attempted to resolve the conflict before submitting the request to the enrollment broker. Copies of all disenrollment documentation will be maintained in the member's record.

Notification of member death or incarceration

If AmeriHealth Caritas Iowa becomes aware of the death or incarceration of one of its members, we will notify the state, in the prescribed format, within 30 calendar days.

Attachment 7.4-A: Member Communication Example

AmeriHealth Caritas Iowa wants to here about your experience

We hope that you will always be satisfied with AmeriHealth Caritas Iowa and our health care providers.

If you have questions or concerns about your AmeriHealth Caritas Iowa benefits or services, please call Member Services. Our Member Services representatives can help with most questions and concerns. If you still are not happy, you do have the right to file a grievance.

What is a grievance?

A member grievance is an oral or written report when you are not satisfied with:

- The quality of care you received.
- The quality of service you received.
- Rudeness of a health care provider or a network employee.
- Network administration practices.

How do I file a grievance with AmeriHealth Caritas Iowa?

A member grievance may be filed by a member, health care provider or personal representative, either by a phone call or by mail within 30 days from the action or occurrence. Call Member Services at **1-XXX-XXX-XXXX,** or write a letter to:

AmeriHealth Caritas Iowa
Member Services Supervisor
P.O. Box XXXX
Town Name, Iowa XXXXX

- An acknowledgment letter will be mailed within 1 business day of when we receive your grievance.
- Member Services will document the grievance and work with the appropriate departments to resolve your issue.
- If we need more information from you or your provider about this issue, we will call you or send you a letter to let you know.
- You or your provider will have 14 days to get back to us about the additional information.
- If we do not hear from you or your provider with in those 14 days, your grievance will be closed. We will let you know we closed your grievance.
- The grievance will be opened again once we receive the information.
- Within 90 days. AmeriHealth Caritas Iowa will resolve the grievance and send you a letter to let you know the outcome. The member Services liaison will also call you as a courtesy.

AmeriHealth Caritas Iowa

8. Member Services

Please explain how you propose to execute Section 8 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 being a long-term partner with Iowa. We care about members and are focused on building trust-based relationships by listening to the members' wants and needs. Our grassroots approach to service engages members and other stakeholders, builds relationships and empowers us to improve health outcomes for members and strengthen their communities.

- AmeriHealth Caritas Iowa is dedicated to its members and has a "no wrong door" approach in offering services and support.
- AmeriHealth Caritas Iowa is partnering with Iowa stakeholders to understand needs and develop Iowa-specific programs.
- We are committed to the communities we serve.

We improve outcomes by engaging members and their providers through a strategically tailored and fully integrated approach to communication and interaction. Coupled with industry-leading digital channels, we empower our members and their caregivers to make the best possible healthcare decisions by providing education and resources to help them get the right care in the right setting. For example, when AmeriHealth Caritas Family of Companies (AmeriHealth Caritas) realized a pattern of over-utilization of emergency room (ER) services for non-emergent care at the Children's Hospital of Philadelphia (CHOP), we collaborated with providers to develop the 4 Your Kids Care educational program to ensure that our members understood the proper use of the ER versus when a visit to the Primary Care Provider (PCP) was more appropriate. There was a 25 percent reduction in the inappropriate use of the ER for participants of the program. The success of the program illustrates AmeriHealth Caritas' approach of identifying a problem and developing a solution that is truly tailored to the needs of the community. Additional information about this program can be found in our response to question 8.7.

AmeriHealth Caritas Iowa's systematic and organized approach to member engagement and cultural competency will mirror that of its affiliates who have earned national distinction. Affiliate health plans in South Carolina and Pennsylvania were among the first in the nation to adopt the National Committee for Quality Assurance's (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 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.

Our promise of delivering high-quality, cost-effective care to people who need it most means there are "no wrong doors" for members receiving our full support in their journey to healthier lives. Every contact point counts, and our strategies and processes are designed to drive engagement and outcomes. From our community relations representatives and Community Outreach Solutions (COS) team, who engage members in their neighborhoods, to mailings, phone calls, mobile, web and other digital technologies, AmeriHealth Caritas Iowa will constantly evolve and innovate a tailored approach to determine the most

effective method of communication for Iowa members. What sets us apart is our commitment to building strong relationships with both providers and members to ensure we understand the unique challenges our members face. While we are a nationally recognized healthcare company serving more than six million members in 16 states and the District of Columbia, we go back to our roots as a small community health plan in West Philadelphia to support our mission of helping people get care and build healthy communities. Driven by our history and mission, we blend into the fabric of the communities we serve to become trusted partners with members, providers, stakeholders and states. We have not wavered in that approach from our founding more than 30 years ago.

Our efforts in Iowa are ongoing as we build additional relationships with advocacy groups, provider systems and special-needs service organizations. By recognizing their goals and concerns, we will be positioned to collaborate, educate and innovate to meet their needs and the needs of our members, just as we have accomplished in other states in our 30 years of Medicaid experience.

Providing healthcare is more than just our industry, it is our promise. We are committed to building a healthier Iowa, investing in the State (e.g., programs and infrastructure such as Community Wellness Centers), and making Iowa the launch pad for the next generation of healthcare delivery and the healthiest State in the country.

8.1 Marketing

1. Describe in detail your marketing and outreach plans.

AmeriHealth Caritas is committed to making lasting improvements in the well-being of the families and communities we serve. Our marketing and communications programs are designed to educate, motivate and, ultimately, help Iowa recipients recognize AmeriHealth Caritas Iowa as the most capable and trustworthy Medicaid partner in the market. Our marketing and outreach approach will be tailored to the specific needs of Iowans and will call upon our more than 30 years of experience and successes in other markets. We align with advocacy organizations where our members live and work to improve the quality and accessibility of care to low-income individuals.

To meet the needs of the entire State, we are executing a rural marketing strategy that takes into account the distinctive landscape of rural and urban centers in Iowa, similar to our successful approaches in Nebraska, South Carolina, Louisiana and Central and Northeast Pennsylvania. In cooperation with the State of Nebraska Department of Health and Human Services, AmeriHealth Caritas participated in community education forums to educate the population on managed care with a special emphasis on understanding the importance of the PCPs, enhanced benefits, 24/7 Nurse Call Line, member services and the statewide Medicaid enrollment hotline. Presentations were facilitated with the local county Nebraska DHHS offices and key community stakeholders to increase community participation by providers, community service organizations and Medicaid beneficiaries. We will take the same approach in Iowa to ensure that Iowans have a sound understanding of Medicaid managed care.

AmeriHealth Caritas Iowa will recruit, hire and train local COS teams (such as our community outreach specialists and State social services experts, detailed in the following response) from the communities we serve, leveraging our relationships with community advocates to reach and provide education to members, as well the general public. We will have a physical presence at local events to help maximize every opportunity to effectively serve our members, provide health information and encourage screenings and preventive care.

Our goal is to increase member engagement, retention and continuity of care by promoting the completion of needed screenings and preventive services, such as Healthcare Effectiveness Data and Information Set (HEDIS)/State measurements.

Strategies/tactics

- Multi-channel outreach:
  - Utilize our outbound call center through live interaction calls to ensure completion of Health Risk Assessments to promote well care and prevention and to perform targeted campaigns to address health issues for specific populations.
  - Utilize call campaign technology to send alerts to members in need of eligibility redetermination, increase awareness of health prevention practices through mass distribution of educational materials and provide education to members on how to navigate through health plan service and health systems through a personal, one-on-one interaction with members.
- Targeted outreach:
  - Provide focused outreach to members and in communities meeting risk criteria. For example, AmeriHealth Caritas Iowa will increase community outreach in counties with the highest number of Medicaid eligible or noncompliant members for screenings/HEDIS measures to drive increased access, care and outcomes.
- Make every member contact count:
  - Regardless of how a member engages with AmeriHealth Caritas Iowa — through phone, mail, email or the Web — every contact will be designed to provide maximum value to the member. There is “no wrong door” for members in these interactions with AmeriHealth Caritas. Our Contact Center of Excellence (CCOE) representatives and COS teams are provided with information, such as where gaps in care are identified for the member and members of their household, community services and supports available near a member’s home, and critical information relative to eligibility and redetermination. This availability ensures members are informed, educated and prompted to take positive actions toward improving their healthcare and the healthcare of their families.

General marketing strategies/tactics

- Create widespread knowledge and awareness in health interventions through word of mouth.
- Utilize AmeriHealth Caritas Iowa Community Wellness Centers for education, outreach and support.
- Connect multiple sectors toward improving the culture of health within the community.
- Combine financial resources, provider groups and community-based organizations to support more community outreach in health events/activities for organizations with limited funding.
- Continue to identify opportunities in which existing partnerships can be further strengthened.
- Hire bilingual COS representatives to work within Latino communities (understanding this is Iowa’s largest minority community) to help maintain and increase relationships in both partnerships and memberships.
- Participate on community boards like the Iowa Community Action Association, the Central Iowa Shelter and other service organizations.

- Seek sponsorship opportunities with community-based organizations that share our mission to serve the underserved, such as the Iowa Area Agencies on Aging, the Primary Care Association and Lutheran Services, the Coalition for Family and Children's Services, the Arc of Iowa, and the Food Bank of Iowa, to name just a few. AmeriHealth Caritas recently sponsored the Iowa Public Health Association's annual Governor's Conference on Public Health and had interaction with the Visiting Nurses Association and the Hawkeye Area Community Action Program.

In our 30-year history, we have closely adhered to all State marketing regulations and have not had marketing compliance issues. Specific examples of how AmeriHealth Caritas will implement our strategy in Iowa follow.

Maintaining a field presence with community stakeholders

AmeriHealth Caritas Iowa is building strong community partnerships throughout the State. Our partnerships help accelerate awareness, create trust and support better health outcomes. These relationships are important because they allow for grassroots organizations that will align with AmeriHealth Caritas Iowa's mission to collaborate for more community engagement in health awareness, health education and health activities. These alliances create strong forces that can help improve health equality, reduce poverty conditions and increase overall community wellness for both our members and the population at large. Partnerships include, but are not limited to, organizations that serve our communities in healthcare-related services, education, economics, housing, food and social services.

In Nebraska, for example, AmeriHealth Caritas affiliate Arbor Health Plan partners with the Community Action Partnership of Western Nebraska's home office and the local community health center in Gering, Nebraska, the United Way, the Health Department and the YMCA to offer community baby showers and health fairs to increase health awareness and provide benefit information to Arbor Health Plan members and the community. The program creates a warm, supportive atmosphere for health screenings and educational support for expectant mothers. The goal is to ensure that women receive access to quality prenatal care and encourage mothers to make behavioral changes that lead to better birth outcomes.

AmeriHealth Caritas Iowa Community Wellness Centers

Our commitment to Iowa will continue as we invest in the opening of three AmeriHealth Caritas Iowa Community Wellness Centers, tentatively identified for Des Moines, Sioux City and Cedar Rapids. These centers will provide a location for members to receive health plan and non-urgent health services, administrative support and education, and act as a reliable source of interaction with AmeriHealth Caritas Iowa.

The AmeriHealth Caritas Iowa Community Wellness Centers will allow members to speak face-to-face with AmeriHealth Caritas Iowa staff, including care connectors, COS team members and a team of social service experts who will assist members in navigating complex healthcare and social service systems throughout the state. To promote a holistic approach to our members, the social services unit experts will also help members locate services for other basic needs such as food, clothing and shelter.

Through the Community Wellness Centers, AmeriHealth Caritas Iowa will work with community partners to facilitate events like healthy cooking demonstrations, fitness classes, health education programs and Stakeholder Advisory Council and provider meetings. In addition, we will utilize the center to connect members and others in the community to resources for workforce trainings, free computer/Internet use, help with tax preparation, financial aid and other workshops that provide the tools to empower them to take action.

The AmeriHealth Caritas Iowa Community Wellness Centers will look very similar to our First Choice Community Center in South Carolina, which has served over 14,000 members over the last five years. The

Center has a dedicated on-site team. Here, members are educated on how to better understand their benefits and navigate the complex healthcare system. The Community Wellness Center also provides members the opportunity to receive face-to-face assistance when re-determining their Medicaid eligibility to help maintain their continuity of care.

Below is a photo from our First Choice Community Center in South Carolina where members are educated on how to stay healthy. Also below is an overview of AmeriHealth Caritas Iowa Community Wellness Center services.

Exhibit 8.1-A: Educational event at First Choice Community Center (South Carolina)

Exhibit 8.1-B: Overview of AmeriHealth Caritas Iowa Community Wellness Center Services

Our assessment of where to locate our community wellness centers considers:

- The Vulnerable population's footprint in the community to maximize access to the centers to Iowans who are below the poverty line.
- Community health needs, including estimation of the volume of impactable preventable hospital events and lack of access to primary care.

We have found that with our extensive experience in their design and implementation, our community centers can effectively help support member engagement and outreach, preventive care, access to care and, ultimately, drive positive health outcomes.

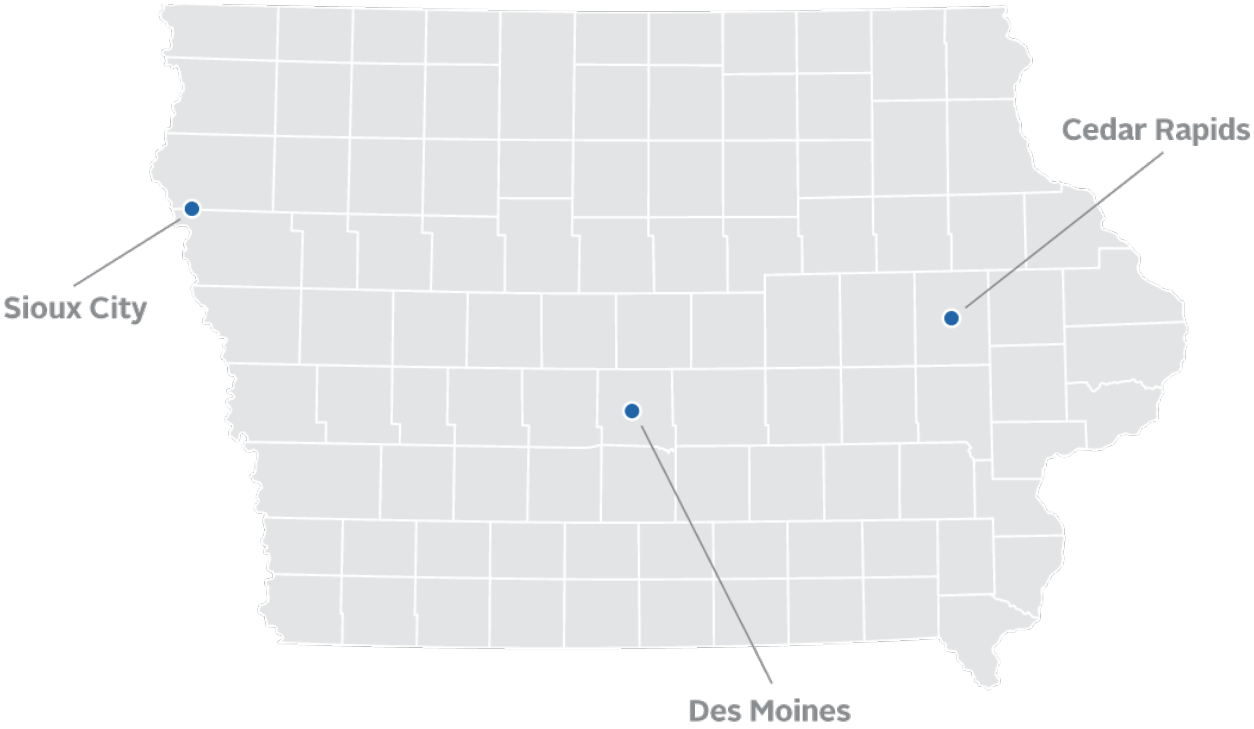

Exhibit 8.1-C: Proposed Community Wellness Center locations in Iowa

AmeriHealth Caritas Iowa Community Outreach Solutions (COS) team

AmeriHealth Caritas Iowa will recruit, hire and train a COS team. The COS team will be a dedicated group of associates that will locate and engage difficult-to-access members. The COS associates will live and work in targeted geographic areas where a high number of chronically ill members reside and with whom maintaining contact is challenging.

The COS team will serve as AmeriHealth Caritas Iowa's "feet on the street," making outreach visits to members' homes when traditional outreach has failed to establish contact by more traditional means, such as phone or mail. For example, at AmeriHealth Caritas' affiliates in Philadelphia and the District of Columbia, the COS teams have reached out to over 10,000 households in each health plan in the past year. These members often have multiple chronic conditions that require frequent medical care or health screenings, and associated gaps in care. These members usually have not had a primary care visit within six months.

Approximately 50 percent of a COS associate's time in Iowa will be spent supporting Intensive Case Management (ICM) members with chronic and co-morbid conditions based on the Chronic Illness and Disability Payment System (CDPS) model. The COS associates will be deployed when the claims reports reflect that a member has not been seen by their PCP or specialist within a six- month period.

The other 50 percent of the COS team member's time will be spent supporting Medical Management by re-engaging contact with members. The COS team will support these members by helping them complete health assessments, schedule medical appointments, provide health education and reconnect the member with case management and Rapid Response teams, a team (detailed later in this response) that is available to assist with a variety of member-related concerns (e.g., housing, acquiring medication and arranging transport).

COS Team Time Distribution

Exhibit 8.1-B: COS Team time distribution

Example of the COS team following up on high-risk discharges

After two unsuccessful attempts to contact "Crystal," a 42-year-old woman with diabetes who had two inpatient admissions in 30 days, the care manager (CM) sent a COS worker to track Crystal down. The COS worker discovered that Crystal had moved and was able to establish contact at Crystal's new residence in Philadelphia.

Crystal still had not seen her PCP after her most recent hospital discharge, and reported that she was having difficulty getting an appointment. The CM made a three-way call, linking the member and the physician office to schedule an appointment for three days away. After verifying that Crystal had transportation available, the CM talked with her about the need to have an eye examination due to her diabetes, and gave Crystal contact information for community resources, including a discount voucher, to help her obtain glasses. The CM verified that Crystal had the diabetic supplies and medications she needed and understood how to test her blood sugar and take her medication. Despite the fact that Crystal declined further assistance, the CM verified that Crystal attended the PCP appointment and reinforced the CM's availability to help in the future if additional needs arise.

COS team maternity outreach specialists have a specific role in supporting the Bright Start® program (detailed further in 8.7). They visit members needing postpartum care, schedule appointments, coordinate transportation and provide parenting and infant care education for new mothers, which will be critical in states, such as Iowa, that struggle with OB/GYN access.

COS team postpartum follow up at a member's home

Jaime, an AmeriHealth Caritas COS worker in Pennsylvania, went to see "Lily" after Lily and her new baby boy, "Mark," came home from the hospital. Jaime's goal was to ensure that Lily had an appointment for postpartum care, and that she set up an appointment with a pediatrician for her new son. While in the home, Jaime talked with Lily about care needed for her new baby. Lily, who recently moved from another State, was not aware of services available through the Women, Infants and Children (WIC) program. Jaime helped get an appointment for Lily and Mark with the local WIC coordinator, providing an extra level of support for the new family.

AmeriHealth Caritas Iowa COS team goals:

- Meet and exceed HEDIS results.
- Meet and exceed membership projections.
- Reduce health disparities.

COS team example outreach: general health screenings at AmeriHealth Caritas Iowa community events

Heart disease, cancer and diabetes are among the top 10 causes of death in Iowa according to the Iowa Department of Public Health. AmeriHealth Caritas Iowa will execute general health screenings to promote awareness and prevention. The COS staff will leverage our relationships with community-based organizations, churches, schools, providers and local housing authorities to target our members who are non-compliant for HEDIS measures in an effort to facilitate health screenings, provide education, close care gaps and reconnect members with their PCPs. These community health events provide members with the following screenings: total cholesterol, HDL, LDL, triglycerides, glucose, HbA1c, BP, pulse rate, height/weight, dental, adolescent well visits and body mass index (BMI).

Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) initiatives

There are currently 13 Federally Qualified Health Centers (FQHCs) in Iowa, including 12 community health centers and one migrant health center. Iowa has one additional community health center classified as an FQHC look-alike. Each of the 14 centers is an Iowa safety net member.

In order to improve engagement of children under the age of 21, AmeriHealth Caritas Iowa will collaborate with FQHCs and large physician practices to plan and create an event where we will assist with scheduling non-compliant members and provide incentives to promote adolescent well visits and dental screenings to improve HEDIS results. Due to this cohort's high concentration of noncompliant membership, our team will engage the FQHCs through ongoing collaboration with programs utilized in AmeriHealth Caritas's other health plans outlined below (with additional program examples listed in 8.7). We have actively engaged Iowa Primary Care Association leadership and they are partnering with us to develop programs designed to better support members. (A reference letter from the association is available in Tab 5 of our response.)

AmeriHealth Caritas' State Social Services Expert Unit

AmeriHealth Caritas understands that social determinants significantly impact healthcare outcomes and costs for Medicaid recipients. Our team coordinates the delivery of physical and behavioral clinical care with essential social services like housing, food, education and employment. These different sectors, working along with local community involvement, can 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 positive experience of care.

AmeriHealth Caritas Iowa will implement a dedicated State Social Services Expert Unit staffed with individuals who have skills that include community development, public policy and social service sector work. AmeriHealth Caritas Iowa staff will provide strategic and operational leadership and work through existing health plan infrastructures, including but not limited to, AmeriHealth Caritas Iowa care management services, community offices, community health educators, provider network management and data analytics.

This team will be accountable to:

- Establish and maintain relationships with State officials and regional social services agencies, public health authorities and key community-based organizations to seek out collaboration for access to and delivery of services to meet non-clinical member needs. Potential interfaces may include referral, information exchange, educational sessions, co-location of services, formal and informal coordination agreements, aligned financing and payment models, proposals for funding, technology solutions and other quality improvement projects.
- Support the inventory, development and maintenance of regional community asset maps, including the technology infrastructure to support the query, referral and tracking of services for members. As gaps and opportunities are identified, strategies will be implemented to better meet the needs of all stakeholders.
- Serve as an in-house resource to all AmeriHealth Caritas Iowa staff to ensure maximal uptake and coordination of these services as well as provide training for associates and Contracted providers.
- Build and monitor escalation processes in response to identified member needs and serve as resource for associates working with members with complex needs.
- Participate with local, regional or State initiatives aimed at improved coordination of services, as well as advocacy in response to social service needs of our membership and their communities.

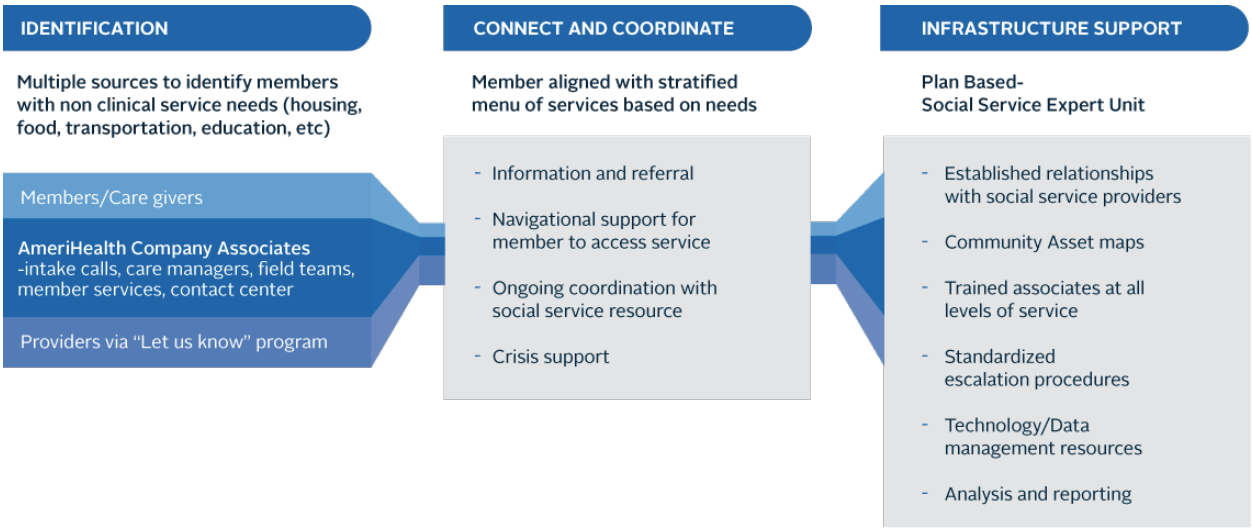

Exhibit 8.1-C: AmeriHealth Caritas' State Social Services Expert Unit

8.2 Member Communications

1. Describe your overall strategy for communicating with members.

As stated in section 8.1 above, AmeriHealth Caritas Iowa is building community partnerships throughout the State. These partnerships will facilitate communications with our Iowa members and their communities as we accelerate awareness, earn trust and build a system of care delivery that will improve health outcomes.

These relationships enable grassroots organizations like the Central Iowa Shelter & Services, Mainstream Living, The Arc of Story County, Public Health Association, and Coalition for Family and Children Services to

align with our mission as we work together to promote community engagement in health awareness, health education and health activities. These collaborations will further improve health equality, reduce poverty conditions and increase overall community wellness for both our members and populations at large. Partnerships include, but are not limited to, organizations that serve our communities in education, economics, housing, healthcare-related services, food and social services.

Access to information and care is one of the most important and valuable core deliverables we provide for our members. It is the driving force behind our "no wrong door" approach to member engagement. Enabling access to AmeriHealth Caritas Iowa through multiple channels while providing a seamless customer experience will drive our next generation of healthcare delivery. It will turn a one-way communication into a two-way conversation and enhance our ability to provide a wide array of services and supports regardless of how a contact occurs.

AmeriHealth Caritas understands that digital channels are critical and that 35–40 percent of Medicaid members, nationally, have smartphones. One of our digital premises is reaching members through their mobile devices, without requiring them to use their data plans to get healthcare information. We are also focused on creating innovative solutions that are sensitive to our members' concerns. We have a robust mobile strategy centered on extensive research through focus groups and other sources, to most effectively meet our members in the right place, with the right information, at the right time.

Texting to support member outreach

We piloted a member texting program at our Washington, D.C. affiliate to improve communication and increase the level of member engagement. In Iowa, text messaging will allow AmeriHealth Caritas Iowa to connect with members in a faster, timely and less expensive way than traditional telephone calls. Depending on the coverage area, texting has many applications, such as:

- Reminding members about follow-up visits.
- Prescription refill reminders.
- Targeted reminders to help members manage existing conditions.
- Reminding members of redetermination requirements.

AmeriHealth Caritas' multi-channel consumer engagement

Understanding that our members are increasingly utilizing communication alternatives to phone and mail contact, AmeriHealth Caritas has created a multi-channel, customer-engagement program that utilizes text, email, chat and other mobile and Web-based communications, in addition to traditional phone and mail, which may still be the preferred mode of communication for our Long Term Services and Supports (LTSS) members. Our information platform provides the materials and tools necessary to support a full spectrum of integrated customer service, from benefits and eligibility to gaps in care and scheduling appointments. Additionally, our customer service representatives (CSRs) are equipped with information regarding additional social services and support available through various State and local agencies to assist our members in accessing help that may fall outside of the Medicaid program.

Illustrative use case:

"Linda" misplaced a letter from her State Medicaid agency indicating that she needed to provide documentation to ensure she remains eligible for the Medicaid program. Concerned that she may miss the deadline, Linda calls the toll-free number that has been loaded into her phone contacts via a push notification from the AmeriHealth Caritas Iowa mobile phone app. (The app gives the member the option to accept or reject push notifications; Linda accepted.)

After verifying her contact information with the AmeriHealth Caritas Iowa CSR, Linda provides some minor details that she can recall from the letter, but isn't sure what she was being asked to do. The CSR searches her integrated desktop system for known State correspondence going to Medicaid recipients and finds that Linda likely received a redetermination letter.

The representative reviews Linda's eligibility information and determines that Linda is up for redetermination and must submit documentation by the end of July. With Linda's consent, the CSR emails Linda a link where Linda can find the instructions for submitting verification documentation.

The CSR also is prompted by the system that Linda's son "Michael" is several months overdue for his regular Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening. Linda explains her hectic life and that she is now in school several days a week, in addition to her part-time job. Using the online appointment calendar of her son's PCP, the CSR assists Linda in scheduling the appointment and offers help with transportation. An automatic confirmation of the appointment is sent to Linda's email and phone.

Before closing the call, the CSR notes that there is an upcoming AmeriHealth Caritas Iowa-sponsored health fair near Linda's home that she and Michael may enjoy. The call is closed and the CSR ensures that all of the information gathered and shared is recorded and archived appropriately in the system.

Two days later, Linda is on the AmeriHealth Caritas Iowa website and is reviewing the instructions for redetermination. She is still a bit concerned about exactly what she must do when a chat request from a CSR pops up on the screen. Linda connects and asks for assistance before deciding to call the AmeriHealth Caritas Iowa phone line to speak to someone live. The CSR walks Linda through the instructions and Linda confirms she understands. The CSR reminds Linda of Michael's appointment and asks if there is anything further she can do for Linda. The call is closed with all activities and information gathered, shared, recorded and archived.

The following week, and three days before Michael's appointment, Linda receives a text message and email confirming the appointment with the doctor's name, address and time of appointment. Upon arriving at the doctor's office, Linda cannot find Michael's member identification (ID) card. Using her AmeriHealth Caritas Iowa mobile phone app, which has her and her son's member ID card available electronically, the office is able to make a copy of the card image and verify eligibility.

Linda sends an email thanking the AmeriHealth Caritas Iowa team for their assistance, but notes that her wait in the office was too long and that she was not happy with the experience she and Michael had with the doctor. An AmeriHealth Caritas Iowa CSR reviews the email and sends notification of Linda's issues through the Provider Complaint team to the doctor's office for follow up. The office reports that an emergency that day created a long wait for scheduled patients — no other complaints are found regarding the doctor's services. This information is recorded in the system for tracking provider compliant trends and noted in Linda's information, as well.

An AmeriHealth Caritas Iowa CSR calls Linda to inform her of the reason for the delay. Linda indicates that no further action is necessary.

As mentioned earlier, AmeriHealth Caritas Iowa will recruit, hire and train Community Outreach Solutions (COS) team members who live and work throughout Iowa to provide comprehensive education and on-site presence at service agencies and provider offices. The goal of the COS team will be to provide sensitive, compassionate support to members. The team will use proactive retention and care coordination strategies to help support continuity of care, reduce churn and control rising healthcare costs by increasing access to preventive care.

In Nebraska, the COS team serves as Arbor Health Plan's "feet on the street" by furthering the company's mission to help people get care, stay well and build healthy communities. In addition, the team distributes information about health-related events and screenings that are scheduled in our members' communities.

Arbor Health Plan is the only managed care organization to have its COS team participate in an extensive 10-week community health worker training course, which is led by DHHS and designed to provide a baseline understanding of the role of patient navigation for community health workers. AmeriHealth Caritas plans to roll out this same training in Iowa.

The Arbor Health Plan's COS team is responsible for:

- Try the Y Program — A collaboration among Arbor Health Plan and select YMCAs across the State that allows our members to use their local YMCAs at no cost during a 90-day period. In 2014, five YMCAs in various parts of the State participated in the program, resulting in 182 households and 646 people who took advantage of the program over the three-month period.
- Community Baby Shower — An event that involves community partners and engages mothers-to-be in rural Nebraska. Attendees receive education and guidance on how to stay healthy during pregnancy and receive dental and health screenings.
- Arbor Angels — An employee-led committee that directs a portion of the company's charitable contribution dollars to individuals and families requiring assistance. Arbor Angels identify people who need assistance as part of our annual Adopt-a-Family tradition, which has allowed employees to shop for, wrap and deliver gifts to people in need over the holiday season. In total, Arbor Health Plan has helped make the holidays a little brighter for 22 children and 12 adults.

2. Describe your plans to provide oral interpretation services and translated written information and how you intend to notify members of the availability of these services and how to obtain these services.

AmeriHealth Caritas values diversity and understands that language barriers can play a role in health disparities. As such, we ensure that every member is aware of and has access to oral interpretation services and translated written information. All member materials include a language tagline in State and regional predominant languages, explaining the availability of all of our AmeriHealth Caritas materials in any language requested (AmeriHealth Caritas Iowa will utilize an external translation specialist to provide written translation). Our materials also alert members that they may call our member-service, toll-free number for assistance at any time and will receive that assistance in their primary language, either through a bilingual CSR or through the use of interpreter services.

Our CSRs and COS staff are alerted to the members' primary language through our integrated member data system to ensure members are addressed through their appropriate preferred language. This will also prompt our AmeriHealth Caritas Iowa representative to ask the member if they are in need of face-to-face interpretation services for provider visits. In addition, availability of interpretation services for provider visits is noted in our Member Handbook and welcome kit. To identify emerging languages, AmeriHealth Caritas' Medical Economics department provides input on the language needs in a State semi-annually

based upon demographics to determine threshold languages — five percent of the member population or 1,000 members, whichever is lower.

AmeriHealth Caritas maintains a current demographic and cultural profile of our members. We use this to profile health plan services. AmeriHealth Caritas Iowa will continually monitor the needs of our members by reviewing monthly demographic reports that include racial, ethnic and preferred language information.

In our analysis of the Iowa population, we have found that most of our prospective members speak English or Spanish. Accordingly, all welcome packet components will initially be made available in at least these two languages. In addition, we will hire certified bilingual community health educators to communicate with members in Spanish. Realizing there are emerging populations in Iowa, such as Sudanese and Bosnian in central Iowa, we will also solicit and respond to member requests in their preferred language. As an example, in response to members in Louisiana, we created an expanded language tagline for inclusion in the member newsletter once a year. In addition to Spanish and Vietnamese offered in Louisiana, we mention the availability of translations in Arabic, Brazilian, Portuguese, French, Nepali and Burmese.

For any population meeting the standard Medicaid threshold (at least five percent of members speak the language), we will translate all written member materials into the language spoken and add taglines to materials in the appropriate language informing members of their right to free interpretation and translation services. Even for language needs in less than .01 percent of our member populations, members will be able to call and request material in their preferred language.

Robust language support

We strive to ensure that the material we provide can be understood and absorbed by our members. However, effective communications are never one-sided, and we want to understand what members have to communicate to us. To achieve this goal, we utilize the services of Language Services Associates (LSA), which facilitates communication with members in more than 200 languages. We monitor the language line to identify emerging population trends. Through our annual language access services survey, AmeriHealth Caritas Iowa will survey a sampling of members, providers and internal associates to gain feedback on the provision of our language services.

When members who need alternative formats are identified, a third-party vendor provides translation and interpretation services. In-person American Sign Language interpretation at appointments will be made available to members who are hearing impaired. We work closely with our LSA vendor to record languages needed, amount of time spent on phone with language translators and increases in requests for certain languages. As those trends are identified, we will know which languages we need to add to our translation of written materials.

In 2014, AmeriHealth Caritas:

- Provided nearly 44,000 language translations.
- Completed nearly 623,000 minutes (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.

3. Describe your plans to provide all written materials in alternative formats and how you will identify members needing alternative formats.

AmeriHealth Caritas Iowa will ensure that members, regardless of language preference or any sensory impairment, fully understand the services of the health plan and are well prepared to access healthcare

services. We will ensure that all member education materials are easy to read and culturally sensitive. AmeriHealth Caritas ensures all member materials, including new member materials, letters, health education materials, website content and reminder postcards, meet fourth-grade reading level requirements, using the Flesch-Kincaid Index to assess and validate the reading level. As noted above, we include language taglines on all member materials alerting members that materials are available in other languages and formats.

Ensuring alternative formats

Member materials are available in multiple alternative formats, including Braille, large print, compact disc or audio tape, as well as WAV and MP3, to accommodate members with sensory impairments. Members with a hearing impairment will be able to call AmeriHealth Caritas Iowa's toll-free teletypewriter/telecommunication device for the deaf (TTY/TDD) number to request materials in an alternative medium. This line will be accessible 24 hours per day, seven days per week.

Members will also be able to contact AmeriHealth Caritas Iowa via the Relay Iowa service. Through this text-to-voice/voice-to-text service, assistants will facilitate communication between TTY/TDD and voice telephones by voicing everything typed on TTY/TDD and typing everything voiced on the conventional telephone. All calls will be strictly confidential.

Identifying members needing alternative formats

AmeriHealth Caritas Iowa will collect self-reported race, ethnicity and written and spoken language preference for each member and ensure that this information is available to all AmeriHealth Caritas Iowa staff engaging with members. We will also have processes in place to accept and archive data provided from State-approved enrollment files that indicate the member's preferred language and special needs, which has included Braille for blind members and American Sign Language for those who are hearing impaired.

4. Describe your policies and procedures for ensuring materials are accurate in content and translation.

AmeriHealth Caritas member materials are developed by associates who have undergone comprehensive annual training in cultural competency and are instructed in health literacy and reading-level requirements. Our writers use a toolkit adopted from the work of the Partnership for Clear Health Communication at the National Patient Safety Foundation to ensure that our communications to members are easy to understand and culturally competent.

Review of materials

All AmeriHealth Caritas Iowa draft member materials will be edited for readability and reviewed through a two-step internal review process prior to submission for State approval. Our Editorial Review Committee will conduct an initial review to ensure that all materials meet our own strict standards for cultural competency and health literacy. Representatives of our Regulatory, Compliance and Legal Affairs teams will conduct a second review to verify compliance with regulatory and State Contract requirements. Our internal material production management system will ensure materials have the required approvals from internal stakeholders, as well as from the Iowa Department of Human Services (DHS), before they are printed or distributed. Our process will include documenting reviews and approvals before final production can commence. After approval by DHS, materials will be sent to our language services vendor for translation. All language service vendors will provide their process for certification and quality assurance on an annual basis.

5. Provide sample member enrollment materials as described in Section 8.2.6.

AmeriHealth Caritas Iowa's member enrollment materials will fulfill all of the needs set forth in Section 8.2.6 of the Scope of Work. AmeriHealth Caritas Iowa will engage with its members to best manage their health and ensure each has the necessary information and tools to access quality care and maximize wellbeing.

Samples of the following are provided as an attachment to the end of this section:

- Welcome brochure example: Attachment 8.2-A.
- Member Handbook example: Attachment 8.2-B.
- "How and where to get help" member overview: Attachment 8.2-C.

6. Describe your processes for identifying significant changes as described in Section 8.2.8 and notifying members of such changes.

Significant changes, depending upon their nature, can be identified in advance through multiple channels within our systems. Our robust information technology (IT) systems and business processes will help flag when a significant change is set to take place in our system (such as a change in policy or restriction in provider coverage) and which members it will affect.

A minimum 30-day advance notice is standard across all AmeriHealth Caritas health plans; however, we will work to meet any required time frames set forth by DHS. As discussed in 8.2 of this response, we are able to provide notifications to members through various channels (e.g., text, email, phone, mail) and will do so in their preferred method. Standard communication to members is by first-class mail with the mailer/letter being pre-approved by DHS. Under certain circumstances, and with DHS advance approval, we may communicate significant changes through the member quarterly newsletter instead of a letter if timing of the newsletter's mailing is at least 30 days in advance to the change. In addition to notification by first-class mail, the changes are made to appropriate member materials such as the Member Handbook, website, policies and procedures, and other member materials.

8.3 Member Services Helpline

1. Describe your plans for the Member Services helpline, including the days and hours of operation.

The Contact Center of Excellence (CCOE) member services helpline will operate 24 hours a day, seven days a week, 365 days a year. Members will also have 24/7/365 access to speak with a medical professional through the Nurse Call Line that is available to handle health-related questions or determine if immediate medical help is necessary. Member services include inbound inquiries and outbound calls (welcome, health risk assessment and wellness) with inbound inquiries handled through our Philadelphia service center, and outbound calls through our Jacksonville service center. For business continuity purposes, all calls can be transferred to any of our service centers located in Philadelphia, Jacksonville and Salt Lake City.

CCOE uses best-in-class technology and practices including skills-based routing of calls to the most appropriate expert to meet our members' specific needs, 100 percent call recording and automated call documentation, real-time call auditing and monitoring to ensure the highest quality of customer service, and member alerts, including care gaps alerts for every member of the household.

CCOE represents one "door" through which members can access AmeriHealth Caritas Iowa. It will be designed to accommodate members who prefer phone interaction. It will also serve as a way to introduce

members to our additional services, such as the COS team, the Social Services Experts Unit and AmeriHealth Caritas Community Wellness Center associates.

2. Describe the process you will utilize to answer, route, track and report calls and inquiries. Indicate if an Interactive Voice Response (IVR) system is proposed.

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 the associated database handling instructions. This system allows us to track and monitor all incoming calls and adjust staff levels as needed to accommodate call spikes. More importantly, it provides us with the capability to direct calls to the most appropriate representative based on the nature of the call and member data. For instance, a member calling for a replacement card may be routed to a representative rather than offered a self-service option if they have gaps in care or members of their household needing services. A member with a chronic condition not adhering to a treatment plan may be routed directly to the Medical Management team.

Within our system, an Interactive Voice Response (IVR) will be used to support automated, self-service call routing for members and providers to obtain answers to questions, such as member eligibility, claim status or requests for new ID cards.

The automated routing begins tracking in-bound calls at the point which the member or provider selects among various options. Once the selection is made, the calls are queued and routed to the next available phone line in each skill set. Information tracked for each call includes call-waiting time, off-phone time, hold time and abandon time. To help support management and reporting, a standard set of statistics and reporting levels are available for all call center management to utilize. All calls will be recorded and documented.

3. Describe your plans to provide services for the hearing impaired and non-English speaking population.

AmeriHealth Caritas understands the importance of communicating effectively with members who have very limited English skills or who are hearing impaired. In addition to representatives communicating in English, AmeriHealth Caritas Iowa will provide bilingual services for Spanish in-house, including via a 24/7 language service line. Additional languages are added as needs are identified.

To assist callers who require other language assistance, AmeriHealth Caritas Iowa will utilize the services of Language Services Associates (LSA), which enables customer communication in more than 200 languages. The representative will facilitate a three-way call between the members and LSA. This service will be available through our CCOE at no charge to members. Our years of experience in providing service to the Medicaid population have demonstrated that members prefer to speak with someone who speaks their language and understands their cultural needs. LSA employees understand the specific needs of the Medicaid population, which helps ensure the call meets the member's needs.

CCOE will have the technology to respond to TTY/TDD calls. A desktop application will be loaded on the representative's desktop, where the representative logs into a TTY/TDD server. This will allow for sharing central TTY modems over a network. When a call is received, an alert will appear on the desktop to notify the representative that a call is waiting. This optimizes call-handling procedures, because the representative will be equipped to handle an incoming TTY/TDD call without the need for additional equipment. The TTY/TDD line will be available 24/7.

As we continue to innovate to serve our members, AmeriHealth Caritas is building chat capabilities to help support the hearing impaired, as well as the broader population. We expect to have these capabilities available to our members in early 2016.

Giselle Correa is an AmeriHealth Caritas' bilingual associate in Jacksonville, Florida. Recently, Giselle received a phone call from a Spanish-speaking member, "David" who had just been moved to a managed Medicaid plan. David began to outline his challenges to Giselle:

First, there were multiple issues with securing medical help for David's liver-related health issues. He could not find a provider who would treat him due to the language barrier. David had been going to the emergency room (ER) for regular doctor's visits since this was the only place that seemed to have someone who could speak with him in Spanish.

Second, David shared with Giselle how he was on a tight, fixed budget and could not afford to feed himself. David said he was eating only every other day.

Third and finally, David told Giselle he had had enough with his health issues and his inability to feed himself, and that he was going to use one of his guns to take his life.

Giselle, while still talking to the member, signaled her supervisor who listened in on the call and encouraged Giselle to keep talking to the member. The supervisor notified our, Rapid Response Team, and explained the challenges the member was experiencing and the language barrier. The manager of the Rapid Response team, bilingual and trained for these types of escalated situations, asked for the call to be transferred directly to her. While Rapid Response continued engaging the member, Giselle's supervisor contacted the local police department and law enforcement was dispatched to the member's house.

Through coordination with law enforcement and help from the Rapid Response unit, David did not take his life. A bilingual case manager was assigned to David and helped him with access to care issues, both with a new Spanish-speaking PCP and by arranging an interpreter for the member when he saw specialists. The Rapid Response team worked with a local food bank to ensure that David also received assorted food packages to help supplement his diet.

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4. Describe your training program curriculum and training process for call center staff.

Initial training

The training process begins with our recruitment strategy, even before official hire. Recruitment is executed with the goal of identifying candidates who already possess the necessary experience and skills that will translate to providing high-quality customer service to our members. A major step in our recruitment process is our testing for upfront skills and computer proficiency. Every CCOE candidate must pass this test to be considered as a potential applicant and move forward with the interview process.

From the first day of employment, trainees are prepared to become an integral part of CCOE. Our dedicated Training Unit conducts an extensive training program for new hires. The New Hire Training program consists of five weeks of classroom instruction, as well as side-by-side, on-the-job training.

Examples of initial training topics

- Iowa geography, including correct pronunciation of place names.
- Iowa-specific Medicaid benefits.

- Key contact numbers, such as the enrollment broker and DHS.
- Healthcare fundamentals.
- Healthcare 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 — supervised live calls.

All AmeriHealth Caritas Iowa CCOE staff will also receive 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). This program introduces participants to risk factors and warning signs of mental illnesses, builds understanding of their impact and reviews 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 appropriate professional, peer, social and self-help care. The program also teaches the common risk factors and warning signs of specific types of illnesses, such as anxiety, depression, substance use, bipolar disorder, eating disorders and schizophrenia. Like cardiopulmonary resuscitation (CPR), MHFA prepares participants to interact with a person in crisis and 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?" AmeriHealth Caritas' certified MHFA 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.

The training curriculum is a combination of instruction, illustration and application. Instruction via introduction to policies, procedures and system usage is facilitated during class lecture. Illustrations are utilized to reinforce topics covered during the class lecture, including policies, procedures and system navigation. Thereafter, training provides a hands-on opportunity to ensure the accurate application/demonstration of subjects learned.

Each class includes a phone lab that provides a progressive introduction to taking live calls. Collaboration with quality auditing occurs during this period. This segment concludes the training class, and as such, assists trainees in transitioning from their training experience to their respective departments.

Associate engagement and participation is encouraged throughout each stage of the program, which includes instruction, illustration, application and phone lab. In addition, activities and assessments are administered to confirm associate's understanding of principles shared, and each has a minimum requirement for passing. The question-and-answer technique is used in conjunction with recap in preparation for assessments. Each assessment is graded and reviewed. If results from the assessments identify opportunities, those topics are reinforced.

Trainees are audited for call quality and accuracy while in training. They are given feedback on calls and provided assistance with challenges before being released to the floor. Training and Quality Auditing staff, along with supervisors, meet with each trainee through coaching sessions at day 30, 60 and 90 to review overall quality scores, knowledge base and progress.

Ongoing training

Our seasoned representatives strengthen their skills through our well-rounded ongoing training program. All AmeriHealth Caritas Iowa employees, including representatives, will be required to attend a series of training sessions per year to meet their individual and departmental goals. The training courses can be related to specific issues in their department or other professional and career development training. Continuous learning is also supported through feedback sessions with supervisors and our Quality Assurance department on a daily, weekly and monthly basis. Cultural training is also performed and includes demographic and geographical overviews. This training will be regularly conducted by Iowa staff that has firsthand knowledge of regional nuances.

Examples of ongoing training topics

- Caring for customers.
- Creative decision-making and problem solving.
- Cultivating winning attitudes and countering negativity.
- Defusing emotionally charged situations.
- Handling difficult people.
- Handling conflict with tact and finesse.
- Team grammar — the essentials of English grammar for business.
- Helping your team work.
- Reaching for stellar service.
- Write better, quicker, clearer.

All associates are required to take annual compliance training regarding the code of conduct, fraud, waste and abuse (FWA) and HIPAA. Additionally, all AmeriHealth Caritas Iowa employees will be required to complete a cultural competency training program upon hire and annually thereafter. Employees also avail themselves of courses offered online to be followed at their convenience through Anytime Learning, a self-paced, online instruction program. Anytime Learning provides access to online reference materials and training on skills in many different areas. Modules include topics such as systems software skills, assorted business and accounting skills and various personal/professional effectiveness skills. It is aptly named Anytime Learning because it can be accessed anytime, from any location, for all our associates, 24 hours a day, 7 days a week.

Targeted training modules are developed specifically for customer service staff based on training needs. For ease of access, these courses are stored in a Web-based training portal that facilitates self-directed, self-paced, Web-based training for immediate on-the-spot instruction without having to utilize a trainer or individual training session. Customer service representatives can use both Anytime Learning and targeted training modules to address any refresher training need that is identified by their supervisor or themselves.

5. Describe your call center monitoring process to ensure helpline performance metrics are achieved.

CCOE's management team has an extensive list of real-time and historical reports that are used to manage performance. The Avaya telephony system comes with a suite of standard reports, as well as customizable reports that will allow AmeriHealth Caritas Iowa to monitor specifically defined performance requirements based on the specific service level expectations for Iowa. Multiple processes and systems are used to manage performance.

Workforce management

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

We benefit from our service centers being located in multiple geographic locations. As a result, we are able to leverage additional staff in other geographical areas to address unexpected increases in call volume. Further, we partner with a third-party vendor who has the ability to ramp up quickly to address new business, new initiatives and unexpected increases in membership.

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

- Real-time adherence.
- Total average handle time.
- Average hold time.
- Off-the-phone time.

AmeriHealth Caritas will build upon its experience across the country to meet and exceed the Iowa service level requirement of 80 percent for incoming calls, calculated using the required equation to take into account calls answered or abandon after 30 seconds.

The metrics yielded from this monitoring process are favorable. Statistics for year-to-date performance for CCOE show an average speed of answer for AmeriHealth Caritas member calls of 15 seconds and an average abandon rate for AmeriHealth Caritas member-related calls of 1.09 percent. Our quality auditors have assessed calls to member services at a year-to-date score of 98.7 percent for quality and accuracy. This performance demonstrates our success in meeting our goals and outperforming State requirements.

Our processes, technology and experience give us the ability and agility to meet and exceed all contractual service level goals that may be required in Iowa. 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 our additional member services centers.

Daily, weekly and monthly historical reports

Historical reporting is used to help forecast and track call trends, as well as monitor the performance of staff. A sample daily summary report is included as Exhibit 8.3-A.

Split/Skill Summary Interval - M1ENG

Report Edit Format Tools Options Help

Date: **4/3/2015**

Split/Skill: **M1ENG**

Time	Avg Speed Ans	Avg Aban Time	ACD Calls	Avg ACD Time	Avg ACW Time	Aban Calls	Max Delay	Flow In	Flow Out	Extn Out Calls	Avg Extn Out Time	Dequeued Calls	Avg Time to Dequeue	% ACD Time	% Ans Calls	Avg Pos Staff	Calls Per Pos
Totals	**:04**	**:06**	**738**	**5:20**	**:38**	**2**	**:48**	**2**	**2**	**288**	**1:28**	**0**		**12.68**	**99.46**	**25.6**	**29**
8:00 - 8:30AM	:04		13	4:52	:24	0	:12	0	0	9	1:21	0		11.55	100.00	30.2	0
8:30 - 9:00AM	:04		25	5:46	:49	0	:11	0	0	7	1:49	0		14.42	100.00	35.7	1
9:00 - 9:30AM	:06		23	4:27	:23	0	:48	0	0	4	2:18	0		13.60	100.00	39.0	1
9:30 - 10:00AM	:05	:00	27	4:28	:44	1	:30	0	0	4	1:32	0		15.77	96.43	47.1	1
10:00 - 10:30AM	:05		40	6:30	:27	0	:22	0	0	19	:42	0		19.15	100.00	51.6	1
10:30 - 11:00AM	:04		53	6:09	:36	0	:15	0	0	15	:56	0		16.38	100.00	61.9	1
11:00 - 11:30AM	:05		46	5:55	:33	0	:14	0	0	21	1:23	0		17.89	100.00	62.0	1
11:30 - 12:00PM	:06	:12	60	4:46	:33	1	:25	0	0	25	1:39	0		17.53	98.36	62.0	1
12:00 - 12:30PM	:05		42	5:07	:50	0	:21	0	0	15	1:19	0		13.74	100.00	61.1	1
12:30 - 1:00PM	:04		47	5:03	:36	0	:08	0	0	17	2:05	0		17.58	100.00	60.1	1
1:00 - 1:30PM	:04		52	5:44	1:02	0	:08	0	0	36	1:21	0		20.46	100.00	60.0	1
1:30 - 2:00PM	:04		49	5:17	:41	0	:08	0	0	25	1:35	0		17.57	100.00	60.0	1
2:00 - 2:30PM	:06		47	5:19	:38	0	:35	0	0	21	1:15	0		14.96	100.00	59.0	1
2:30 - 3:00PM	:04		33	5:08	:45	0	:07	0	0	14	1:25	0		10.16	100.00	58.9	1
3:00 - 3:30PM	:04		47	5:22	:40	0	:12	0	0	16	1:34	0		19.23	100.00	59.0	1
3:30 - 4:00PM	:05		39	5:21	:49	0	:25	2	2	11	2:27	0		13.85	95.12	54.2	1
4:00 - 4:30PM	:04		25	5:24	:28	0	:07	0	0	15	1:37	0		9.21	100.00	54.0	0
4:30 - 5:00PM	:04		19	5:37	:18	0	:15	0	0	3	:25	0		9.48	100.00	35.2	1
5:00 - 5:30PM	**:03**		**18**	**3:53**	**:16**	**0**	**:04**	**0**	**0**	**4**	**1:23**	**0**		**10.80**	**100.00**	**28.1**	**1**
5:30 - 6:00PM	**:04**		**14**	**5:23**	**:46**	**0**	**:11**	**0**	**0**	**1**	**6:24**	**0**		**10.28**	**100.00**	**24.3**	**1**
6:00 - 6:30PM	**:04**		**10**	**3:55**	**:11**	**0**	**:04**	**0**	**0**	**4**	**:41**	**0**		**7.23**	**100.00**	**17.4**	**1**
6:30 - 7:00PM	**:04**		**8**	**6:01**	**:21**	**0**	**:04**	**0**	**0**	**2**	**:47**	**0**		**11.72**	**100.00**	**13.2**	**1**

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Exhibit 8.3-A: Example Avaya historical report

Quality assurance

In addition to silent monitoring capabilities, CCOE has defined criteria and protocols for quality monitoring and assurance. On a monthly basis, the call quality auditor reviews a random sample of calls, listening to conversations and reviewing what action the representative took in the system to ensure accuracy of responses and use of appropriate phone etiquette. AmeriHealth Caritas uses the Verint technology to record all calls and "screen scrape" so every activity performed on the call is captured. The screen scrape technology also captures any system activity generated by the representative during the call. The quality auditors audit 10 to 14 calls per month for each representative. This is a critical tool used when providing feedback to staff and for the quality process.

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

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

Based on the quality scores, the supervisor will create an individual action plan for the representative. If trends are identified, the training department is engaged to provide refresher training. Quality grades are part of the CSR's monthly feedback and their annual appraisal. The supervisor meets with every

representative monthly, or more as needed, to review their quality scores and address any issues. AmeriHealth Caritas standard for quality is 98 percent accuracy.

In addition, on a monthly basis, CCOE and AmeriHealth Caritas Iowa executive staff will complete call sample calibration sessions. This provides the local executive staff the opportunity to monitor a random selection of sample calls, provide feedback to staff on call quality and accuracy of information provided and assist with Iowa-specific background and information. Calibration monitoring will serve as a valuable opportunity for AmeriHealth Caritas Iowa to hear firsthand concerns expressed by members to CCOE. This information ensures that all programs and written material are developed effectively to tackle actual member needs.

Interacting with other customer service lines maintained by community organizations

AmeriHealth Caritas Iowa will maintain the telephone numbers for critical State, county or city organizations under the "Important Telephone Numbers" section in the Online Benefits Directory. Some of these organizations include United Way 2-1-1, Foundation 2, Iowa Substance Abuse Information Center (ISAIC), Iowa COMP, Long-Term Care Ombudsman, AAA Associations, as well as providers of utility assistance, housing assistance and homeless shelters. We will work with State, parish and city agencies to incorporate the information specific to their programs into our training program. If a member needs assistance in accessing other services during a call, the representative will perform a warm transfer to the specific agency to help advocate for the member. For example, if we are talking with a member who needs information about programs to prevent domestic violence, we will transfer them to the appropriate agency and/or our Rapid Response team. The Rapid Response team, our dedicated unit of staff trained in how to access social services in a particular region, will be engaged to provide in-depth assistance to the member. The Rapid Response team will help members access utility assistance programs, housing assistance, community support agencies and crisis hotlines.

Our affiliate, AmeriHealth Caritas Louisiana, collaborated with community support agencies when Hurricane Isaac hit in 2012. AmeriHealth Caritas Louisiana's service center was open 24/7 to help members find shelter, assist them in finding providers that were still operational and help answer questions related to out-of-State care.

AmeriHealth Caritas recognizes the importance of integrating medical and social services to address all of the needs of its members. In Iowa, it is our goal to work with DHS to provide truly cohesive care. AmeriHealth Caritas Iowa intends to integrate critical social and community support data and information into the system to enable interfaces with community systems that make each member contact count. When a member calls, the representative will receive a screen alert that includes all of the member's key information, care gaps, health initiatives and even services offered by local agencies. This type of system integration will greatly enhance the customer experience, as well as provide critical information to impact the member's health outcomes and quality of life. For example, a contact with a member would not only prompt them to choose a PCP, but might also inform them of other services and supports for which they may be eligible or that are available in their local community.

After-hours procedures

Being able to reach a live representative after hours can produce better results than those achieved when these calls are handled by an answering service. Members receive better access to care and services, enhanced coordination between behavioral and physical health and better coordination with the 24/7

Nurse Call Line. Ultimately, this leads to higher member satisfaction. Accordingly, we will exceed State requirements by offering a CCOE that is staffed 24 hours a day, seven days a week, 365 days a year.

The same procedures utilized during normal business hours will be followed after hours. CCOE management employees, as well as a Utilization Management nurse and physician, will be available on-call to assist with any issues that may arise. Our after-hours services will ensure members receive access to needed services quickly, improving the overall quality of care and ensuring progress toward our goal of helping members get care, stay well and build healthy communities.

6. Describe your plans for a backup solution for phone service in the event of a power failure or outage or other interruption in service.

Member and provider services will be handled through a dedicated team in our Philadelphia service center, which will be specifically trained for the Iowa population. Staff located in our Jacksonville and Salt Lake City sites will also be trained to handle Iowa calls. As the AmeriHealth Caritas Iowa health plan grows, we will evaluate the possibility of locating a call center in Iowa. Redundancy of our service centers is supported internally with sites utilizing the same telephony platform and technology allowing us to switch calls immediately among sites, as necessary. In addition, our sites are located in different weather bands to significantly decrease the likelihood of concurrent events.

AmeriHealth Caritas' telephony infrastructure has a comprehensive back-up system with full redundancy capabilities. AmeriHealth Caritas Iowa will utilize the Avaya Single Image Switch architecture, a fully distributed Voice over IP (VoIP)-based phone system. This system provides feature transparency across AmeriHealth Caritas and also extends CCOE and other applications throughout the enterprise. The main Avaya Communication Manager server resides in Philadelphia, Pennsylvania and supports all AmeriHealth Caritas locations, including our data center and all affiliates. The secondary standby server is located in a separate location to ensure continuity of service. The Avaya Single Image Switch platform renders all sites fully capable of providing CCOE call handling for any type of situation.

This architectural design also takes into account survivability in the event of wide area network failures. If the AmeriHealth Caritas Iowa site was to lose connectivity to the main Avaya server, the local Avaya gateway(s) at the affiliate site would register to the local Avaya Communication Manager standby server. In essence, this site would function as a standalone PBX and would be fully capable of servicing calls.

In the event of a shutdown of the AmeriHealth Caritas Iowa site, full phone-system functionality would be achieved by the Philadelphia corporate site or any other affiliate location. Phone providers would redirect calls to such a location to provide seamless transition of call handling during any event. This functionality includes mitigating multiple service interruption scenarios, including floods and hurricanes, to maintain the uninterrupted function of member services.

7. Describe if any separate Member Services lines or staff will be used to address member needs by service type (i.e., physical health, behavioral health and long-term care (LTC) services).

To ensure easy and immediate access to AmeriHealth Caritas Iowa, one Member Services helpline number will be utilized for all members regardless of their service needs. Utilizing our intelligent call routing capabilities, members will be routed to the most appropriate representative or, if applicable, to our expert staff trained to address special needs or complex issues based on criteria such as the member's health risk, gaps in care, contact frequency and eligibility status. Members may also select the option to speak with a specialized representative at the outset of the call.

If necessary, and as described below, a warm transfer of the member to other internal and external departments, services or support areas will ensure our members receive the assistance necessary to address their needs. Representatives will have access to clinical staff to support them in managing a crisis 24 hours a day, 7 days a week.

8. Describe proposed entities to which you will be capable of warm transferring member calls.

Our warm transfer process will ensure a service representative stays on the line with both internal and external entities until all of the members needs are met. Examples of warm transfers currently in place are provided. This is not an exhaustive list and more can be built easily through our systems depending upon the needs of Iowa members.

Department/Service
Case management: For pregnant members calling about Bright Start program.
Case management: Use the extension for transferring members.
Foster care: Use for transferring DHS caseworkers needing orientations for foster care members.
Language line services.
Marketing/enrollment: For prospective members inquiring about joining AmeriHealth Caritas Iowa during normal business hours only.
Marketing/enrollment after hours: For prospective members inquiring about joining AmeriHealth Caritas Iowa during after-hours only.
Member services: Transfer to local teams, such as COS team, Social Services Expert Unit and AmeriHealth Caritas Iowa Community Wellness Center.
Member services/pharmacy issues: Use this extension to transfer members having pharmacy issues from outside of Member Services.
Member Services supervisors: Generally used only for elevation.
Behavioral health call center: Provider-only inpatient behavioral health management/inquiries.
Provider claims investigation: Transfer providers here only if the provider needs detailed claims investigation.
Provider claims status: Providers will contact this number to verify the status of a claim. This number routes to Member Services.
Provider medical disputes: For transferring providers seeking to initiate a medical appeal.
Provider network services: For provider issues, such as provider grievances and contracting questions.
External resources: For example, United Way, Aging Resources of Central Iowa, Iowa COMPASS Disability Resource Database, LifeLong Links Iowa.

Exhibit 8.3-B: Example warm transfers

8.4 Nurse Call Line

1. Describe how the Nurse Call Line will be publicized to members.

We publicize the availability of the Nurse Call Line through the following vehicles:

- Member Handbook.
- The health plan website through a phone number and a secure email capability.
- Letters from Care Management include information about our 24/7 Nurse Call Line.
- At the end of every call, the Rapid Response team reminds members that they have access to a nurse.

PCPs play a central role in the delivery, management and promotion of high-quality healthcare. Encouraging and supporting the relationship between Iowa members and their PCPs is at the heart of our core principles of access and quality. When they cannot reach their doctor's office or when the health plan's Medical Management department is closed, Iowa members will be able to call a 24/7 Nurse Call Line and receive support as they need it. The 24/7 Nurse Call Line staff will provide warm, compassionate service and helpful, easy-to-understand answers to members' questions. Members will be able to call toll-free and talk with a registered nurse any time of the day or night, every day of the week.

The nurses may help members with the following items:

- Address symptoms they are having and provide direction to seek appropriate care.
- Decide if there is an emergency and if they need to go to the ER.

The 24/7 Nurse Call Line will also mirror information provided by Care Management, such as:

- Learn about health and medical concerns so they can discuss them with their PCP.
- Learn about the medicines they are taking.
- Pick the best exercises and foods for a healthy lifestyle.
- Address questions and learn about medical tests and procedures.
- Enhance their understanding of specific medical problems like diabetes or asthma, and also be referred to the appropriate health plan programs.
- Obtain important information about community resources available in their area.

All calls to the 24/7 Nurse Call Line will be recorded for quality purposes. A triage/encounter report on each call will be provided to the health plan on a daily basis. These reports will be reviewed by the Care Management team. Members will receive a follow-up call to discuss the outcome of the call and determine if there has been a change in their health status and/or to determine if additional assistance is needed. It is also an opportunity for the care manager to determine if the member would benefit from ongoing support provided in the Care Management program. Members will be encouraged to seek care from their PCP and offered assistance scheduling appointments and arranging transportation services. The assigned PCP will receive a faxed copy of the member triage report for their files.

During the implementation of 24/7 Nurse Call Line, the Delegation Oversight team will work with the Care Management team and all other departments of the health plan to ensure 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 will ensure members' questions and any issues are quickly addressed or

referred to another area in a seamless fashion. Ongoing training programs will be 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 will provide 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 there is a building emergency or other situation that causes 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 will ensure clinical staff is always available to address a member's question or concerns through any health plan phone number that is dialed, regardless of the time, situation or day.

2. Describe the credentials Nurse Call Line staff must possess.

Following IVR processing, callers will be routed to a specially trained medical service representative (MSRs), which we subcontract with SironaHealth. SironaHealth's MSRs are required to have a high school degree or equivalent and possess basic personal computer (PC), keyboarding and telephone system skills. SironaHealth seeks out individuals who have experience working in customer service/call center environments as well as physicians' offices or other healthcare provider settings.

SironaHealth's nurse consultants are required to have a current registered nurse (RN) license in the State where their office is located, with a minimum of three years' recent clinical experience in an acute or ambulatory care setting. Primary source verification is completed on all licensed clinical staff. In addition, nurses must possess telephone communication and basic PC skills. Clinical staff is required to complete a minimum of 15 continuing education contact hours annually.

3. Describe processes and protocols for when a physician must be consulted.

Secondary triage is an extremely effective mechanism to reduce ER referrals by an additional 50 percent from the 24/7 Nurse Call Line. This is achieved by paging the on-call practice physician under clearly defined emergent circumstances.

How does this work?

If the triage process determines the patient needs immediate attention or the patient needs attention within a time period where physician offices or urgent care facilities are not available and rules exist to page a physician, the on-call physician will be paged to call the member. Triaging calls and consulting physicians will occur through a three-step process:

I. Rules for secondary triage

- Clinical guidelines combined with clinical judgment determines disposition.
- Common dispositions that can trip a secondary triage include:
  - ER now or PCP triage (lower acuity than ER now, determined by guidelines).
  - See PCP in four hours (and no office is open in four hours).
  - See PCP in 24 hours (and no office is open in 24 hours).
  - Member refuses to go to the ER or other disposition and insists PCP is paged.

II. Provider rules — a number of options are available

- Secondary triage is required for all ER visits. Every situation in I.2 above results in a page to a physician.

- Secondary triage is turned on by disposition. Only designated dispositions result in a page to a physician.

III. Rules for who gets paged

There are no limits to who gets paged or when. If deemed appropriate by the State, we could associate each health plan member with a provider network and route calls based upon time of day. For example:

- 8:00 a.m. to 6:00 p.m. — page on-call physician in the ER.
- 6:01 p.m. to 11:00 p.m. — page on-call physician in the urgent care facility.
- 11:01 p.m. to 5:59 a.m. — page the PCP.

In addition to associating a member to a provider network, the rules can also apply to a specific practice:

- 8:00 a.m. to 6:00 p.m. — page Dr. One.
- 6:01 p.m. to 11:00 p.m. — page Dr. Two.
- 11:01 p.m. to 5:59 a.m. — page Dr. Three.

We will confer with the State during implementation to determine the exact rules for paging.

Disposition	Time Frame	Care Options
Call PCP now	Immediately	Call PCP. If no PCP is available, call the urgent care center, then the ER as a third option.
Go to labor and delivery (L&D) now (or PCP triage)	Within one hour	Call PCP if able to see member in one hour or if authorization is needed. If no PCP/no authorization is needed, call L&D, then the ER as a third option.
Go to ER now (or PCP triage)	Within one hour	Call PCP, if available, to see in one hour or if authorization is needed. If no PCP/no authorization needed, call the urgent care center, then the ER as a third option.
See physician within four hours (or PCP triage)	Within four hours	Call PCP, if available, to see in four hours or if authorization is needed. If no PCP/no authorization needed, call the urgent care center, then the ER as a third option.
Call local agency now and see physician within 24 hours	Within 24 hours	Call PCP, if available, to see in 24 hours or if authorization is needed. If no PCP/no authorization needed, call the urgent care center, then the ER as a third option.

Exhibit 8.4-A: Typical escalation dispositions

Procedure for dispositions of ER now or PCP triage requiring authorization

The nurse will page the on-call physician and instruct the member to call SironaHealth back if they have not received a call from the nurse or the physician within 30 minutes. If the member has not received a call within 30 minutes, the nurse will attempt to contact the on-call physician according to the on-call paging escalation rules. The member will be instructed to call SironaHealth back in 15 minutes if they have not received a call from the nurse or the on-call physician. If the member calls back after the second page, the nurse will instruct the member where to go to access care.

Per AmeriHealth Caritas policies and procedures, the nurse may use nursing judgment at any time during this process if he or she feels the patient is unable to wait for authorization to be seen.

Documentation of disposition and outcome

When known, nurses will document the name of the facility where the patient will go for care in the nurse's notes. For all escalation dispositions, the nurse will be required to document the outcome:

- RN advice — Indicating what level of care the nurse recommended based on availability (PCP, urgent care clinic or ER).
- Outcome-intended action — Exactly where the patient intends to be seen (PCP, urgent care clinic or ER).

8.5 Electronic Communication

1. Describe how technology will be leveraged to communicate with members.

AmeriHealth Caritas' digital transformation

AmeriHealth Caritas knows our members and providers want to interact with our health plans in many different ways. And we understand that digital communications are a fundamental reality and component of the next generation of healthcare delivery. We have begun a digital transformation initiative this year focused on defining and delivering a digital experience tailored to the needs and expectations of our members and providers.

With the assistance of an industry-recognized digital communication agency, we are conducting an assessment of our digital communication platforms. Examples of the platforms include our plan website, Member Portal, Provider Web Portal and social media. We will deliver information, access and value to our members and providers in the ways that work and matter most to them. To inform our efforts, we are conducting focus groups with our members and providers so we can fully understand how they prefer to interact and communicate with us.

Proactive outreach manager to assist in outbound communication

AmeriHealth Caritas' outbound call center utilizes an outbound dialer, which allows us to connect with our members live or send alerts to increase awareness of health prevention practices. We utilize historical contact rates to determine the best times to reach our members to ensure we can complete items, such as member health risk assessments when our members are most available. The proactive outreach manager is the technology that supports the dialer and enables us to create and execute automated outbound voice, email, or SMS text campaigns, providing valuable information and enabling members to take immediate action via self-service or live agent interaction.

Digital communication as part of our holistic "no wrong door" approach

As discussed within the response for 8.2 Member Communication, AmeriHealth Caritas Iowa will leverage technology as part of our "no wrong door" approach to member engagement. Members will be able to interact with AmeriHealth Caritas Iowa digitally, through the plan website, Member Portal (discussed in 8.6) and texting. In addition, our outreach and communication with members will be tracked and monitored to continuously improve their effectiveness. For additional detail on our technology solutions, please refer to Section 13 of our response.

2. Describe how information on member's preferred mode of receipt of communication will be collected and how information will be sent in accordance with such selection.

We want to interact and communicate with members in ways that are most meaningful to them and reflect natural engagement points. To ensure each member receives information in the way that best meets individual needs, we will allow members to opt-in to electronic communication. That preference will be passed to the welcome kit supplier and all documents sent electronically or via a link. Conversely, we will also be able to interact with members through non-electronic means (e.g., phone or mail) if that is their preference.

3. Describe how electronic communication will be received.

Members will have the option to select the "contact us" feature on the plan website and the Member Portal, which triggers the export of the request for review by a CCOE representative. The CCOE representative will then follow up with the member directly to resolve the inquiry/request.

8.6 Member Website

1. Describe your plan to develop a member website and mobile applications in English and Spanish, and the kinds of information you will make available to members in these formats.

AmeriHealth Caritas Iowa will develop websites and applications in English and Spanish that are accessible and functional via cell phone. Our Member Portal will be a secure resource with member access to searchable provider network information, personal health information on care gaps, prescription drugs and healthcare visits. Members' access to this administrative and clinical information strengthens their ability to be informed managers of their benefits, health and wellness.

Other available tools on the plan website will include searchable tools to allow members and providers to find up-to-date information on network providers, pharmacies, covered medication and tactical health and wellness tools, such as a BMI calculator.

We will ensure our plan website and Member Portal are frequently refreshed and updated with relevant and helpful information. Through these means, we will disseminate health and wellness information and invite member engagement.

Overview of tools and information on the Member Portal

The Member Portal will include:

- PCP demographic information via online provider directory.
- The ability for members to change their PCP.
- Medical claims detail to track the status of member claims, including the stage in the process, the amount approved, the amount paid, member cost and the date paid, if applicable.
- Prescription information, including determining financial responsibility for a drug, initiating the exceptions process, managing refill reminders, finding the location of an in-network pharmacy, conducting a pharmacy proximity search by ZIP code, determining potential drug-drug interactions,

determining a drug's common side effects and significant risks and determining the availability of generic substitutes.

- Prescription history for past six months, including the date prescribed, medication name, dosage and prescribing physician.
- Health visit history, including recent visits to the doctor, hospital and ER.
- In partnership with WellSource, links to a health and wellness library and related self-management tools related to healthy weight (BMI) maintenance, smoking cessation, encouraging physical activity, healthy eating, managing stress, avoiding risky drinking and identifying depressive symptoms.
- Submit questions and comments via a secure contact form and receive answers from Member Services.
- A health risk assessment with questions on member demographics and personal health history, including chronic illness and current treatment, self-perceived health status and the identification of effective behavioral change strategies. It will also assess personal health characteristics and behaviors, including weight, height, smoking, physical activity, healthy eating, stress, productivity or absenteeism, breast cancer screening, colorectal cancer screening, cervical cancer screening, influenza vaccination, risky drinking and depressive symptoms. It will also pose questions to identify members with special needs in the areas of hearing impairment, vision impairment and language preference.
- Request a new ID card or Member Handbook.
- Online enrollment in disease management programs.

AmeriHealth Caritas Iowa's Web development team follows industry best practices, while continuing to innovate and improve as a leader in this space

Our web development team supports best practices and leading innovations in the development of its services:

- HIPAA security requirements.
- Cross-browser compatibility.
- Accessible through desktop and mobile devices without losing usability or access to information.
- Meets all coding standards set by the World Wide Web Consortium for markup language, link validation and Cascading Style Sheet.
- Best practice designs based on the United States Government's Web Guidelines on usability.
- Meets or exceeds requirements in Section 508 of the Americans with Disabilities Act and meets all standards the Act sets for people with visual impairments and disabilities that make usability a concern, including the Web Content Accessibility Guidelines (WCAG) 2.0.
- Frequency of information updates, including updating provider network information every two weeks at minimum.
- Tracking website activity to determine what information members are actually using, so the website is tailored to their needs and interests.
- NCQA standards for Member Connections will be in place by July 2015.

Website input from members via the AmeriHealth Caritas Iowa Member Advisory Committee

AmeriHealth Caritas Iowa will regularly review the website with the Member Advisory Committee to ensure that Web content is displayed in a manner easily understood, navigable and containing content that addresses member needs. This committee, comprising members and community partners, will be an excellent source of feedback that can shape website content.

Past experience in engaging members and improving technology

The AmeriHealth Caritas affiliate in the District of Columbia recently launched a Member Wellness Advisory Council (MWAC), comprising members, community partners and providers. The MWAC provides a forum for these groups to share feedback and suggestions on the affiliate's programs and strategies. The goal of the group is to help AmeriHealth Caritas strengthen its focus on members and to enhance service delivery to its communities.

"We are so pleased to have this type of participation from our members and partners to ensure customer-driven programs," said Stephanie Hafiz, director, Customer Service Operations. "The Council will help keep us focused on ensuring that our members get the care and service delivery they need to achieve the best possible health outcomes."

During its recent inaugural meeting, the Council provided feedback on the use of a tablet to assist children challenged by asthma, which could also be used for other chronic illnesses. Feedback was collected and shared with PerformRx, AmeriHealth Caritas' pharmacy benefit management organization, and the affiliate's communication staff so changes could be made to improve the product. The council meets quarterly, with meetings rotating through the four quadrants of the District of Columbia.

Mobile app overview

In addition to a mobile-friendly website, AmeriHealth Caritas Iowa will provide a user-friendly and effective mobile app to its members. The mobile app will allow members to conveniently access needed information wherever they are and support access and adherence to care.

Examples of functionality for the mobile app include:

- Access to the front and back of Member ID cards, with the ability to fax them to their providers.
- PCP contact information, including a direct-call link.
- List of specialist physicians for each member (through analysis of member activity/claims).
- Provider directory, including map and directions from current location.
- Pharmacy medicine cabinet, including information to help members manage their medications, picture of the medicine, date dispensed, label warnings/interactions and drug information. To support adherence, a member can also schedule alerts to take his or her medication.
- Care gap alerts to support care plan adherence.
- Member/household link providing access to a members' household information to support integrated family care.
- Prenatal care reminders for pregnant members.

8.7 Health Education and Initiatives

1. Describe your proposed health education initiatives including topic areas and strategies for communication. Provide sample materials.

AmeriHealth Caritas believes quality of care is built on a foundation of education. This will enable us to empower the Iowa Medicaid population to make the best possible decisions about their health, understand the value of our approach to care, and — above all else — adopt healthy behaviors to drive outcomes. We see this approach as a key driver to making Iowa the healthiest State in the country.

Our educational materials and initiatives are developed following a process designed to address the specific needs of our membership population, which are identified through inputs, such as demographic information, initial health-risk screenings and any medical or claims data available on our members.

AmeriHealth Caritas improves health outcomes by empowering and educating members to make healthy choices and live healthier lifestyles for themselves and their families. We use many points of contact to deliver critical health information to members. From the information we include in enrollment materials to the newsletters and flyers we distribute at health events, we make every member contact count by facilitating equitable access to high-quality care. Our high-touch, local outreach teams are hired from within the communities they serve. This enables them well to engage with members on how to access appropriate care, overcome barriers and connect with social supports. Because managed care will be a new concept for some in Iowa, we will use our time with members to not only educate about health issues, but to ensure that members have a deep understanding about how to make the most of the benefits available to them through the Iowa High Quality Healthcare Initiative. When we launched our affiliate Arbor Health Plan in Nebraska in 2012, the open enrollment period coincided with the Nebraska State Fair in Grand Island, Nebraska. A team of Arbor Health Plan associates staffed a table for several days to introduce managed care and how to determine/enroll eligibility. We also provided general health education materials, and offered health screenings and “meet the doc” sessions. This was a great opportunity to learn about the concerns of members or potential members and demonstrate how we truly become part of the communities we serve. We look forward to using the same approach when we launch in Iowa.

Sample materials are provided as attachments at the end of this section:

- Attachment 8.7-A: Diabetes Educational Material.
- Attachment 8.7-B: Cardiovascular Health Educational Material.
- Attachment 8.7-C: Depression Educational Material.

Educational materials

AmeriHealth Caritas Iowa will develop materials designed to educate members about specific health issues, equip them with strategies for improved wellness and encourage them to take responsibility for their health. Example topics include asthma control, diabetes management, stress management, high blood pressure and healthy living. Our member educational materials:

- Explain healthcare options.
- Describe health plan benefits and services.
- Inform about health conditions, including how to manage a specific disease or condition.
- Coach on how to stay healthy and prevent illness.

AmeriHealth Caritas Iowa will make information available to members through various communication channels. We develop and maintain a comprehensive library of useful and relevant educational materials, which include, but are not limited to:

- Member education mailings.
- Quarterly newsletters.
- Online links to health information.
- Secure Member Portal.
- Materials that support community outreach initiatives.
- Posters and flyers.
- Annual Message to the Community booklet.

AmeriHealth Caritas Iowa will develop educational materials with the needs of the members in mind and in conformance to all DHS requirements. Materials we use across AmeriHealth Caritas health plans to increase members' understanding of managed care include, but are not limited to:

- Members' Bill of Rights.
- Member notices, including notices of provider termination.
- Notification of any changes that DHS defines as significant in the required time frame.

Stratified educational materials

AmeriHealth Caritas' ICM and Rapid Response teams send educational materials targeted to members in our ICM program through an evidence-based software program. Topics for education are specifically selected based on members' identified nursing assessment needs, as well as individualized care plans goals. AmeriHealth Caritas Iowa will provide these materials to members through our Medical Management programs and upon request.

We will mail disease-specific information to membership segments identified as having symptoms and/or diagnosed with a condition through our aggressive Care Management programs. For instance, a member with diabetes may be sent a letter or other form of communications to encourage HbA1C testing.

In addition to the many brochures targeted to the low- and high-risk pregnant mothers (and listed in this response under Prenatal Services and Prematurity Prevention), a few other examples of our brochures include:

- Heart-Healthy Habits.
- Diabetes Checklist.
- What is Heart Failure?
- Congestive Heart Failure Reporting and Emergency Plan.
- Coronary Artery Disease.
- High Blood Pressure: The Silent Killer.
- Power Over Asthma — Asthma Triggers.
- Tips to Manage COPD.
- Living Healthy with Sickle Cell Disease.

Educational programs

AmeriHealth Caritas Iowa's COS team will provide educational programs to the community to supplement the direct-access materials available to members. The educational programs that will be offered include:

- **Healthy Heart** — Teach participants the primary function of the heart and its importance. Participants are shown exercises and foods that are heart healthy.
- **Asthma Management** — Teach participants the basics about asthma and important steps to take to effectively manage the disease.
- **Diabetes Management** — Teach participants a sound awareness of the high prevalence of diabetes, including risk factors, steps to reduce the risk and available treatment for the disease.
- **Latino Diabetes** — A diabetes education program focusing on the Latino/Hispanic population, which includes information on the basics of diabetes, ways to introduce regular physical activity, smoking cessation, medication adherence and healthy eating habits, such as tips on cooking Latino favorites using less fat, salt and sugar.
- **Empower the Advocate (ETA)** — The "ETA" initiative engages individuals in their community, faith-based organizations and social service agencies (i4As, LeadingAge, IDAAN) to provide in-services to their staff about the importance of preventive care, medical management and the AmeriHealth Caritas Iowa ICM.
- **Childhood Weight Management** — Aims to increase physical activity and improve nutrition through smart snacking and increased consumption of fruits and vegetables.
- **Child's Health** — Focuses on common childhood illnesses, such as fevers, colds, ear infections, stomach aches. It also promotes and encourages dental care. Parents/caregivers are provided education on the steps that can be taken at home, when to call their doctor and basic facts about these illnesses and conditions.
- **Medicine Safety** — Educates participants on what medication they are taking, why they are taking them and what the instructions mean.
- **Caring for the Caregiver Events** — Engaging and educating key caregivers about the benefit of health plans in support of the model of care reducing the risk of acute hospital admissions and supporting the transition of members from institutions (adult assisted living facilities and nursing homes) to home and community-based services (HCBS).
- **Maternal Health** — This program is geared towards women who are either expecting or wish to become pregnant. The program educates women about the importance of early and regular prenatal appointments, use of prenatal vitamins and risk factors for premature birth.
- **Poison Prevention** — This program outlines how to recognize poisons, where they may be found, how poisoning can occur, how to prevent them and what to do in a poison emergency.
- **Teen Health** — Topics include healthy relationships, healthy eating, physical activity, personal and internet safety, dental health and depression.
- **Women's Health** — Focuses on three areas of women's health: breast, cervical and heart.
- **Youth Sports Safety** — Geared towards youth, ages six to 14, to help reduce their risk of a sports-related injury by identifying key components to safety, such as location, equipment and good instructions.

- **Bullying** —This presentation is for children and gives an overview of the definition of bullying, types (physical, verbal, social and cyber) and examples of each.
- **Healthy You, Healthy Me** — Currently, the COS teams are conducting "Healthy You, Healthy Me" initiatives in their territories throughout AmeriHealth Caritas affiliate Medicaid plans. Programs are a collaborative effort with agencies such as Boys and Girls Clubs, afterschool programs, school districts, The Salvation Army and neighborhood centers.

As mentioned earlier, AmeriHealth Caritas Iowa will design and implement health education initiatives with the specific needs of Iowa's population in mind, intended to drive improved outcomes through member engagement and education. We will work with the DHS to implement programs appropriate for Iowa's population that will drive the ultimate outcomes and efficiencies sought after.

Examples of the robust member-centered programs that AmeriHealth Caritas affiliates have launched in other states

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 operated by AmeriHealth Caritas. The Healthy Hoops 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, BMI, height/weight, spirometry), individualized asthma action plans and targeted health education.

Gift of Life

A wellness program designed to alert women who are non-adherent to mammography and breast cancer screenings per HEDIS measures is in its seventh year. Members are identified per claims review and ZIP codes and are invited by phone to attend screening events at local provider facilities. Transportation is provided, as well as personal support while the members are waiting for their screenings. Upon completion of the screenings, gift card incentives are given to the members. Women who need additional diagnostic services are referred and further assisted through the care process. Partnerships with local mobile mammography vans also provide opportunities for members during community health fairs at local venues, including faith-based organizations, supermarkets and FQHCs. The Rapid Response team also supports outbound health education telephonic campaigns, alerting members to follow up on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and adult healthcare including:

- Flu shots for all ages.
- Childhood immunizations.
- Blood lead screenings.
- Well visits for those up to age 21.

Your "Gift of Life" Appointment Reminder

Hello AmeriHealth Caritas Iowa Member, you were recently scheduled for a mammogram.

Members will receive:

- A $15 gift card (for completed screening).
- A small token of our appreciation for caring about yourself.

If you have any questions about your appointment please call XXX-XXX-XXXX.

Thank you,
Rapid Response and Outreach Team

Please bring your AmeriHealth Caritas Iowa card and a photo ID with you.

AmeriHealth Caritas Iowa

Exhibit 8.7-A: Gift of Life sample material

Moms2B program

The Moms2B program focuses on reducing the incidence of premature and low-weight births through intensive case management services, the use of cell phones for calling and texting appointment reminders, and key pregnancy information and incentives to promote prenatal and postpartum care. The program engages high-risk pregnant members providing a high-intensity program tailored to individual needs.

Community baby showers

Community baby showers are designed to engage pregnant women for the purpose of introducing the Bright Start program, providing risk assessments to determine needs, offering outside resources, providing dental screenings for pregnant women and providing parenting preparation courses about infant care, stress management, nutrition, cognitive development and effective parent-child communications.

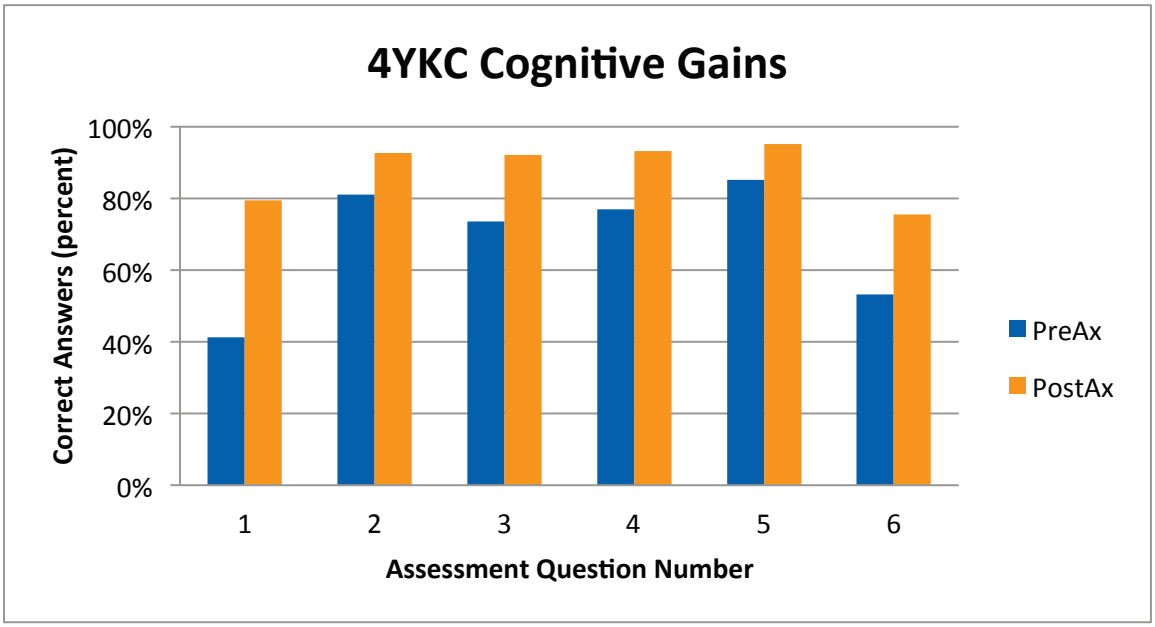
Parents in the Know

Newly launched in 2014, this program is a groundbreaking community awareness program for parents and caregivers to help identify sexual abuse predators and protect their children. Developed in collaboration with local rape crisis centers, AmeriHealth Caritas affiliates have held awareness workshops for parents providing hands-on techniques to voice concerns and help protect their children.

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, 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.

- Approximately 2,832 head-of-household members have attended 4 Your Kids Care since its implementation in 2011 in Southeastern Pennsylvania.
- 2012 program statistical outcomes (one-year look back and one-year look ahead) shows a 25 percent drop in ER utilization and costs for those who attended.



*PreAx= Prescreening result, PostAx= Post Screening Result
*Source: 4YKC Surveys, David Keleti 4YKC Article "Reducing Nonurgent ED Utilization in Pediatric Members"

Exhibit 8.7-B: Example 4 Your Kids Care Outcomes

The 4 Your Kids Care manual supports education, including the following questions:

1. Your child is younger than two months old and has a fever of 100.4 degrees. You should:
   A. Go to the ER.
   B. Call the PCP.
   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 three are usually
   A. NOT normal. You should take your child to the emergency room.
   B. Normal. You should call the doctor when your child has one.

Make Every Calorie Count

AmeriHealth Caritas' Make Every Calorie Count (MECC) program aims to help members become healthier, particularly those who have been diagnosed with obesity and have other chronic conditions. The individualized six-week program provides suggestions for small changes to everyday activities over the course of the program. The program also encourages participants to establish routines, set their own custom goals and learn about the benefits of a healthy lifestyle.

MECC includes health assessments, one-on-one care management, individualized care planning and patient education. Members participating in care management can also be referred to an expanded nutritional counseling session with a registered dietician.

Make every calorie count. It's a way of life.

Daily Food and Activity Log Book

Member name

Nurse name

Nurse phone

AmeriHealth Caritas Iowa

Make every calorie count. It's a way of life.

Welcome!

The Make Every Calorie Count program is about wellness and feeling good. It's about finding balance and setting real goals so you can be the best you can be. It's not about big changes, dieting or giving up foods you enjoy. It is about small things you can do to lose weight and feel better.

AmeriHealth Caritas Iowa

Exhibit 8.7-C: Make Every Calorie Count – Example AmeriHealth Caritas Iowa Materials

Eligible members with their BMI between the 85th and 94th percentile and/or eligible members identified with a claim diagnosis of being overweight, obese or morbidly obese receive an invitation to join MECC, along with a calendar that outlines healthy eating tips and activities associated with each month of the year. In addition, the program is offered to members working with a care manager who are interested in weight management.

When a member enrolls in the program, the care manager collects data on the member's current eating habits and level of motivation to develop a healthy lifestyle. The questions are non-judgmental. The care manager uses motivational interviewing techniques to encourage members to think about making small but sustainable changes. Members completing the assessment begin to work on their individual goal as part of their plan of care and are sent additional tools, including a pedometer, tape measure and a journal for celebrating progress.

The Care Management staff receives additional training on assisting members to achieve a healthy weight from a physician skilled in weight loss counseling.

Lose to Win Program

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 on 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, BP and BMI.

Sample outcomes

- Glucose: Seven out of 10 members screened (pre/post) had lower glucose readings post-program. Glucose declined by an average of 46 points for entire pre/post cohort, which represents an average change of 17.73 percent.
- HbA1c: Six out of 10 members screened (pre/post) had lower HbA1c readings post-program. HbA1c declined by an average of 1.09 points for the entire pre/post cohort, which represents an average change of 9.57 percent.
- Weight: Seven out of 10 members screened (pre/post) lost weight during the program. Weight declined by an average of 7.38 pounds for the entire pre/post cohort, which represents an average change of 2.30 percent.
- Blood Pressure:
  - Systolic: Eight out of 10 members screened (pre/post) had a lower systolic blood pressure reading post-program. Systolic blood pressure declined by an average of 8.4 points for the entire pre/post cohort, which represents an average change of 6.29 percent.
  - Diastolic: Six out of 10 members screened (pre/post) had a lower diastolic blood pressure reading post-program. Diastolic blood pressure declined by an average of 1.8 points for the entire pre/post cohort, which represents an average change of one percent.

Health Empowerment Tour/40-Day Journey

The 40-Day Journey to Better Health, designed by AmeriHealth Caritas, is a program designed to target individuals to change their eating and exercise behaviors. The program promotes eating fruits, vegetables and whole foods for 40 days.

In a recent roll out in Philadelphia, there was a 13 percent drop in total cholesterol across attendees, 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.

Dental and adolescent well initiative

In an effort to improve engagement of children under the age of 21, Keystone First, the AmeriHealth Caritas affiliate in southeastern Pennsylvania, collaborates with FQHCs and large physician practices to assist with an event where we provide assistance with scheduling non-compliant members and provide incentives to promote adolescent well visits and dental screenings to improve HEDIS results. While dental care is not a service that would be provided by AmeriHealth Caritas Iowa, we recognize the importance of partnering with dental providers to ensure that our members, especially our pregnant members, are connected to the services they need to keep them healthy.

Philadelphia Housing Authority (PHA) and Shelter System collaboration

The Philadelphia Housing Authority (PHA) and Shelter System collaboration was established to provide health screenings and health information through on-site events and activities to the most vulnerable

members who reside in PHA sites and homeless shelters. The program educates homeless members on how to use the health plan and provides step-by-step guidance through onboarding transition with the goal of retaining membership and reducing gaps in care. Members are screened for total cholesterol, HDL, LDL, triglycerides, glucose, HbA1c, BP, height/weight, dental and BMI. Similarly, AmeriHealth Caritas associates met with the executive director of the Central Iowa Shelter & Services (CISS) to discuss potential collaborations, which are detailed later in our response.

General health screenings at community events

Public affairs and marketing department affiliates target Keystone First members who are non-compliant for HEDIS measures in an effort to facilitate health screenings, provide education, close care gaps and reconnect them with their PCPs. In 2014, our Public Affairs and Marketing departments participated in 88 community health events and provided members with the several screenings, including total cholesterol, HDL, LDL, triglycerides, glucose, HbA1c, BP, pulse rate, height/weight, dental, adolescent well and BMI.

Within five business days for controlled results or 48 hours for elevated and emergent results, all member-screening results are sent to their respective PCPs for follow-up and HEDIS documentation. Within the same respective time frames, member-screening results are sent internally to Public Affairs, Quality Management, Medical Economics, Care Management, HEDIS, Rapid Response and the network medical director for follow-up, HEDIS documentation and internal record keeping.

Parent Series — a behavioral health program offering

PerformCare, AmeriHealth Caritas' behavioral health affiliate, has been working with parents to develop an educational offering we call the Parent Series. The idea of the Parent Series came from meetings we hosted with family groups, such as the Autism Advisory Group and Family Issues Group. The questions and concerns expressed at these meetings showed the need to better educate families about services and the "system" to help increase understanding and access to services for their children or themselves.

PerformCare was originally created by behavioral health providers in Pennsylvania under the name Community Behavioral Healthcare Network Providers (CBHNP). Once CBHNP became part of AmeriHealth Caritas and moved beyond Pennsylvania, it was decided to change the name to PerformCare so as not to be viewed as a Pennsylvania-only health plan.

The series is covered over three sessions and addresses subjects, including:

- Behavioral HealthChoices and PerformCare — What and who are they and what do they offer?
- How to access services.
- Insurance — What if you have other (private) insurance?
- Treatment expectations — What should families expect from the services their children receive?
- The factors that go into decisions regarding services.

Parents are involved in the planning and look of the series and its content (what should be in the series and what should not be). We also offer parents the opportunity to assist with the presentations.

We reimburse (time and mileage) those who agree to assist with this series. For those willing to participate with presentations, reimbursement will come at a special rate and mileage to meetings will be reimbursed. Regular reimbursement for time and mileage will be offered to those who attend the introductory meetings.

Grocery store collaboration

AmeriHealth Caritas has partnered with various grocery stores for the purpose of providing health screenings and education. The partnership is made up of three components: providing members' access to

important health screenings, offering grocery-store gift-cards as an incentive for healthy behaviors and introducing members to fresh fruits and vegetables. AmeriHealth Caritas recently met with the Pharmacy department leadership at HyVee's corporate office to discuss a variety of programs for potential collaboration. In addition to educating members on the proper use of medications, AmeriHealth Caritas Iowa will partner to provide health screenings and supermarket tours to teach members how to make good food choices.

Effective member outreach and health education at work from the Keystone First health plan in southeastern Pennsylvania: "When should a child go to the ER?" by Paul Jablow, Philadelphia Inquirer, March 1, 2015

The Philadelphia Inquirer
philly.com

Six years ago, when her 3-year-old daughter developed a fever and a discharge from her ear, Latasha Anderson took her to the hospital emergency room. A few weeks ago, in a basement meeting room at the Woodland Avenue Health Center in Southwest Philadelphia, she learned the visit probably hadn't been necessary.

The condition, she discovered, was quite common for a child that age and could have been treated at home. "I always thought that if your child got a fever, you went to the emergency room," Anderson said. "Now I know I probably didn't have to take her."

Anderson, 34, was attending one of a series of two-hour seminars sponsored by her health insurer, Keystone First, aimed at reducing unnecessary pediatric emergency room visits.

Lily Higgins, medical director for Keystone [First], the largest Medicaid insurer in Southeastern Pennsylvania, said the company's reasons for this include cost, treatment quality, and convenience. Higgins estimated an ER visit costs Keystone [First] about $400 the minute a child is brought through the door and escalates quickly into the thousands. (Someone without insurance would be billed far more.)

Alice Honeywell, Keystone First Health Community Health Educator (left) speaks at a session on when children should go to emergency rooms. (RACHEL WISNIEWSKI / Staff Photographer)

And no matter how competent the ER physician, she said, in a nonemergency situation, children generally are better off being treated by physicians who know them. That's one reason the seminar leaders encourage parents to develop a close relationship with a primary care physician.

There also is the matter of what Higgins called convenience for the parent, for whom an hours-long ER visit could mean lost work time or hassles arranging sitters for other children at home - although surveys also show some adults go directly to emergency rooms because 24-hour availability is easier than scheduling doctor's appointments.

"Part of it is economic but the bigger part is a better relationship with their primary care provider," Higgins said. In fact, Anderson said that only in recent months had she established a good relationship with a family pediatrician.

Since 2011, about 3,000 parents have attended the seminars, which are offered two or three times a week to members at various locations. Keystone [First] says the program reduced pediatric ER visits by 25 percent in the first year.

According to a 2010 report by the New England Healthcare Institute, overuse of emergency rooms by patients of all ages nationwide wastes $38 billion a year. And the problem has grown along with the expansion of Medicaid under the Affordable Care Act, according to an estimate released in September by the Colorado Hospital Association. Contrary to some policymakers' expectations, people with health insurance actually use emergency rooms more.

There is disagreement, however, over how many of those visits are unnecessary. There is no simple definition of appropriate ER use, Stephanie B. Abbuhl, vice chair of emergency medicine at the Hospital of the University of Pennsylvania, wrote in a commentary in the journal Academic Emergency Medicine.

Medicaid patients present particular challenges. Participants tend to be less educated, and lower incomes can lead to more stress, raising the risk of a range of health problems. Poverty also is associated with more frequent moves, which can make it hard to maintain connections with doctors.

In Keystone [First]'s experience, many Medicaid patients don't have a good relationship with a primary care physician and are used to the ER as a first rather than a last resort, Higgins said. The ER physician "can only take care of one piece of the child," she said. "They don't really know the whole child. There's no continuity of care."

To deal with the issue, Keystone First reviews its records to find parents who have taken a child for at least one ER visit that seemed unnecessary. Invited parents are given lunch and a $10 Walmart gift card; child care is provided. They also get medical literature and a kit of household medical supplies.

The program teaches the difference between emergency and nonemergency situations, and how to deal with common childhood ailments. "A fever isn't considered an emergency in most situations," community health educator Alice Honeywell told Anderson and a half-dozen others at the recent gathering. "A fever fights infections." Honeywell and her colleague Marsha Walker took them through a series of medical scenarios involving fevers, vomiting, earaches, and other common pediatric problems.

They also introduced them to Keystone [First]'s 24-hour nurse hotline. "They're there to talk you off the ledge or say you need to go to the ER," Walker said.

In addition to imparting medical knowledge, Walker sees her job as dispelling common misinformation. She went through a variety of beliefs ranging from cold baths for a feverish child and using Q-tips to clean out ear wax to putting sliced onions in a sock to drain off illnesses, all of them useless or risky.

"Don't listen to your neighbor who says, 'When I was a child,' " Walker said.

For emergency room physicians, the trick is to be both an educator and a doctor. “I never want families to feel unwelcome," Margaret Samuels-Kalow, a pediatric emergency room physician at Children's Hospital of Philadelphia, said in an interview. "We try hard not to judge who should be in the emergency department. But preventable visits are a burden to families."

When she sees children whose conditions could have been handled at home or at a primary care provider's office, Samuels-Kalow said, she tries to find out why they were taken to the hospital." Is it resources, being unable to afford home medications? Is it an issue of education?"

She said she often gives out educational materials. "What we're really hearing from families is that they want teaching that doesn't involve medical jargon," Samuels-Kalow said. "It's an important and unrecognized part of what we do."

2. Describe how you would propose to participate and interface with the Healthiest State Initiative.

AmeriHealth Caritas applauds the Healthiest State Initiative, which supports addressing the “health of the whole person.” We look forward to partnering with DHS to promote this initiative as we move toward delivering the next generation of healthcare in Iowa and help Iowa reach the number-one spot in the Gallup-Healthways Well-Being Index®. When selected, AmeriHealth Caritas Iowa will meet with DHS as soon as possible to identify and launch activities to support and achieve the goals of Iowa’s Healthiest State Initiative. We share your belief that health is a state of complete physical, mental and social well-

being and not merely the absence of disease or illness. We also believe that Medicaid beneficiaries should be provided the same tools available to all Iowans to help them learn how to make comprehensive lifestyle changes to improve their health statuses. In addition to the programs previously described that will support Iowa's health and wellness goals, AmeriHealth Caritas is ready to help promote Iowa's Healthiest State Initiative directly with members.

AmeriHealth Caritas Iowa's member mailings and outbound call campaigns will be utilized to promote awareness and involvement in the Healthiest State Initiative. The identification of care gaps and health opportunities will also support and interface with the initiative. The plan website and Member Portal will provide wellness information and support the initiative.

AmeriHealth Caritas affiliates have partnered with government agencies on similar initiatives in the past. As an example, our affiliate plan in Washington, D.C. developed the "I am healthy" campaign to promote healthy living to its members and the general public.

Exhibit 8.7-D: "I am healthy" campaign example

8.8 Cost and Quality Information

1. Describe proposed strategies to provide price and quality transparency to members.

AmeriHealth Caritas understands members want to make decisions about their care and where to seek treatments and solutions, based upon credible information. The members must trust their information source to provide reliable and actionable information on physicians, hospitals and other providers. We believe such information is readily available and we will provide it through the AmeriHealth Caritas Iowa website. This includes links to the following tools:

- NCQA resources:
  - NCQA certified PCMHs: http://recognition.ncqa.org/PSearchResults.aspx?sstate=IA&rp=6

  - NCQA recognized physicians in diabetes: http://recognition.ncqa.org/PSearchResults.aspx?state=IA&rp=3
  - NCQA recognized physicians in heart disease and stroke: http://recognition.ncqa.org/PSearchResults.aspx?state=IA&rp=2
- Centers for Medicare and Medicaid Services (CMS) resources:
  - CMS Physician Compare: http://www.medicare.gov/physiciancompare/
  - CMS Hospital Compare: http://www.medicare.gov/hospitalcompare/results.html#dist=25&state=IA&lat=0&lng=0
- AmeriHealth Physician Finder, which includes information on board certification statuses and languages spoken.

AmeriHealth Caritas Iowa will also make these links available through the online physician directory found on our website. Additional information will be provided to explain how the data is collected and how the member can use this information to make informed choices. Members without Internet access can request information by mail.

These credible sources of information have been demonstrated to have impacts upon selection of physicians and hospitals, which may translate into better patient outcomes and experience of care.

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. 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. Theranos also provides a detailed level of transparency by publishing its test menus and prices, and is committed to reducing the overall cost of care. We are empowering our members to fully engage in their healthcare. It is important that our members and their healthcare providers have the information they need, when they need it, to develop personal health care plans and make healthcare decisions.

2. Provide sample EOBs as an exhibit or attachment.

Attachment 8.8-A (at the end of this section response) provides a sample EOB that will be duplicated for AmeriHealth Caritas Iowa.

3. Describe processes for making provider quality information available to members.

As described in Section 8.8.1, AmeriHealth Caritas Iowa will utilize publicly available data and provide this information directly to members through the AmeriHealth Caritas Iowa website and Member Portal.

8.10 Member Rights

1. Describe your process for ensuring member rights as described in section 8.10.

AmeriHealth Caritas Iowa will provide and support the exercise of member rights in compliance with federal and State of Iowa laws and regulations, including those listed in Section 8.10 of this RFP. AmeriHealth Caritas Iowa will have policies in place that will be utilized in training our associates to ensure

awareness and compliance with member rights, as well as when onboarding and training in-network providers. These policies will be made readily available to our associates through internal documentation, but also to providers and members through the Provider Web Portal/Provider Manual and plan website and Member Portal, respectively.

8.11 Redetermination Assistance

1. Describe in detail your plans to assist members in the eligibility redetermination process and control against prohibited activities.

Educating and assisting with member redetermination to avoid churn and lapse in health coverage

AmeriHealth Caritas has experience administering programs intended to assist State agencies with Medicaid renewal efforts. As an example, our affiliate Select Health of South Carolina has been supporting South Carolina Department of Health and Hospitals (SCDHHS) for several years in reaching out to members to remind and assist them in completing necessary Medicaid recertification requirements to prevent lapse of coverage and increase member retention.

Our program, administered through our Member Services outbound call department, utilizes annual eligibility review data provided via the member enrollment file. Members who are within 60 days of annual eligibility review date are identified. The CCOE then utilizes a mail and phone outreach campaign to contact members about returning annual review forms. To assure no member contacts are missed, recertification dates are loaded into the health plan's care gap system. This makes every member contact count by allowing any associate or provider who is in contact with the member provide recertification information. The efforts of the CCOE are also supported by in-house, SCDHHS-sponsored case workers who are available to answer questions that members may have regarding recertification.

This program has demonstrated successful member retention of the members contacted by the health plan, with 53 percent remaining eligible 60 days post-annual-renewal date. With approval, AmeriHealth Caritas is equipped to bring this program to Iowa and looks forward to similar successful results.

8.12 Member and Stakeholder Engagement

1. Describe in detail your member and stakeholder engagement strategy.

AmeriHealth Caritas was founded on the promise to help those who need it most get the care they need to get well and stay well. For over 30 years, we have fulfilled that promise by building grassroots relationships with providers, stakeholders and members.

In Iowa, we have engaged stakeholder groups and are developing partnerships with key groups in the State. Our executive team has met personally with the groups below and will actively continue to engage key people to gain a deeper understanding of the challenges our members face.

- **Providers:** Iowa Primary Care Association, Iowa Medical Society, Mercy Health Network, University of Iowa Health Alliance, the Iowa Medical Society, Iowa Association of Community Providers and the Mainstream Living, Inc.
    - Some organizations provide exceptional opportunities to reach out to providers through newsletters, roundtables and other educational activities.

- **Behavioral health and development disabilities:** Iowa Behavioral Health Association and Disability Rights IOWA.
  - Potential joint coordination around two key issues: 1) transportation to ensure accessibility to services, and 2) supportive employment by taking experience from our other markets to partner with local organizations to institute supportive employment programs that employ the homeless, veterans and others. This helps provide sustainable wages and life-skills demand training.
- **Aging:** Iowa Area Association on Aging.
  - Continuing our strong AAA precedence in South Carolina and Michigan, we are establishing strong relationships to contract with the i4A and the 6 regions to provide HCBS, which has a longstanding reputation and trust in the community and has begun their own provider transformation.
- **Children's services:** Coalition for Family and Children's Services (CFCS) and Iowa Child & Family Policy Center.
  - AmeriHealth Caritas Iowa has the potential to engage CFCS in activities around integrated health homes, transitioning children from institutions and the Adverse Childhood Experiences (ACE) model.
  - We plan to collaborate with the Iowa Child & Family Policy Center to focus on social determinants (employment, housing and education) and their long-term effect on the children of Iowa.
- **Advocacy organizations:** Iowa Health Care Association, Iowa Center for Assisted Living, Iowa Community Action Association, Iowa Public Health Association and The Arc of Story County.
  - AmeriHealth Caritas Iowa supported the Iowa Public Health Association conference and will sponsor the Heartland Rural Physician Alliance (HRPA) Annual Summit in May.
  - We will engage the Iowa Association of Community Providers, as well as LeadingAge Iowa, to reach providers, including those in rural areas.
- **Caregivers/parents/members:**
  - Working with advocates that reach our members is as critical as reaching our members themselves. Our approach is to educate and empower our members utilizing community partners.
  - We plan to partner with the Community Action Centers, one of the strongest organizations in Iowa, which plays a critical role in engaging Temporary Assistance for Needy Families (TANF) recipients via its Family Development Self-Sufficiency (FaDSS) program to build strong families. These organizations and advocates work with our members every day and relay information critical to care and community health.
  - We will develop caregiver events to educate and engage waiver eligible families on integrating with our model of care.
  - We will meet with organizations such as the United Way, YMCAs, The ARC, Volunteers of America, National Alliance on Mental Illness (NAMI), Orchard Place, Visiting Nurses Association, Youth & Shelter Services and others to ensure they have the education and resources that benefit our members and their community.
- **Community mental health centers and advocacy groups:** Iowa Association of Community Providers.
  - AmeriHealth Caritas Iowa plans to work with Youth & Shelter Services in Ames to support multi-dimensional family therapy and working to expand best practices throughout the State.
- **Faith-based organizations:** Lutheran Services in Iowa.
  - AmeriHealth Caritas Iowa plans to engage in its strong record of partnering to offer comprehensive services to children and the elderly.

AmeriHealth Caritas is focused on community engagement

"The March of Dimes and Select Health [AmeriHealth Caritas' South Carolina health plan] have a longstanding partnership and commitment to improving the health of moms and babies. Our relationship has positively impacted the more than 60,000 babies born in our State each year."

Kathryn Douglas, State Director, South Carolina Chapter March of Dimes

AmeriHealth Caritas Iowa's member and stakeholder engagement strategies are focused on activities that support improving member access, quality of care and health outcomes with all efficiencies. Specific engagement objectives in our strategy include:

- Informing, supporting and incentivizing members for healthy behaviors, including wellness and disease management
- Eliciting from members and their families, personally meaningful objectives and barriers in order to develop member specific health and wellness plans.
- Providing information about the Iowa High Quality Health Care Initiative and AmeriHealth Caritas Iowa's services and benefits.
- Supporting providers:
  - Account service model to educate providers on transforming to a quality managed care environment.
  - Minimize administrative tasks so providers can focus on care, e.g., behavioral health outpatient services require no authorization. Delivery patterns are monitored via claims.
  - Rapid Response team is available to assist with a variety of member-related concerns, such as housing, acquiring medication and arranging transport). Providers are encouraged use Rapid Response for help.
  - Provide quality feedback to providers relative to claims and service-delivery patterns to assist them in improving operations and quality of care.
  - Engage and educate caregivers and family advocates to support the disabled and HCBS population.

In addition to the member-focused programs we will offer (detailed in 8.7 of this response), we will engage community stakeholders through specific activities, such as:

- Advisory committee participation: Participation in local advisory committees held by stakeholder groups in Iowa.
- Community events/activities: Leadership and participation in community events for stakeholders.
- Presentations and informational outreach: AmeriHealth Caritas Iowa expects to provide presentations and information outreach to members and stakeholders in the community.

AmeriHealth Caritas engagement strategies are dynamic, tailored for Iowa and carry the full weight of our resources to provide a wide range of community events, outreach and educational programming within the network. Many of these programs and efforts are based on consumer/family input, which allows the opportunity to remain close to matters most important to members and community stakeholders.

To continue this success, efforts to obtain and maintain member, community and family participation will be important. AmeriHealth Caritas Iowa, through its programs, systems and service infrastructure, will be committed to supporting member and stakeholder engagement.

2. Submit your Stakeholder Advisory Board strategy and discuss how meaningful representation from member stakeholder groups will be ensured.

The AmeriHealth Caritas Iowa Stakeholder Advisory Council (SAC) will be an essential vehicle to ensure member engagement and communication among Iowa's High Quality Healthcare Initiative participants and AmeriHealth Caritas Iowa to gain feedback, share best practices and utilize resources most efficiently.

Council members will range in experience and will incorporate members (consumers), agencies (service providers) and advocates representing healthcare, the community-at-large, as well as social issues impacting health equity. Insight and feedback from the SAC will be used to make enhancements to programs and processes that may lead to improved customer service (member or provider) and health outcomes.

Purpose and primary functions

The SAC will advise AmeriHealth Caritas Iowa on the health education needs of its members and its community stakeholders. The SAC will also facilitate communication to members and/or providers about quality, programs and services offered to members and the community.

SAC's primary functions will include:

- Identifying members' health education needs and serving as ambassadors by providing information and promoting AmeriHealth Caritas Iowa's health education outreach programs.
- Acting as an advocate for issues that impact AmeriHealth Caritas Iowa's members.
- Assisting in the planning, implementation and evaluation of health education and outreach activities.
- Reviewing and providing meaningful guidance for the development of programs, access standards, practice guidelines and satisfaction surveys.

Goals and objectives of the Stakeholder Advisory Council

To maintain a council that includes consumers, providers, caregivers, advocates and members of the community-at-large and to provide information and recommendations on the health education needs of AmeriHealth Caritas Iowa's members, policy, quality and advocacy-related issues, we will:

- Enhance and facilitate opportunities for SAC members to serve as advocates for critical issues that impact AmeriHealth Caritas Iowa's constituency.
- Collaborate on efforts and align resources that advise and support the development of AmeriHealth Caritas Iowa's health education outreach priorities, programs and initiatives.
- Serve as a focus group to strengthen the role of health education and outreach as the key to meeting requirements of the State, CMS, The Substance Abuse and Mental Health Services Administration (SAMSA) and other regulatory agency requirements if applicable.
- Identify members' health education needs, successful outreach programs and best practices.
- Serve as ambassadors promoting AmeriHealth Caritas Iowa's health education initiatives.
- Provide AmeriHealth Caritas Iowa with input and community feedback.
- Evaluate proposals and ongoing health initiatives.
- Support the development, implementation and evaluation of innovative initiatives, programs, services and activities.

- Assist in the identification of opportunities to improve population health in AmeriHealth Caritas Iowa's community-service area.
- Provide a link back to community constituents to aid in achieving AmeriHealth Caritas Iowa's mission, vision and goals.

Holistic representation from the community

The SAC will be comprised of up to 12 members who are invited/selected by the AmeriHealth Caritas Iowa CEO or designee. Representation on the SAC will be diverse with regard to gender, race, special needs and age, and will include caregivers, members and key community stakeholders from advocacy organizations, faith-based and community-based organizations.

SAC members will have two-year staggered terms. Initially, six members will have one-year terms and six members will have two-year terms. The SAC can elect to ask a member to serve an additional 12-month (one-year) term. The SAC will be chaired and co-chaired by AmeriHealth Caritas Iowa's designee. The chair will serve an unlimited term or as specified by the AmeriHealth Caritas Iowa CEO. The co-chair will serve a two-year term.

It is expected that SAC members will:

- Commit to thoroughly review agenda and supporting meeting materials in advance of meetings and come prepared to discuss and make decisions/recommendations at meeting.
- Attend 100 percent of scheduled meetings (or send a previously agreed alternate).
- Adhere to AmeriHealth Caritas Iowa's code of ethics, confidentiality and conflict-of-interest policies.
- Demonstrate understanding of the mission of the health plan and an interest in the services and community/members served by AmeriHealth Caritas Iowa.
- Educate and inform others in the community about the programs and outreach initiatives of AmeriHealth Caritas Iowa.

3. Describe how feedback obtained from the Stakeholder Advisory Board will be utilized.

As mentioned previously, insight and feedback from the SAC will be used to make enhancements to programs and processes that may lead to improved customer service (member or provider) and health outcomes. Information and meeting summaries will be referred by AmeriHealth Caritas Iowa CEO/designee to the appropriate internal or external parties as deemed appropriate for program, AmeriHealth Caritas Iowa, service enhancements or quality improvements. Questions/issues that cannot to be answered during a meeting will be noted in an issues log and followed up with the relevant AmeriHealth Caritas Iowa leader. The issues log will be posted, distributed and reviewed at each meeting.

8.13 Stakeholder Education

1. Describe your plan for stakeholder education including proposed timelines and topics.

AmeriHealth Caritas Iowa's stakeholder education occurs in many layers in the community, with the ultimate goals to:

- Encourage and incentivize members regarding health education, such as wellness, disease management and post-discharge instruction).
- Support providers with administrative support and healthcare delivery improvement initiatives.
- Provide orientation about the Iowa High Quality Health Care Initiative.
- Provide information about AmeriHealth Caritas Iowa's services and benefits.
- Engage advocates and service providers as collaborators and partners.

We engage members, providers and advocates at various levels to explore synergies, leverage resources and encourage program participation and awareness. AmeriHealth Caritas Iowa is proposing similar strategies that have been successful in other markets, but will be customized to Iowa's needs, including engaging stakeholders on various plan councils and committees, as well as seeking opportunities for AmeriHealth Caritas Iowa associates to engage with external committees. Our community teams, comprised of community wellness centers and Social Services Expert Units, will act as additional avenues for stakeholder engagement and education. We will also incorporate participation in and support of community- and AmeriHealth Caritas Iowa-driven activities that increase member, provider, advocate and community engagement. Some of the programs we anticipate for Iowa include:

- 4 Your Kids Care.
- Community baby showers.
- Asthma education.
- Smoking cessation.
- Autism education and support.
- Recovery resources and support.
- Health disparities/health equity education.
- Housing/employment support.
- Caring for the caregiver.
- Empower the Advocate.
- Wellness (weight control, nutrition, cardiovascular health).
- Medication adherence.
- Alzheimer's disease awareness.
- Healthy living.
- Exercise and movement for seniors.

Proposed timelines for these activities are ongoing. They may take place as a series or a single episode based on program design/activity and in locations throughout the State to facilitate maximum participation. An approximate and high-level overview of our stakeholder education relative to go-live on January 1st is as follows:

Timeline relative to go-live	Activities / Topics
180 days prior	Engagement with current relationships that have been built and other key groups to help educate and prepare for a new program in the State.
120 days prior	Marketing and member education materials submitted to the State for approval.
90 days prior	Education and communication to stakeholders and members regarding go-live, AmeriHealth Caritas Iowa programs and available support.
60 days prior	Continuing member and stakeholder education in preparation for launch.
Go-live and beyond	Ongoing stakeholder education specifically designed around Iowa-specific AmeriHealth Caritas programs and stakeholder needs.

Exhibit 8.13-A: Stakeholder Education Timeline and Proposed Activities/Topics

2. Describe how you will identify and outreach to stakeholders.

AmeriHealth Caritas Iowa has engaged various stakeholders to identify service gaps, best practices and potential collaborations that can add value and improve service delivery and health outcomes in Iowa. As also described in 8.12, stakeholders include grassroots organizations, faith-based organizations, service providers, advocates, providers and many others. We will continue to identify stakeholders that help our members and providers through collaborations with the Department of Public Health, DHS, and others.

Below are examples of our ongoing outreach and collaboration with stakeholders in Iowa:

- During a meeting with CISS' founder, we identified an opportunity to transition case management services within the program operations and developed a recovery room that will be used to support a quicker and more effective transition model.
- The Iowa Medical Society (IMS) shared the success it has had facilitating roundtables throughout the State with key providers. AmeriHealth Caritas Iowa is partnering with IMS to ensure that providers fully understand managed care and how to partner with our company. ISM also shared information about its weekly newsletter that is distributed to all office managers and will be made available for us to educate and engage providers.
- AmeriHealth Caritas Iowa is working with the Community Action Agency (CAA) to educate key social service leaders throughout the State by developing educational webinars and orientations for the 17 CAAs across the State. Educating parents on managed care is one of the executive director's biggest concerns based on previous experiences with the Hawkeye implementation. We will develop a strong, new-member, Medicaid-managed-care orientation presentation and materials to share with organizations like CAA.
- The Iowa Behavioral Health Association is identifying key long-term advocates for us to discuss and establish an advisory committee for establishing an education process for physical health providers. The discussion was focused on the need to increase communication between MH/BH/SA providers and PCPs.
- The Disability Rights Association of Iowa provided some real-life examples of the need to establish transportation in the urban and rural communities. The Association shared specific policies that create barriers to accessing prevention and acute services for the population. Engaged customer service and the use of appropriate vehicles are critical for success in order to move the population into using preventive services.
- We are supporting the Iowa Area Association on Aging as it develops a six-region program by connecting them with other AAA's around the country to build a contracting vehicle to provide coordinated HBCS services statewide.

In all of our markets, AmeriHealth Caritas has engaged stakeholders to provide awareness about the managed care program, community resources and other timely topics, including policy or health topics, such as flu prevention, breast cancer/cervical cancer screenings, parent support programs, mental health resources and autism awareness. As also mentioned in 8.12, stakeholders will be engaged to participate on various committees and councils, for example, the Stakeholder Advisory Council (SAC), the FQHC Council and the Quality Committee.

8.14 Implementation Support

1. Describe proposed strategies to support members during program implementation.

AmeriHealth Caritas Iowa will be fully engaged with members during program implementation and transition to our health plan. As mentioned earlier, we have a "no wrong door" approach to our interactions with members and this includes the implementation process. AmeriHealth Caritas Iowa will publicize methods for members to obtain support and ask questions. Resources will include:

- AmeriHealth Caritas Iowa website.
- Member Handbook.
- Additional informational mailings.
- Member Services helpline.

During implementation, new members will receive a call welcoming them to AmeriHealth Caritas Iowa. During that call, the member will be educated on the plan website and the Member Handbook. The welcome call also includes completion of the health risk assessments, which is then loaded into Jiva, our population health-management system, to identifying any health needs a member may have, and to assist the new member in scheduling an initial appointment. The Member Services helpline is available 24 hours a day, 7 days a week, 365 days a year to answer all member questions regarding implementation support and navigation through AmeriHealth Caritas Iowa.

8.15 Grievances, Appeals, and State Fair Hearings

1. Describe in detail your system for resolving inquiries, grievances, and appeals, including how your system ensures all policy and processing requirements are met.

Our grievance and appeals system will be based on a proven and rigorous process similar to those implemented by AmeriHealth Caritas in its participating states, customized and specific to meet Iowa requirements. All employees performing review of all grievance and appeals will have clinical training and extensive experience.

Iowa Medicaid members have the right to express dissatisfaction and expect unbiased resolution of their issues. AmeriHealth Caritas Iowa will recognize the rights and responsibilities of members and providers acting on a member's behalf to engage in the grievance system, which comprises the grievance process, appeals process and State fair hearings. AmeriHealth Caritas Iowa's grievance system associates will be trained in policies, procedures and processes of the grievance system. They will also have relative experience and clinical expertise, in addition to certification and/or licensure.

AmeriHealth Caritas Iowa will have an internal process to receive, track, resolve and report on grievances from its members. The appeal process will include an administrative review process and access to the State fair hearing system. The appeals process will include an internal process that must be exhausted prior to the member accessing a State fair hearing.

We will have written policies and procedures that describe the required components and detailed operation of the health plan's grievance system. The grievance system will consist of a grievance, appeal and State fair hearing processes. The policies and procedures will be available in the member's primary language. In addition, the Grievance System and Appeals Process Policies and Procedures will be submitted

to the DHS for initial review and approval. The Grievance System and Appeals Process Policies and Procedures will be updated annually.

As part of our policy, AmeriHealth Caritas Iowa will advise and inform members of the process for filing an expedited or standard appeal and access to the State fair hearing process through member publications and materials, such as the Member Handbook and notice of action). The information provided to members will contain, among other things:

- The toll-free telephone number and business address to file an appeal or a State Fair Hearing request, obtain information about the process or request information about the status of an appeal or State fair hearing.
- Information about the availability of staff to assist with the appeal or State fair hearing process.

We also will advise providers of the process for filing an expedited or standard appeal and access to the State fair hearing process on behalf of a member (with their written content) via the provider manual, provider publications and other written communications.

Definitions

- **Action:** An action, as defined in 42 CFR 438.400(b) is the: (i) denial or limited authorization of a requested service, including the type or level of service; (ii) reduction, suspension or termination of a previously authorized service; (iii) denial, in whole or in part, of payment for a service; (iv) failure to provide services in a timely manner, as defined by DHS; (v) failure of the Contractor to act within the required time frames set forth in 42 CFR 438.408(b); or (vi) for a resident of a rural area with only one Contractor, the denial of a member's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network, if applicable).
- **Appeal:** A request for review of an action. It is a clear expression by the member, or the member's authorized representative, following a decision by the Contractor, that the member wants the decision reconsidered and reviewed. The Appeal Review Committee is a committee that includes one or more employees of the Contractor, including a licensed physician, who was not involved in any previous level of review or decision-making on the subject of the appeal.
- **Grievance:** As defined in 42 CFR 438.400(b), is an expression of dissatisfaction about any matter other than an "action."
- **Medically necessary services:** Those covered services that are, under the terms and conditions of the Contract, determined through Contractor utilization management to be:
    - Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the member.
    - Provided for the diagnosis or direct care and treatment of the condition of member, enabling the member to make reasonable progress in treatment.
    - Within standards of professional practice and given at the appropriate time and in the appropriate setting.
    - Not primarily for the convenience of the member, the member's physician or other provider.
    - The most appropriate level of covered services, which can safely be provided.

- **Notice:** Notice means a written statement of the action the Contractor has taken or intends to take, the reasons for the action, the member's right to file an appeal and request a fair hearing with the DHS and the procedures for exercising that right.

To ensure that our grievances and appeals process has integrity for our members, we guarantee that decision makers on grievances and appeals were not involved in the previous level of review or decision making involving the matter under consideration.

The appeal process will includes the member grievance coordinator forwarding the administrative or clinical appeal to the Medical Management Appeals department for investigation. The initial review performed by the appeals coordinator will include collection of the following information: research of member appeal request, initial clinical information, initial denial letter, initial denial reason, benefit rules and case documentation. All individuals who participate in the appeal review are documented in the appeals case, which serves as a tracking mechanism to determine that any decision makers were not involved in any previous level of review.

Details of our appeals policy and procedures

Policy overview

- The Contractor does not charge member a fee for filing an appeal.
- The Contractor designates and trains sufficient staff to be responsible for receiving, processing and responding to an appeal in accordance with the requirements of the policy.
- The Contractor staff performing the appeal review has the necessary training, clinical expertise and experience to make an informed and impartial determination regarding issues assigned to them.
- The Contractor ensures that any healthcare professional involved in the review, resolution or clinical determination of an appeal is licensed in the State of Iowa and has appropriate training and clinical expertise in treating a member's condition or disease when deciding to file a(n):
  - Appeal of a denial based on lack of medical necessity.
  - Grievance of denial of expedited resolution of an appeal.
  - Grievance or appeal involving clinical issues.
- The Contractor does not use the time frames or procedures of the appeal process to avoid the medical decision process or to discourage or prevent the member from receiving medically necessary care in a timely manner.
- The Contractor accepts a member's appeal verbally or in writing.
- The member will have access to a toll-free number that can be used to file an appeal.
- The Contractor accepts an appeal from individuals with disabilities in alternative formats, including TTY/TDD, Braille, audio tape, computer disk and other commonly accepted alternative forms of communication. The Contractor informs employees who receive telephone appeals of the speech limitation of some members with disabilities so they can treat these individuals with patience, understanding and respect.
- The Contractor offers members the assistance of the Contractor associates throughout the grievance and appeal process at no cost to the member.

- The Contractor ensures that anyone who participates in making the decision on an appeal was not involved in and is not the subordinate of anyone who was involved in any previous decision making in the case at issue.
- The Contractor permits the member, the parent, guardian or member representative of a minor, member child or the authorized representative or estate representative of a deceased member, including a provider who has the member's written consent, to file an appeal.
- A representative with proof of the member's written authorization of consent may be involved and/or act on the member's behalf to file an appeal either verbally or in writing. The written authorization or consent must comply with applicable laws, Contract requirements and Contractor procedures.
- At any time before or during the appeal process, the member or their authorized representative may request access to and copies of all documents, criteria, records and other information relevant to the subject of the appeal. This information is provided at no charge to the member.
- The Contractor documents the substance of the appeal and any actions taken. A full investigation of the substance of the appeal, including any aspects of clinical care involved, is performed.
- Oral request for an appeal is committed to writing by the Contractor and provided to the member and member representative for signature via the acknowledgement letter. If the member or member representative's signature is not received, the appeal will not go forward.
- The Contractor provides foreign language interpreter services when requested by a member, at no cost to the member.
- The Contractor will ensure that retaliatory action is not taken against a provider who either requests an expedited resolution of an appeal or supports a member's request for an expedited review of an appeal.
- The member or authorized representative has the opportunity to submit written documents, comments or other information relating to the appeal and to present evidence and allegations of fact or law in writing, to the appeal committee.
- The Contractor may provide an attorney to represent the interests of the committee and to ensure the fundamental fairness of the review and that all disputed issues are adequately addressed. In the scope of the attorney's representation of the committee, the attorney will not argue the Contractor's position or represent the Contractor or the Contractor associates.
- A committee member who does not personally attend the review may not be part of the decision-making process unless that committee member actively participates in the review by telephone and has the opportunity to review all information introduced during the review.
- In addition to the appeal process, the member and their representatives may also pursue issues through the separate State fair hearing process. The member or their authorized representatives may file a request for a State fair hearing once the member has exhausted the Contractor's appeal process.
- A member can have all notices related to the appeal process in a culturally and linguistically appropriate manner. The staff will review and document the language of the member in the appeal file so that the member will receive all correspondence in the appropriate language and format.
- The Contractor will conduct semi-annual training (at a minimum) for its associates regarding the appeal and State fair hearing process.

Appeal procedure

- The Contractor will recognize that the member or the member's representative may file an appeal within 30 calendar days from the date of the action notice.
- The Contractor shall resolve the appeal as expeditiously as the member's health condition requires, but no more than 30 calendar days after receipt of the appeal.
- The time frame for a standard resolution of an appeal may be extended by 14 days if the member requests the extension. If the time frame is extended by the Contractor, the Contractor must give the member written notice of the reason for the delay.
- If the time for issuing a decision and/or a service authorization decision is extended, the Contractor must issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date on which the extension/extended period expires.
- When verbal appeals are received, the associate receiving the appeal informs the member of the need to follow the verbal request with a written signed appeal. The associate will acknowledge the appeal in a letter and send the letter to the member to sign. The associate forwards the verbal request for appeal to the appeal coordinator.
- When written appeals are received, the appeal is time and date stamped and forwarded immediately to the appeal coordinator.
- Within three business days of receipt of a standard appeal, an acknowledgement letter will be sent. This will include instructions for completing a written signed appeal request (for use if the appeal was requested verbally).
- If an appeal is filed to dispute a decision to discontinue, reduce or change a service/item that the member has been receiving, the member continues to receive the disputed service/item at the previously authorized level pending resolution of the appeal until one of the following occurs:
  - The appeal is filed within 10 days from the mail date on the envelope of the notice of action.
  - By the effective date listed in the notice of action, whichever is later, and the original period covered by the original authorization has not expired.
  - The Contractor will keep services in place until one of the following occurs:
    - Member withdraws the appeal.
    - Ten days after the resolution of an appeal against the member unless the member requests a State fair hearing within the appropriate time frame.
    - Appeal period or service limits of the previous authorized service have been met.
- The appeal coordinator logs the appeal request in the Contractor's electronic reporting system.
- The substance of the appeal is documented and a full investigation is completed.
- The committee receives a written report from a licensed physician or other appropriate provider in the same or similar specialty that typically manages or consults on the service/item in question.
- The appeal is presented to the appeal committee. The committee will include at least a physician with appropriate experience or credentials if the appeal is clinical.
- The committee prepares a summary of the issues presented and decisions made, which is maintained as part of the appeal record.

- A written notification regarding the appeal determination is issued within the established time frames. If the Contractor completely overturned the denial, the appeal notice reflects that decision and the date on which the decision was made.
- Services will be put in place within five days of approval or as expeditiously as the member's health condition requires.
- If the Contractor upholds the denial, the appeal notice includes:
  - The specific reasons for the appeal decision, in easily understandable language.
  - A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
  - Notification that the member, upon request, can obtain a copy of the actual benefits provision, guideline, protocol or other similar criterion on which the appeal decision was based.
  - Notification that the member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents or records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.
  - A list of titles and qualifications, including the specialty of the physicians participating in the appeal review.
  - The appeal decision notice must be mailed within five business days after the date of the decision.
  - Information on how to initiate a State fair hearing.
  - How to keep services in place pending the State fair hearing.
  - The Contractor shall direct the member to the DHS appeal and request for hearing form as an option for submitting a request for an appeal.
  - This shall also include notice that the member may be held liable for the cost of those benefits if the hearing upholds the Contractor's action.

Expedited appeal

An expedited appeal may be requested if the member or member representative believes that the member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the standard appeal process. An expedited appeal review may be requested either verbally or in writing. The Contractor shall also provide general and targeted education to members regarding expedited appeals including when an expedited appeal is appropriate and procedures for providing written certification thereof.

- The Contractor must receive a signed provider certification that the member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the standard appeal process.
- The Contractor shall resolve an expedited appeal within three days from the date that the provider certification is received.
- If an expedited resolution is denied, the appeal is processed as a standard appeal. The member is given prompt verbal notice that their expedited appeal was denied, followed up with a written notice within two business days.

- If an appeal is filed to dispute a decision to discontinue, reduce or change a service/item that the member has been receiving, the member continues to receive the disputed service/item at the previously authorized level pending resolution of the appeal:
- The appeal is filed within 10 days from the mail date on the envelope of the notice of action.
- By the effective date listed in the notice of action, whichever is later.
- The original period covered by the original authorization has not expired.
- The expedited appeal is logged by the Contractor.
- The substance of the appeal is documented and a full investigation is completed.
- The committee receives a written report from a licensed physician or other appropriate provider in the same or similar specialty that typically manages or consults on the service/item in question.
- The appeal is presented to the appeal committee. The committee must include a physician with appropriate experience or credentials.
- The committee prepares a summary of the issues presented and decisions made, which is maintained as part of the appeal record.
- The member and provider will be notified of the appeal outcome via a telephone call immediately, again the same day and no later than two days after outcome. Attempts to reach the member and the provider will be documented. Written notification regarding the appeal determination will be sent within the established time frames. If the Contractor completely overturned the denial, the appeal notice reflects that decision and the date on which the decision was made.
- Approved services will be authorized or provided within one day.
- If the Contractor upholds the denial, the appeal notice includes:
    - The specific reasons for the appeal decision, in easily understandable language.
    - A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
    - Notification that the member, upon request, can obtain a copy of the actual benefits provision, guideline, protocol or other similar criterion on which the appeal decision was based.
    - Notification that the member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents or records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.
    - The appeal decision notice must be mailed at least 10 days before the date of action, except as permitted under 42CFR 431.213 and 431.214.
    - A list of titles and qualifications, including the specialty of the physicians or clinicians participating in the appeal review.
    - Information on how to initiate a State fair hearing
    - How to keep services in place pending the State fair hearing.
    - The Contractor shall direct the member to the DHS appeal and request for hearing form as an option for submitting a request for an appeal.
    - This shall also include notice that the member may be held liable for the cost of those benefits if the hearing upholds the Contractor's action.

State fair hearing

For appeals not resolved wholly in favor of the member, the written notice must include the right to request a State fair hearing, including the procedures to do so and the right to request benefits while the hearing is pending, including instructions on how to make the request. The Contractor shall direct the member to the DHS appeal and request a hearing form as an option for submitting a request for an appeal. This shall also include notice that the member may be held liable for the cost of those benefits if the hearing upholds the Contractor's action.

- The Contractor shall permit the member, the member's authorized representative or a provider on behalf of a member with the member's written consent to request a State fair hearing within 90 calendar days of the date of notice from the Contractor on an appeal decision to request a State fair hearing.
- The Contractor shall recognize that parties to the State fair hearing include the Contractor as well as the member and his or her representative, or the representative of a deceased member's estate.
- The Contractor shall provide each member with notice in writing of the member's rights to request a State fair hearing in the case of a dispute involving the denial, delay, termination or reduction of an item or service.
- The Contractor shall ensure this notice (regarding the member's rights to request a State fair hearing) contains the following:
  - If benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:
    - The member withdraws the request.
    - Ten days pass after the Contractor has mailed the notice of an adverse decision, unless a State fair hearing has resolved the matter.
    - The time period or service limits of a previously authorized service has been met.
- If the final resolution of the appeal is adverse to the member, that is, it upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements to maintain benefits in accordance with 42 CFR 431.230 and 42 CFR438.420.
- In accordance with 42 CFR 438.424, if the Contractor or State fair hearing officer reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the Contractor must authorize and provide the disputed services promptly and as expeditiously as the member's health condition requires. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services
- The Contractor shall comply with the State fair hearing board's decision. The State fair hearing board's decision in these matters shall be final and not subject to appeal by the Contractor.
- The Contractor shall, if notified of the State fair hearing board's decision to reverse a decision, authorize or provide the service no later than two business days after reversal or notification of reversal. In cases involving an expedited appeal, services shall be authorized or provided within 24 hours of the reversal.

Reporting and monitoring

The Contractor shall submit the following reports to their internal Quality Review Committee and DHS/State governing body on appeals and State fair hearings:

- A quarterly appeals report which includes, at a minimum:
  - The number of appeals filed by type and their resolutions.
  - The number of expedited appeals filed by type and their resolutions.
  - Average number of days to process a standard appeal and an expedited appeal.
- An annual summary of all, appeals, and State fair hearings by type and resolution.
- A quarterly report on the number of State fair hearings by type and resolution.

AmeriHealth Caritas Iowa will use the appeals procedure to continually improve processes and better serve our members. Our responsibilities will include documenting individual appeals and State fair hearings in our medical management documenting system, coordinating resolutions for completion, tracking data and reviewing grievances with and appeals for trends using an internal database and medical management logs. Compliance the policy, regulatory and accreditation requirements are monitored via internal reports and/or case file reviews.

2. Describe your proposed exception to Contractor policy process.

AmeriHealth Caritas does not have an exception process; however, we will work with our members to get the services they need as we continue to do within other AmeriHealth Caritas affiliates in other States. As an example, if a member needs a home modification, we will help our member find a solution. While we may not finance the service, we help facilitate identifying solutions for our members.

The process to review decisions overturned in State fair hearings are reviewed by the medical management appeals manager and documented and coordinated with other Contract departments for completion and resolution.

Contractor decisions overturned in State fair hearings are processed promptly and as expeditiously as the member's health condition requires if the services were not furnished while the appeal is pending and the Contractor or the hearing decision reverses a decision to deny, limit or delay services.

We will pay for disputed services if the Contractor or State fair hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending.

Adverse decisions received as the result of a State fair hearing are reviewed for performance management, policy and internal process changes to enhance improvement of the grievance system.

Attachment 8.7-A: Diabetes Educational Material (example)

Knowledge is Power!

The more you know about diabetes, the more power you can have over this disease. A great way to start is to learn about the exams or tests you need. Diabetes can affect many parts of your body. Because of this, you need to have regular checkups—to catch problems early. You also need to know your results. Remember, Knowledge is Power!

On the back of this sheet is a diabetes exam log. You can write the results of your tests on it to track your progress. Take this sheet with you to the doctor. Your doctor can help you fill out the form. Ask what your target results should be. They are not the same for everyone. Keep this log where you will remember to take it with you to the doctor.

Know your numbers.

Blood pressure:

Try to keep this below 130/80 to lower your risk of heart and blood vessel problems.

Foot exam:

Check your feet daily for redness, cuts, sores and blisters. Your doctor should also check your feet at every visit.

Weight: Track your weight.

Even small changes in weight can make a big difference in your blood sugar levels.

Dilated eye exam (once a year):

Make sure the eye doctor dilates your eyes to check your retina. This is important even if you can see fine. They can catch and treat eye problems early and save your vision.

A1C (at least twice a year):

This test tells your average blood sugar level over the last 3 months. This should usually be less than 7.

LDL level (once a year):

This is the "bad" cholesterol. Keep it under 100.

Microalbumin test (once a year):

This tests for protein in the urine, which is often the first sign of kidney problems.

Heart:
get your blood tested!

Kidneys:
get your urine tested!

Eyes:
get your eyes tested!

AmeriHealth Caritas Iowa

Take this form with you to every doctor visit.

Diabetes exam log for: Date:

Doctor name: Doctor phone number:

	Blood Pressure (each visit)			**Usual goal:** below 130/80			**My target:**			
Date										
Result										

	Foot Exam (each visit)						**My target:**			
Date										
Result										

	Weight (each visit)						**My target:**			
Date										
Result										

	A1C (every 3 to 6 months)			**Usual goal:** below 7			**My target:**			
Date										
Result										

	Dilated Eye Exam (once a year)						**My target:**			
Date										
Result										

	LDL (once a year)			**Usual goal:** below 100			**My target:**			
Date										
Result										

	Microalbumin (once a year)						**My target:**			
Date										
Result										

If you have any questions about diabetes or would like to speak to a nurse, please call 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**.

Qúy 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

AmeriHealth Caritas Iowa

Attachment 8.7-B: Cardiovascular Health Educational Material (example)

Important Health Information for You

Actions for a Healthy Heart

Stop or significantly reduce smoking.

- It's never too late to quit smoking! No matter how long or how much you have smoked, your risk of serious heart disease drops as soon as you quit.
- Whenever possible, avoid secondhand smoke.
- If you know you have a smoking problem, let us get you connected with someone who can help.

Limit alcohol.

- Alcohol is a stimulant and causes your heart to work harder. Alcohol in excess affects your ability to remember things and take care of yourself.
- Excessive alcohol also can cause liver disease. It can interfere with or prevent your heart medication from working properly.
- Check with your doctor about drinking alcohol while taking prescription or over-the-counter medication.
- If you know you have an alcohol problem, let us connect you with someone who can help.

Prevent obesity. Lose weight.

Extra pounds require your heart and lungs to work hard. Tips for a successful weight loss program:

- Increase regular physical activity.
- Reduce calories.
- Change eating habits to include more vegetables, fruits and grains, as well as less fat.
- Check with your doctor before going on a diet.

Heart Failure - Action Plan

Part of feeling your best includes knowing and reporting early signs and symptoms of heart trouble. Having an action plan is an important part of your treatment.

Quick tip:
Spend 10 minutes each day reading or thinking alone.

AmeriHealth Caritas Iowa

Actions for a Healthy Heart continued

Use this chart as a quick reference to help you to decide the best course of action.

Call Your Doctor if

- You wake up at night short of breath. You have to sit up. You have to use more pillows. You need to use oxygen to catch your breath.
- You are shorter of breath than usual doing normal activities.
- Your ankles and feet are swollen more than usual.
- Your clothes feel tighter than usual around the waist.
- You gained 3 or more pounds in a day or you gain 5 pounds in a week.
- You have a new cough or you cough at night.
- You have problems urinating or you are not urinating.
- You are more tired or you have less energy than usual.
- You have a loss of appetite.
- You are in the hospital or you go to the emergency room.

Call 911 if

- You have new or worsening (different from usual) pain, pressure, dullness or heaviness in your chest.
- You take 3 nitroglycerine tablets at 5-minute intervals, and there's no relief for your chest pain within 15 minutes.
- You are suddenly short of breath, and you cannot catch your breath.
- You have sudden and constant numbness or weakness in any part of your body for more than 10 minutes.
- You have a sudden loss of speech or vision.

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**.

Qúy 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**.

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Attachment 8.7-C: Depression Educational Material (example)

Brighter Days Ahead

A guide to help you understand your moods and feel better

AmeriHealth Caritas Iowa

Everyone responds to life's ups and downs differently.

Life is full of surprises. Some days are good and others are not so great. One thing is certain — life can be hard. Everyone feels sad at times. These feelings are usually short-lived and pass in a couple of days. But when the sad feelings hang on and don't seem to get better, it could be a sign of a health problem called depression.

For people with depression, life can be a daily struggle. When the challenges of family, work and school put a strain on one part of us, it can affect the other parts, too. Over time, the stress of daily mental struggles takes a toll on physical health. So, to protect your overall health, it's important to get in touch with your feelings and be aware of how they affect your behavior.

Here's a tool doctors use to check patients' mental health. It can show if someone is just sad or actually depressed. It's called the Patient Health Questionnaire-9 (PHQ-9). Answer each question and don't leave any blanks. This could help show if you have depression and, if so, how severe it is. Knowing this is the first step to improving your overall well-being.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

0 + _____ + _____ + _____

= _____ Total

If your total is [#] or more, you may have a mental health condition called major depression.

It helps to monitor your mood, energy and sleep

If you do have depression, the road to wellness begins with the decision to help yourself. This is true no matter how depressed you feel. The symptoms of depression can be different for each person. So it's important to be aware of how you feel and act throughout the day. Keeping track of your mood, energy levels and how much sleep you get each night will help you understand your condition and learn ways to get better.

For example, depression can lower self-esteem. This could make you feel bad about yourself, like you're not worthy of a good quality of life. Identifying things that trigger these types of thoughts and feelings gives you the power to change them from negative to positive.

That's why it's a good idea to keep a mood journal. It actually lets you see how you feel. Use the chart on page 5 to help you get started thinking about your mood, energy and sleep habits.

How are you really feeling?
Overall, how has your depression been the past 2 weeks?
On average, how much sleep did you get per day in the past 2 weeks?
0 hours 1 hour 2 – 3 hours 4 – 6 hours 6 – 10 hours 10+ hours
Write down 3 things you enjoy doing.
_____ _____
How many times did you do at least 1 of these things in the past 2 weeks?
0 times 1 time 2 – 3 times 4 – 6 times 6 – 10 times 10+ times
Who are 3 people you feel support you?
_____ _____
How many times have you talked to at least 1 of these people in the past 2 weeks?
0 times 1 time 2 – 3 times 4 – 6 times 6 – 10 times 10+ times
What is a problem you are struggling with right now?
How can you break this problem into smaller parts? What are some things you can do to make this better?

It's also important to keep track of big mood swings. If you have been overly sad or overly happy for more than 2 weeks, talk to your doctor. This can be a sign of a mental health problem. Take your mood journal or the chart you completed here to your doctor. It can help your doctor find the best treatment for you.

The power to change

Taking care of your mental health is just as important as taking care of your physical health. Improving mood and energy level can be hard for someone with depression — but it can be done. Start slow. Use these tips on your journey to wellness:

- **Stay active.** Exercise can take your mind off the day-to-day worries and release chemicals in your brain that make you feel good. Being active over time can give you more energy. It can help you sleep better at night. Take a short walk, dance around the house, work in the garden or take a bike ride. No matter how you choose to be active, keep your body moving for at least 30 minutes each day. Children should be active for at least 60 minutes each day.
- **Eat healthy foods.** In addition to exercise, eating healthy foods can boost your energy throughout the day. Be sure to get plenty of fruits and vegetables and drink lots of water.
- **Find support.** Try not to spend too much time alone. Spend time with friends or family who support you. It may help to share your thoughts with the people you trust.
- **Break down tasks.** For your tasks and responsibilities, break them down into smaller parts. Do a little bit each day, even though you might not feel like it. Set priorities and do what you can.
- **Be positive.** Push negative thoughts out of your mind and focus on the positive. Try to find small things that you enjoy or that make you laugh.
- **Don't use alcohol or drugs.** Depression and substance abuse are often linked together. Drugs and alcohol can also make your symptoms worse. Only take medicines as directed by your doctor.
- **Boost your self-esteem**. There are plenty of healthy ways to deal with life's struggles. Do things that make you happy, and keep up with healthy hobbies you may have. Make a list of your good qualities and the things you like about yourself.
- **Try to understand your conditions.** It takes time to get better when you have depression. But if you follow these tips, you'll see your mood improve little by little. If you have questions, ask your doctor. He or she may be able to recommend some books about what you are going through.

Seeing a doctor can help

Most people are familiar with seeing doctors when they don't feel well physically. But if you don't feel well emotionally, it is often harder to ask for help. You may be afraid no one will understand or that you'll be judged. But there's no reason to feel ashamed. You are not alone.

If you think you may be depressed, please visit your doctor. Bring your mood journal and the PHQ-9 you completed in this guide. Tell the doctor how you have been doing and what steps you have taken or need to take to improve your mental health.

Some types of depression can be treated just by talking to someone, like a counselor or health professional. Your doctor can help you find the right person to contact. Other types of depression may need medicines. Your doctor may prescribe antidepressants or other medicine for you. Take these medicines only as directed.

During your doctor appointments, your doctor will ask you questions. Some questions may be uncomfortable or different from what you are used to hearing. Your doctor may ask about your symptoms, family history, domestic abuse, or drug and alcohol use. Being honest will help the doctor make the right decisions for you.

It takes courage to admit signs of mental illness and even more courage to ask for help. Medications, therapy and other methods can treat people with depression. There is plenty of support available. We are here for you.

If you need to see a doctor about your depression, call [Health Plan] Member Services at [1-555-555-5555]. If you are having a crisis, call 9-1-1.

Remember: Your mental health is important to your overall health. **Start with 3 small changes and see if you begin to feel better after 3 months.** You can do it. Your happiness depends on it.

Sources:

Centers for Disease Control and Prevention and U.S. Department of Health and Human Services. The PHQ-9 was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

Burns, David D., M.D., Feeling Good (New York, N.Y.: HarperCollins Publishers Inc., 1980).

AmeriHealth Caritas Iowa

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Attachment 8.2-A: Welcome brochure example

Quality care you deserve

AmeriHealth Caritas Iowa is a member of the AmeriHealth Caritas Family of Companies. Together, we have experience serving Medicaid members just like you. We are focused on making sure your family gets the care they deserve. Our mission is simple: help people get care, stay well and build healthy communities.

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**.

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AmeriHealth Caritas Iowa

Member Services
XXX-XXX-XXXX

Welcome

We care about you and your family.

AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa

CARE IS THE HEART OF OUR WORK

As an AmeriHealth Caritas Iowa member, you get extra benefits like:

- Adult dental: 2 exams with cleaning and 1 set of X-rays per year. Limited fillings and/or extractions. (Package value is $500 per year.)
- Adult vision: exam with $10 copay and $100 discount on glasses or lenses every 2 years.
- Health Care Rewards Program:
  - $10 gift card for each household completing the plan orientation.
  - $20 gift card for members over 21 who get a primary care practitioner (PCP) visit in the first 90 days.
  - $20 gift card for children ages 3 – 21 who get an annual visit to their PCP when they are well.
  - Up to $75 in gift cards for completing expected prenatal and postpartum visits.
- Free cell phones with 250 minutes per month.
- Extra medication help.
- Weight loss support with certified dietitian.
- GED exam fee reimbursement.
- Circumcision for newborn boys.

You'll also receive a complete set of health benefits through Bayou Health, including:

- Doctor and hospital visits with no copays.
- Member Services and the 24/7 Nurse Call Line. We are always here to answer your questions.
- Access to bilingual staff.
- Free help to find a doctor, schedule appointments and get transportation.
- Free health education to promote healthier lifestyles.

This is a short list of the benefits and services for our members. For more information about our services and benefits, please visit our website or call Member Services at **XXX-XXX-XXXX**.

Our team is here to help you be as healthy as possible:

- Pregnant moms: Our Bright Start® program can help you have a healthy pregnancy and baby! Your care manager will help you make appointments, get a ride to the doctor's office and get other resources.
- Pregnant moms (continued)
  We also offer quarterly community baby showers with certified breast feeding instructors. You can get a free baby blanket and matching cap along with the *Happiest Baby on the Block* DVD or book for calling us when you know you are pregnant.
- Help for members with complex medical needs. Our care managers will work with doctors and social service agencies to address your needs.
- We also bring health education and health screenings right to your community. Community health educators help members through home visits and other events in your neighborhood. Reminder campaigns, like below, help you become aware of benefits and stay healthy.
  - **Diabetes Boot Camp** is an adult program for members on how to manage their diabetes.
  - **Safe Playground Build** promotes healthy lifestyles for kids.
  - **Health-centered baby showers** with breast feeding coaches.

If you have questions or for more information, call Member Services at **XXX-XXX-XXXX**.

AmeriHealth Caritas Iowa

CARE IS THE HEART OF OUR WORK

Attachment 8.2-B: Member Handbook example

Your Personal Guide to Better Health

Member Handbook

CARE IS THE HEART OF OUR WORK

AmeriHealth Caritas Iowa

Attachment 8.2-C: "How and where to get help" member overview

How and Where to Get Care

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

Is it an emergency?

CALL 911 for problems like:

- Chest pain
- Choking
- Poisoning
- Severe wound/heavy bleeding
- Not able to breathe right
- Severe spasms/convulsions
- Loss of speech
- Broken bones
- Severe burns
- Drug overdose
- Sudden loss of feeling or not being able to move
- Severe dizzy spells, fainting or blackouts

Yes

I don't know

Before going to the emergency room:
Please call your doctor or the 24/7 Nurse Call Line at XXX-XXX-XXXX.

No

Do you need urgent care?

No

Yes

Call your doctor or the 24/7 Nurse Call Line for problems like:

- Coughing
- Vomiting
- Diarrhea
- Sore throat
- Colds
- Pink eye
- Stomach ache
- Rashes
- Bruises
- Toothache - call your dentist or Member Services if you don't have a dentist.

Call your doctor or the 24/7 Nurse Call Line for problems like:

- Toothache
- Sunburn
- Skin rash
- Sexually Transmitted Disease (STD)
- Earache
- Sprains
- Animal or insect bite
- Fever
- Minor cuts

AmeriHealth Caritas Iowa

Attachment 8.8-A: Sample EOB statement

Keystone Connect
200 Stevens Drive
Philadelphia, PA 19113-9802

Return Service Requested

WHITE STOCK

TEST

Statement Date: 02/05/2015
Member Name: THEBAULT PFOB
Member ID: 51339832

SINGLE PIECE

1 0.6871 SP 0.480

THEBAULT PFOB
107 PARK AV 6TH ST W C
PHILADELPHIA, PA 19121

1 OF 3 F

ENV 1

Have more questions about your claim?
Call Member Services at:
Phone: 1-855-332-0434
TTY: 1-855-707-5815
Member Services is available 24 hours a day, 365 days a year
Website: www.keystoneconnectpa.com

Explanation of Benefits (EOB) Statement

This is not a bill. Do not pay. This is to notify you that we have processed a claim for services provided to you.

Provider Name: MA, XIAOLI
Date of Service: 10/31/14-10/31/14
Claim #: 20007166300

TYPE OF SERVICE	EXPLANATION CODE**	AMOUNT BILLED	APPROVED AMOUNT	PAID TO PROVIDER	COPAYMENT AMOUNT	PLACE OF SERVICE
Practitioner Visit (99214)	PDC	105.00	84.00	84.00	0.00	OUTPATIENT
Claim Totals:		105.00	84.00	84.00	0.00	

Explanation Code**

PDC The charge has been reduced based on a discount arrangement with the provider of service

VOID

P5500128000

WHITE STOCK

TEST

1 OF 3 B

ENV 1

Messages:
We want you to have the best care possible. Keystone Connect received a claim from your provider for these services. **Please let us know if you did not receive these services,** or if you have any questions about this EOB such as:

1. What are my complaint and appeal rights?
2. Can I get more information about these services?

You can call Member Services at 1-855-332-0434. You can also write to us at:
Keystone Connect, Attn: Member Services, 200 Stevens Drive, Philadelphia, PA 19113

Date of Service	The date that services were provided to you .
Type of Service	A brief explanation of each service.
Amount Billed	Amount charged by the physician or health care professional for each service on the claim.
Approved Amount	The amount we approved for payment based on your plan benefits prior to the deductible, coinsurance, copayment or other member cost-sharing (if applicable).
Paid to Provider	The total amount paid to your physician or health care professional for the services performed.
Co-Payment Amount	Some of your covered health care services have copays. Copays are fixed dollar amounts you pay for a covered service. You usually will pay the copay when you receive the service.
Place of Service	Where the service was received such as a doctor's office, a hospital inpatient or an ER.

Unauthorized Services provided outside of the network and non-covered services may be the responsibility of the member.

VOID

9. Care Coordination

Please explain how you propose to execute Section 9 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience

Overview

Today, too many vulnerable individuals, especially those with both physical and behavioral health conditions, receive care in fragmented systems with little to no coordination across providers. AmeriHealth Caritas Family of Company's (AmeriHealth Caritas') next-generation model of care applies a person-centered approach that addresses the physical, behavioral health, pharmacy management and social needs of our members. AmeriHealth Caritas Iowa will collaborate with the Iowa provider community and supporting social service resources to address our members' care coordination needs. We will implement strategies to extend care management into the neighborhoods where our members live-to engage them where they are and ensure they are connected to services. We have a 30 year history of designing fully-integrated coordinated care programs that improve health outcomes and empower our members to live healthier, happier lives.

- AmeriHealth Caritas Iowa will implement its Integrated Healthcare Management (IHM) program to meet the variable and unique needs of Iowa members.
- Our IHM program has a strong track record of improved clinical and financial outcomes, and member satisfaction in the other states we serve.
- AmeriHealth Caritas Iowa has a local approach: our model is designed to leverage and strengthen existing community infrastructure and assets.

AmeriHealth Caritas' Integrated Healthcare Management (IHM) program is designed to meet members' diverse and unique needs. Our IHM program is population-based and person-centered — focused on increasing self-management capabilities whenever possible.

AmeriHealth Caritas' Integrated Healthcare Management (IHM) program is designed to meet members' diverse and unique needs. Our IHM program is population-based and person-centered — focused on increasing self-management capabilities whenever possible.

There are six core components to the AmeriHealth Caritas IHM program, aimed at serving the diverse needs of all our adult and pediatric members, whether they are low-risk members who require surveillance for preventive services or high-risk utilizers who require intensive engagement and intervention. AmeriHealth Caritas' Care Management programs include:

- Pediatric preventive health care.
- Episodic Care Management for those with short-term or intermittent needs.
- Bright Start® maternity management.
- Complex care management for those with complex and long term service support (LTSS) needs.
- Rapid Response team for urgent needs.
- Team-based community care management to engage our hardest to reach members where they are.

Behavioral health, disease management and social supports are integrated into each of these components to provide holistic care.

AmeriHealth Caritas employs a wide array of chronic disease management and wellness programmatic support, including diabetes care, chronic asthma management, HIV, coronary artery disease, congestive heart failure, depression, sickle cell disease management, pregnancy and well child care. Algorithms to address each of these areas are embedded within the care manager's workflow, as indicated for each member enrolled in a care management program.

AmeriHealth Caritas Iowa's IHM program will be tailored to meet the unique needs of Iowa's Medicaid population. For example, knowing that Iowa has relatively few OB/GYN providers for the member population, our IHM staff will actively work to identify and engage all pregnant members in our Bright Start® program early in their pregnancies and focus on ensuring timely access to OB/GYN care through innovative strategies, including centering programs and telemedicine support. AmeriHealth Caritas Iowa will also work to improve transitions of care for all of our members, including LTSS members, to ensure that all necessary services are coordinated and members receive the most appropriate care in the most appropriate setting. Additionally, we will make sure that increasing the number of members enrolled in Health Homes is a core performance metric for our care management program, given that effectively coordinating with existing Health Home programs is a core goal in Iowa's Healthiest State Initiative.

Our IHM program has a strong track record for clinical and financial outcomes, and member satisfaction in the other states we serve. We fully expect to maintain those same standards of excellence for AmeriHealth Caritas Iowa. For example:

- In 2014, members with congestive heart failure experienced fewer admissions per 1,000 members compared to 2013, with the largest drops seen in our southeast Pennsylvania, Louisiana and South Carolina affiliate plans, 21 percent, 16 percent and 8 percent, respectively. For members with secondary cardiovascular disease, admission rates dropped by 10 percent to 20 percent in our two Pennsylvania and Louisiana plans.
- Member-reported wellness using a 12-item short form across six of our plans in 2014 showed improvement in every area of the tool, with greatest improvements in member assessment of general health, energy level, and feeling calm and peaceful.
- In a financial outcomes review by Reden and Anders (now part of United Healthcare), our care management program in Pennsylvania achieved $122 per member per month in gross savings, which equated to over 9 percent of projected costs and $6.1 million in total savings within a 12-month period.
- Our Community Care Management program in our South Carolina affiliate achieved a 15 percent reduction in total cost of care within six months of enrollment.

AmeriHealth Caritas is successful in conducting basic health screenings for assigned members through a combination of mail, telephonic and community based outreach. We are successful in engaging 98 percent of members contacted for care management support. We augment initial health risk screening with advanced data mining techniques, referral pathways and event triggers. We apply proprietary claims analytics queries to identify the highest-risk members in our overall population. For example, certain behavioral health diagnoses (e.g., severe and persistent mental illness, alcohol or other substance use), social barriers to care (e.g., lack of public transportation), and polypharmacy are the top predictors for poor health outcomes. For members identified with these and other special needs, we perform an additional comprehensive health risk assessment, and then work with the member and other relevant stakeholders to create an individual plan of care and track its impact. Our comprehensive model allows

members to move seamlessly from one component of the program to another, as necessary, depending on the member's own unique level of need and priority.

Our model leverages person-centered decision support to drive communication and care plan development through a multidisciplinary approach to management. The IHM program includes reassessing and adjusting the care plan and its goals as needed. AmeriHealth Caritas uses a comprehensive population health management platform, Jiva™ (ZeOmega) to integrate all of our medical management utilization and care management departmental functions, including behavioral health and pharmacy management. Authorizations-based medical economics reports and operational reports to monitor staff efficiency are also generated from this system to proactively manage care.

The AmeriHealth Caritas IHM team includes nurse case managers, social workers, care connectors (community health workers), clinical pharmacists, behavioral health clinicians and plan medical directors. Primary Care Providers (PCPs), specialists, members and caregivers (parents/guardians) are recruited to actively participate. Care management services are performed locally, in every state in which we operate. Under the direction of a medical director, the primary nurse case manager assigned to the member collaborates with other team members and the PCP to effect the care plan. Care coordination is achieved through clear communication and a commitment to understand the 360-degree view of our patient. This work is supported by a web-based platform that can be accessed by patients, caregivers and providers. The team works to meet members' needs at all levels in a proactive manner that is designed to maximize health outcomes.

Our model of care is designed to leverage and strengthen existing community infrastructures and assets. As we enter any market, we conduct a thorough inventory of available programs and supports. This allows us to draw on those programs to supplement the services available through the member's Medicaid benefit package. We also seek ways to partner with community organizations to strengthen their offerings. For example, we provide diabetes screening services at church gatherings and anti-violence education programs for after-school organizations.

We also work creatively to enhance our providers' ability to deliver high quality healthcare services. Our Network Account Executive team provides education and practice transformation support for providers looking to build patient-centered medical home (PCMH) or Health Home capabilities. Our clinical educators provide training for office staff on behavioral health screening and interventions. Our team-based community care management approach places care managers and care connectors in the community and at provider sites. In addition to improving our ability to effectively engage complex members in their healthcare, these efforts extend the provider's reach beyond their office walls.

"The Keystone First [AmeriHealth Caritas Iowa's southeastern Pennsylvania affiliate] Community Case Management team has been instrumental in the management of the most medically and social-economically complicated patients of our practice. The opportunity to collaborate with nurses, social workers and community care workers from Keystone First, and more closely work with the patients themselves, allows us to better exchange information and combine resources. The results are expanded services and improved coordination of care for our challenging patients."

George Valko, M.D.
The Gustave and Valla Amsterdam Professor of Family and Community Medicine
and Vice Chair for Clinical Programs and Quality
Thomas Jefferson University Hospitals

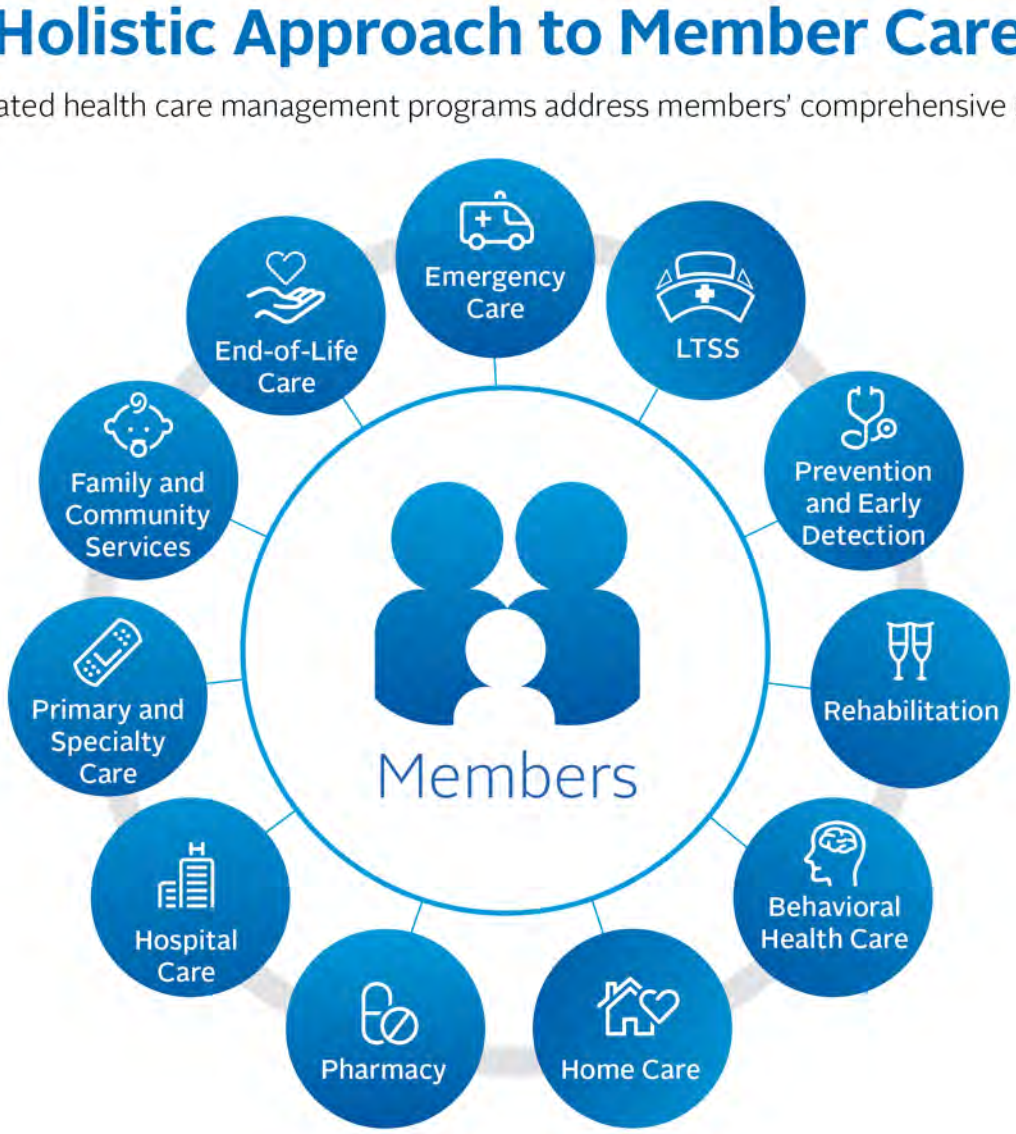

Exhibit 9.0-A: AmeriHealth Caritas' Care Management Model

9.1 General

1. Describe proposed strategies to ensure the integration of LTSS care coordination and Contractor-developed care coordination strategies as described in Section 9.

Members currently receiving or eligible for LTSS will automatically receive all complex care management services that non-LTSS members receive. In order to maintain a smooth member experience, each member receiving LTSS will work through a single primary care manager (the member will not have a

separate LTSS and CCM care manager). In addition, each LTSS recipient will receive ongoing face-to-face care management assessments and interventions with personalized care plans to meet their specific needs. AmeriHealth Caritas Iowa will contract with LTSS providers to deliver community-based services to ensure stability and long-term successful integration of these members in the communities they live.

AmeriHealth Caritas Iowa will establish communication points and referral pathways for organizations and individuals identifying members for LTSS assessment, including but not limited to:

- **Member** — Information on the LTSS program and criteria to be included in member materials and on our plan website. Members can call our toll-free Call Center of Excellence (CCOE) to request an evaluation.
- **Providers** — Information on the LTSS program and criteria will be included in the Provider Handbook and on our plan website. Providers can call our toll-free Rapid Response line or submit a fax request to have a member evaluated.
- **Data review** — Available utilization data (including hospital admissions) and claim data will be aggregated and reviewed to identify members who may meet the eligibility criteria for any of the seven Home and Community Based Service (HCBS) waivers or the LTSS, including:
  - Targeted diagnoses, such as multiple chronic conditions (hypertension, overweight, heart disease, diabetes, asthma, substance abuse, mental health condition, HIV, intellectual disability); brain injury (neoplasm, anoxic brain damage, hemorrhage, or other debilitating cerebrovascular disease); physical disability (quadriplegia, paraplegia, or other physical impairment) or serious emotional disturbance.
  - Targeted age range in combination with the above diagnoses, based on the requirements of each HCBS waiver.
  - Utilization pattern indicating member needs are not being met through the traditional Medicaid healthcare delivery infrastructure.

We will comprehensively educate Care Management and Utilization Management (UM) teams on LTSS availability and referral triggers to facilitate internal referrals of potential LTSS candidates to the LTSS assessment team. The LTSS assessment team will coordinate the information collection and in-person assessment of the member's care needs. With the assistance of the care connector assigned to the member's interdisciplinary care team, the care connector will facilitate referrals and assist the member to connect with available community services. To support members in need of complex community service support or assistance navigating bureaucratic requirements, the care manager will involve one of AmeriHealth Caritas Iowa's social service experts. Focusing strictly on mapping and building relationships with community organizations and government programs (such as subsidized housing agencies), AmeriHealth Caritas Iowa's social service experts will help ensure that members can access supplemental services to support the member in the community.

As part of the assessment process, we will coordinate and collect information from existing agencies and service providers involved in the member's care. AmeriHealth Caritas proactively forms relationships and establishes bi-directional contact points with organizations involved in the provision of LTSS care coordination. There will be several strategies in place throughout the care coordination continuum to ensure integration of LTSS care coordination. For example, In Michigan, we are working closely with the Michigan Area Agencies on Aging to provide in-home support for our Medicare Medicaid Program (MMP) demonstration members.

- During the assessment phase, we will collect information on all existing support being provided, services that are required and emergency plans. This compendium of shared information helps us

form a complete view of the member, ensures that we do not duplicate services or supports, allows us to identify any additional services that may be required and allows us to incorporate and track all of these services in our care plan.

- Once information has been collected, the care manager will reach out to community caseworkers, and together, they will collaborate to develop a single patient-centered care plan.
- As in our other markets, based on member's need, we will establish routine care conferences, including representatives from the member, providers and LTSS organizations.
- We will also make the member's care and service plans available to individuals, providers and organizations involved in the member's care, with the member's permission. This information can be accessed over our secure web portals.

We are working actively with key stakeholders in Iowa to shape our program to meet State needs. For example, we are working with the Iowa Association of Community Providers to develop a collaborative partnership to address the needs of disabled Iowan children and adults. We have also signed a Letter of Intent (LOI) with the Iowa Area Agencies on Aging (AAAs) in order to have them serve as a core vendor for waiver services. For greater detail on our LTSS care coordination strategies, please see Section 4 of our response.

9.1.1 Initial Screening

1. Describe your plan for conducting initial health risk screenings.

Health risk assessments (HRAs) are a valuable tool for helping members identify their health needs and prioritize their health goals. Information gathered during the completion of an HRA can be used to foster better communication between the member, the provider and the health plan, which can lead to engagement, empowerment, improved health outcomes and satisfaction with the healthcare experience.

AmeriHealth Caritas Iowa will conduct initial health risk screenings for:

- New members, within 90 days of enrollment for the purpose of assessing need for any special healthcare or care coordination services.
- Members who have not been enrolled in the prior 12 months.
- Members for whom there is a reasonable belief they are pregnant.

We will align our tools, messages and incentives closely with existing programs in Iowa, such as linking with the AssessMyHealth.com portal (member risk self-assessment) and supporting Iowa's Healthiest State Initiative. As outlined in section 10.2 of this response, many of our community education programs and several of the behaviors linked to our member incentive CARE card program mirror Healthiest State campaign goals.

Based on our experience with states with similar urban/rural composition and population density (e.g., South Carolina non-dual and dual demonstration programs), we will utilize a multi-channel approach to complete screenings.

New members and members who have not been enrolled in the prior 12 months will be automatically flagged in the Jiva population health platform upon enrollment, which triggers initial screening outreach. We will contact our members through:

- **Mail** — For all members, the initial HRA will be included as part of their mailed welcome packet. Members can complete the HRA and mail it back in the provided self-addressed stamped envelope.
- **Telephone** — The initial HRA can also be completed through inbound or outbound calls. All telephonic interviews will be conducted by clinical and member services staff.
- **Inbound calls** — Members have the option to call a toll-free number and complete the assessment by phone.
- **Outbound calls** — Member enrollment files will be provided to the Rapid Response Outreach team (RROT) for telephonic outreach to complete the health risk screening. During the initial phase of the contract, AmeriHealth Caritas Iowa plans on supplementing our phone outreach efforts with a contractor. Additionally, our member service unit will make welcome calls to all new members. During this call, we will work with the member to complete the HRA if it is not already in the system. The plan will also take advantage of any member contact through both inbound member and outbound calls to conduct an assessment.
- **Member Portal** — Through our main website, Members will also be able to access our secure Member Portal (website) to complete the initial screening. All members will have access to our Member Portal, which allows members to establish a user ID and password for secure access to a wealth of information.

For members who have not completed an HRA after 30 days, we will send them a postcard reminder with a toll-free number to call. At the same time, the member service team will continue outreach calls to members who are missing the HRA.

For members who have not completed an HRA after 60 days, AmeriHealth Caritas' Rapid Response and Community Outreach Solutions (COS) teams will provide additional support. Staff reviews claims history for members we have been unable to reach via phone, and performs outreach to providers and pharmacies that the member may have used in order to obtain the member's most up-to-date contact information. For members who have any high-risk markers, which might include a behavioral health diagnosis or prior use of community-based services, a COS representative will attempt to contact the member in-person using the best known address information.

Members who have not completed an HRA after 90 days are referred to our COS team for an in-person screening. Members that have not completed the initial health risk assessment will have a care connector sent to their home to complete the screener in person. We will use the Community Outreach Solution (COS) team workers for the in-person HRA. We will have COS staff stationed throughout the state to maximize our presence in the community. They will perform a variety of functions, including in-person follow-up for missing HRAs, post-discharge visits to high-risk members, coordinating community health and awareness events, establishing relationships and supporting local community agencies

Members for whom there is reasonable belief may be pregnant

Members we believe may be pregnant — either through presumptive eligibility category or other data inputs — will be contacted by our Bright Start maternity team to complete the HRA, ensure connection to prenatal care and begin the Bright Start program. Members using our mobile app will receive a text message asking them to call the Bright Start team to complete the HRA and begin with the program. We will also use the additional strategies outlined below in order to help identify members who are pregnant:

- "Are you or could you be pregnant?" is a standard question asked as part of RROT contact with a member and is also as part of the overall HRA telephonic screen.

- Obstetrics (OB) practitioners will be financially incentivized to submit Obstetrical Needs Assessment Form (ONAF) immediately following the member's first prenatal visit.
- AmeriHealth Caritas Iowa will mine administrative claim data for pregnancy diagnoses, specific procedure codes (e.g., OB ultrasound) and electronically submitted Logical Observation Identifiers Names and Codes (LOINC) indicating positive pregnancy.
- AmeriHealth Caritas Iowa will mine additional data sources, including pharmacy data for medications prescribed, which might also indicate pregnancy.

2. Submit a proposed initial health risk screening tool. Exhibits and attachments may be included.

AmeriHealth Caritas Iowa will utilize Wellsource®, an industry leader in health risk assessments and wellness programs, for our HRAs. We chose Wellsouce as it will provides a number of key benefits for the Iowa population. Their tool is National Committee for Quality Assurance (NCQA)-certified as a Health Appraisal and Self-Management Tool.

Our HRA tool will be available in both an online version and in a paper format. AmeriHealth Caritas Iowa understands that all members may not have reliable Internet access in rural locations in the state, and some members may prefer to complete the HRA in a hard copy document. The added benefit of having a printed version available is that the HRA materials can be included in membership mailings, such as new member welcome packets, and can be mailed directly to the Care Management team.

An additional feature of the Wellsource HRA is the ability to add customized questions to the assessment. These questions will be tailored to address specific areas of focus and unique health concerns relative to the Iowa population. For example, AmeriHealth Caritas Iowa will include additional questions to identify Member behavior related to physical activity and produce consumption to support our ability to deliver person-centered interventions and education related to Iowa's Healthiest State initiative. Questions can be modified over time, as foci change or new programs are launched. (Example questions can be seen in Exhibit 9.1.1-A)

We have also selected the Wellsource HRA tool because of its ease of use and its consumer-friendly summaries, which are provided to the member in an easy-to-read language, appropriate for Medicaid populations. For members with limited health literacy, a companion video is available. The video provides information about how to use the member's individual report in an audio and visual format called the Healthy Living Guidelines. The video walks the member through each section of the individual report, explaining scores and educating members on how to achieve optimal health based on their own results. The video is can be streamed online for members with Internet access or viewed on DVD. For Members without internet access, we will mail the DVD upon request.

3. Describe the methods that you will use to determine whether changes in member health status warrant subsequent screening.

AmeriHealth Caritas Iowa will deploy three key methods to determine whether changes in member health status warrant subsequent screening:

Data Mining

AmeriHealth Caritas Iowa will mine administrative claims data for utilization history to determine whether a member potentially needs subsequent screening (e.g., multiple inpatient admissions, emergency room visits, inpatient admissions or emergency room visits for conditions that are typically managed in the outpatient setting, such as diabetes, asthma and otitis media).

One main indicator we will screen for is a new diagnosis for a member. For example, a need for subsequent screenings would be triggered by new diagnoses appearing in claim data, such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), hypertension, cardiac disease, depression, Attention Deficit Hyperactivity Disorder (ADHD), hepatitis C, substance abuse, pregnancy, and serious mental illness.

Biometric data outside of optimum parameters, such as lab results (e.g., elevated HgbA1c, LDL-C, lead level) and recorded BMI will also serve as a trigger.

AmeriHealth Caritas Iowa will also utilize a predictive modeling capability to identify activities and lack of preventive care visits in a member with certain co-morbidities (e.g., behavioral health) to identify individuals for whom more intensive screening and intervention is warranted. Our analysis will focus on combinations of potentially preventable services (PPS) and admissions (PPAs), medical cost, and specific levels of behavioral health, diabetes and cardiac disease comorbidities.

Solicitation of provider and member referrals

Let Us Know is a program we will market to providers to encourage them to contact the plan about members with a new diagnosis or health status change. Providers can call or fax to request assistance, which will prompt a subsequent screening.

Furthermore, member materials and access channels (e.g., on-hold messaging, Member Portal, mobile application) will remind members that they can contact RROT for assistance accessing care or when their health status changes.

Health Plan Activity

Routine workflows and training for all health plan teams that have contact with members include procedures to connect members who have a change in health status or unmet healthcare needs to RROT for screening and intervention.

4. Describe methods that you will use to maximize contacts with members in order to complete the initial screening requirements.

AmeriHealth Caritas Iowa will make the most of each and every contact in order to help improve member outcomes, including completing the initial screening requirements. We are focused on completing the initial screening in the most optimal way, and on creating an easy experience for Iowa's population. In that critical effort, we have created several different screening options so members' needs can be best met:

- **Prompting contact upon enrollment** — All members' health cards will have a sticker on them that will instruct the member to call RROT to activate the card. When the member calls, AmeriHealth Caritas Iowa will complete the screen and help with the family's healthcare needs. AmeriHealth Caritas implemented this process in our affiliate plan in Washington, D.C. with successful results.

- **Multi-channel outreach** — AmeriHealth Caritas Iowa will provide several additional mechanisms for completion of the initial screening tool. Members can complete the screen on paper and return it via a pre-stamped envelope, call a toll-free phone number or complete the screening using the secure Member Portal.
- **Inbound call alerts ("Make all calls count")** — Whenever the member calls the plan, an alert will pop up for any member who has not completed the initial screen. The Member Service or Care Management staff speaking with the member will then facilitate completion of the screening tool.
- **Family-centered approach** — In cases where more than one family member has coverage, AmeriHealth Caritas Iowa will utilize a family-centered approach. Our associates have the ability to access a "family link," allowing them to view information, including a missing initial screening, for other family members who are participating in the program. The family link within AmeriHealth Caritas Iowa's medical management platform system allows AmeriHealth Caritas Iowa to capitalize on each contact we have with our members. Since the average Medicaid household has 2.5 members, use of family link allows us to double our conversion rate during telephonic outreach.
- **Automated messaging** — Automated voice or text messages are sent to the member's phone number on file as a reminder to complete initial screenings. The phone message gives the member the option for a warm transfer to the Member Services staff to complete the initial screening. Through the text message, members receive a direct phone number they can call for the same service on a dedicated line. Campaign outreaches occur throughout the day and also in the early evening.
- **Member Portal** — All members will have access to a secure Member Portal. As stated above, this tool allows members to establish a user ID and password for secure access to a variety of information, including the online screening tool.

9.1.2 Comprehensive Health Risk Assessment

1. Submit a proposed validated comprehensive health risk assessment tool. Exhibits and attachments may be included.

When a member is identified in the initial screening process as having a special healthcare need, or when there is a need to follow-up on problem areas identified in the initial screening, the screening will be followed up by comprehensive assessment. Accurate and timely comprehensive assessments are an incredibly important piece of care coordination because they help ensure that members are connected to and supported with the right set of supports and services. HRAs are especially important given the rural nature of Iowa, as unmet needs of members in outlying areas may go unnoticed (as we have learned in our affiliate plans in Nebraska, South Carolina, and northeastern Pennsylvania).

The AmeriHealth Caritas Care Management team uses three age and condition-specific assessment tools, depending on whether the member is an adult, child or pregnant woman. A separate tool, discussed in Section 4, is used for members being evaluated for LTSS.

The assessment incorporates subjective findings from the member, such as perception of health (utilizing the SF-12 tool) and PHQ9 assessment. The assessment includes health literacy level, lifestyle choices (such as tobacco use, alcohol and drug use, and weight management), cultural and linguistic needs and contact preferences. The topics addressed through our assessment are listed below:

Health problems	Current health problems. Length of time. Knowledge related to cause and treatment. Providers involved in the member's care (physical health, behavioral health & dental).
Medications	Medications used. Dose/frequency. Understanding of reason for the medication. Allergies.
Cultural and religious preferences	Cultural/traditional or home health remedies. Cultural and religious beliefs and preferences. Language preferences (written and spoken).
Medication barriers	Reasons for not taking medication. Assistance needed for medications.
Awareness	Medication/condition alert bracelet/card. Emergency support system. Advance Directives.
Physician care	Frequency of doctor visits. Date of next appointment. Plan if not feeling well.
Hospital/ER use	History of use (inpatient admissions and emergency room visits). Reason for event.
Functional status	Self-care (activities of daily and independent living). Mobility limitations.
Living Arrangements	Location, access and safety. External activities (including school, educational programs and work).
Health literacy	Problems reading or understanding information.
BMI	Height/weight. Frequency monitored.
Nutrition	Type of diet. Ability to adhere to diet.
Substance use	Tobacco use. Drug use. Alcohol use. Frequency of each.
Lifestyle	Frequency of exercise. Cultural practices.
Health care access	Available transportation. Barriers to care.

Behavioral health	Depression. Anxiety. ADHD.
Cognitive and sensory limitations	Care manager assessment of cognition. Hearing or vision abilities
Condition-specific Target conditions include, but are not limited to: • Asthma. • COPD. • Diabetes. • Heart failure. • Pregnancy. • Sickle cell disease. • Obesity.	For each identified target condition: • Understanding of condition. • Adherence to recommended clinical guidelines. • Lifestyle factors. • Self-management skills. • Presence and management of complications.

Exhibit 9.1.2-A: Health Risk Assessment Topics

Dependent on the findings from the initial screening and/or the above assessment process, the care manager will perform additional focused assessments to address identified physical or behavioral health conditions. Examples of validated tools and topic areas used in that process include:

- Asthma Control Test.
- Behavioral health condition-specific screens, including:
  - Age-based screens for anxiety.
  - Attention Deficit Hyperactivity Disorder (ADHD).
  - Autism spectrum disorders (ASD).
  - Bipolar spectrum disorder.
  - Depression.
  - Post-traumatic stress disorder.
  - Psychotic disorders (e.g., schizophrenia, schizoaffective, etc.).
  - Substance use disorders.
- Diabetes.
- Cardiovascular disease.
- Weight management.

AmeriHealth Caritas' assessment tools comply with NCQA Case Management standards. Attached (at the end of this section) is an example of our comprehensive assessment tools: Attachment 9.1.2-A: Comprehensive Assessment — Adult.

2. Propose the timeframe in which all comprehensive health risk assessments shall be completed after initial member enrollment.

Comprehensive health risk assessments are predicated by the initial member screen. They are completed in a time frame compliant with NCQA guidelines:

- When a member is identified for care management, the member will receive a comprehensive assessment within 30 days. Note: This follows the NCQA requirement for the initial assessment to be completed within 30 days of enrollment into care management.
- As part of the comprehensive assessment, the member will also receive a depression screening within the 30-day window.
- Any high risk condition(s) identified during the initial screen will also be assessed as within 30 days.
- All members who receive a comprehensive screening also receive a quality of life assessment (SF-12) within 30 days. The SF-12 gauges the member's perception of their health and ability to function.

3. Describe how the assessment process will incorporate contact with the member and his/her family, caregivers or representative, healthcare providers and claims history.

Input from claims history

At the start of the assessment, the AmeriHealth Caritas Iowa care manager reviews information from the member's claim-based clinical summary (MCS). The MCS contains information on identified conditions; missing or overdue services (care gaps); recent inpatient admissions and emergency room visits; medications received from the pharmacy; specialty type and visit dates for providers involved in the member's care; radiology procedures and key laboratory results. For pediatric members, the MCS also contains a list of all immunizations and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings in the claim history. As mentioned in the previous section, through the 360-degree member view in AmeriHealth Caritas Iowa's medical management platform, the care manager can also view detailed information for all claims on file for the member.

Input from the member and his/her family, caregivers or representative

The second phase of the assessment involves collecting detailed information from the member and his/her family, caregiver or representative. This interaction can occur over the phone, or for member's engaged through one of AmeriHealth Caritas Iowa's embedded care managers, in person at the provider's office. Assessments for LTSS (discussed in Section 4) are always performed in person.

AmeriHealth Caritas Iowa believes that members should drive their own care to the extent possible. We follow person-centered planning and treatment principles, in conjunction with motivational interviewing techniques, to empower the member to determine who provides input to the assessments and care plan.

Care manager testimonial:

I find 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 our care management services, that member is already engaged in telling their story and generally likes 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.

Input from the member's healthcare providers:

The final phase of the assessment involves collecting information from providers involved in the member's care. The care manager contacts the provider via phone, fax or direct message in the Provider Web Portal to solicit information on the member's strengths and needs, along with prescribed medications and treatment plans. When needed, treatment team meetings are scheduled to include the member and any other participants they identify, including providers and the member's natural supports.

9.1.3 Care Coordination

1. Describe in detail your proposed care coordination program including selection criteria and proposed strategies.

AmeriHealth Caritas' IHM program provides a holistic solution across the care continuum and uses a population-based approach to provide comprehensive care coordination services. This fully integrated model allows members to move seamlessly from one component to another, depending on each member's unique needs. From this integrated solution, AmeriHealth Caritas delivers and coordinates case 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 IHM process includes reassessing and adjusting the care plan and its goals as needed. AmeriHealth Caritas uses leading technology to integrate our medical management departments and functions, including behavioral health, pharmacy management, medical economics and operations. Our program includes strategies and activities to address the needs of our members across the healthcare continuum. Program components include:

- Wellness and prevention.
- Catastrophic Case Management.
- Disease management.
- Community Care Management teams.
- Rapid Response Outreach team.
- Community Outreach Solutions.
- Programs to target members overusing and / or abusing services.
- Discharge planning.
- Transition planning.

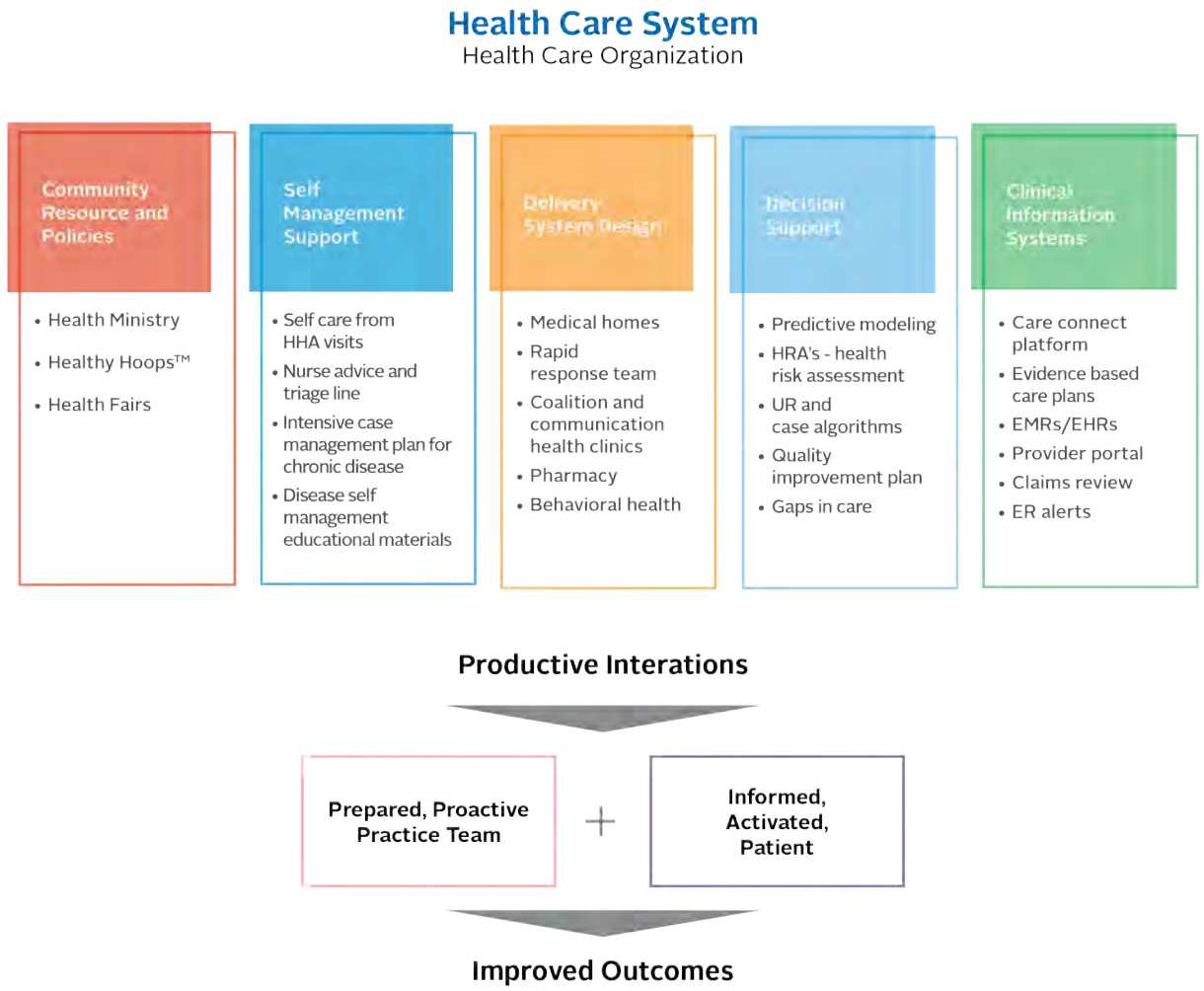

Exhibit 9.1.3-A: AmeriHealth Caritas' Integrated Healthcare Management Program

Members are selected for components of the program using a combination of data mining, event monitoring and information gleaned from individual provider and member interactions. Available medical, behavioral health and pharmacy claim data are analyzed to identify conditions and utilization patterns, and are run through predictive modeling algorithms to identify members at risk for future avoidable episodes of care. Information from member events, such as Admission-Discharge-Transition data from ERs and selection of a new PCP, are monitored to trigger specific care management interventions. Information from provider and member requests for assistance create additional opportunities to identify care management needs.

Members are assigned to wellness, low-risk or high-risk levels based on the outcome of the above activities. The member's risk group may change as new data becomes available, or based on information gleaned through utilization management, provider interactions or member contact.

Members whose needs are primarily wellness and preventive care receive preventive health reminders. These members also have access to access to the 24/7 Nurse Call Line and on-demand care management services through the Rapid Response team.

Members with controlled chronic conditions and short-term needs are assigned to the low-risk group. The low-risk group receives disease management education and monitoring, access to the 24/7 Nurse Call Line and on-demand care management services through the RROT.

AmeriHealth Caritas employs a wide menu of chronic disease management and wellness programmatic support, including diabetes care, chronic asthma management, HIV, coronary artery disease, congestive heart failure, sickle cell disease management, pregnancy and well-child care. Algorithms to address each of these areas are embedded within the care manager's workflow, as indicated for each member enrolled in a care management program.

Members identified as a potential candidate for the high-risk group or long-term support services are contacted for a case management assessment by the AmeriHealth Caritas Iowa care manager who works with the member and caregivers to develop an individualized plan of care.

Discharge planning and transition support occur across all population strata, beginning with the initial contact between AmeriHealth Caritas Iowa and the hospital when the member is admitted. On-site care managers provide additional assistance and contact points for members in high-volume facilities. Post-discharge follow-ups ensure a successful transition is coordinated through the RROT and COS staff.

Wellness and prevention

Our approach to wellness and prevention encompasses screening, immunizations and related care for pediatric members; support, education and prenatal care reminders for pregnant women; general health and wellness reminders focused on healthy nutrition and activity and supportive programs for tobacco use cessation.

Pediatric preventive healthcare

The Pediatric Preventive Health Care (PPHC) program is designed to improve the health of members under age 21 by increasing adherence to EPSDT program guidelines. We accomplish this by identifying and coordinating preventive services for these members. The PPHC combines scheduled written and telephonic outreach with state-of-the art informatics that provides point-of-contact notification of EPSDT needs to associates and providers.

Bright Start

The Bright Start maternity program is managed by a dedicated team of care managers and care connectors. The Bright Start team outreaches to pregnant members and engages them into the program based on internal and external assessments that stratify them into high- and low-risk categories. Care managers coordinate care and address various issues throughout the member's pregnancy and post-partum period, including dental and depression screenings. Members assessed as low-risk receive information via mailings with access to a care manager as necessary. Members identified as high-risk are managed by the plan with a team of both care managers and care connectors.

Healthy nutrition and activity

To support healthy nutrition and activity in our members, AmeriHealth Caritas Iowa will offer free memberships with participating YMCA organizations and free Weight Watchers® memberships for members looking to attain a healthy weight. As needed, care managers will arrange for nutrition counseling sessions for members in need of additional support and guidance.

All of our member materials reinforce simple steps a member can take to improve their health. Nutrition choices and activity levels play a prominent role in that effort. We also offer a selection of health-promotion community education sessions, delivered at local community venues. Topics are focused on

specific age groups and include 25 Ways to Wellness; Healthy You, Healthy Me (weight management); Healthy Heart; Healthy Tips for Teens; Stay Strong, Live Healthy; and Manly Tips for Healthy Living.

Tobacco use cessation

AmeriHealth Caritas Iowa will provide coverage of counseling sessions to help members quit using tobacco products. In addition to seventy counseling sessions per calendar year, AmeriHealth Caritas Iowa will cover a range of tobacco cessation medications. Counseling sessions may be provided in either group or individual counseling formats. Members do not need a referral or pre-approval to go to a counseling session, but they will receive encouragement and support from the RROT to find the counseling services that fit them best. The Provider network will also be educated on AmeriHealth Caritas Iowa's tobacco cessation benefits and local/state-wide resources.

Wellness and Prevention	
Selection criteria	• Open to all members. • Specific outreach topics based on age and gender according to EPSDT and preventive health guidelines. • Pregnant members identified using pregnancy-related category of aid, data mining (claims with a pregnancy diagnosis or for pregnancy-specific services such as obstetrical ultrasound), self-identification or provider notification. • Tobacco use is identified through data collection during the initial health screen, as well as during more in-depth case management assessments.
Strategies	***General*** • CARE Card is a customizable member incentive program where member earns incentive dollars on a re-loadable debit card by completing age/gender-specific preventive health services. • Sponsor/facilitate community education events featuring health and wellness services, such as preventive dental screenings, lead screening and blood pressure monitoring. • Community education programs delivered to community groups and faith-based organizations highlighting health topics. • Care gap identifications programmed for a variety of preventive health services appear as alerts on the Provider Web Portal and AmeriHealth Caritas Iowa staff screens. • Care gap reports, available at the practice level, provide physician offices with information on missing preventive health services for their members. ***Additional strategies for pediatric preventive care*** • Birthday cards including reminders for recommended EPSDT services and developmental milestones associated with the child's age. • Outreach calls to the parent/guardian to remind of recommended immunizations and screenings and assist in appointment scheduling. • Data mining to identify members who are missing recommended services. • Focused outreach from RROT care connectors to assess for barriers and facilitate appointments. • EPSDT service summary attached to the pediatric MCS in the secure Provider Web Portal lists immunizations and screening services with date received. • Care gap alerts, returned when a provider office checks eligibility through the NaviNet Provider Web Portal, notify providers of needed services at the point of care. ***Additional strategies for Bright Start*** • Providers receive an extra payment for submitting an ONAF at the time of the member's first prenatal visit. • Member can earn CARE Card incentive dollars for obtaining prenatal care in the first

Wellness and Prevention	
	trimester, attending 85 percent of recommended prenatal care visits and attending a post-partum visit in the recommended post-delivery timeframe. ***Additional strategies for healthy nutrition and activity*** • Enhanced benefits for YMCA and Weight Watchers memberships. • Community-based education programs to promote healthy nutrition and activity levels. ***Additional strategies for tobacco use cessation*** • Active referrals to the QUITLINE IOWA Program. • Assistance for the Member and PCP to complete forms necessary to participate in QUITLINE IOWA • Assistance connecting to tobacco cessation counseling services

Exhibit 9.1.3-B: AmeriHealth Caritas' Wellness and Prevention Approach

Catastrophic case management:

Members are identified for assessment for Catastrophic Case Management (CCM) services based on the results of data mining, referrals from providers, assessment triggers encountered during utilization management activities and requests from members or caregivers. Identified members are enrolled in the CCM arm of our program. These members receive comprehensive and disease-specific assessments and reassessments, along with the development of short-term and long-term goals and an individualized care plan, created with input from the member/caregiver and the physician(s). In addition to their care plans, Members in this category receive additional assistance with managing their care. For example, some may receive assistance making appointments and arranging transportation to attend their appointments with Providers. Others may need face-to-face care management from Community Care Management teams (CCMTs) or field care management staff.

The CCM team contains registered nurse care managers and non-clinical care connectors. Under the direct supervision of the care manager, non-clinical care connectors assist the member with various interventions. Care managers coordinate care and address various issues, including but not limited to, pharmacy, durable medical equipment (DME), dental access, assistance with transportation, identification of and access to specialists, and referral and coordination with behavioral health providers and other community resources. The care manager also refers members meeting LTSS trigger criteria for an LTSS assessment and assists with coordinating services that are outside the core benefits of the plan.

Catastrophic Case Management	
Selection criteria	***Data mining*** • Members with dominant chronic conditions[1] (e.g., heart failure, diabetes, serious mental illness, chronic obstructive pulmonary disease, chronic kidney disease) or asthma and potentially preventable events.[2] • Frequent ER or inpatient admissions (< 30 days apart). • High-risk diagnoses (e.g., failure to thrive, transplant candidacy). • Special needs Children (Down's syndrome, cleft lip/palate, genetic disorders, cardiac disorders, sickle cell disease). • Multiple prescriptions and/or multiple prescription drug prescribers. ***Utilization Management Triggers*** • Mental health or substance abuse admission. • Requests for in-home supportive care. • Requests for behavioral health services (e.g., applied behavioral analysis for autism, behavioral health rehabilitation services). • Catastrophic situations (e.g., burns, motor vehicle accident, trauma). • Antenatal complications. ***Assessment findings*** • Multiple co-morbid conditions with an unstable support system. • Dependency for basic care needs (e.g., bathing, eating, shelter).

1 AmeriHealth Caritas Iowa licenses 3M Clinical Risk Grouper (CRG) as the risk-adjustment tool and clinically-based classification system to identify members with dominant chronic conditions (DCCs), which are serious lifelong conditions that usually result in progressive deterioration of one's health. The underlying categorical clinical model for 3M CRGs is applicable to all types of episodes and across all potential configurations of episodes (window lengths, included resources, etc.). It considers all of the diagnoses, procedure and prescription medications coded in the member's medical and pharmacy claims collected longitudinally, along with recent time period and frequency of services, as well as demographics information, such as age and gender to assign each individual to a single, mutually exclusive risk group.

2 AmeriHealth Caritas Iowa uses 3M Potentially Preventable suite of products to identify potentially preventable events (PPEs), including potentially preventable admissions (PPAs), potentially preventable readmissions (PPRs), potentially preventable ER visits (PPV) and potentially preventable ancillary services (PPSs). For PPRs, 3M uses comprehensive software solutions that include global and clinical exclusions to determine the patients at risk and identify 30-day readmissions that are clinically related to the initial admission. PPAs, PPVs and PPSs are expressed as a list of clinical conditions, although PPVs following a hospitalization may require additional exclusions. PPAs are expressed as a list of all patient refined Diagnosis-related groups (APR) DRGs and PPVs and PPSs are expressed as a list of enhanced ambulatory patient groups (EAPGs). APR DRGs and EAPGs are used to risk adjust the services and are comprehensive method of determining a patient's reason for admission or ambulatory visit and severity of illness. APR DRGs expand upon DRGs by also assigning to each case a severity of illness (SOI) subclass and risk of mortality (ROM) subclass. EAPGs classifies and consolidates services across the full range of ambulatory settings including same day surgery units, hospital emergency rooms, and outpatient clinics based on procedure codes, presence of Evaluation & Management (E&M) codes and diagnoses codes

Catastrophic Case Management	
Strategies	• Motivational interviewing, used by all care management staff to assist member/caregiver to identify person-centered goals and initiate steps to meet the goal. • Integrated care management platform facilitates aggregation of all data related to the member in one view and data sharing with the PCP and other providers and community agencies involved in the member's care. • Holistic assessment and planning process includes a focus on social determinants of health. • Person-centered focus facilitates engagement and maximizes self-management skills. • Fully-integrated behavioral health and pharmacy capability eliminates fragmentation, including routine assessment for behavioral health co-morbidities and drug therapy management evaluations. • Community-based extensions of the care management team (e.g., COS team, CCMT) deliver care management interventions where the member is, improving engagement rates and persistence. • Blended disease management approach integrates disease-state education and monitoring into the plan of care for all members receiving complex care management services. • Care manager expertise drawing on a wide variety of clinical and educational backgrounds, including social work, nursing, and behavioral health and medical subspecialties.

Exhibit 9.1.3-C: AmeriHealth Caritas' Catastrophic Case Management Approach

Community Care Management teams

Members who fit the classification of "super utilizer," based on a history of or a risk for a disproportionate utilization of services and cost, are targeted for engagement by a Community Care Management Team (CCMT), where geographically available. The CCMT provides a high-touch, face-to-face engagement through a community-based team of nurses, social workers and community health workers to help members navigate and increase their access to needed medical, behavioral health and social services. The team also supports the development of member self-management skills through encouragement and coaching for chronic disease management. In addition to improving the care and health outcomes of members, this community-based team provides valuable information for and coordination with other health plan staff and services, as well as other providers in the community.

In rural locations, where the concentration of members does not support a full team, members will still have opportunity for face-to-face interventions using the local COS team for home based assessment and member engagement, linking members to the appropriately licensed telephonic care manager (registered nurse or case manager).

Community Care Management	

Selection criteria	• Analysis of medical and behavioral health claim data to identify members with any of the following:
	  o 10 or more ER admissions in the year.
	  o Four or more hospital admissions in the year.
	  o Two or more hospital admissions in six months.
	• Referrals from AmeriHealth Caritas Iowa Care Management staff or PCPs identifying members who have additional needs beyond those that can be met by the current ambulatory care system and are difficult to engage through telephonic outreach.

Community Care Management	
Strategies	• Home and community-based face-to-face engagement and ongoing visits to build a trusted personal relationship, using trauma informed/sanctuary model of care and doing whatever it takes to support the member toward better health • Assessment techniques aimed at identifying unmet needs, understanding the members goals and categorizing the barriers present that keep the member from managing their condition and accessing indicated resources and care, including. o Individual interview. o Home environmental assessment, including medication in the home. o Assessing the presence and effectiveness of the care team assisting the member. • Establishing a plan that is aligned and prioritized with member goals and coordinated with the member's care team, which may include medical and behavioral health providers, pharmacists, health plan care managers and community-based organizations that support education, utilities, housing and food. Medication confusion is often evident and the team works closely to understand what medication has been prescribed, to get it in the home and to enhance member's adherence. • Work is organized into the following pathways: o Behavioral health pathways — Harm reduction, connect or coordinate with providers, drug and alcohol support services. o Medical Pathways — Connect and coordinate access to PCP, specialist, pharmacy services. This often includes transportation and navigational assistance. o Medication pathways — Assessment, medication reconciliation and ongoing support for adherence. o Social service pathways — Connect and coordinate with necessary services to include, but not limited to, child assistance, food, housing, transportation, legal, clothing, utilities, employment and education. o Self-management support pathways — Chronic disease management, exercise, risk behaviors, red flags, diet and blood glucose monitoring. o Biometric monitoring — Weight, glucose readings, heart rate and blood pressure. o Care Gaps — Address unmet preventive or chronic care quality gaps. • Members graduate from this program when they are effectively connected to a care team that can support ongoing care management. In some cases, this may include a different level of care. It often takes months of regular face-to-face interaction and many small steps to reach this goal.

Exhibit 9.1.3-D: AmeriHealth Caritas' Community Care Management Approach

Disease state education

AmeriHealth Caritas uses a blended ICM model that combines case and disease management into a holistic approach. An algorithmic "blueprint" is developed for each targeted condition. The blueprint outlines the population management approach and metrics used to manage that condition. Each blueprint includes the following sections:

- Importance — The relevance of the condition to the membership.
- Clinical guideline — The guideline on which the program is based.

- Program goals — Specific goals related to the condition.
- Outcome measures — Specific metrics used to evaluate the program's success.
- Stratification — Logic used to stratify members into low- and high-risk groups.
- Interventions — Program interventions by stratification level.
- Priority interventions — Focused interventions for inclusion in all care plans and assessments.
- Educational materials/resources — Materials available for associates to use in providing disease-state education.
- Innovations — Synergistic initiatives that support the program goals.
- Provider connection — Method for involving provider in the program.
- Internal education — List of internal education programs for associates.
- External education — List of member and provider education related to program goals.
- Reporting — List of dates program updates and evaluation provided for review.

A comprehensive evaluation of each disease management program is conducted annually as part of the IHM program evaluation.

We use the following considerations to identify disease states to target in our Chronic Care/Disease Management program:

- Incidence of the identified disease state in the population.
- Ability of evidence-based healthcare to improve the health state of the affected member.
- Availability of current professional standards, supported by scientific evidence and research.
- AmeriHealth Caritas Iowa will implement Chronic Care/Disease Management programs for the following conditions during the first year of the contract: Diabetes, asthma, cardiovascular disease, depression and obesity.

Disease Management	
Selection criteria	• **Data mining** — Identification of members with targeted conditions using claim diagnoses and condition-related medications (where possible, industry-accepted algorithms are utilized). • **Provider referrals** — identifying members with a newly diagnosed condition. • **Member self-identification** — Through contact with an AmeriHealth Caritas Iowa call center indicating the presence of a targeted condition (e.g., a request from a member on where to obtain a glucometer).

Disease Management	
Strategies	• **Care gap identification**: — Programmed for a variety of condition monitoring algorithms, which appear as alerts on the Provider Web Portal and AmeriHealth Caritas Iowa staff screens. • **Care gap reports** — Available at the practice level for provide physician offices with information on missing condition-related services for their members. • **Member education** — Easy-to-understand, culturally relevant materials designed to educate the member on the disease process and simple steps for managing the condition. • **Care gap outreach** — Reminder calls to educate on recommended condition monitoring services, such as HgbA1c monitoring for members with diabetes, and assist with appointment scheduling and transportation arrangements. • **Individual coaching** — For members managing multiple conditions who need additional support and assistance navigating needed healthcare and community services. • **Community education programs** — Delivered at local community sites that address condition-related topics, including diabetes and asthma management. • **Coordination with available community resources** — Additional support for member needs, including food pantries that supply fresh produce and utility assistance to ensure refrigeration for insulin.

Exhibit 9.1.3-E: AmeriHealth Caritas' Disease Management Approach

Rapid Response and Community Outreach teams

An important component of the IHM model, the RROT was developed to address the urgent needs of our members and to support our providers and their staff. The RROT team consists of registered nurses, social workers and non-clinical care connectors.

There are three key service functions performed in the RROT unit:

- **Inbound call service** — Members and AmeriHealth Caritas providers may request RROT support via a direct, toll-free Rapid Response line. Referrals to RROT will also be received through many sources, including customer services, pharmacy services, utilization review, and provider services. The RROT toll-free number will be provided as a contact point for all member mailings and automated messaging, encouraging members who need additional support or information to call. The number will also be publicized to providers through provider newsletters, provider orientation and interactions between the network account executives and the provider through our "Let us Know" program. Let us Know is a campaign designed to encourage physician offices seeing our members to reach out to us for assistance supporting the member's needs, whether the needs are related to healthcare follow up, such as starting a new medication or coordination of other support services, such as food pantries or utility grants.
- **Outreach service** — Outreach activities include telephonic contact to address care gaps and support special projects or quality initiatives, such as a fall flu vaccination campaign. RROT associates also initiate follow-up calls to members recently discharged from the hospital and members who contacted the 24/7 Nurse Call Line the previous day to assist those members to reconnect with their PCP office.
- **Care management support** — Care connectors support care managers by completing tasks and reminder calls in support of the individualized plan of care. These include appointment scheduling and

reminders, transportation support, member educational mailings and other administrative tasks assigned by care managers.

Care managers are also part of the RROT and provide care management services for members with urgent health concerns that are clinical in nature. Calls are triaged by the care connector, who involves the care manager when indicated by the urgent needs assessment or clinical situation.

Rapid response associates are trained to assist members in investigating and overcoming the barriers to achieving their healthcare goals. Staff can address questions concerning how to obtain medications, supplies or medical equipment, offer assistance in finding a PCP or specialist physician or how to get help with making physician appointments. Both care managers and care connectors are well informed of available community services and are available to assist with the application process and follow-through until service delivery.

Rapid Response and Outreach	
Selection criteria	• Available to all members through a toll-free phone number.
Strategies	• **Make every contact count** — Medicaid recipients are often difficult to contact. Addressing member issues and probing for additional needs while the member is on the phone fosters trust and enhances the member's willingness to engage in self-management activities. • **Let us Know** —Providing physician offices with an easy-to-access mechanism to get assistance managing their patients once the patient leaves the office provides critical follow-up, as well as reduces the fear some physicians have about their ability to meet the needs of Medicaid recipients. • **Outbound contact campaigns** — Use of an autodialer so the time care connectors spend speaking with members is maximized and not wasted dialing the phone.

Exhibit 9.1.3-F: AmeriHealth Caritas' Rapid Response and Outreach Approach

Avoiding Readmission

Sofía is a 62 year-old Spanish-speaking female diagnosed with metastatic cervical cancer. A bilingual RROT care connector contacted Sofía the next day to review her discharge instructions, verify that her home healthcare was in place, that she had a follow-up medical appointment and to identify any barriers to following her plan of care.

Sofía's daughter was providing some of her care. The daughter indicated that Sofía had her new pain medication, that the home health nurse had visited and established a visit schedule and that the wound care supplies were delivered. However, the daughter was in need of irrigation syringes and a drainage bag for her mother's care. The care connector contacted the equipment company to arrange for the missing supplies and marked Sofía's case for a follow-up call to check on the supplies and Sofía's pain control.

During the follow-up call, the care connector uncovered that the additional supplies had not arrived. After several unsuccessful calls to the equipment vendor, the care connector arranged for the home health nurse to deliver the supplies.

Community Outreach Solutions

As an integral component of the IHM model, the COS team extends core components of the IHM program in the community. COS team members are hired from and stationed in communities across the AmeriHealth Caritas service area. The COS team provides two key functions:

- Community engagement — COS team members form relationships with community organizations in their assigned territory to facilitate awareness of services and programs available to AmeriHealth Caritas members. Through these relationships, the COS team identifies opportunities for partnerships, including education for organization staff on how to contact us to access services for a member and delivery of community education programs at the organization's site.
- In-person care management follow-up — COS team members provide face-to-face follow-up with high risk members at the request of other members of the AmeriHealth Caritas IHM teams to confirm connections and identify barriers to ambulatory care. These in-person interactions provide opportunities to identify and address barriers and member needs, as well as reinforce services available through AmeriHealth Caritas Iowa's care coordination program.

Community Outreach Solutions	
Selection criteria	• Members identified through care management interactions that need additional in-person support and follow-up. • High-risk members who the care management team is unable to reach via telephonic outreach. • High-risk members who are discharged from the hospital.
Strategies	• Community care connectors are hired from the communities they serve, providing innate knowledge of community norms and concerns. • Face-to-face interactions engender a higher degree of trust than telephonic encounters. • Community care connectors wear brightly colored apparel carrying the AmeriHealth Caritas Iowa logo (and carry AmeriHealth Caritas Iowa picture identification) to identify themselves to community representatives.

Exhibit 9.1.3-G: AmeriHealth Caritas' Community Outreach Approach

24/7 Nurse Call Line

Our 24/7 Nurse Call Line provides members with access to symptom counseling and healthcare guidance by a registered nurse. This is particularly helpful for a rural population, as clinical counseling is made available at all times to any member with access to a telephone. A summary of the member's interaction with the 24/7 Nurse Call Line is faxed to the Rapid Response team and the PCP. Our RROT care connectors subsequently contact the member to assess any additional needs and to help reconnect the member with the PCP, if appropriate.

24/7 Nurse Call Line	
Selection criteria	Available to all members through a toll-free phone line.
Strategies	Providing easy access to a registered nurse who can provide basic health education and symptom counseling gives members who are unsure if they are experiencing an emergency an alternative to an emergency room visit.

Exhibit 9.1.3-H: AmeriHealth Caritas' Nurse Call Line Overview

Programs to target members overusing and/or abusing services:

AmeriHealth Caritas monitors utilization patterns at the member level to identify members overusing and/or abusing services. Our approach encompasses specific initiatives for members who are receiving multiple prescriptions (polypharmacy), receiving controlled substance medication prescriptions from multiple prescribers and/or pharmacies, members whose utilization patterns don't match their age/gender profile or medical history, and members with frequent emergency room visits.

Polypharmacy — Drug therapy management

Members receiving 10 or more prescription medications, receiving multiple oral hypoglycemic or antipsychotic medications and children receiving psychotropic medications are referred to our drug therapy management (DTM) program for a comprehensive clinical and pharmacy review. Pharmacists and pharmacy technicians review integrated data (e.g., pharmacy, medical, lab, vision, dental), identify gaps in therapy and proactively address any identified issues though personalized consultations with patients and prescribers. All information on the review, recommendations and actions taken is recorded in the member's record in our population health management system. Care management staff follow-up with the member (or parent/guardian in the case of a child) to ensure understanding of any changes to therapy.

Controlled substance prescriptions

For members prescribed controlled substances, AmeriHealth Caritas Iowa will monitor refill patterns, number of prescribing physicians and number of pharmacies filling the prescription. Members receiving multiple prescriptions from different physicians and/or filled by different pharmacies are flagged for a care management assessment. Information on the member's prescription patterns is communicated to the prescribing physicians, to ensure that the member is receiving a coordinated treatment approach. Where permissible, we will restrict the member to receiving controlled substance prescriptions from one physician and one pharmacy.

Depending on the member's needs and goals, we will assist the member to locate appropriate substance use counseling. Suspicious activity, on the part of the member or physician, is referred to the AmeriHealth Caritas Iowa Special Investigations Unit (SIU) for further evaluation.

Mismatched utilization

Through ongoing data analysis, AmeriHealth Caritas Iowa will monitor for members whose claim history does not match their age/gender/medical history profile, as this may indicate lending of the AmeriHealth Caritas Iowa identification card to other individuals. Examples include claims for a well visit and prostate-specific-antigen lab test for a 38 year old woman, or a claim for a left foot bunionectomy for a member with a left below-the-knee amputation. Results from the data analysis are reviewed by the SIU, with further evaluation and action taken as appropriate.

In addition, all AmeriHealth Caritas Iowa staff receives training on identifying potential abuse and the mechanism to forward those cases to the SIU for investigation.

Frequent ER utilization

Members with frequent visits to the ER are flagged for outreach, assessment and education by the RROT. Based on the frequency of emergency room visits and the information gathered from the member's clinical and behavioral health history, outreach may occur via an educational mailing (used for members with 2 visits), phone outreach, education and individual care management support (as warranted for members with 3 or more visits) or referral for in-person care management (for members with multiple visits and unstable support systems).

Educational components of this program include information on emergency room alternatives (24/7 Nurse Call Line, telemedicine visits), locations of urgent care centers and information on availability of other PCP locations, including health homes for members who don't feel their needs can be met with their current PCP

Over Use and Abuse of Services	
Selection criteria	***Drug therapy management*** • Members receiving prescriptions for 10 or more medications. • Members receiving multiple oral hypoglycemic or antipsychotic medications. • Children prescribed psychotropic medications. ***Controlled substance review*** • Members receiving more than one controlled substance medication per month. • Members receiving controlled substance prescriptions from more than one physician. ***Utilization mismatch*** • Members with claims for services that are not consistent with the member's age, gender or previous medical history ***Frequent ER utilization*** • Members with more than 2 emergency room visits in a 90-day period. Additional outreach strategies employed for members with higher levels of ER utilization
Strategies	***Drug therapy management*** • Clinical review of medical, behavioral health claim history and medication regimen by a pharmacist or pharmacy technician. • Discussion of pharmacist recommendations between the pharmacist and the physician. • Discussion of member opportunities between the member and the care manager. ***Controlled substance review*** • Referral for complex care management assessment and intervention, including person-centered care. • Where permissible, restriction of the member to one prescribing physician and/or pharmacy. ***Utilization mismatch*** • Data analysis and referral to SIU for investigation and action. ***Frequent ER utilization*** • Educational outreach on appropriate use of the ER and urgent care alternatives, including 24/7 Nurse Call Line, telemedicine visits and urgent care centers. • Individual assessment and barrier identification with ongoing care management as warranted. • In-person engagement and support as part of an ongoing care management plan.

Exhibit 9.1.3-I: AmeriHealth Caritas' Overuse and Abuse of Services Approach

Discharge Planning

AmeriHealth Caritas 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 hospital to identify and coordinate the member's post-discharge care needs. AmeriHealth Caritas coordinates with facility discharge planners, the hospitalist caring for the member in the hospital, and the member's PCP and needed post-discharge care providers to develop a comprehensive discharge plan.

AmeriHealth Caritas is also exploring options to embed Acute Care Transition (ACT) care managers in high-volume facilities and primary care practices. We have successfully used this model in our other markets. The embedded care manager works directly with the member and the provider staff to coordinate additional services, initiate follow-up for treatment plan changes and provide direct member education in support of treatment.

Hospital discharge planners, PCPs and specialists are encouraged to contact AmeriHealth Caritas' 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 monitors 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 identifies the member's potential discharge care needs, the level of follow-up and care coordination needed from AmeriHealth Caritas.

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 communicates with the member's providers throughout this transition to coordinate prior authorization requests, referrals and medication regimens.

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.

AmeriHealth Caritas 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.

Behavioral health admissions

For members admitted for inpatient behavioral healthcare, additional discharge planning efforts focus on ensuring that the member transitions to outpatient follow-up care within a seven day period. To facilitate those transitions, AmeriHealth Caritas Iowa will seek to mirror programs in other our affiliate markets where outpatient behavioral healthcare visits begin the day of discharge or are facilitated through home behavioral health visits.

- In all of our affiliate markets, discharge planning from behavioral health inpatient admissions begins upon admission. Our clinical care reviewers ask about aftercare information at every review. We provide information to the inpatient provider regarding other providers involved with the member, supports that AmeriHealth Caritas provides, such as Rapid Response and Catastrophic Care Management, as well as their responsibility in scheduling aftercare appointments for the member within seven days of discharge.

- In Indiana and Washington, D.C. affiliates, AmeriHealth Caritas contracted with multiple home-based mental health providers to provide the behavioral health-related outpatient aftercare appointments in the comfort of the member's home. In Indiana, these initiatives have resulted in increasing the HEDIS Follow-Up after Hospitalization for Mental Illness (FUH) rate from 20 percent to 60 percent over a four-year period.
- In Indiana, bridge appointments were added to the fee schedule. Bridge appointments, occurring on the day of member discharge, ensures that the member understands the aftercare plan, identifies and resolves any barriers to member adherence to the aftercare plan. Bridge appointment providers link the member back to their behavioral health outpatient provider and the plan's IHM team.
- In Washington, D.C., AmeriHealth Caritas has contracted with the McClendon Center, community-based mental health center in downtown Washington, D.C. for adults diagnosed with serious and persistent mental illnesses (SPMI). In the McClendon pilot program, our affiliate, AmeriHealth Caritas District of Columbia, notifies the McClendon Center of a member's admission to any psychiatric inpatient unit within the District of Columbia. A patient discharge coordinator (PDC) from the center meets with the member within one day, and remains in contact through phone and every other day visits until discharge. Upon discharge, the PDC accompanies the member to the first outpatient therapy visit.
- AmeriHealth Caritas Iowa also recognizes that psychiatrist availability in some parts of the state may be limited. As such, we will leverage telepsychiatry services to augment provider availability for timely follow up visits.

Lauren is a 14-year-old girl with a diagnosis of reactive airway disorder (RAD), triggered by viral infections and extreme activity. Lauren was subsequently diagnosed with major depression after a reported sexual assault. After initially participating in outpatient therapy, Lauren stopped taking her medications and attempted suicide in January. She resumed outpatient therapy and was restarted on medication. A few months later, she again attempted to end her life by a drug overdose.

To assist Lauren and her mother successfully navigate the transition home process and connect her with additional outpatient therapy, the AmeriHealth Caritas care manager aligned with the facility arranged to meet with Lauren and her family before a scheduled family planning session with Lauren. The care manager gathered assessment information; answered questions related to the authorization process and allayed concerns the family had about costs associated with Lauren's care. The care manager explained several components of the transition home process available to Lauren, including the availability of a behavioral health clinician to visit Lauren and the family in their home within seven days of Lauren's discharge. Lauren's family was extremely grateful for the times that the care manager spent with them and pleased that the care manager would continue to be available to them for follow up 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 Individualized Education Plan (IEP) with the school to address Lauren's poor grades and difficulty paying attention while performing school work.

Members receiving LTSS

All members approved for or receiving LTSS are contacted by their assigned care manager within the first day of the hospitalization to initiate discussions on the discharge planning process. For members who are

medically unstable, the initial contact may be with the member's appointed representative. At the appropriate time during the hospitalization, the care manager meets in person with the member and available family/caregivers to identify changes needed in the member's community support infrastructure and develop plans to address those needs. This may include arranging for additional equipment in the home, a different level of transportation, or additional direct care support.

Transition success

Jay is a 44-year-old male who became eligible for Medicaid following a massive stroke. He had no prior medical coverage and had a feeding tube, tracheostomy and multiple medications at the time of discharge. The AmeriHealth Caritas care manager assisted his family in coordinating skilled nursing and home health aide visits so he could return home. They also 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 Jay to a community agency to evaluate his needs and determine what type of services would be beneficial. As a result of this referral, his sisters have been designated as his primary caregivers and are being paid by the community agency to provide personal care services. With these supports, Jay has successfully been cared for in his home since discharge.

Discharge Planning	
Selection criteria	• Members admitted to inpatient facilities. • High-risk criteria: o Admitted for inpatient behavioral healthcare. o Admitted with a condition related to a dominant chronic condition (DCC) or asthma. o Readmitted following a previous discharge. o Admitted with a pregnancy complication. o Receiving or eligible for LTSS.
Strategies	• Ongoing contact with inpatient facilities to ensure they have AmeriHealth Caritas Iowa contact information or Provider Web Portal access to report admissions and initiate discharge planning • ACT care managers stationed at high-volume facilities interact with the member, family and treating providers to plan for services and support needed for ongoing care needs. • AmeriHealth Caritas Iowa utilization management staff work closely with facility reviewers and discharge planners to identify available supports and ongoing care needs, make arrangements to initiate services upon discharge and enter any needed authorizations, and schedule a follow-up physician appointment. • Authorization requirements for the first six home health visits are waived. • Outpatient follow-up visit appointments are made prior to the member leaving the hospital. • For high-risk and LTSS members, the member is contacted during the inpatient stay to identify needs and plan appropriate post-discharge care and support.

Exhibit 9.1.3-J: AmeriHealth Caritas' Discharge Planning Approach

Transition planning

AmeriHealth Caritas uses a variety of monitoring and outreach methods to follow members post-discharge. Recently discharged members are a priority population for our Rapid Response team. We also use in-person outreach and Care Management teams to follow-up with recently discharged members in their communities.

RROT associates perform additional critical roles throughout the discharge planning process to prepare for the transition. Upon receipt of a referral from UM upon member admission to an inpatient facility, an RROT associate refers the member to a care manager, mails several notification letters, including a "notification of inpatient admission" letter to the member's PCP, a transition letter to the member and a "hospital care manager notification" letter to the behavioral health inpatient facility where the member was admitted so they are aware of the care manager's name. The RROT associates then investigate to determine whether the member lives in an area where the plan can arrange a home visit.

After the member transitions out of the acute-care setting, AmeriHealth Caritas care managers or Rapid Response associates call the member to assess 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 works with the member to identify a local home health provider and then contact the member's provider to initiate a referral.

When possible, high-risk members receive additional in-person follow up from community-based care managers or COS associates. COS and care management staff will be stationed across the state to facilitate in-person follow-up with members in the high-risk category. The focus of these face-to-face encounters is to assess understanding of the post-discharge treatment instructions, ensure that needed services (such as home healthcare or equipment) are in place and working satisfactorily, facilitate review of prescribed medications and identify any barriers to keeping scheduled follow-up appointments.

Behavioral health transitions

Ensuring connections to outpatient behavioral healthcare is a critical component of post-discharge follow-up for members discharged after a behavioral health admission. In addition to developing mechanisms to connect the member to outpatient services prior to leaving the facility, AmeriHealth Caritas care managers follow all members discharged from a behavioral health inpatient setting for a minimum of 60 days to encourage attendance at outpatient therapy appointments. AmeriHealth Caritas Iowa will ensure that the member's PCP is aware of the discharge summary and aftercare appointments to enable collaboration between physical health and behavioral health providers.

Our care manager will use available resources as clinically indicated. These resources include network providers, peer supports, community outreach specialists, community health workers, community agency supports and the member's natural support system. As needed, the care manager will arrange for a peer support specialist or community care connector to accompany the member to the first outpatient appointment. The focus of the transition is to provide sufficient supports to the member to be safely maintained in their community.

Members receiving LTSS

All members approved for or receiving LTSS receive a home visit from a care manager on the day of discharge. During the visit, the care manager reviews discharge instructions and verifies the member's and caregiver's understanding of symptoms to report and reconciles medications, so that the member and

caregiver are clear on which medications the member needs and when. The care manager also verifies the date, time and transportation arrangements for the member's next physician visit. This initial home visit is followed by two to three subsequent home visits by members of the care team during the next seven days. These visits are used to verify that all aspects of the plan of care are functioning, and gauge member and caregiver stress level and ability to maintain the needed level of services. As needed, the care manager will work with the member's PCP to order additional hours or levels of support.

Additional support and planning, discussed in Section 4, occurs for LTSS members who wish to transition from a residential facility back to the community.

Transition Management	
Selection criteria	• Members admitted to inpatient facilities • Additional support for high-risk and LTSS members and members discharged following a behavioral health admission
Strategies	• Follow-up contact after discharge focused on evidence-based tenets: o Member/caregiver understanding of discharge instructions o Member/caregiver understanding of symptoms to report to the physician o Medication reconciliation/availability o Follow-up appointment scheduled; transportation available • Home visits for high-risk and LTSS members • Peer Support services for members discharged from a behavioral health admission

Exhibit 9.1.3-K: AmeriHealth Caritas' Transition Management Approach

Avoiding readmission

Carol is a 60-year-old with a history of heart failure, COPD, diabetes, hypertension, gastro esophageal reflux, coronary artery disease, gait imbalance due to an old ankle fracture and two cardiac stents. Carol was discharged from the hospital after being admitted with chest pain. The RROT care connector contacted Carol the next day to review her discharge instructions, verify that she had her medications and a follow-up PCP appointment, and identify any barriers to following her plan of care.

During routine probing, Carol identified that she did not have her glucometer anymore. The care connector arranged for delivery of a new glucometer to be delivered and marked Carol's case for a follow-up call to check on the glucometer and the upcoming PCP appointment. During the follow-up call, the care connector verified that the glucometer arrived.

In conversation with Carol about the upcoming PCP appointment, Carol identified that she was not sure she could get to the doctor's office due to her inability to walk meaningful distances. The care connector initiated the process to connect Carol to the county transportation service, making multiple phone calls to the PCP office, Carol and the transportation provider to get the paperwork completed prior to Carol's appointment.

2. Provide data on outcomes achieved in your care coordination programs operated in other states, if applicable.

AmeriHealth Caritas has demonstrated strong care coordination outcomes across the states in which we operate. We believe a focus on care coordination is essential to helping members achieve the best possible

outcomes, both in terms of health and lifestyle. We track outcomes across several domains, including clinical guideline adherence, appropriate utilization, member reported wellness, and member and provider satisfaction. Results of our overall integrated healthcare management program were independently evaluated by the Milliman, Inc. The evaluation showed that we achieved a 4.3 percent reduction over the expected cost trend, which we estimate to amount to over $20 million in savings for our Indiana affiliate's Aged-Blind-Disabled (ABD) population. We recently looked at the impact of our integrated healthcare management program in our South Carolina affiliate and observed a 40 percent decrease in inpatient admissions for individuals enrolled in the program, statistically significantly greater than the experience of a control group of non-enrolled members. Over 95 percent of members enrolled in AmeriHealth Caritas care management programs are "Satisfied" or "Very Satisfied" with their care manager and the services received during the program. They are more likely to engage in primary care services and receive recommended care.

Improved health outcomes

Looking at data from AmeriHealth Caritas' longest running health plan, Keystone First, members engaged with an AmeriHealth Caritas care manager have higher completion rates for preventive and condition-specific care than that of plan membership as a whole.

	Total Plan	Engaged Members	% Difference
Women's health			
Breast cancer screening (BCS)	66.19%	78.93%	19.25%
Cervical cancer screening (CCS)	70.95%	87.50%	23.33%
Cardiovascular disease			
Controlling high blood pressure (CBP)	60.44%	70.59%	16.79%
Persistence of beta blocker after a heart attack (PBH)	94.74%	100.00%	5.55%
LDL-C screening performed	79.20%	92.31%	16.55%
LDL-C control (<100 mg/dL)	43.14%	57.69%	33.73%
Comprehensive diabetes care (CDC)			
Hemoglobin A1c (HbA1c) testing	82.51%	87.50%	6.05%
HbA1c poor control (>9.0%)	36.72%	34.38%	-6.37%*
HbA1c control (<7.0%)	39.23%	42.86%	9.25%
Eye exam (retinal) performed	51.67%	59.38%	14.92%
Medical attention for nephropathy	80.92%	90.63%	12.00%
**Lower results are better for this measure*			

	Total Plan	Engaged Members	% Difference
Use of appropriate medications for people with asthma (ASM)			
Total	**86.91%**	**95.05%**	**9.37%**
Adult access to preventative/ambulatory health services (AAP)			
Total	**85.57%**	**99.08%**	**15.79%**
COPD management			
Use of spirometry testing in the assessment and diagnosis of COPD (SPR)	25.82%	30.36%	17.58%
Pharmacotherapy management of COPD exacerbation (PCE)			
Systemic corticosteroid	78.30%	83.33%	6.42%
Bronchodilator	91.39%	97.37%	6.54%

Exhibit 9.1.3-L: AmeriHealth Caritas' Keystone First Outcomes Overview

Appropriate utilization

Bending the curve for "super utilizers"

Members with chronic medical conditions and behavioral health comorbidities that fall into the highest segment of inpatient and emergency room utilization pose a special challenge to health plans. These members often have challenges forming productive relationships with the traditional healthcare delivery system, and the delivery system is often not able to adequately address the members' multiple complex needs. AmeriHealth Caritas uses community care management teams to form one-on-one engagement relationships with the member and assist the member to connect to a custom support web. The typical member has four to five admissions in a six-month period, little to no engagement with a PCP or health home, three or more chronic medical conditions and at least one behavioral health condition. There are currently four Community Care Management Teams operating in AmeriHealth Caritas plans across the country. The results for these programs demonstrate statically significant reductions in utilization and medical costs, driven primarily by reductions in inpatient utilization. As expected, slight increases were seen in outpatient utilization and prescription drug costs.

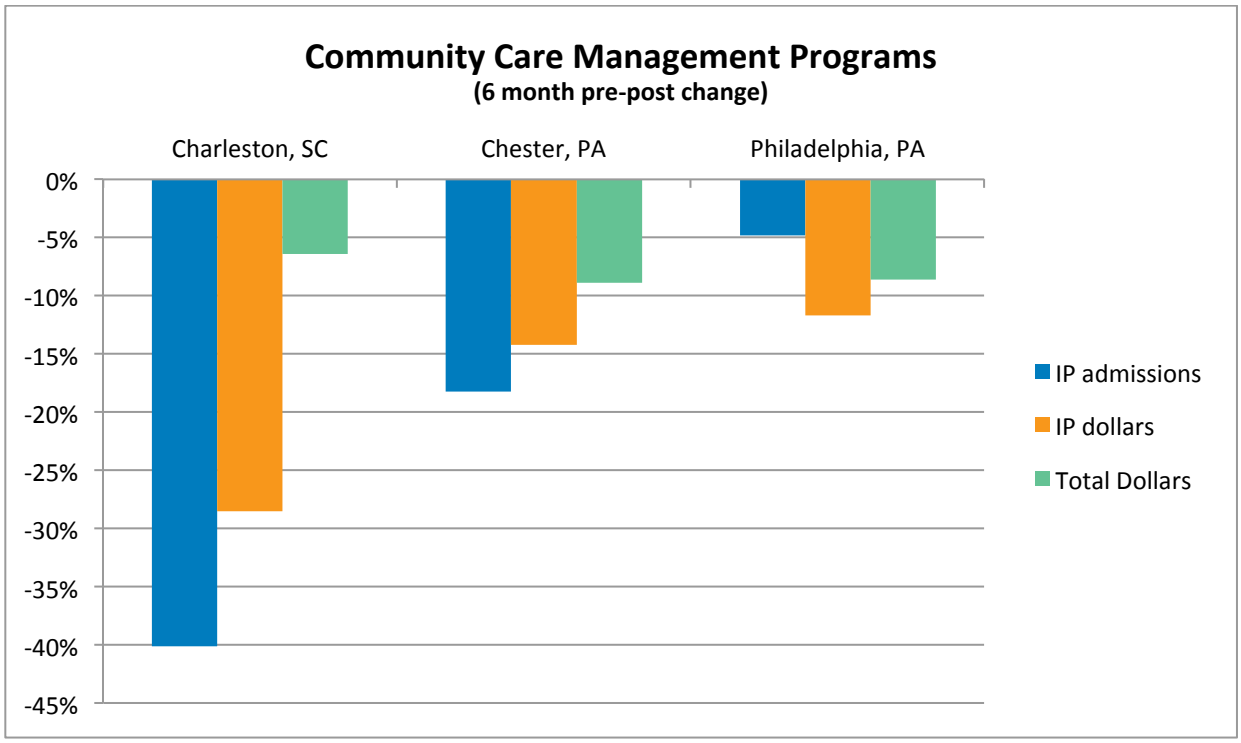

Exhibit 9.1.3-M: AmeriHealth Caritas' "Super Utilizers" Outcomes

Medication Adherence

Medication non-adherence is a primary cause of suboptimal chronic disease management. During 2013, AmeriHealth Caritas undertook an enterprise effort to incorporate education and refill reminder efforts in our care coordination programs to improve adherence for members prescribed asthma controller medications, hypoglycemics, statins and/or antihypertensives. Using a cohort approach, members prescribed the target medications who had a baseline Proportion of Days Covered between 20 percent and 66.7 percent (the corporate average) and also had a valid Proportion of Days Covered in the measurement year, were include in the study. Proportion of Days Covered, which measures the number of days in the period for which medication was dispensed, was used as a proxy for medication adherence. A patient was included in the adherence measure calculation if they had received at least two fills of medication during the period measured to account for potential therapy discontinuation.

Medication Class	Percent Change in Proportion of Days Covered
Antihypertensive	24.1%
Asthma controller	5.2%
Hypoglycemic	22.4%
Statins	25.5%

Exhibit 9.1.3-N: Example Medication Adherence Outcomes

Additional analysis is underway to quantify the impact of these results to utilization and medical costs. Preliminary analysis indicates that members with asthma prescribed an asthma controller medication saw

the greatest reductions in inpatient admissions and total medical costs. To further support these efforts, AmeriHealth Caritas is adding prescription refill reminders to our mobile application.

Optimizing utilization and cost

Ongoing analysis for members involved with AmeriHealth Caritas' Integrated Care Management model demonstrates reductions in overall costs and costs related to inpatient care.

Population	Market	Results
Members engaged through care managers embedded in Primary Care Practices3	Southeastern Pennsylvania	• 23% decrease in emergency room visits. • 21% decrease in emergency room costs. • 33% decrease in inpatient admissions. • 26% decrease in inpatient costs.
Members engaged in telephonic care management4	Central Pennsylvania	• 36% decrease in emergency room visits. • 27% decrease in emergency room costs. • 30% decrease in inpatient costs. • Comparisons for this group to a risk-adjusted cohort showed statistically significant decreases (p<.0001) in ER and inpatient cost and utilization.
Members engaged in telephonic care management[1]	Southeastern Pennsylvania	• 32% Decrease in emergency room visits. • 231% Decrease in emergency room costs. • 41% decrease in inpatient costs. • Comparisons for this group to a risk-adjusted cohort showed statistically significant decreases (p<.0001) in ER and inpatient cost and utilization.
SSI Members engaged in telephonic care management5	South Carolina	• 19% decrease in emergency room costs. • 48% decrease in inpatient costs. • 40% decrease in inpatient admissions. • Comparison for this group to a risk-adjusted cohort showed statistically significant decreases (p<.0001) in inpatient admissions and costs and emergency room visits.
SSI Members engaged in telephonic care management with behavioral and physical health comorbidities	South Carolina	• 19% decrease in emergency room costs. • 8% decrease in emergency room visits. • 48% decrease in inpatient costs. • 40% decrease in inpatient admissions. • Comparison for this group to a risk-adjusted cohort showed statistically significant decreases (p<.0001) in inpatient admissions and costs and emergency room costs.

3 KF CY 2013 compared to CY 2012
4 ACPA CY 2013 compared to CY 2012
5 SHSC May 2013 through April 2014 with at least 6 months engagement

Population	Market	Results
Super utilizer members engaged through Community Care Management teams[4]	Charleston, South Carolina	• 45% decrease in inpatient costs • 45% decrease in inpatient admissions • 18% decrease in total claim costs
Super utilizer members engaged through Community Care Management teams6	Chester, Pennsylvania	• 22% decrease in inpatient costs • 25% decrease in inpatient admissions • 6% decrease in total claim costs
Super utilizer members engaged through Community Care Management teams7	Philadelphia, Pennsylvania	• 11% decrease in inpatient costs • 4% decrease in inpatient admissions • 8% decrease in total claim costs

Exhibit 9.1.3-O: Overview of Utilization and Cost Outcomes across AmeriHealth Caritas

Reducing potentially preventable events (PPEs)

AmeriHealth Caritas monitors potentially preventable events (PPEs) as an indicator of opportunity to improve member connections with care. PPEs include:

- **Potentially preventable initial admissions (PPA)** — Avoidable hospitalizations based on conditions that are determined to be ambulatory care sensitive. Adequate patient monitoring and follow-up can often avoid the need for admission.
- **Potentially preventable ER visits (PPV)** — May result from a lack of adequate access to care or ambulatory care coordination.
- **Potentially preventable ancillary services (PPS)** — High cost imaging, minor cardiac and vascular tests, and certain lab tests that may not provide useful information for diagnosis and treatment.
- **Potentially preventable readmissions (PPR)** — Return hospitalizations within a 30-day readmission time interval that are clinically-related to a previous hospital admission.

PPEs are used both as a trigger for a care management evaluation in members with chronic conditions, and as a metric to evaluate the effectiveness of care management engagement. AmeriHealth Caritas health plans experienced the below results for members with dominant chronic conditions (according to the 3M methodology) who had high levels of PPEs:

Market	Results
Southeastern Pennsylvania	36% decrease in PPEs, driven by a 46% decrease in PPAs
Central Pennsylvania	46% decrease in PPEs, driven by a 65% decrease in PPAs
Louisiana	37% decrease in PPEs, driven by a 52% decrease in PPAs
South Carolina	40% decrease in PPEs, driven by a 653% decrease in PPAs
Indiana	50% decrease in PPEs, driven by a 76% decrease in PPAs

6 12 month pre vs post; claims incurred through 9/30/14.
7 6 month pre vs post; claims incurred through 9/30/14.

Market	Results
Nebraska	48% decrease in PPEs, driven by a 69% decrease in PPAs
District of Columbia	57% decrease in PPEs, driven by a 63% decrease in PPAs

Exhibit 9.1.3-P: Overview of PPE Outcomes across AmeriHealth Caritas

Reducing readmissions

In evaluating the impact of our program on readmission rates, AmeriHealth Caritas focused on members with at least one dominant chronic condition or the moderate chronic condition of asthma. These members have a 7.5 times higher readmission rate than members without data markers for those conditions. Through extensive redesign of transition management processes and creation of new member education campaigns, AmeriHealth Caritas decreased readmission rates for members in this target population by 10.9 percent from 2013 to 2014. Market-specific data is displayed in the table below.

Readmissions per 1,000 member year				
LOB	**12 Months Ending Nov. 2013**	**12 Months Ending Nov. 2014**	**Absolute Change**	**% Change**
Keystone First	19.39	17.70	-1.69	-8.7%
AmeriHealth Caritas Pennsylvania	8.49	7.60	-0.89	-10.5%
AmeriHealth Caritas Louisiana	13.70	11.28	-2.42	-17.7%
Select Health	9.07	8.34	-0.74	-8.1%
MDwise Hoosier Alliance	3.32	3.30	-0.02	-0.6%
Arbor Health Plan	7.08	5.00	-2.07	-29.3%
OVERALL	**11.83**	**10.47**	**-1.36**	**-11.5%**
Note: AmeriHealth District of Columbia removed due to insufficient historical data (prior to May 2013).				
Current 12 months vs. prior 12 months — claims incurred through Nov. 2014 and paid through Feb. 2015 to allow for 90 days runout.				

Exhibit 9.1.3-Q: Reduction in Readmissions across AmeriHealth Caritas

To further demonstrate the effectiveness of the enhanced discharge protocols, AmeriHealth Caritas analyzed readmission rates by number of successful contacts. Successful contacts are defined as outbound Care Management, Rapid Response or UM calls where the care manager speaks directly to the member. Successful follow-up calls led statistically significantly lower 30-day readmission rates. Compared with no successful follow-up calls, the odds of readmission were reduced by:

- 22 percent for one contact — OR=0.78; 95 percent CI (0.71-0.86).
- 27 percent for two contacts — OR=0.73; 95 percent CI (0.64-0.83).
- 46 percent for three or more contacts — OR=0.54; 95 percent CI (0.48-0.62).

Member-reported wellness

Member perception of their health and wellness is measured using the 12-item Short Form (SF-12) licensed through Optum™. Members receiving complex care management services are assessed during the initial engagement phase, and then every six to 12 months they are in the program. Analysis of the results identifies improvement in the members' assessment of their general health. Results below depict improved ratings of health and wellness by members engaged in the complex care management program throughout six AmeriHealth Caritas plans in 2014. Members reported improvements in all aspects measured by the assessment tool, with the greatest improvements seen in their overall assessment of their health, energy level and feeling calm and peaceful, as well as less interference of pain, feelings of being downhearted or depressed.

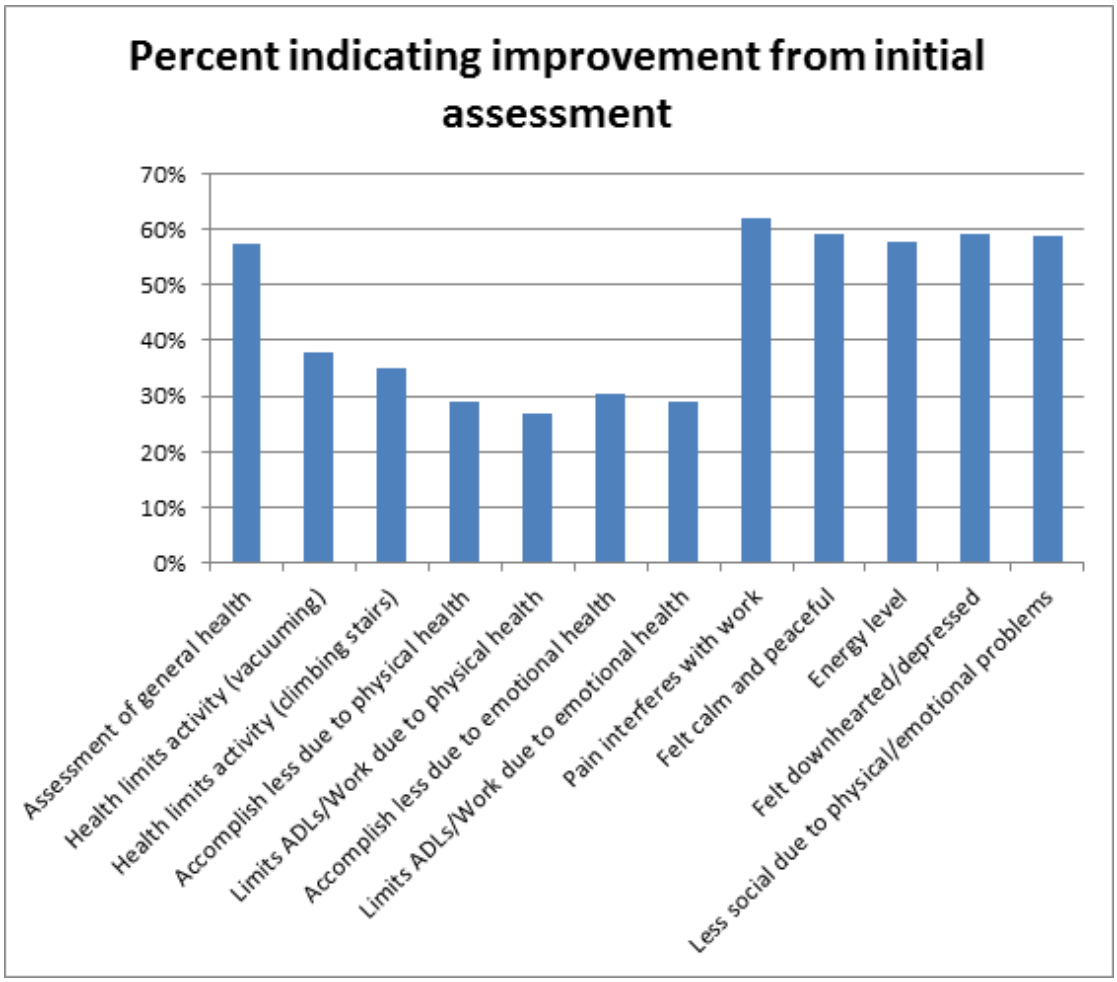

Exhibit 9.1.3-R: Overview of Member-reported Improvement

Member satisfaction

AmeriHealth Caritas also measures satisfaction with its Care Management programs through a formal satisfaction survey process. Surveys are administered by The Meyers Group using a phone interview to collect the member's perception of complex care management and disease-specific program services. Across all plans, members continue to report satisfaction with the interactions and assistance provided by the care management team, increasing their understanding of their condition and quality of life. They also give high marks to the helpfulness of AmeriHealth Caritas' written materials.

Formal results for AmeriHealth Caritas' four largest health plans for surveys conducted in 2014 are summarized below.

Members engaged in Complex Care Management

Composites/Attributes		KF	ACP	LA	SC	Average
Understanding of condition	Extremely or very helpful	84.2%	83.8%	86.1%	92.5%	86.7%
Written materials	Extremely or very helpful	80.0%	82.0%	96.4%	84.6%	85.8%
Quality of life	Greatly or somewhat improved	82.6%	85.3%	83.3%	90.8%	85.5%
Overall satisfaction	Excellent or good/very good	77.6%	74.4%	80.5%	86.4%	79.7%

Exhibit 9.1.3-S: Complex Care Management Member Survey Overall Results

Members receiving condition-specific Services

Diabetes		KF	ACP	LA	SC	Average
Helpfulness of DM care manager	High (8–10)	88%	87%	81%	94%	87.8%
Written materials	Extremely/very easy to understand	83%	93%	91%	93%	89.9%
Satisfaction with program	Excellent or very good	89%	87%	78%	96%	87.5%
Asthma						
Helpfulness of DM care manager	High (8–10)	94%	87%	81%	97%	89.6%
Written materials	Extremely/very easy to understand	82%	79%	91%	96%	86.8%
Satisfaction with program	Excellent or very good	86%	87%	78%	94%	86.2%

COPD						
Helpfulness of DM care manager	High (8–10)	91%	86%	N/A	N/A	88.6%
Written materials	Extremely/very easy to understand	83%	81%	N/A	N/A	81.9%
Satisfaction with program	Excellent or very good	82%	97%	N/A	N/A	89.5%
Heart Failure						
Helpfulness of DM care manager	High (8–10)	88%	60%	N/A	N/A	74.0%
Written materials	Extremely/very easy to understand	73%	100%	N/A	N/A	86.4%
Satisfaction with program	Excellent or very good	87%	88%	N/A	N/A	87.1%

N/A — Not Assessed: Due to small volume of members with a primary disease focus of heart failure or COPD in these specific plan populations, separate metrics were not assessed.

Note: KF = Keystone First, ACP = AmeriHealth Caritas Pennsylvania, LA = AmeriHealth Caritas Louisiana, SC = Select Health of South Carolina; DM = disease management

Exhibit 9.1.3-T: Complex Care Management Member Survey Condition-Specific Results

9.1.4 Risk Stratification

1. Describe your proposed risk stratification methodology.

AmeriHealth Caritas Iowa's risk stratification methodology will combine data analysis with assessment findings to assign the member to a wellness, low-risk or high-risk group.

Clinical risk groups

AmeriHealth Caritas Iowa's risk stratification will inform the intensity and frequency of follow-up care that is required for each member participating in the Care Coordination program. Our approach focuses on identifying members whose clinical diagnoses and utilization demonstrate patterns that suggest that the members are unable to manage their conditions on their own. To identify this population, we utilize the 3M risk adjustment and patient classification methodologies to assist us in identifying a target population. Our target population goes beyond the sickest members, including those that have serious chronic conditions that could lead to progressive health deterioration, making them future high utilizers of healthcare services. In our experience, this population benefits significantly from care management programs.

To complete the analysis, we will utilize the 3M Clinical Risk Grouper (CRG), a risk-adjustment tool and clinically-based classification system used to measure a population's burden of illness. 3M CRGs uses

AmeriHealth Caritas' standard medical and pharmacy claims collected longitudinally to assign each individual to a single, mutually exclusive risk group. The underlying categorical clinical model for 3M CRGs is applicable to all types of episodes, creating a uniform and stable clinical language. Across all potential configurations of episodes (window lengths, included resources, etc.), the episode clinical model remains unchanged. 3M CRGs relate the historical clinical and demographic characteristics of the individual to the amount and type of healthcare resources that the individual will consume in the future.

Since the 3M CRGs are clinically-based, rather than a regression risk-adjustment model, they create a language that links the clinical and financial aspects of care. This "language" is easily understood by clinicians and therefore actionable. 3M CRGs provide a comprehensive and clinically specific classification for a full range of populations.

Our strategy in utilizing the 3M CRG methodology is to focus on members with dominant chronic condition, moderate chronic condition of asthma, or pregnancy. Dominant chronic conditions are serious lifelong conditions that often result in progressive deterioration of an individual's health if untreated, including conditions such as heart failure, diabetes and chronic obstructive pulmonary disease.

Potentially preventable events

In addition to focusing on members who have the above conditions we also further concentrate on members who have the highest potentially preventable utilization.

PPEs include avoidable hospital admissions and readmissions, unnecessary emergency room visits, unnecessary ancillary services and hospital-acquired complications. AmeriHealth Caritas currently monitors the following PPEs:

- **Potentially preventable initial admissions (PPA)** — Avoidable hospitalizations based on conditions that are determined to be ambulatory care sensitive. Adequate patient monitoring and follow-up can often avoid the need for admission.
- **Potentially preventable ER visits (PPV)** — May result from a lack of adequate access to care or ambulatory care coordination.
- **Potentially preventable ancillary services (PPS)** — High cost imaging, minor cardiac and vascular tests, and certain lab tests that may not provide useful information for diagnosis and treatment.
- **Potentially preventable readmissions (PPR)** — Return hospitalizations within a 30-day readmission time interval that are clinically-related to a previous hospital admission.

Additional data mining techniques

Additional data sets that factor into our stratification methodology include Logical Observation Identifiers Names and Codes (LOINC®), DTM algorithms and care gap algorithms. Commonly found in laboratory billing data, LOINC data facilitate the exchange of clinical results, such as maternal risk conditions. Reports based on maternity-related LOINC are used to identify pregnant women who may have a change in their pregnancy risk status, which will trigger a care management re-assessment by the Bright Start maternity management team. DTM algorithms identify members receiving multiple medications where there may be an opportunity to streamline the medication regimen and improve adherence. Care gap algorithms identify members who are not receiving recommended care related to preventive care and chronic condition management guidelines.

Stratification

Using the results of the above data analysis, an initial stratification is completed based on the presence of PPEs, chronic conditions, pregnancy status and unmet care needs. Members with high levels of PPEs are prioritized for additional outreach and assessment. Members are also identified for in-depth care management assessments through referrals from providers, identification of risks during utilization management, rapid response encounters and member self-identification.

Results of information gathered during the assessment process are used in conjunction with available data analysis results, to place the member in the appropriate risk group. Additional segmentation is performed using a four-quadrant model based on the level of behavioral health versus physical health needs.

2. Describe your proposed risk stratification levels.

Members are assigned to one of three risk levels based on available claim and assessment data: Wellness, low risk or high risk. All LTSS members, whether approved for LTSS or on a waiting list, are assigned to our high-risk level cohort.

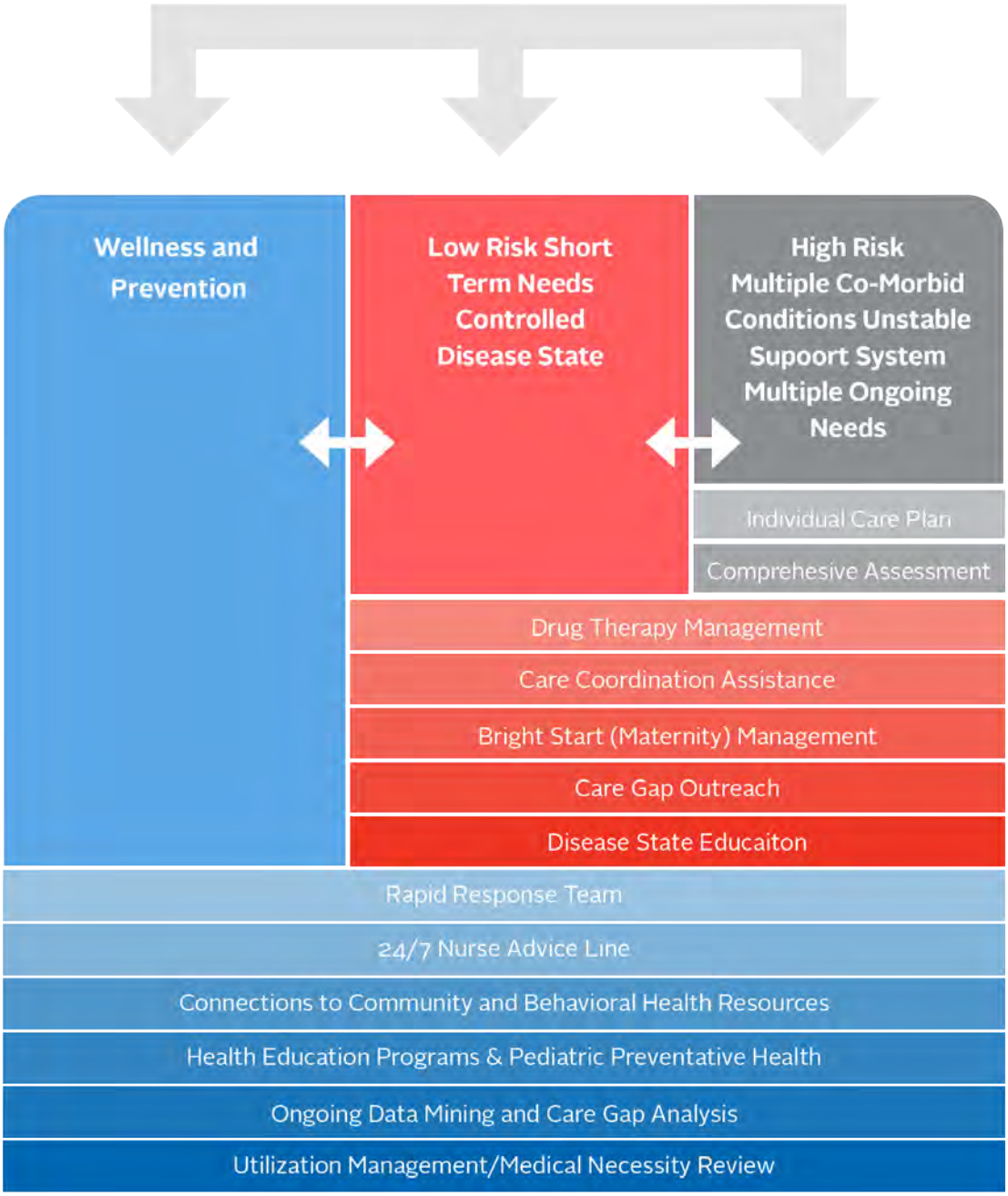

Exhibit 9.1.4-A: Overview of AmeriHealth Caritas Iowa Risk Stratification

We modify the member's risk group assignment as new data becomes available, or based on information gleaned through utilization management, provider interactions or member contact. For example, a member who has well controlled type 2 diabetes mellitus may be initially grouped in the low risk category, but through the care manager contact, social barriers to care are identified and the member is moved to the high-risk category. This movement is especially fluid for members in the high-risk level who may need to be evaluated for long-term support services due to changes in their health or changes in the health or availability of their informal caregiver supports.

- **Wellness and Prevention** — Members that currently do not have a chronic condition are assigned to this group. These members typically need reminders for preventive health services and education related to activities related to health promotion.
- **Low Risk** — Members with controlled chronic conditions and short-term needs are assigned to the low-risk group. These members benefit from education on their condition, reminders for health monitoring and medication refills, and assistance coordinating treatment and follow-up care. They typically have capacity for self-management and may also benefit from additional support and connection to community resources.
- **High Risk** — High risk members are those that have multiple co-morbid conditions, have catastrophic events, unstable support system, social instability and / or multiple ongoing needs, such as transition of care or inpatient episodes with discharge planning. These members need assistance navigating and connecting with needed healthcare services, as well as help identifying and connecting with available community supports. They usually need coaching to strengthen their self-management skills or may not be capable of self-management.

High-risk members are further classified based on their level of physical health and behavioral health needs. This classification provides guidance in the identification of the best team member to take the lead on the member's care management team:

- **Level I** — Members with low behavioral health and low physical health needs will be managed through the Episodic Care Management team.
- **Level II** — Members with high behavioral health and low physical health needs will be managed by a behavioral health specialist.
- **Level III** — Members with low behavioral health and high physical health needs will be managed by a registered nurse (RN).
- **Level IV** — Members with high behavioral health and high physical health needs will be managed by an RN with strong behavioral health experience.

3. Describe how care would be managed for members in each risk stratification level.

Wellness and Prevention — Members in this group receive preventative health reminders and health education programs to continue wellness and prevention activities. They have access to the 24/7 Nurse Call Line and on-demand care management services through the Rapid Response team. These members are monitored through data mining, care gap analysis and health risk screens to identify unmet needs or the need to transition the member to a higher risk level.

Low Risk — Members in the low-risk group receive educational materials on their chronic condition(s) and preventive care, access to the 24/7 Nurse Call Line and on-demand care management services through the Rapid Response team. Available biometric data (hgbA1c, LDL-C and blood pressure readings) and medication refill information are added to the data mining and care gap analysis performed for this population. Ongoing monitoring scans for changes in their condition that could move them to high risk.

High Risk — High risk members receive telephonic and face to face interaction from care managers. These members receive a comprehensive assessment, including a focus on social and environmental needs. Assessment information is also collected from family, caregivers and providers involved in the member's care. The care manager works with the member/family to identify preferences and prioritize goals. Based on the agreed upon goals, the care manager develops a care plan designed to capitalize on the member's strengths.

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 for transfer to a home or community setting.
- Members with physical conditions impairing their ability to get care and services away from living environment.
- Members with advanced illness or end of life.
- Those living in a facility based setting.
- Non-institutionalized members who qualify for a nursing facility 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.

9.1.5 Member Identification

1. Describe how you will identify members eligible for care coordination programs, including how the following strategies will be utilized

Predictive modeling

AmeriHealth Caritas Iowa's algorithms incorporate analysis of medical, behavioral health and pharmacy claims to identify members belonging to targeted chronic condition populations. We have a robust Medical Economics department that provides reports on high dollar claims in addition to targeted chronic conditions.

AmeriHealth Caritas Iowa focuses on targeting members with unusually high utilization patterns (suggestive of poor disease self-management) who are therefore in need of intervention. To identify this at-risk population, we utilize the 3M CRG risk adjustment and patient classification methodology to assist us in determining the members who would benefit most from care management programs.

AmeriHealth Caritas runs its standard medical and pharmacy claims collected longitudinally through the grouper model to assign each individual to a single risk group. The grouper platform relates the member's historical clinical and demographic characteristics to the quantity and type of healthcare resources that he/she is projected to consume in the future, thereby linking the clinical and financial aspects of care, providing comprehensive and clinically specific classifications for a full range of populations and supporting our provider value-based payment models.

By using this methodology, we are able to focus on members with any dominant chronic condition, moderate chronic condition of asthma, who are pregnant or who have the highest potentially preventable utilization.

PPEs include avoidable hospital admissions and readmissions, unnecessary emergency room visits, unnecessary ancillary services and hospital-acquired complications. AmeriHealth Caritas currently monitors the following PPEs: PPAs, PPVs, PPSs and PPRs.

Focusing on and reducing PPEs leads to improved patient outcomes and lower medical costs, and can be achieved through better coordinated care and first targeting interventions for individuals with multiple chronic conditions . Using this approach, AmeriHealth Caritas reduced readmissions by 11.5 percent across seven Medicaid health plans in 2014.

Claim review

In addition to predictive modeling, we review claim data monthly to identify members who are newly diagnosed with targeted conditions, including diabetes, asthma, depression and hypertension. Identified members are enrolled in our disease management programs.

Claim review is also used to identify members with high utilization patterns, including inpatient and emergency room care. These members are referred for educational outreach, care management assessment and community care management intervention.

Review of pharmacy claims is conducted routinely to identify members with polypharmacy (more than 10 prescription medications). These members are referred for Drug Therapy Management review by a licensed Doctor of Pharmacy and a care manager.

Claim review is also used to identify events that need additional follow-up, such as a new prescription for ADHD medication or a missed refill for an asthma medication. These events trigger an outreach call by the Rapid Response team to coordinate needed services, provide educational reminders and identify/address any barriers to care. LOINC data may indicate a new pregnancy complication, which triggers re-assessment by the Bright Start team.

Member and caregiver requests

Members may also be identified through request either by the member themselves or caregivers by:

- Calling directly into Member Services or RROT.
- Being contacted during outreaches to members through RROT for care gaps,
- Being contacted during our outreaches for care management if a sibling or parent in the family has a need.
- Receiving educational mailings with our contact information.
- Receiving reports from 24/7 Nurse Call for member-initiated after-hours calls followed by referral received by care manager.
- Requesting services through our website.
- Requesting services while they are attending community events.

Provider referrals

Physicians and other providers may refer members into care coordination programs through the Let Us Know program (see above for description and below for examples), by calling directly into Member services or RROT, referrals through our Provider Web Portal or referrals through the account executives.

Member follow-up through "Let us Know"

The PCP office for Luke and Ryan, 8 and 12 year old members who were missing appointments, called to ask for assistance. The RROT care connector reached out to the boys' parent with no response to four outreach calls. The case was forwarded to the COS team. The COS worker went to the parent's address and was able to speak with the boy's mother and connect her to the RROT care connector. The mother explained that she had not taken the children to appointments because she was taking care of her mother who was on dialysis. She allowed the RROT care connector to assist her in scheduling appointments for the well visits of both children. Later, the mother was reminded of the appointment by the care connector. She did attend the appointment and the well visit was completed successfully.

9.1.6 Care Plan Development

1. Describe in detail how person-centered care plans will be developed for each member.

AmeriHealth Caritas uses a person-centered care plan approach where each care plan has two main objectives. The first objective is centered on the member achieving a maximum level of self-management for their health condition(s), and social and environmental needs. The second objective is centered on how the care manager will guide and assist the member to reach self-management goals, and at the same time, educate, assess and move the care plan forward.

All AmeriHealth Caritas Iowa care management staff are trained in cultural sensitivity and preferences, motivational interviewing and strength-based planning. These skills assist the care manager to develop a plan focused on things that are important to the member. Care managers work with the member to select and prioritize goals. They also employ techniques from minimally disruptive medicine research to avoid overwhelming the member and caregiver with multiple tasks and changes at the same time.

The care manager will begin by eliciting the primary concern of the member. The first step for each situation is to identify the member's biggest concern with the member's current health state. That concern may not be related to the issue identified in the member's assessment findings and utilization data. The care manager will ask the member to identify personal goals, as opposed to healthcare goals. By focusing on the member's concerns, like wanting to walk a child to school or go dancing with friends, the care manager can address items like nutrition for healing of a foot wound or proper use of asthma medication. Once plans are in motion to address the member's personal goal, the care manager will work toward addressing additional issues revealed in the assessment findings and utilization data. For each intervention, the care manager will focus the discussion on how the particular intervention will benefit the member.

2. Describe how the care plan development process will be individualized and person-centered.

Our individualized, person-centered care plan empowers the member to take charge of their treatment, choose who is on the treatment team, establish and prioritize goals on the individualized plan of care. The member determines what "success" is for them. To elicit the member's goals, we use open-ended questions and frame questions beyond just the scope of healthcare, asking about things the member would like to see changed. We then assist the member to identify small steps and changes that will move them toward that goal.

We incorporate healthcare elements in the plan in terms of how they will support the member's goal. For example, a member who wishes to spend time playing with her grandchild may identify that she could spend more time if she was less short of breath. This will lead to a discussion of mechanisms to reduce shortness of breath associated with the member's COPD.

We use motivational interviewing techniques to form a collaborative conversation for strengthening a person's own motivation and commitment to change. The goal is to more effectively help members get the care they need when they need it the most. Motivational interviewing is another integrated care management tool that treats the whole person and considers the unique needs of each individual. It focuses on a member's motivation and commitment toward changing unhealthy behavior.

Motivational interviewing is based on collaboration, not confrontation. It is designed to strengthen an individual's motivation for, and movement toward, a specific goal by eliciting and exploring the person's own reasons for change. Our care managers evoke an individual's own thoughts rather than imposing the care manager's ideas. The power for change rests with the member rather than the care manager.

AmeriHealth Caritas conducted intensive, interactive two-day on-site training programs for care managers on how to use motivational interviewing effectively. We also developed a train-the-trainer approach — cultivating clinical trainers and other staff as future motivational interviewing trainers. Feedback has been overwhelmingly positive.

So far, more than 300 Care Management associates in Pennsylvania, South Carolina, Louisiana, District of Columbia and Indiana have completed motivational interviewing training and training continues to expand.

As an example, early in 2014 our associate Chris was serving as an integrated care manager for Select Health. He worked with Jane, a member with poorly managed diabetes, to schedule her diabetes follow-up appointments. Having completed motivational interviewing training, Chris used reflective listening and open-ended questions to further explore Jane's concerns with visiting her primary care doctor to address her uncontrolled diabetes.

"Jane was using the word 'uncomfortable' when discussing how she felt leaving her house to go to the doctor," Chris said. "I used the stronger word 'afraid.' After a brief pause, Jane agreed she was fearful of leaving her home, but also concerned she was not seeing her doctor. She acknowledged behavioral health problems were her biggest barrier to care."

Rather than offer unsolicited advice, Chris 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 Chris, without any prompting, why she had protein in her urine and how she could better protect her kidneys. Chris again asked permission to offer advice and helped her understand the consequences of uncontrolled diabetes, the qualities of medications that protect the kidneys and the importance of medication compliance.

"I only used a few of the basic tenets of motivational interviewing and saw immediate results," said Chris, who now is a motivational interviewing trainer in corporate clinical systems. "Our relationship improved. I continued exploring Jane's perceived barriers and advocated the benefits of change — change that offered hope and energy for her future."

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3. Describe how the care plan development process will incorporate findings of the initial health risk screening, comprehensive health risk assessment, medical records and other sources.

The care plan development process incorporates all finding of the initial health risk screening, comprehensive risk assessment, medical records and any other information AmeriHealth Caritas Iowa has incorporated in the member's records. It is important to leverage this prior information in order to build the most informed and personalized care plan. We make this information available through our Jiva care management platform.

The initial health risk screening is stored in Jiva, and this information is readily available and reviewed by the care coordinator prior to contacting the member for the initial care management comprehensive review. This information provides the foundation for the member's initial discussion with the member.

Additionally, Jiva allows the care manager instant access to medical, pharmacy and behavioral health claims data along with inpatient and outpatient authorization information. The system includes information on medication refills, gaps in care, identified conditions and dates of last PCP appointments. Information on inpatient and ER visit information are at the care manager's fingertips. All of this information is reviewed prior to contacting the member. We then have a "picture" of the member's health status when we call or visit the member and can devote our time with the member to uncovering new information and working forward on a plan, versus recapping information that is already known to AmeriHealth Caritas Iowa.

During the comprehensive health risk assessment the care manager collects additional information related to health status and history, functionality, mental health and behavioral health, psychosocial issues, life planning, cultural linguistic, visual and hearing needs, caregiver resources, knowledge of plan benefits and community resources, barriers to care and cognitive function. All of this information is extremely important in understanding the member's needs and strengths.

Our Providers are our partners, and they are a critical component to our ability to improve the overall health and wellness of individuals, families and communities, while at the same time, reduce healthcare costs for individuals and the overall healthcare system. 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 health care Provider about their overall health and wellness and comprehensive care plans. Theranos' revolutionary lab service platform uses dramatically smaller samples than traditional labs, with samples collected from both capillary draws and traditional methods. Results are returned much faster than industry averages, with the overwhelming majority of results reported within 24 hours of sample collection. We are empowering our Members to fully engage in their healthcare. It is important that our Members and their healthcare Providers have the information they need, when they need it, to develop personal healthcare plans and make healthcare decisions.

Information from the providers involved in the member's care is also collected to provide insight into the members' needs and treatment plan from the provider's perspective. In most cases, the care manager will arrange a time to speak with the physician or clinician involved in the member's care. In some cases, the provider may designate a member of the practice to serve as that communication point.

Using all of the gathered data as a backdrop, the care manager engages the member and, as appropriate the member's family/representatives, in dialogue around the member's goals and aspirations. By starting the care plan process as a means to meet a need identified by the member, the care manager begins to develop a trusting relationship, which is critical to ongoing engagement in the process. The care manager

will ask permission to offer options on activities (based on the needs and strengths identified during the assessment process) that will assist the member in meeting the identified goal(s).

4. Submit a sample care plan for each proposed risk stratification level.

Wellness, prevention and low risk

Care plans for members whose needs are based on reminders for preventive health services, healthy behaviors and basic condition management are generated upon completion of the initial health risk assessment. A sample plan is included within Attachment 9.1.6-A.

Catastrophic care management

Care plans for members receiving individual care management services, including LTSS, are generated by the care management team. The topics addressed in the care plan are prioritized to match the member's goals and preferences. Care is taken not to overwhelm the member by entering large numbers of problems and tasks into the initial plan of care. As one goal is met, additional goals and activities are added. Depending on the capacity of the member and the member's support system, the steps and pace at which the plan can advance may be slow. Progress on health-related goals may be impeded by other social determinants of health and other events in the member's life.

Long-term support services

In addition to the complex care management care plan described above, members eligible for LTSS receive a comprehensive service plan, describe in Section 4 of this response.

Example care plans

See Attachment 9.1.6-A (at the end of this section) for example care plans.

Tracy 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 (nine) 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. Tracy 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 eight-month old child. Tracy is easily overwhelmed. She recently stopped smoking. Tracy has a history of non-compliance with specialist and PCP appointments, lab work and diagnostic tests due to her agoraphobia and anxiety.

The care manager began by establishing a rapport with Tracy, slowly helping her through her fears. On several occasions, Tracy 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 Diagnostics to do blood draws at the home to foster compliance with the ongoing blood tests necessary to manage Tracy's warfarin (anticoagulant) medication.

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

Tracy successfully completed the visit — her first in years. Next, Tracy and the care manager are working on a visit to the specialist.

5. Describe how you will ensure that there is a mechanism for members, their families and/or advocates and caregivers, or others chosen by the member, to be actively involved in the care plan development process.

In order to develop the most effective care plan, AmeriHealth Caritas Iowa believes it is important to encourage the involvement of members, families/caregivers, advocates or others chosen by the member to be actively involved in the care development process. To do this, we work closely with the member to develop the plan in the way that is best for them. We work with the member to understand their preferences in terms of care plan team, care plan development location, and actual goals and steps in the care plan.

First, the member will always be given the option to include whomever they wish when developing the care plan. Next, the plan will offer the option of conducting care plan development either at the member's home or onsite at a provider's office. Finally, the members will be involved in the actual care plan develop by choosing and prioritizing goals. This is a core tenet of our care management process. Plans are much more successful when members have worked closely with the plan development. Lastly, we view care plan development as a conversation across all the parties involved to build plan that best meets the needs of the member and will be supported by the member, along with the member-chosen family members, caregivers, providers and advocates.

6. Describe how you will identify other caseworkers to be included in the care plan process and how services will be coordinated to avoid duplication and/or fragmentation of services.

AmeriHealth Caritas has great experience coordinating other services in the community. AmeriHealth Caritas Iowa is committed to creating a coordinated care plan across caseworkers to help ensure the best outcome for the member. The first step is identifying other caseworkers to be included. AmeriHealth Caritas Iowa uses keywords in Jiva to identify members with community caseworkers. With the member's approval, our goal is to always include the caseworker in the care plan process.

AmeriHealth Caritas works with the member and family/caregiver to identify caseworkers. We also work with other providers / practitioners that are involved in the members care to identify caseworkers. We believe it is important to establish relationships and bi-directional contact points to facilitate communication with other case workers. We will work with other case workers when creating the care plan and share the final plan with other caseworkers. All services the member is receiving and the source of that service will be included on the service plan. This means that there will be one compilation for all care the member is getting and will ensure we do not duplicate services. As appropriate, we will follow-up with other caseworkers as working through the care plan.

Coordinating with other care workers

At the request of a waiver coordinator, the care manager became involved in the case of Christian, a 6-year-old male adopted from foster care, who was born prematurely and had a feeding tube, a tracheotomy

and mental retardation. Christian was receiving home support services through a waiver Monday through Friday, 6:30 a.m. to 3:30 p.m. The mother had also adopted Christian's brother, another special needs child. When the care manager contacted the member's mother, she was in tears. She had been told by the waiver coordinator that the nursing services were being cancelled, although the waiver case worker did not know why and had been unable to resolve the issue.

The AmeriHealth Caritas care manager contacted the agency coordinating the care. When she was unable to make contact, she escalated the issue to the supervisor. Following an investigation into the member's file, the agency determined that at the time of the last review, the case was coded incorrectly, which resulted in a cancellation of the waiver services. The care manager was able to have the services reinstated with no break in coverage.

By working collaboratively with personal care agencies, one of our care managers was able to quickly reinstate medically necessary home services for this 6-year-old boy.

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7. Indicate how you will ensure that clinical information and the care plan is shared with the member's PCP (if applicable) or other significant providers.

AmeriHealth Caritas Iowa has several mechanisms available to share clinical information and the member's care plan with the PCP.

Member clinical summary

Through our secure Provider Web Portal, the PCP can access a claim-based MCS, which details the following information:

- Current medications the member filled, including fill date, dosage, prescribing physician name and pharmacy name.
- Clinical conditions associated with the member.
- Inpatient admission information, including date of admission, facility and diagnosis.
- Emergency room visit information, including date of visit, facility and diagnosis.
- Physician visit history, including date of visit, physician name, physician specialty and diagnosis.
- Radiology procedures performed, including date of procedure, procedure description, facility and diagnosis.
- Laboratory results, including date of test, test performed and test result.

For members age 18 and younger, the MCS also includes information on EPSDT services, including:

- Immunization information, including immunization descriptions and data received.
- Screening information, including screening type (e.g., well visit, vision, hearing, dental).

The MCS is available as a PDF file which can be printed, and a CloneCD, which can be uploaded into the provider's electronic medical record.

AmeriHealth Caritas

Member Clinical Summary

Date of Report: 05/10/2015

Member Information

Name : [redacted]
Address1 : [redacted]
Address2 :
City/St/Zip : [redacted]
Phone : [redacted]
Gender : [redacted]
DOB : [redacted]
Member ID : [redacted]

PCP Information

Provider Name : STELLA VICTORIA G.
Address1 : 145 N 6TH ST 2ND FL
Address2 :
City/St/Zip : Reading, PA 19601-3096
Phone : 610-378-2440

Medications (within past 06 months)

Fill Date	Name & Strength	Days Supply	Prescriber Name	Pharmacy Name
5/6/2015	ACETAMINOPHEN-COD #3 TABLET	10	Sandhya Prasad	RITE AID PHARMACY 01581
5/6/2015	PAIN RELIEVER 500 MG CAPLET	30	Sandhya Prasad	THE COMMUNITY PHARMACY
4/20/2015	VITAMIN B-6 50 MG TABLET	20	Dawn M Liberto	PENN PHARMACY
4/20/2015	PROMETHAZINE 12.5 MG TABLET	7	Dawn M Liberto	PENN PHARMACY
3/7/2015	BETAMETHASONE DP AUG 0.05% CRM	30	Kristi L Hackman	RITE AID PHARMACY 01581

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)

Date	Provider Name	Speciality	Reason

There are no data records available for this section

Imaging

Date	Facility	Reason
9/2/2014	CURTIN WILLIAM M.	76819 -Fetal biophysical profile; without non-stress testing
6/23/2014	TESTA CHRISTOPHER J.	7681626-Ultrasound pregnant uterus real time with image documentation follow-up eg re-evaluation of fetal size by measuring
6/23/2014	ST JOSEPH MEDICAL CENTER	76816TC-Ultrasound pregnant uterus real time with image documentation follow-up eg re-evaluation of fetal size by measuring

Exhibit 9.1.6-A: Member Clinical Summary Overview

Member care plan

Through the Provider Web Portal, the PCP can also access the member's care plan. The care plan contains goals, interventions and responsible parties based on the member's prioritization.

Care gap alerts

Additionally, providers entering a member ID number into the Provider Web Portal will receive an alert if that member has care gaps. Care gaps are clinically recommended services based on evidence-based clinical practice guidelines for which there is no claim evidence that the member received the service. We evaluate claim data at least monthly for all members. Care gap algorithms exist for a full range of preventive services and chronic disease states.

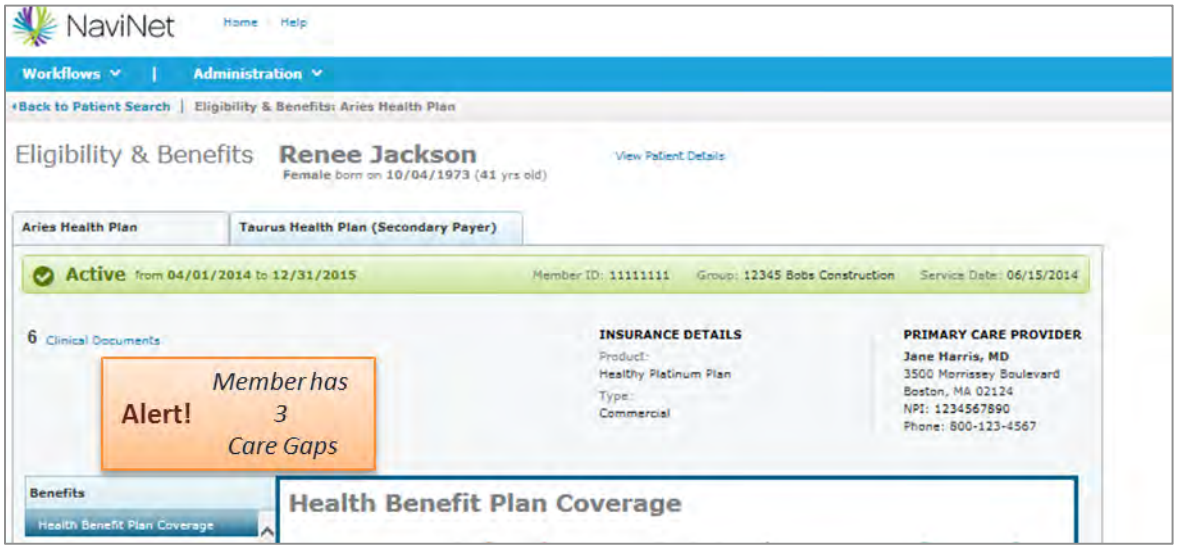

Exhibit 9.1.6-B: Care Gap Alerts Display on the Provider Web Portal

8. Describe how cultural considerations of the member would be accounted for in the care planning process and how the process will be conducted in plain language and accessible to members with disabilities or limited English proficiency.

Cultural consideration

AmeriHealth Caritas Iowa fully recognizes the importance of addressing the needs of members in a culturally competent and linguistically appropriate manner from a philosophy of promoting health equity. This is an integral part of our overarching strategy to deliver person-centered care and reduce health disparities. Accordingly, AmeriHealth Caritas Iowa agrees to continue our successful and consistent practice of ensuring that services are provided to all members in a manner that values, affirms and respects their worth and protects and preserves their dignity.

AmeriHealth Caritas Iowa promotes diversity and inclusion in our efforts to help the underserved and chronically ill stay well and build healthy communities. Among our eight defined organizational values are advocacy, dignity and diversity — elements that are critical in culturally competent care.

Through our comprehensive assessment we collect information on cultural and religious preferences related to healthcare. We identify the member's preferred language by leveraging bilingual staff and interpreters (live and telephonic), though ensuring that the care plan process is conducted in a language that the member is comfortable with. We also tailor our printed materials in different languages and can use a telecommunications device for the deaf (TTD)/teletypewriter (TTY) or an in-person visit with a sign-language interpreter for the hearing impaired.

Finally, we assess for cultural considerations and use a cultural guide to help us understand the differences within cultures. Annually, care managers receive refresher training on healthcare preferences associated with different subpopulations.

All AmeriHealth Caritas Iowa associates are trained upon hire and annually thereafter in Culturally and Linguistically Appropriate Services (CLAS) standards and health equity. This helps engrain our philosophy throughout the organization so that all associates are empowered to help members receive equal access to care. We also provide this training to our physician and dental communities. Recently, the Medicaid medical director for the State of Louisiana requested our CLAS training materials to share with her staff.

Use of plain language

Where ever possible, our care managers use non-clinical terms when discussing health issues and developing care plans with the members. We understand the relationship between low health literacy, poor health outcomes and the associated impact on healthcare costs. Members with low health literacy — those who cannot read, understand or act on health information and instructions — face multiple health risks. Confusion about or lack of healthcare information may result in poor control of chronic illnesses, more hospitalizations and longer lengths of stay, and improperly taken medications.

All of our written materials adhere to literacy and plain language guidelines. We follow a documented process to produce all communication materials in accordance with cultural competency and literacy requirements. Materials are available in alternative formats to members with specialized needs. Strategies that help us accomplish this include:

- Using simple vocabulary to convey information and minimizing the use of medical jargon.
- Using language that is at or below a sixth-grade reading level.
- Choosing appropriate design formats that maximize white space and include easy-to-read fonts and layouts.
- Translating materials into Spanish, Vietnamese and other alternate languages.
- Making materials available in alternate formats (e.g., large print, Braille, compact disc, audiotape).
- Testing our materials with member focus groups.
- Using diverse graphics on materials to engage members.

AmeriHealth Caritas Iowa's member materials are developed by associates who undergo annual training in cultural competency and are instructed in health literacy and reading-level requirements. Our writers use a toolkit adopted from the work of the Partnership for Clear Health Communication at the National Patient Safety Foundation to ensure that our communications to members are easy to understand and culturally competent.

Members with disabilities

For members who are unable to communicate their needs through spoken words, we use a variety of techniques to ensure their inclusion in the care planning process. Care managers can use chalkboards or picture/word boards to understand member preferences and goals for non-verbal members. For members

who are hearing impaired, sign-language interpreters or TTD/TTY systems can be used to conduct the conversation.

Members with limited English proficiency

For members who are not proficient in English, interpreters or bilingual care management staff are used to conduct care planning conversations. For in-person conversations, the interpreter will be brought to the meeting, when possible. For language needs that are not common in the population, AmeriHealth Caritas Iowa will employ the services of Language Services Associates to provide real-time language interpretation. Language Services Associates is able to provide interpretation services in over 200 languages.

In addition, AmeriHealth Caritas Iowa will translate written materials into needed languages. Many materials are already available in Spanish. We contract with a translation service capable of translating materials into over 100 languages.

AmeriHealth Caritas Iowa maintains a current demographic and cultural profile of our members. We use this profile to plan services accordingly. AmeriHealth Caritas Iowa will continually monitor the special needs of our members by reviewing monthly demographic reports that include racial, ethnic and preferred language information.

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, we provided interpreter services for over 58,000 member interactions. The top 10 languages requested appear below and provide insight into the depth of services we can offer:

- Spanish.
- Arabic.
- Mandarin.
- Haitian Creole.
- Gujarati.
- Vietnamese.
- Korean.
- Russian.
- Portuguese.
- Cantonese.

For additional information regarding these Member Services, please see our response in Section 8.2.

Success story: Meeting a member's language needs

Our care manager reached out on behalf of Mariam, a member of our affiliate plan in Louisiana, who was pregnant. The only contact number available belonged to Mariam's husband. After the care manager attempted several times to contact the member's husband without success, he called back when he was with Mariam. The care manager got permission from Mariam to speak with her husband about her care. The care manager learned that Mariam speaks only Urdu, but her husband speaks English.

The husband related that he was having trouble getting Mariam's progesterone prescription refilled. The care manager related that prior authorization may be needed from Mariam's doctor. The care manager called PerformRx℠, our prescription benefits manager, and after confirming that prior authorization was needed, reached out and left a message with Mariam's doctor.

The care manager then followed up with Mariam's husband to let him know the status. He informed the care manager that Mariam was seeing a different doctor as a result of a complication with her pregnancy. He provided the name of the new doctor. The care manager indicated that she would call the doctor,

inform him of the need for prior authorization of the prescription and get back in touch with Mariam's husband.

During this conversation, Mariam's husband expressed his concerns about interpreting for his wife. The care manager reassured him that she would use the services of an interpreter. Satisfied that Mariam would be able to communicate her needs to the care manager through this means; her husband gave the care manager Mariam's personal cell phone number.

The care manager called the doctor's office to provide prior authorization instructions and followed up once more with Mariam's husband. She let him know that he could call the doctor's office for further instructions or reach out again to the care manager with any problems. He expressed his gratitude for all of the assistance in getting the medication refilled.

Utilizing the Urdu language line, the care manager then reached out to Mariam directly to engage her in her care and learn of any other needs she had. Mariam agreed to have educational materials mailed to her In Urdu. The case manager reached out to the plan's CLAS coordinator to request translation of materials into Urdu for Mariam. The team arranged for the translation into Urdu for the Welcome Packet, as well as educational materials targeted to Mariam's needs, including "Fetal Kick Count" and "Understanding Pre-term Labor." These were then mailed to Mariam.

The care manager reached out to Mariam again after she delivered her baby. Mariam confirmed that she had received the translated materials and offered her thanks.

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9. Describe how the proposed care plan process will include a system to monitor whether the member is receiving the recommended care

In addition to developing a sound person-centered care plan, AmeriHealth Caritas has a process in place to monitor whether the member is receiving the recommended care. Within our care plan, we place reminder follow-ups to review activities and interventions the member or the care manager is providing to the member.

- Our population health management system, Jiva, has the ability to set follow up dates to review the care plan outcomes with the member. For members receiving in-home services, we will review satisfaction with services and timely delivery of services.
- We mine our member data to generate care gaps for services recommended based on age, gender and condition for which there is no evidence of completion. These gaps are disseminated through our alert system (populating the member service, care management and Provider Web Portal systems). This triggers outreach, including automated calls and text messages, and is also detailed on provider reports to enable PCP and Health Homes practices to best manage their populations.
- With our PBM services, we monitor prescription refill timeliness for key medications and trigger outreach when the refill is not obtained within seven days of being due
- For members receiving in-home LTSS, we plan to contract with providers who utilize electronic visit verification systems. Per AmeriHealth Caritas standards, visit completion data will be reviewed weekly by the AmeriHealth Caritas Iowa care management team.

9.1.7 Tracking and reporting

1. Describe how you propose to track and report on care coordination programs and share care coordination information with the member, authorized representative and treatment providers.

Tracking and reporting is an important step in care coordination in order to help achieve the best outcomes for members. AmeriHealth Caritas Iowa has the ability to track the results of the initial health risk screening, comprehensive health risk assessment, the care plan, member outcomes and has the ability to share care coordination information with the member, their authorized representatives and all relevant treatment providers.

Program-level data

AmeriHealth Caritas Iowa tracks, evaluates and reports several data elements at the program level:

- Participation rates are tracked by calculating the number of members enrolled in a program segment divided by those who were identified for the program.
- Members with an active care plan are assigned an acuity level based on the level of contact and services needed to support the member's plan of care.
- HEDIS outcomes are used to monitor clinical guideline adherence and health outcomes.
- EPSDT participation.
- Cost and utilization reports.
- Member and provider satisfaction with program services.

PCPs receive additional program-level outcome data specific to their assigned members through panel-level outcome reports. These reports show outcomes for key program metrics, such as preventive care and diabetes management, and comparative rates for a peer group of physicians. Similar reports are also produced for cardiologists and obstetricians.

Annually, AmeriHealth Caritas Iowa will perform a comprehensive evaluation of its care coordination programs to identify successful strategies and areas where opportunities exist for improvement. This information is used to guide and inform program changes in the subsequent year.

Highlights of the program-level evaluation are shared with AmeriHealth Caritas Iowa members, representatives and providers through a Report to the Community.

Member-level care coordination

Information related to care coordination plans and activity for individual members is shared through several mechanisms, including our secure Web portals, care management team meetings, and, upon request, mailed paper documents.

Member access

Members and caregivers/representatives authorized by the member can access clinical information on the Member Clinical Summary (MCS) (described in Section 9.1.6.7, above) and the member's care plan. The MCS contains information on identified conditions, missing or overdue services (care gaps), recent inpatient admissions and emergency room visits, medications received from the pharmacy, specialty type and visit dates for providers involved in the member's care, radiology procedures, and key laboratory

results. For pediatric members, the MCS also contains a list of all immunizations and EPSDT screenings in the claim history.

The care plan contains the goals identified by the member and the agreed upon steps to meeting those goals, along with start and target end dates. The care plan also lists members of the care team, emergency contacts and information on community service organizations supporting the plan. Members and their representatives can also submit notes related to the care plan for the care manager to review. Both documents are formatted for printing.

For members who do not have access to the Member Portal, or who request to have hard copies of the documents, the care manager will arrange to mail or deliver copies.

PCP and specialist access

PCPs and specialists involved in the member's care can access the same set of documents (Member Clinical Summary and care plan) through the secure Provider Web Portal. All participating providers have access to the MCS from the member's eligibility screen. This access allows providers who are seeing a member for the first time or treating a member in the emergency room to have information on the member's medical history and medications at their fingertips. The medication refill dates on the MCS is also valuable to physicians (PCPs and specialists) who are trying to understand if the reason a medication is not having the desired effect is that the patient requires a higher dose or the patient is not filling the prescription.

Access to the member's care plan is granted based on a link to the provider in the member's plan of care. PCPs are automatically linked to the care plan. Specialists are added as care team members by the care manager during the care plan development process with the member. Once added as a care team member, the specialist can access the member's plan of care through the secure Provider Web Portal and submit notes related to the care plan for the care manager to review.

Behavioral health provider access

Behavioral Health providers have the same access to the MCS and the care plan as other specialists. They are able to access the MCS from the member's eligibility screen. Once added, with the member's consent, as a care team member, the behavioral health provider can access the member's plan of care and submit notes related to the care plan for the care manager to review.

Other providers and community organizations

The AmeriHealth Caritas Iowa Member Portal also provides access to the member's care plan for other providers and community organizations that are identified as part of the member's care team. With agreement from the member, the care manager will add the provider/community organization representative to the care team record in Jiva. Once added, the representative can access the member's plan of care through our secure portal and submit notes related to the care plan for the care manager to review.

2. Describe the system that you will use to integrate and share information about members in order to facilitate effective care coordination

Our care management information system, Jiva, is used to integrate and share information about the member to facilitate care coordination. Jiva integrates care management, utilization records and clinical data. The system contains claim history, assessment responses, care plan goals, interventions, barriers and problems, authorization history, blood test results, medication history, care gaps and call records.

The Jiva application is a collaborative healthcare management platform for case and disease management, preventive health (EPSDT) and utilization management. Jiva serves as the core system of our Integrated Care Management program. Jiva's extensive capabilities, coupled with our robust analytic and data mining capabilities, form a comprehensive care management information system. Highlights of our system capabilities include:

- Defined business rules that automatically evaluate care requests to determine whether the request should be approved or pended for further review.
- Clinical rules for clinical consistency in care management processes, based on evidence-based medicine, reference materials, industry-standard best practices and physician expertise.
- Identification and stratification of target patients and populations to set appropriate levels of intervention and improvements for a member's care.
- Integrated access to medical, pharmacy, lab and behavioral health data to provide a 360-degree view of the member.
- A series of care management clinical pathways that enable the efficient implementation of our holistic approach to the management of chronic conditions, pregnancy, pediatric preventive care and quality management initiatives that reduce costs and improve the health outcomes.
- Comprehensive outreach pathways that incorporate current member needs, health reminders and missed service strategies.
- Integrated correspondence that allows automatic generation of customized faxes, letters and email based on approved letter templates.
- Robust reporting templates and the ability to create ad hoc reports for care management data.
- Provider Web Portal interface allowing providers to create, update and view information on medical necessity authorizations and determinations.
- Clinically validated care gaps and electronic health records derived from claims and care management data.
- Through Jiva's workflow capabilities, care managers can set reminder activities to ensure care plan follow-up and add activities to the member's plan of care to prompt other members of the care team to complete work, such as schedule transportation or call with an appointment reminder. The system's 360-degree view of the member puts all available data at the fingertips of care team members.
- Sensitive messaging functionality allows care team members to place an alert on the member's record to notify anyone reviewing the record of key information, including changes in guardianship and information sharing restrictions. Screen displays visually alert care team members to changes in the member's status, such as admission to the hospital.
- Access to Jiva is integrated in our secure Provider Web Portal, providing seamless entry for users without the need to re-enter user ID and password information. Through Provider Web Portal, providers can access key member information including the member's care plan and submit notes related to the care plan for the care manager to review.

9.1.8 Monitoring

1. Describe your care coordination monitoring strategies.

AmeriHealth Caritas Iowa performs ongoing monitoring of the care coordination program at the program level, member level and care team level. Results from monitoring activities are used to drive improvement activities.

- **Care management caseloads** — The number of cases and case-load acuity weight is reviewed weekly for each care manager. This activity allows the care management supervisors to direct referrals and make assignment adjustments to ensure that a care manager has the capacity to meet the care management needs of the assigned members.
- **Care management audits** — On a quarterly basis, a sample of care management case documentation, including assessment timeliness, care plan content and currency, and outreach frequency, are audited for each care manager. Results are used to provide individual coaching and education for care managers, as well as to identify education opportunities for the whole team.
- **Motivational interview coaching** — On a quarterly basis, a motivational interview coach listens to interactions between the care manager and the member. Feedback on the use of motivational interviewing techniques is provided to the individual care manager to strengthen the care manager's skill set.
- **Health outcomes** — Monthly and annual health outcome data is collected and reviewed to monitor the impact of care coordination interventions. Where possible, industry-accepted metrics are utilized, including HEDIS, CHIPRA and PPEs.
- **Process monitoring** — Weekly reports are used to monitor key process steps, including new member assessment completion, overdue care plan activities and LTSS member contacts.

Annually, a comprehensive evaluation of the Integrated Healthcare Management program is conducted for each segment of the program, including pediatric preventive health (EPSDT), Bright Start, complex care management, women's health and LTSS. Outcomes and recommendations are reported to the Quality of Clinical Care Committee and the Quality Assessment Performance Improvement Committee.

2. Describe how case specific findings will be remediated.

During our monthly departmental review, we look and set timelines for areas of improvement. The monthly review includes case audit results, program challenges and plans to improve operations. For example, during a recent review, an affiliate Pennsylvania health plan identified that the existing staff structure and caseloads were not providing enough time to conduct needed new assessments. In response, they were restructuring their care management positions to dedicate one care manager to just handle new assessments.

In addition, each year after the program's annual review, at least two opportunities for improvement are identified, and interventions are put in place to address those areas. During the last year, these efforts have resulted in the expansion of care management into the community through placement of additional embedded care managers and the launch of four Community Care Management teams. In addition, a motivational interviewing coach position was created and hired to strengthen staff skills for this important technique.

9.1.9 Reassessment

1. Describe in detail your process for reviewing and updating care plans.

Care plans are reviewed and updated on an as needed basis, at a minimum each time a member is contacted. Care plans are updated no less than annually. Members or providers can also request reassessment. Additionally, outside of normal contact, there are several triggers that immediately move a member to a more assertive level of care, including a new diagnosis, an inpatient admission or an emergency room contact.

Jiva includes a system to set timeframes for the next contact with the member. The system automatically places those activities on a calendar on the care manager's work screen. The care manager can block days on the calendar when he/she is not available, so that activities are not scheduled during those times. Supervisors can also access the calendar for care managers on their team. This allows the supervisor to reassign planned contacts for care plan reevaluation when the care manager is unexpectedly not available.

Members who experience an event, such as an inpatient admission or an ER visit are flagged in the system with the addition of a visual "widget" to the member screen. In addition, the system automatically creates a care management activity that is placed on the care manager's work list with an urgent priority level. This alerts the care manager that the member needs to be contacted for reassessment and adjustments to the plan of care.

Gerri is a one-year-old with Stickler syndrome (congenital face and eye abnormalities, joint pain and hearing loss) and gastric reflux. Her care manager connected Gerri's mother to WIC and food stamp programs to bring additional nutrition in the home, and Healthy Families and First Steps programs for additional support and monitoring. She continued contact with Gerri's mother to follow up on Gerri's attendance at well child appointments.

During a recent routine call, Gerri's mother was crying on the phone. She told the care manager that the family's home burned down the night before. Three of their dogs died in the fire. Fortunately, the mother, her boyfriend and Gerri's maternal grandmother escaped without harm. The family was staying next door with a relative.

The care manager contacted the local county Salvation Army, local Red Cross Chapter, local churches and other community organizations. Since Gerri's mother was so upset, the care manager, with the mother's consent, made the calls on behalf of the family.

A few days later, in a follow-up call, Gerri's mother related that she had received positive responses from many of the connections, and had already received assistance from the Red Cross, Salvation Army and a local church. She was also contacting WIC to replace the vouchers lost in the fire. She was making arrangements to move into a trailer and planned to use some of the money from the Red Cross for furniture. The care manager increased the follow-up schedule for Gerri and her mother to ensure that Gerri's appointments were kept and needs were met as Gerri's family continued to adjust to their new circumstances.

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2. Describe the protocol that you will use for re-evaluating members to determine if their present care levels are adequate.

AmeriHealth Caritas Iowa uses a series of assessment tools to re-evaluate members' care levels. At each contact with a member of the Care Management staff, an urgent needs screen is conducted to identify changes in the member's condition and barriers to obtaining services and medications. Positive answers to this short set of questions triggers more in-depth analysis by the care connector or care manager.

In addition, the Care Management team conducts routine re-evaluations using condition-specific monitoring tools, such as the Asthma Control Test. Available for all of the targeted chronic conditions, these tools address important aspects of the evidence-based condition management protocols. Members whose response indicates a change in condition or a gap in services undergo a re-evaluation to identify appropriate care levels.

Care levels are also re-evaluated as members demonstrate improved self-management skills. The care manager will monitor actions the Member is able to complete with lower levels of support. For example, a member who needs to make ongoing appointments with a cardiologist may initially need the care manager to prompt the member and schedule the appointment using a three-way call between the member, care manager and provider office. As the member becomes more confident in his/her ability to take action in support of the care plan, the care manager may just need to remind the member to schedule the appointment. As the member's self-management skills continue to strengthen, the care manager may just need to follow-up to confirm with the member that the appointment was made.

Trigger events also lead to a re-evaluation of care levels. High-risk and LTSS members who are admitted to the hospital are automatically re-evaluated to identify opportunities to augment existing services. For Members eligible for or actively receiving LTSS, AmeriHealth Caritas Iowa's care manager will conduct level of care reassessments in-person, using DHS designated tools, to determine an enrollee's continued functional eligibility for LTSS (HCBS and nursing facility [NF]). These reassessments will occur when the 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 would indicate an earlier reassessment include:

- A transition in care or setting (e.g., hospital to home; hospital to skilled nursing facility [SNF], rehabilitation facility or ICF/ID; SNF, 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 or her designated representative believes that the individual needs to initiate, eliminate, or continue a particular service.

3. Indicate the triggers which would immediately move the member to a more assistive level of service.

There are several triggers that immediate move a member to a more assistive level of service, including:

- Loss or reduction of caregiver support.
- New diagnosis of a chronic or behavioral health condition.
- Inpatient admission for a chronic or potentially preventable condition.
- Pregnancy.
- Pregnancy complication.
- Entry into foster care or guardianship.
- New diagnosis related to EPSDT screening or developmental milestones.

- Catastrophic event, such as a motor vehicle accident or burn.
- Change in functional status, such as a fall or loss of motor function (including mobility and speech).
- Change in ability to manage activities of daily living.
- Change in cognitive status.

As stated earlier, AmeriHealth Caritas' IHM program is a holistic solution that is in-place to provide comprehensive care coordination services. Using our tools and leveraging our expertise, AmeriHealth Caritas Iowa will be able to provide the care coordination services needed to ensure improved outcomes at greater efficiency for DHS and Iowa members.

Attachment 9.1.1-A: Wellsource HRA (example/subset)

HRA 205 Question Set

April 6, 2015

First name

- [Input Box]

Last name

- [Input Box]

When were you born?

- [Input Box]

Are you male or female?

- Male
- Female

What is your race?

American Indian or Alaskan Native

You can be more than one race group. Say "yes" if you have origins in any of the original peoples of the Americas (North, Central, and South America). You maintain cultural identification through tribal affiliation or community attachment.

- Yes
- No

Asian

You can be more than one race group. Say "yes" if you have origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent, such as: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Is

- Yes
- No

Black or African American

You can be more than one race group. Say "yes" if you have origins in any of the black racial groups of Africa.

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- Yes
- No

Native Hawaiian or other Pacific Islander

You can be more than one race group. Say "yes" if you have origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

- Yes
- No

White

You can be more than one race group. Say "yes" if you have origins in any of the original peoples of Europe, the Middle East, or North Africa.

- Yes
- No

Don't know

- Yes
- No

Don't want to say

- Yes
- No

Are you Hispanic, Latino, or of Spanish origin?

You can be any race and also any ethnic origin. Say "yes" if your culture of origin is Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture, regardless of race.

- Yes
- No

Zip code

- [Input Box]

Country

- [Input Box]

How much school have you finished?

The last grade you finished.

- Grade 1-8
- Grade 9-11
- Grade 12 or High School GED
- Some College
- Bachelor's Degree
- Graduate Degree

Which language do you prefer to speak?

- English
- Español
- 中国
- Tagalog
- Français
- tiếng Việt
- Deutsch
- 한국의
- русский
- العربيـــة

How do you rate your health?

- Great!
- Good
- Fair
- Poor

Compared to one year ago, how do you rate your health?

- Much better
- Some better
- About the same
- Some worse
- Much worse

What is your outlook on your future?

- Don't look forward to the future
- Not sure what the future holds
- Hopeful and expect things to work out well

How do you feel about your life?

- Things are very good
- Things are mostly okay
- Things are mostly not okay
- Things are not okay

In the last 4 weeks:

How many days did poor health make you get less done?

Or you did not do as good a job as usual.

- [Input Box]

[CONDITIONAL] How much did your poor health affect you?

Very little: No one noticed a change. Some: You did a worse job, or got less done. A lot: You did at least a third less than normal.

- Very little
- Some
- A lot

How often have you felt stressed?

Stress can make you have tense muscles and headaches, be grumpy, and feel nervous. These can make it hard for you to sleep.

- Never or almost never
- Sometimes
- Often
- All the time

Attachment 9.1.2-A: Comprehensive Assessment — Adult

Initial Assessment — Adults

1. **Who is providing responses to assessment questions? Check all that apply.**

- ☐ Member
- ☐ Spouse
- ☐ Significant other
- ☐ Parent
- ☐ Guardian
- ☐ Caregiver other than parent or guardian
- ☐ Child of adult member
- ☐ Family member
- ☐ Friend
- ☐ Other

Comments:

2. **Is the member willing to participate in the Integrated Care Management (ICM) program? If yes, please read Bill of Rights & Disclosure per LOB policy**

- ☐ Yes
- ☐ No

Comments:

Initial Assessment — Adults

3. Which of these condition(s) is/are the member's primary health concern(s)? Document length of time under each condition. Check all that apply.

- ☐ ADHD/ADD
- ☐ ALS
- ☐ Alzheimer
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Behavioral/Mental
- ☐ Bipolar
- ☐ Bronchiolitis
- ☐ CAD
- ☐ Cancer
- ☐ Cellulitis
- ☐ Cerebral Palsy
- ☐ Chest Pain
- ☐ Chronic Pain
- ☐ Cirrhosis
- ☐ Congenital Anomalies
- ☐ COPD/Emphysema
- ☐ Crohn's Disease
- ☐ CVA/Stroke
- ☐ Cystic Fibrosis
- ☐ Depression
- ☐ Developmental Delay/ Disability
- ☐ Diabetes
- ☐ Drug Overdose
- ☐ End Stage Liver disease
- ☐ ESRD/CRF
- ☐ Failure to Thrive
- ☐ GERD
- ☐ Hearing Impaired
- ☐ Heart Failure
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV/AIDS (self disclosed)
- ☐ HTN
- ☐ Hyperlipidemia
- ☐ Lymphedema
- ☐ MI
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Pancreatitis
- ☐ Panic Disorder
- ☐ Para/Quadriplegia
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Pregnancy
- ☐ Pre-term labor
- ☐ Psychosocial needs
- ☐ PTSD
- ☐ PVD
- ☐ RAD
- ☐ Respiratory Failure
- ☐ Rheumatoid Arthritis
- ☐ Schizophrenia
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ Spina Bifida
- ☐ Substance Abuse
- ☐ Technology Defect
- ☐ Transplant
- ☐ Traumatic Brain Injury
- ☐ Ventilator Dependent
- ☐ Vision Impaired
- ☐ Other

Comments:

Initial Assessment — Adults

4. What are the member's past health condition(s)? Document length of time next to each condition. Select all that apply. Refer to question #3-same responses.

- ☐ ADHD/ADD
- ☐ ALS
- ☐ Alzheimer
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Behavioral/Mental
- ☐ Bipolar
- ☐ Bronchiolitis
- ☐ CAD
- ☐ Cancer
- ☐ Cellulitis
- ☐ Cerebral Palsy
- ☐ Chest Pain
- ☐ Chronic Pain
- ☐ Cirrhosis
- ☐ Congenital Anomalies
- ☐ COPD/Emphysema
- ☐ Crohn's Disease
- ☐ CVA/Stroke
- ☐ Cystic Fibrosis
- ☐ Depression
- ☐ Developmental Delay/Disability
- ☐ Diabetes
- ☐ Drug Overdose
- ☐ End Stage Liver disease
- ☐ ESRD/CRF
- ☐ Failure to Thrive
- ☐ GERD
- ☐ Hearing Impaired
- ☐ Heart Failure
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV/AIDS (self disclosed)
- ☐ HTN
- ☐ Hyperlipidemia
- ☐ Lymphedema
- ☐ MI
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Pancreatitis
- ☐ Panic Disorder
- ☐ Para/Quadriplegia
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Pregnancy
- ☐ Pre-term labor
- ☐ Psychosocial needs
- ☐ PTSD
- ☐ PVD
- ☐ RAD
- ☐ Respiratory Failure
- ☐ Rheumatoid Arthritis
- ☐ Schizophrenia
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ Spina Bifida
- ☐ Substance Abuse
- ☐ Technology Defect
- ☐ Transplant
- ☐ Traumatic Brain Injury
- ☐ Ventilator Dependent
- ☐ Vision Impaired
- ☐ Other

Comments:

Initial Assessment — Adults

5. What current treatments does the member receive?
Document when treatment began and expected length of time under each selected item.
Select all that apply.

- ☐ None
- ☐ Behavioral Health Therapy
- ☐ Substance Abuse Treatment
- ☐ Cardiac Rehab
- ☐ Dietary Restrictions
- ☐ DME
- ☐ Home Health Care
- ☐ Medication Management
- ☐ Occupational Therapy
- ☐ Oxygen
- ☐ Physical Therapy
- ☐ Skilled Nursing
- ☐ Speech Therapy
- ☐ Wound Care
- ☐ Other

Comments:

6. What past treatments has the member received?
Document when treatment was received under each selected item. Select all that apply.

- ☐ None
- ☐ Behavioral Health Therapy
- ☐ Substance Abuse Treatment
- ☐ Cardiac Rehab
- ☐ Dietary Restrictions
- ☐ DME
- ☐ Home Health Care
- ☐ Medication Management
- ☐ Occupational Therapy
- ☐ Oxygen
- ☐ Physical Therapy
- ☐ Skilled Nursing
- ☐ Speech Therapy
- ☐ Wound Care
- ☐ Other

Comments:

Initial Assessment — Adults

7. How often does the member see their primary medical provider?

- ☐ Weekly
- ☐ Twice a month
- ☐ Monthly
- ☐ Every two months
- ☐ Every three months
- ☐ Every six months
- ☐ Yearly
- ☐ As needed
- ☐ Other

Comments:

8. Does the member receive care from a specialist(s)? Select all that apply.

- ☐ Yes
- ☐ Adolescent Medicine
- ☐ Cardiologist
- ☐ Dentist/Oral Surgeon
- ☐ Dermatologist
- ☐ Developmental Pediatrician
- ☐ Endocrinologist
- ☐ ENT
- ☐ Gastroenterologist
- ☐ OB/GYN
- ☐ Hematologist/Oncologist
- ☐ Infectious Disease
- ☐ Neonatologist
- ☐ Nephrologists
- ☐ Neurologist
- ☐ Nutrition/Wt Management
- ☐ Oncologist
- ☐ Ophthalmologist
- ☐ Orthopedic
- ☐ Pain Management
- ☐ Perinatologist
- ☐ Psychiatrist/Therapist
- ☐ Podiatrist
- ☐ Pulmonologist
- ☐ Rheumatologist
- ☐ Surgeon
- ☐ Wound Care
- ☐ Other
- ☐ No

Comments:

Initial Assessment — Adults

9. What surgeries has the member had?
Document when surgery was performed under each selected item. Select all that apply.

- ☐ None
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Bariatric Surgery
- ☐ Bone Marrow Transplant
- ☐ Breast Biopsy
- ☐ Carotid Endarterectomy
- ☐ Cataract Surgery
- ☐ Cesarean Section
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Coronary Artery Bypass Surgery
- ☐ Debridement of wound, burn or infection
- ☐ Dilation and Curettage (D&C)
- ☐ Excision of Malignancy
- ☐ Hemorrhoidectomy
- ☐ Hysterectomy
- ☐ Limb Amputation
- ☐ Mastectomy
- ☐ Organ Transplant
- ☐ Prostatectomy
- ☐ Skin Graft
- ☐ Tonsillectomy
- ☐ Total Hip Replacement
- ☐ Total Knee Replacement
- ☐ Tracheostomy
- ☐ Other

Comments:

10. What is the member's most recent height and weight, calculate BMI and select BMI range.

- ☐ Height
- ☐ Weight

Underweight: BMI = < 18.5
Normal Weight: BMI = 18.5 - 24.9
Overweight: BMI = 25-29.9
Obese: BMI = or greater than 30

- ☐ N/A

Comments:

Initial Assessment — Adults

11. I would like to review the member's medications, including over the counter meds and samples. I want to make sure they match our records.

List medications, when started, strength, frequency, route/technique used, any problems with taking the medications. If member is unable to provide information, document why.

Comments:

12. Does the member have any environmental allergies or medication allergies? If yes, please list allergies, type of reaction and date.

- ☐ Yes
- ☐ Breathing difficulties
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Tongue swells
- ☐ Other (explain)
- ☐ No
- ☐ Unknown

Comments:

Initial Assessment — Adults

13. Does the member use or have used any of the following?
If yes, how much and when (date). Select all that apply. If other, explain.

- ☐ Use Street drugs
- ☐ Methadone
- ☐ Suboxone

Alcohol

- ☐ Rarely
- ☐ More than 5 drinks per day
- ☐
- ☐ 1-2 drinks per day
- ☐ Other (Free Text)
- ☐ 3-4 drinks per day
- ☐ Overuse of prescription drugs

Smoke cigarettes

- ☐ 1 to 10 cigarettes
- ☐ More than 2 packs
- ☐ NA
- ☐ 1 pack
- ☐ Other
- ☐ Other
- ☐ 1 to 2 packs
- ☐ Use of other tobacco products

Comments:

14. Has the member been admitted to the hospital in the past 6 months?
If yes, list dates and reasons.

- ☐ Yes
- ☐ No
- ☐ Unknown

Comments:

Initial Assessment — Adults

15. Has the member utilized the emergency department in the past 6 months? If yes, list dates and reasons.

☐ Yes ☐ No ☐ Unknown

Comments:

16. What cultural and/or religious needs, preferences or limitations does the member have that might affect their health care decisions?

☐ None
☐ Blood transfusions/blood products
☐ Dietary practices
☐ Examination by a male/female practitioner
☐ Family traditions
☐ Medications (e.g. pork/beef insulin)
☐ Rx/procedures discouraged/not allowed
☐ Transportation by male/female driver
☐ Other

Comments:

Initial Assessment — Adults

17. Does the member have any language needs, preferences or limitations? Indicate preferred language

☐ Yes ☐ No

Preferred Language-select one

☐ Arabic	☐ Chinese	☐ Somali
☐ Bosnian	☐ English	☐ Spanish
☐ Braille	☐ French	☐ Vietnamese
☐ Burmese	☐ German	☐ Other
☐ Cambodian	☐ Russian	

Comments:

18. Does the member have any problems with vision? If yes, list concerns, date of last vision exam and corrective devices.

☐ Yes ☐ No

Comments:

19. Does the member have any problems with hearing? If yes, list concerns, date of last hearing test and corrective devices.

☐ Yes ☐ No

Comments:

Initial Assessment — Adults

20. Has the member been seen by a dental provider in the last six months? If other, explain.

- ☐ Yes
- ☐ No
- ☐ Unknown

Comments:

21. When the member is given things to read about their health, do they have any problems reading them? Select all that apply.

- ☐ No problem
- ☐ Can't see well enough to read
- ☐ Don't like to read
- ☐ Can't read at all
- ☐ Not in main/preferred language
- ☐ Other
- ☐ Unable to read some of the words
- ☐ Difficulty understanding materials

Comments:

Initial Assessment — Adults

22. Does the member have any self care deficits related to any of the following? Select all that apply.

- ☐ Ambulate Independently
- ☐ Bathe
- ☐ Dress yourself
- ☐ Exercise at least 20 minutes at a time(Free Text Box)
- ☐ Feed yourself
- ☐ Groom yourself
- ☐ Laundry
- ☐ Light housekeeping
- ☐ Looking up phone numbers
- ☐ Managing money
- ☐ Prepare meals
- ☐ Read in your preferred language
- ☐ Shopping
- ☐ Toileting
- ☐ Using the telephone
- ☐ Other

Comments:

23. Has the member missed work, school or had to limit daily activities because of their condition(s)?

- ☐ Yes
- ☐ No

Comments:

Initial Assessment — Adults

24. What is the member's living arrangement? If other, please list.

- ☐ Alone
- ☐ With a spouse/partner only
- ☐ With spouse/partner and others
- ☐ With child only
- ☐ With parent(s) or guardian (s)
- ☐ Sibling(s)
- ☐ With other relative(s)
- ☐ With non-relative(s)
- ☐ Homeless
- ☐ Shelter
- ☐ Group home
- ☐ Residential Treatment
- ☐ Facility
- ☐ Other

Comments:

25. Does the member have problems accessing the home? Select all that apply.

- ☐ Yes
- ☐ No difficulty

Comments:

26. If the member has problems accessing the home, please select all that apply.

- ☐ Difficulty with entering or leaving the house
- ☐ Difficulty with navigating in the house
- ☐ Stairs make it difficult or impossible to leave the house
- ☐ In wheelchair with no ramp or elevator
- ☐ Difficulty with transfer
- ☐ Too Weak to leave the house
- ☐ Other

Comments:

Initial Assessment — Adults

27. Do you feel safe in your current environment?

☐ Yes ☐ No difficulty

Comments:

28. Was there a time in your past you did not feel safe in your environment?

☐ Yes ☐ No difficulty

Comments:

29. How does the member get from room-to-room in the home? Select all that apply.

☐ Ambulatory-no difficulty ☐ Use of walker ☐ Bedridden

☐ Use of cane ☐ Use of wheelchair ☐ Other

Comments:

30. Does the member have or need assistance with caregiving?

☐ Yes ☐ No difficulty

Comments:

Initial Assessment — Adults

31. Yes, indicate level of involvement.

- ☐ Caregiver currently provides assistance
- ☐ Caregiver is not likely to provide assistance
- ☐ Assistance needed but no caregiver available
- ☐ Caregiver needs training, supportive service
- ☐ Unclear if caregiver will provide assistance

Comments:

32. Does the member give the CM permission to speak to caregiver? Please indicate name and contact information for caregiver if provided.

- ☐ Yes
- ☐ No
- ☐ n/a

Comments:

33. Is the member/caregiver aware of member's health care benefits and any service limits such as pharmacy, home care, DME, etc.?

- ☐ Yes
- ☐ No, explain to the member the benefits that are available

Comments:

Initial Assessment — Adults

34. If member/caregiver is not aware of health care benefits and any service limitations, please select all topics on which member needs to be educated

- ☐ 24 hour Nurse Line
- ☐ Language Line
- ☐ Medicaid Transportation
- ☐ Member Services
- ☐ Mental Health Services
- ☐ Primary Medical Provider
- ☐ Rapid Response Outreach Team
- ☐ Other

Comments:

35. Does the member have health care needs that are not covered benefits? Please list needs and referrals, if indicated.

Comments:

36. What type of transportation does the member use for medical appointment/services? Select all that apply.

- ☐ Ambulance
- ☐ Cab
- ☐ Public transportation
- ☐ Medical Assistance
- ☐ Medicaid Transportation
- ☐ Caregiver
- ☐ Family/Friends
- ☐ Self
- ☐ Walking
- ☐ No reliable means
- ☐ Other

Comments:

Initial Assessment — Adults

37. Is the member/caregiver aware of where to go for services within the community, such as, urgent care services, stop smoking classes, diabetes classes, food pantries, local Medicaid office, etc.?

- ☐ Yes
- ☐ No, provide member/caregiver with a list of resources and contact numbers.

Comments:

38. If the member/caregiver is not aware of where to go for services within the community, select from below, the resources that been provided to the member.

- ☐ Clothing assistance
- ☐ Disease specific association(s)
- ☐ Food pantries
- ☐ Gym
- ☐ Heating assistance
- ☐ Housing assistance
- ☐ Interpreter Services
- ☐ Smoking cessation
- ☐ Support groups
- ☐ Waivers
- ☐ Other

Comments:

Initial Assessment — Adults

39. What do you see as the member's/caregiver's barriers to following the treatment and/or self-management plan? Select all that apply

- ☐ Communication skills
- ☐ Cultural
- ☐ Difficulty obtaining medications
- ☐ Do not believe participation will improve health
- ☐ Don't know what I need
- ☐ Environmental
- ☐ Financial
- ☐ Geographic
- ☐ Hearing Impairment
- ☐ Lack of caregiver support
- ☐ Lack of DME supplies
- ☐ Lack of knowledge- condition
- ☐ Lack of knowledge- diet
- ☐ Lack of knowledge- disease
- ☐ Lack of knowledge- medications
- ☐ Lack of knowledge- medications benefits
- ☐ Lack of knowledge- transportation benefits
- ☐ Lack of knowledge- transportation
- ☐ Lack of knowledge- physical health benefits
- ☐ Lack of knowledge- mental health benefits
- ☐ Lack of physical exercise
- ☐ Lack of support from family
- ☐ Language
- ☐ Lifestyle Choices
- ☐ No available/convenient par providers
- ☐ No barriers identified
- ☐ Over use of prescription drugs
- ☐ Primary Provider is not responsive
- ☐ Primary Provider's office hours
- ☐ Psychological Impairment
- ☐ Psychosocial factors
- ☐ Religious
- ☐ Specialist's office hours
- ☐ Use of Alcohol
- ☐ Use of Methadone
- ☐ Use of street drugs
- ☐ Use of tobacco
- ☐ Vision Impairment
- ☐ Other

Comments:

Initial Assessment — Adults

40. Does the member have an advance directive and /or healthcare surrogate or durable power of attorney?

- ☐ Yes
- ☐ No, provide member with resource on where to obtain Life Planning information

Comments:

41. Developmental Disability/Cognitive Impairment Assessment

- ☐ Alert/oriented
- ☐ Requires prompting
- ☐ Requires assistance and some direction
- ☐ Requires considerable assistance
- ☐ Totally dependent

Comments:

Initial Assessment — Adults

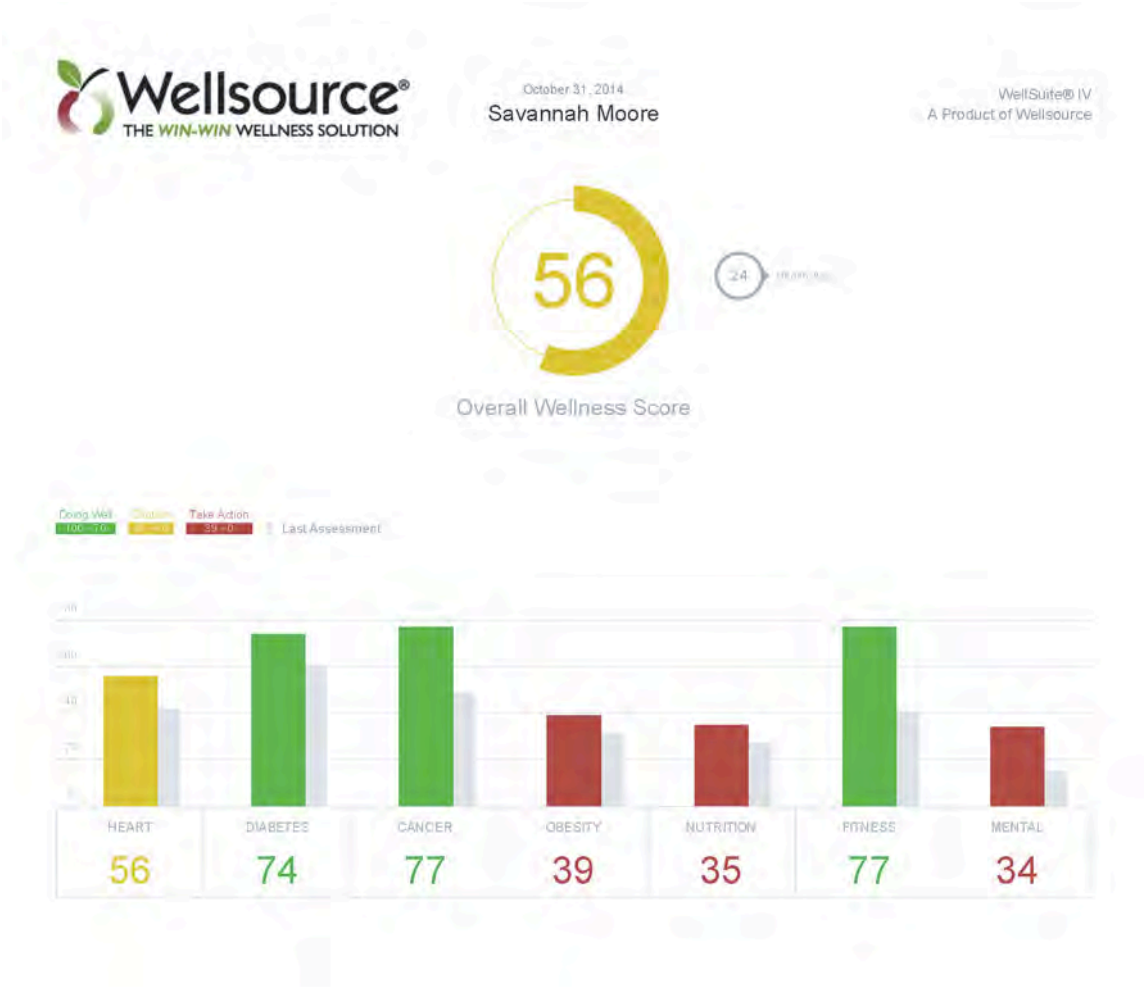
42. What goals does the member/caregiver have for the members self-management plan. Check all that apply. Enter the goal specified by the member/caregiver into the free text box.

- ☐ Behavioral Health Needs
- ☐ Better Control of disease
- ☐ Care Coordination
- ☐ Caregiver needs
- ☐ Diet/ Nutrition
- ☐ Disease knowledge
- ☐ DME
- ☐ Electricity Assistance
- ☐ Housing Assistance
- ☐ Legal Needs
- ☐ Medication Assistance
- ☐ Resources
- ☐ Smoking Cessation
- ☐ Transportation Assistance
- ☐ Waiver Assistance
- ☐ Weight gain
- ☐ Weight loss
- ☐ Other

Comments:

Attachment 9.1.6-A: Example Care Plans

Wellness, prevention and low-risk care plan: example/subset



Heart

56

LDL "bad" Cholesterol ✓

You	Goal
125 mg/dL	<130 mg/dL

Why is this so important?
Having a lot of LDL cholesterol in your blood increases the chance that plaque will build up inside your arteries. This limits or blocks blood flow. LDL levels are strongly linked with the risk of future heart attack. The lower your LDL, the lower your risk.

Blood Pressure !

You	Goal
135/91	<120/80

Heart-Health Foods !

Your Score	Score Goal
36 /100	70+/100

HDL "good" Cholesterol

You	Goal
50 mg/dL	55+ mg/dL

Physical Activity ✓

You	Goal
330 min/wk*	150+ min/wk

Triglycerides ✓

You	Goal
125 mg/dL	<150 mg/dL

Weight ✓

You	Goal
BMI 21	BMI <25

Blood Sugar ✓

You	Goal
80 mg/dL	<100 mg/dL

Tobacco ✓

You	Goal
Tobacco free	Tobacco free

Read About It!

- What is heart disease?
- Family history and heart
- Manage stress and protect your heart
- Sleep and heart
- Warning signs of a heart attack

Probability of a Heart Attack

Each year, more than a million American adults have a heart attack. About 50% of these people die. The others have some heart damage. The more risk factors you have, the higher your likelihood of heart problems or stroke.

What to Eat

- Nuts, seeds, and nut butters
- Berries, citrus fruits, and red grapes
- Whole grains
- Leafy greens
- Virgin olive oil

Diabetes

✓74

Blood Sugar ✓

You	Goal
80 mg/dL	<100 mg/dL

Why is this so important?
Your body uses carbohydrates in the food you eat to make glucose, a type of sugar. Glucose is your body's main energy source. When your body doesn't handle carbohydrates well, your blood sugar level goes up. A high blood sugar level is harmful to your health.

Blood Pressure !

You	Goal
135/91	<120/80

Healthy Foods !

Your Score	Score Goal
39 /100	70+/100

Weight ✓

You	Goal
BMI 21	BMI <25

Physical Activity ✓

You	Goal
330 min/wk*	150+ min/wk

Triglycerides ✓

You	Goal
125 mg/dL	<150 mg/dL

Tobacco ✓

You	Goal
Tobacco free	Tobacco free

Read About It!

- What is diabetes?
- How are diabetes and prediabetes diagnosed?
- Diabetes risk factors
- Diabetes screening
- Cutting back on sodium
- Dealing with stress

Probability of Diabetes

Nearly 1 in 10 adults in the United States has diabetes. Your diabetes risk is high, regardless of your race or sex. The average lifetime risk is 33%. That means reducing any risks for diabetes is important for everyone.

What to Eat

- Whole grains and other high-fiber foods
- Fruits and vegetables (especially legumes)
- Healthy fats (nuts and vegetable oils)
- Low-glycemic index foods
- Fish, skinless turkey and chicken; not red meats

Complex care management member/Medicaid complex member

Cindy is a 45-year-old female with a history of diabetes, hypertension and depression. She has an open wound on her left lower leg that has not healed despite daily dressings for the last 9 months. A widow, Cindy lives with her daughter who works full-time. Cindy had three inpatient admissions in the last year, two related to her diabetes and one as the result of a fall. According to her prescription fill history, Cindy takes 20 different medications and often has gaps in filling her maintenance medications. Her last HbgA1c was 9.5 percent and her LDL-C was 96 mg/dl. Cindy's plan of care contains a member centered self-management plan and a care manager care plan:

Member Centered Self-Management Care Plan				
Problems	**Category**	**Goals**	**Activities**	**Additional Services**
1. Achieve optimum self-management (member's self-management plan)	Complex Medicaid	• Create a Safety Plan —High Priority Goal. • Manage condition by following treatment plan. • Improve ADL's/ functionality.	a. Fall risk plan b. Medication safety plan. c. Refill medications. d. Check for irregularities regarding skin condition. e. Change wound dressing as directed. f. Appropriate use of PCP/urgent care/ER. g. Follow disease specific diet. h. Remove potential fall hazards from the home environment. i. Identify limitations.	• Home evaluation. • Medication reconciliation with pharmacy. • Nutritional assessment.

Member Centered Self-Management Care Plan				
2. Ability to develop and maintain self-management (care manager's plan of care).	Complex Medicaid	• Member/caregiver will obtain optimum level of health by participating in self-management of condition(s) — High Priority Goal.	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. Assess member's understanding of how and when to contact PCP/urgent care/ER. e. Contact PCP/SCP to review treatment plan. f. Develop a member/caregiver self-management plan with member/caregiver involvement and assess progress towards goals. g. Educate on signs and symptoms of condition to report to provider. h. Monitor member's utilization. i. Utilize MI techniques. j. Follow/coordinate with CCMT	• Medication reconciliation with claims and pharmacy. • Obtain treatment plan from PCP/specialist. • Refer member to CCMT for face-to-face visit at PCP and home.

Complex member who qualifies for waiver services in the community

George is a 55-year-old male with a history of hypertension and a recent stroke, resulting in left leg and arm paralysis. George is married and lives with his wife who never worked. The couple often does not have food in their apartment and they were recently without heat or hot water. George takes four medications. His plan of care contains a member centered self-management plan and a care manager care plan:

Member Centered Self-Management Care Plan				
Problems	**Category**	**Goals**	**Activities**	**Additional Services**
1. Achieve optimum self-management (member's self-management plan).	Complex Medicaid	• Create a safety plan. • Meet basic needs — High Priority Goal. • Improve ADL's/functionality.	a. Fall risk plan. b. Apply for fuel/heating assistance. c. Contact food pantries. d. Contact resources for utilities. e. Remove potential fall hazards from the home environment. f. Identify limitations. g. Contact waiver services.	• Home evaluation. • Nutritional assessment. • Contact local trustee. • Contact local food pantries. • Contact with Iowa HCBS Waiver for Persons with Physical Disabilities.
2. Ability to develop and maintain self-management (care manager's plan of care).	Complex Medicaid	• Member/caregiver will obtain optimum level of health by participating in self-management of condition(s) — High Priority Goal.	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. Contact PCP/specialist to review treatment plan. e. Educate on signs and symptoms of condition to report to provider. f. Utilize MI techniques. g. Assess barriers to care and self-management. h. Assist with identifying appropriate resources. i. Follow up on recommended resources.	• Respite care under Iowa HCBS Health and Disability Waiver. • Local resources for heat and food.

Complex member who lives in a residential placement setting — Developmental delay

Kathy is a 24-year-old female with a history of spinal bifida, obesity and depression. Kathy lives in a boarding home and feels isolated from her community. Her plan of care contains a member centered self-management plan and a care manager care plan:

Member Centered Self-Management Care Plan				
Problems	**Category**	**Goals**	**Activities**	**Additional Services**
1. Achieve optimum self-management (member's self-management plan).	LTSS	• Get involved in social/ recreational activities —High Priority Goal. • Develop 1–2 healthier lifestyle choices in the next 3–6 months.	a. Volunteer in the community. b. Attend religious services/programs/ church ministries. c. Avoid high sugar drinks. d. Drink more water.	• Iowa HCBS Intellectual Disabilities wavier for transportation services. • Nutritionist.
2. Ability to develop and maintain self-management (care manager's plan of care).	LTSS	• Member/caregiver will obtain optimum level of health by participating in self-management of condition(s) — High Priority Goal.	a. Self-management plan developed and communicated with member/caregiver by phone. b. Assess and evaluate member/caregiver's readiness to change. c. Assess member's weight gain or loss. d. Develop a member/caregiver self-management plan with member/caregiver involvement and assess progress towards goals. e. Encourage health-promoting behaviors. f. Follow up on recommended resources. g. Utilize MI techniques. h. Discuss available therapy/behavioral health intervention.	• Connect to Nutritionist. • Connect to behavioral health services.

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10. Quality Management and Improvement Strategies

Please explain how you propose to execute Section 10 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Overview

AmeriHealth Caritas Iowa will implement a Quality Management/Quality Improvement (QM/QI) program incorporating a robust set of measurable objectives, provider and member incentives and quality improvement activities that are designed to improve the delivery of healthcare services across the care continuum for all of our members. We proudly bring over 30 years of expertise and leadership in managed Medicaid programs, delivering high-quality care and positive health outcomes in all the markets we serve.

AmeriHealth Caritas' core focus on access, quality and affordability of care is rooted in over 30 years of high-quality performance and success in improving outcomes.

Our focus empowers us to lead the next generation of healthcare delivery — and to realize Governor Branstad's vision for Iowa being the healthiest state in the country.

The AmeriHealth Caritas Iowa quality team will reside in Iowa, with corporate support for data analytic functions. Our data driven approach in Iowa will include the identification of baseline quality outcomes results and the implementation of creative strategies to improve upon them. Those strategies include the use of member and provider incentives to address both physical and behavioral health outcomes.

All AmeriHealth Caritas Family of Companies (AmeriHealth Caritas) health plans undergo National Committee for Quality Assurance (NCQA) accreditation. All AmeriHealth Caritas health plans eligible to receive an accreditation level are currently rated Commendable. Three AmeriHealth Caritas plans have Interim Accreditation, which is the NCQA accreditation available to new health plans. All three interim accredited plans are undergoing full accreditation reviews this year. Additionally, our plans in Pennsylvania and South Carolina are also recognized by NCQA as having their Multicultural Health Care certification and are inaugural participants in NCQA's voluntary Multicultural Health Care Distinction program.

AmeriHealth Caritas has a strong history of collaboration with States and local governments to customize quality assessment/performance improvement (QAPI) program offerings to support specific quality goals and objectives. Our staff recognizes the QAPI program as critical to all aspects of clinical care and service. Our deep commitment to strategic and tactical innovations gives us the flexibility and scalability to tailor current best practices, and design new processes or leverage new technologies, to become best solutions.

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

10.1 Contractor Quality Management/Quality Improvement Program

1. Describe your Quality Management and Improvement Program, addressing all elements outlined in Section 10.1.2. Include how you will monitor, evaluate and

take effective action to identify and address any needed improvements in the quality of care delivered to members.

Program requirements

The AmeriHealth Caritas Iowa Quality Assessment Performance Improvement (QAPI) program meets all requirements of 42 CFR 438 subpart D and NCQA accreditation standards. NCQA is the credentialing body by which all AmeriHealth Caritas health plans are credentialed. Our QAPI program descriptions, as in all the other States we operate, will be developed exclusive to Iowa and shall not contain documentation from other State Medicaid programs or other AmeriHealth Caritas markets.

Our QAPI program integrates knowledge, structure and processes throughout the healthcare delivery system to assess risk and to improve quality and safety of clinical care and services provided to members. The QAPI program provides the infrastructure to systematically monitor, objectively evaluate and ultimately improve the quality, appropriateness, efficiency, effectiveness and safety of the care and service provided to AmeriHealth Caritas members.

Our QAPI program is designed to monitor and evaluate the quality of care and service provided to members. QAPI program activities are conducted using the plan-do-check-act (PDCA) methodology:

1. Plan — Establish objectives and processes necessary to meet performance or outcome goals.
2. Do — Implement the plan and processes; collect data for further analysis.
3. Check — Evaluate and compare the results to the performance/outcome goal; identify differences between the actual/expected/target outcomes.
4. Act — Develop and implement corrective action to address significant differences between the actual and planned results; conduct root cause analysis; as necessary, return to the Plan step.

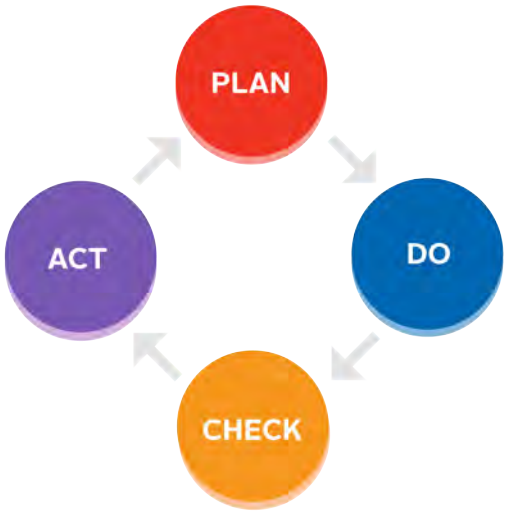


Exhibit 10.1-A: PDCA Quality Process

Program availability

The AmeriHealth Caritas Iowa QAPI program will be submitted to the Iowa Department of Human Services (DHS) for review and approval at the start of the contract period. The full contents of the QAPI program, and the annual program evaluation, will be available to members and providers on the respective AmeriHealth Caritas Iowa member and provider portal sites. In addition, AmeriHealth Caritas Iowa will produce an easy-to-read *Report to the Community* to communicate key outcomes of AmeriHealth Caritas Iowa's programs.

QAPI work plan

AmeriHealth Caritas Iowa will develop an annual work plan and prospective five-year QAPI work plan, as required by the State, which sets measurable goals, establishes objectives and identifies strategies and activities to be undertaken. The work plan will form the basis for QAPI interventions and monitoring

activities throughout the year. The work plan is updated monthly and reviewed quarterly at the QAPI committee meeting.

Quality resources

The Quality Assessment Performance Improvement Committee (QAPIC), AmeriHealth Caritas Iowa's medical director, behavioral health director and manager of quality management collectively have responsibility for planning, designing, implementing and coordinating quality improvement activities.

Key QAPI roles supporting quality management activities for AmeriHealth Caritas Iowa are described below:

A. Medical director — Designated Iowa-licensed physician responsible for the medical leadership, oversight and implementation of the QAPI program; serves as the chairperson of the QAPIC.

B. Medical director, behavioral health — Designated Iowa-licensed behavioral health physician who supports the provision of quality and clinically sound behavioral health and system of care services to all individuals in the system of care.

C. Director of Quality Management — Provides leadership and direction for the QAPI program; responsible for the day-to-day activities and staff associated with quality activities, accreditation, QAPI work plan implementation and program evaluation.

D. Manager, medical economics — Provides oversight of Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) and other QAPI-related data collection and analysis, including reports and analysis to support utilization pattern identification and health outcome improvement.

E. Quality management nurse — Provides clinical review for potential quality of care concerns; assists with QAPI data collection and implementation of QAPI initiatives.

F. Quality performance management specialist — Assists with QAPI data collection and implementation of QAPI initiatives

G. CLAS coordinator — Assists with incorporation of Culturally and Linguistically Appropriate Services (CLAS) standards into quality activities and focused analysis and activity development to address health disparities.

H. Clinical auditor/trainer — Provides education to physician offices on clinical guidelines and condition management in support of behavioral health integration and AmeriHealth Caritas Iowa's QAPI goals.

I. Additional Resources — QAPI activities are supported by leadership and staff roles across the organization, including Integrated Healthcare Management (IHM; includes care management, behavioral health management, long term services and support, rapid response), utilization management, network management, service operations and member services.

The number of resources involved in the QAPI program in Iowa is consistent with staffing in AmeriHealth Caritas' other plans. The adequacy of our staffing will be assessed and adjustments will be made as needed throughout the year to support program goals.

Program scope

The scope of the QAPI program encompasses processes to promote access and availability of healthcare services, activities to improve health outcomes and initiatives to improve satisfaction for members and providers across the physical health, behavioral health and long-term services and supports (LTSS)

domains. The QAPI program is implemented using a comprehensive and integrated systematic process of collecting information, analyzing the information, identifying opportunities to improve care and service, acting upon such opportunities and monitoring the effectiveness of interventions.

The scope of the QAPI program includes the following areas:

- Identification of the member profile.
- Monitoring accessibility and availability of care.
- Assessment of quality of care across the spectrum of healthcare delivery.
- Member, provider and practitioner satisfaction.
- Member grievance and appeal processes and trends.
- Maternity, chronic condition, behavioral health and LTSS improvement initiatives.
- Development, implementation and adherence assessment of clinical and preventive health practice guidelines.
- Member safety.
- Clinical quality initiatives.
- Review of quality of care concerns.
- Assessment of care coordination and continuity of care.
- Monitoring of utilization, including over-, under- and mis-utilization.
- Monitoring of practice pattern variation and identification of outliers.
- Monitoring prescribing patterns for clinical guideline concordance and identification of outlier patterns.
- Assessment of quality of health plan service.
- Credentialing/re-credentialing activities.
- Preventive healthcare services.
- Medical record documentation.
- Oversight of delegated activities.
- Activities to reduce healthcare disparities.
- Activities to improve linguistic and cultural competence.
- Additional performance measurement required by the Centers for Medicare & Medicaid Services (CMS) or DHS.

Practice pattern analysis

Through QAPI program activities, AmeriHealth Caritas Iowa will analyze practice patterns to identify over-utilization, under-utilization, potential mis-utilization and any variation from AmeriHealth Caritas Iowa's clinical practice guidelines. Standard activities in the QAPI work plan include:

Over- and under-utilization identification and targeted intervention — Ongoing analysis is conducted for a number of procedures and services relevant to the AmeriHealth Caritas Iowa population that are prone to over- or under-utilization. AmeriHealth Caritas Iowa will have access to aggregate utilization data from other AmeriHealth Caritas plans and is able to use internal benchmark data, as well as externally published data from similar Medicaid populations to determine if over-utilization of resources is occurring. AmeriHealth Caritas Iowa will risk-adjust data to ensure that populations can be fairly compared. AmeriHealth Caritas health plans have sufficient membership across multiple States, to allow the establishment of reliable benchmarks for Iowa membership.

Over-utilization example: Positron Emission Tomography (PET) scans

Ongoing monitoring of high-level imaging studies identified a significant variation in utilization of PET scans across several AmeriHealth Caritas health plans. Utilization outliers were present even when the results were controlled for population mix and access to PET scan technology. As a result, AmeriHealth Caritas developed and implemented an evidence-based clinical policy for use in reviewing all requests for this technology. Following implementation of the policy, utilization in the highest utilizing State was reduced to the utilization rate observed in other AmeriHealth Caritas markets.

Under-utilization example: laboratory testing

We recognize that laboratory test results drive many healthcare decisions, but the process in obtaining the results can be scary, intimidating, inconvenient and expensive. It's estimated that between 40-60 percent of laboratory tests are not completed, which means that individuals and their healthcare providers likely don't have all the right information at the right time to make important healthcare decisions or develop comprehensive care plans. Theranos' revolutionary lab service platform uses dramatically smaller samples than traditional labs, with samples collected from both capillary draws and traditional methods. Results are returned much faster than industry averages, with the overwhelming majority of results reported within 24 hours of sample collection. Our strategic partnership with Theranos provides an opportunity for us to quickly, and more actively, engage all new members in Iowa in their overall health and wellness.

Under-utilization example: management of hyperlipidemia

When the 2013 American College of Cardiology/American Heart Association updated practice recommendations for the management of hyperlipidemia were adopted by AmeriHealth Caritas health plans, an analysis of statin utilization (including dosage prescribed) was conducted for members with diabetes, documented cardiac disease and hyperlipidemia. Results indicated under-utilization of statin medication for at-risk members. In response, AmeriHealth Caritas developed a continuing medical education (CME) program for network providers and implemented it across all plans to educate physicians on the new recommendations and provided member-specific information to physicians for review and action. Rates have increased across all plans.

Clinical practice guideline adherence — Guidelines selected for adherence measurement are identified by the QAPIC and noted on the annual QAPI work plan. Statistical sampling methodology is used to identify the number of practitioners reviewed. Results are reported as an aggregate rate for the network and at the individual practitioner level. Based on results, educational initiatives are designed to reinforce guideline recommendations with the network as a whole and/or provide education or technical support to individual practitioners. At the direction of the QAPIC, key clinical practice guideline metrics are added to the physician quality incentive program to bolster visibility and adherence.

AmeriHealth Caritas Iowa's Medical Economics team will be able to provide detailed information on macro trends of utilization and also will have the capability to study variations in care at the community or at the practice level. This capability is consistent with the field of small area variation analysis.

Prescribing patterns — Medication prescribing history is continually analyzed to identify patterns that deviate from current clinical practice guidelines and/or indicate a potential over- or under-utilization of

medication. Based on the outcome of the analysis, the medical director and quality team design and implement appropriate initiatives.

Prescribing pattern examples:

Insulin use

Physicians treating diabetic members prescribed two or more oral hypoglycemic medications are contacted and educated on the clinical evidence supporting the use of insulin as a third-line therapy for diabetes control. Providers are encouraged to consider adding basal insulin for members to improve HgbA1c control. Our plan with the highest number of diabetic numbers saw a statistically significant increase in the adoption rate of basal insulin among the identified members. Initially started as a pilot program, this process is now part of our standard care gap identification and physician education strategy.

Suboxone prescribing

AmeriHealth Caritas is currently participating in the Association of Affiliated Community Plans (ACAP) collaborative on substance abuse. Our initiative was developed following analysis of suboxone prescribing patterns. As a result of wide variation in prescribing practice and definite variation from suboxone prescribing guidelines, AmeriHealth Caritas initiated a process to limit the ability to prescribe suboxone for our members to a limited network of physicians who met best practice criteria.

Controlled substance use

In several of our health plans, AmeriHealth Caritas also implements State-approved programs to restrict members receiving numerous controlled substance prescriptions, and/or controlled substance prescriptions from multiple prescribing physicians to one physician prescriber, and in some cases to one pharmacy. This ensures that the physician prescribing the medication is aware of all of the other controlled substance prescriptions the member received. Members are identified through analysis if pharmacy data. Prescription events are also correlated to emergency room (ER) events, as members often use the ER as the avenue to obtain a new prescription from a physician who may not be aware of the member's history. The review is conducted in the context of the member's clinical history. Once potential overuse of controlled substances is identified, the Care Management team initiates outreach to engage the member in care management and notify him/her of the planned restriction. The member has the right to appeal the restriction decision.

Aripiprazole (Abilify) use in children

Analysis of pharmacy data revealed that aripiprazole was the most frequently prescribed psychotropic medication and that it was being used outside of the American Academy of Pediatrics (AAP) guidance. As a result of the analysis, AmeriHealth Caritas plans provide educational material on the AAP guidelines to prescribing physicians and has placed edits related to age and prior medication use to reduce the inappropriate prescribing of this drug.

Treatment effectiveness

AmeriHealth Caritas Iowa will use industry-standard measures of functional status, including the SF-12 Patient Questionnaire (SF12), to measure effectiveness of treatment services. Additionally, the plan will solicit input from practicing physicians to improve effectiveness, as shown in the following example:

Example: treatment service effectiveness

AmeriHealth Caritas Iowa's affiliate in Pennsylvania had a network physician who was concerned that patients in treatment for substance abuse were not being appropriately monitored for concurrent opiate use through the collection of blood or urine. He proposed that the health plan cover salivary testing as a way to reduce "gaming" or errors inherent in blood and urine collection. An evidence-based review was conducted, which led to the addition of salivary testing (but not hair or skin cell testing) to its coverage guidelines for testing members in drug maintenance programs

Written policies

AmeriHealth Caritas Iowa's QAPI program is supported by a detailed program description document and a comprehensive set of written policies. Program policies include sections outlining AmeriHealth Caritas Iowa's policy on the topic, the procedure and method used to implement the policy, timelines for procedure steps, as applicable, and the individuals responsible for the task. Policies are reviewed at least annually and revised as needed.

Monitoring and improving services

AmeriHealth Caritas Iowa's QAPI program will use a comprehensive set of data to monitor and improve the delivery of physical health, behavioral health, LTSS and related health outcomes. Segmental analysis is performed for identified subpopulations including pregnant women, members with serious persistent mental illness, members eligible for/receiving LTSS, members with developmental disabilities and children in foster care/residential placement or other identified special needs. Some of the data sets used include:

- Access and availability data.
- CAHPS results.
- Participant experience survey (HCBS) results.
- Medical, behavioral health and LTSS claim data.
- Clinical guideline performance studies.
- CLAS data.
- Focused reviews.
- Health risk assessment data and screening responses.
- HEDIS and other metrics defined by DHS.
- Member dissatisfaction data.
- Member opt-out data.
- Medical record reviews.
- Performance improvement project/outcome study analysis.
- Pharmacy utilization data.
- Provider and practitioner satisfaction survey results.

- Physician office medical record reviews.
- Quality indicator studies.
- Sentinel condition analysis.
- Utilization data.
- Treo Solutions' 3M Clinical Risk Grouper (CRG) and Value Index Score (VIS) data.
- State or CMS specific requirements.

Developing performance improvement projects

The results of data collection and analysis will be reviewed by AmeriHealth Caritas Iowa's clinical leadership team, led by the AmeriHealth Caritas Iowa medical director. The QAPI committee will assist with prioritization of opportunities and actions. Performance improvement projects (PIPs) will be developed to address areas of concern or low performance, both clinical and service-related, identified through internal analysis and external recommendations. Prioritized projects will include opportunities to improve physical health, behavioral health and long-term care. AmeriHealth Caritas Iowa will monitor, evaluate and improve the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members through peer review, performance improvement plans (PIPs), medical record audits, performance measures, surveys and related activities.

Additionally, AmeriHealth Caritas Iowa will have access to AmeriHealth Caritas' extensive clinical policy development activities so that strategies can be designed to promote evidence-based practice patterns in Iowa that are consistent with those guidelines. AmeriHealth Caritas has published more than 150 clinical policies, and made them available to both members and providers on our public websites. Clinical policies help to improve quality by reducing inappropriate over-utilization. For example, some very frequently requested surgical procedures can have significant complication rates, such as with bariatric surgery and supraglottoplasty. Clinical policies help ensure that these surgical procedures are being performed for individuals for whom the evidence shows that the benefits from the surgery outweigh the risks. Our clinical policy on testing for drug abuse assisted in reducing the under-utilization of testing for patients in substance abuse treatment in several of our markets.

Re-measurement periods are built into the design of all performance improvement plans (PIPs) to allow for systematic and periodic follow up on the effect of the interventions. Goals are set to reflect demonstrable improvement, and/or achievement of benchmark performance, in the targeted health outcome or service.

Assessing performance

The quality indicators used to assess performance are based on accepted industry measures to allow for comparison with external benchmarks and consistency in evaluation across time periods. Wherever possible, nationally published specifications, such as HEDIS, CAHPS and events/1000, are used to measure changes in health outcomes, service levels, functional status and satisfaction associated with a PIP.

Evaluation and reporting

PIPs are monitored and evaluated according to the re-measurement schedule developed as part of the PIP design. Wherever possible, the same methodology is used to evaluate the program as was used for the baseline measurement. On rare occasions the metrics are altered in response to a change in national specifications, such as a HEDIS measure or CAHPS question.

The results of re-measurements are compared to the PIP goal and the identified benchmark. In addition to looking at trends, statistical significance is measured using a t-test or other appropriate statistical vehicle.

The analysis includes identification of barriers that impacted the interventions. Wherever possible, strategies are designed to address identified barriers in the next measurement cycle.

The QAPIC reviews the prioritization, plans and results of quality improvement activities and projects. PIP results are also reported to the Iowa Department of Public Health (DPH) and Iowa DHS, as requested.

Measuring member and provider satisfaction

Member satisfaction is measured through the CAHPS survey. In addition, AmeriHealth Caritas Iowa will administer the Iowa Participant Experience Survey (PES) for members receiving home and community based services (HCBS). Provider satisfaction is measured through an annual practitioner/provider satisfaction survey administered to practitioners and organizational providers on AmeriHealth Caritas Iowa's behalf by a third-party vendor. AmeriHealth Caritas Iowa will complete planning for administration of the CAHPs and PES during the first contract year, for administration the following spring. AmeriHealth Caritas Iowa will complete a provider satisfaction study during the fall of the first contract year. The results, along with analysis and trends on dissatisfactions and member opt-outs, are reported to the QAPI for review and identification/prioritization of opportunities for improvement.

Promoting participant safety

The QAPI department is responsible for coordinating activities to promote member safety. Initiatives will focus on promoting member knowledge about medications, home safety and hospital safety. Members are screened for potential safety issues during the initial assessment.

Participant and provider dissatisfaction

Dissatisfactions or complaints/grievances from members and providers are investigated, responded to and trended. Trends and the results of investigations are reported to the QAPIC, which coordinates initiatives to address identified opportunities for improvement.

Cultural competency and healthcare equity

AmeriHealth Caritas Iowa will initiate a cultural competency plan to promote the delivery of services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, values, affirms and respects the worth of the individual members and protects and preserves the dignity of each. The plan will include mechanisms for assessment of culturally appropriate service delivery, evaluation of healthcare equity across subpopulations and interventions to address identified opportunities.

Activities to assess and promote cultural competency and healthcare equity include the following:

- Collect and analyze practitioner race/ethnicity and language data to determine if the network is responsive to the needs of the membership.
- Develop a plan to address network race/ethnicity and language gaps.
- Support practitioners in providing appropriate language services.
- Conduct baseline assessment of performance on chronic care and preventive care outcome measures by race and ethnicity subgroups; identify and prioritize opportunities to reduce disparities.

Availability and accessibility audits

Annually, compliance to access and availability standards are monitored to ensure that sufficient numbers of network practitioners and providers are available to meet member needs. An assessment is conducted to compare the type, number and location of network practitioners and providers to AmeriHealth Caritas Iowa's standards and to calculate the ratio of full-time equivalent physicians, paramedical and ancillary

heath personnel to members. Provider types assessed include inpatient hospitals, ambulatory surgical centers and LTSS providers. The Quality of Service Committee (QSC) evaluates the report and planned actions annually. Data from the report, including changes in physician ratios and any action taken, is reported to the Iowa Insurance Commissioner, as may be required.

AmeriHealth Caritas Iowa also conducts an annual assessment of primary care providers' (PCPs) compliance to appointment standards for routine, urgent and sick office visits. Results of the survey are reported to the QSC for review and recommendations.

Reporting and evaluation

QAPI program activity will be reported throughout the year to the QAPIC, with updates quarterly to the AmeriHealth Caritas Iowa board of directors. Activity and outcomes will be reported using internal tools in addition to the reporting tools and specifications required by the Iowa DPH and DHS.

The QAPI program is evaluated as needed and at least annually to measure its effectiveness. The evaluation assesses all aspects of the QAPI program, including clinical and service performance improvement projects, quality studies and activities and the rationale, methodology, results and subsequent improvement associated with each study, along with findings and data from external quality review activity. The evaluation includes recommendations for improvement in the QAPI program, proposes goals and objectives for the following year and identifies the resources needed to accomplish the proposed goals and objectives. The QAPI program is revised as needed throughout the year and reviewed/revised at least annually.

In our consistent effort for continual improvement and innovation, the QAPI evaluation is used to determine the QAPI program description and work plan adjustments for the following year.

Improving the quality of care delivered to members

For over 30 years, AmeriHealth Caritas has consistently improved clinical outcomes and the quality of care for the Medicaid population across many States. We constantly analyze a combination of utilization, cost and clinical outcome data to evolve programs and solutions in tandem with the changing landscape. This gives us a complete view of our impact on the member's health status, and the power to change accordingly. We compare members receiving the intervention with a control group, when possible, to evaluate the difference between populations. The example initiatives below highlight our experience in several of our markets.

Management of high-risk pregnancy

Children and women of childbearing age comprise a large percentage of the Medicaid population, and one of AmeriHealth Caritas' primary focuses is on improving performance on maternal-child health outcomes and pediatric preventive care. Pregnant members are automatically enrolled in AmeriHealth Caritas' comprehensive maternity management program, Bright Start®. We are implementing additional tools in the form of interactive mobile phone applications to provide additional support for the member during her pregnancy. Our Moms2B program takes our Bright Start approach one step further for our pregnant members who are at high risk for a preterm delivery.

AmeriHealth Caritas will implement Bright Start in Iowa (as further described in Section 8: Member Services of this response). Once AmeriHealth Caritas Iowa members are identified as pregnant, they will be automatically enrolled in the Bright Start program. The Bright Start program works to improve birth

outcomes and reduce the incidence of pregnancy-related complications through early prenatal education and intervention. The program uses the Institute for Clinical Systems Improvement (ICSI) guidelines for the treatment and management of an at-risk pregnancy.

AmeriHealth Caritas Iowa will also implement its Moms2B program, which focuses on reducing the incidence of premature and low-weight births through intensive case management services. Members are provided with cell phones for calling and texting appointment reminders and key pregnancy information and incentives to promote prenatal and post-partum care. The program engages high-risk pregnant members, providing a high-intensity program tailored to the individual needs of the high-risk member.

Example outcomes

Through the Bright Start program, AmeriHealth Caritas affiliates have improved performance with respect to the percent of pregnant women who receive frequent prenatal care visits (81 percent or more of expected prenatal visits), with all plans at least at the 50th NCQA percentile.

Getting early prenatal care is the first step toward a healthy, full-term delivery. Two of AmeriHealth Caritas' health plans perform above the NCQA Medicaid 75th percentile for this measure.

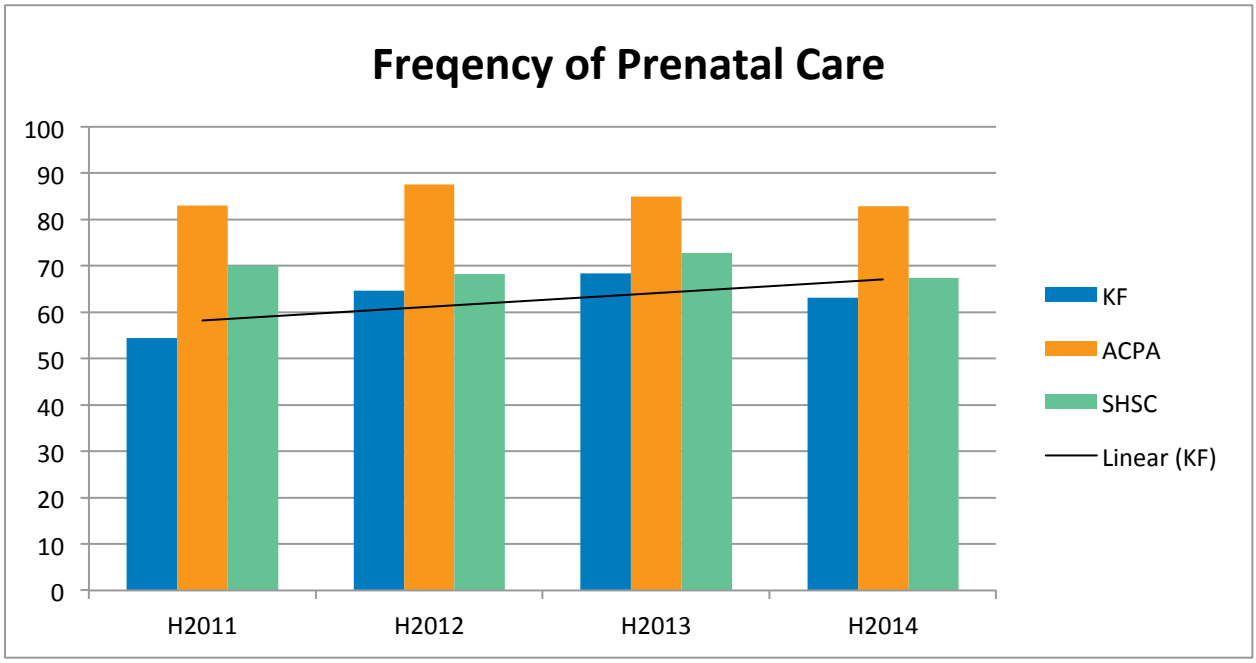


Exhibit 10.1-B: Frequency of Prenatal Care Outcomes

For the most recent enrollment cycle of the Moms2B program at AmeriHealth Caritas Iowa's Pennsylvania affiliate, 57 pregnant women at high risk for premature birth were enrolled. Forty-six of those high-risk pregnancies delivered a singleton birth with 39 of those infants weighing over 2,500 grams. Seven were considered low birth weight (between 1,500 and 2,500 grams) and none were in the very low birth weight (less than 1,500 grams) category. The average gestational age for this group was 37.2 weeks and the average birthweight was 6 pounds 7 ounces. Eight of the enrollees delivered twins, with an average gestational age of 34.8 weeks. Three have yet to deliver.

Reducing C-section rates

Additional outcomes associated with our work on maternal health include reductions in C-section rates and neonatal intensive care unit (NICU) length of stay. We continue to focus aggressively on decreasing the incidence of elective C-section deliveries in all of our markets. Our strategy includes eliminating the pricing differential between C-section and vaginal delivery reimbursement, partnering with obstetrical practices and promoting the March of Dimes "Wait for Labor" campaign. Market-specific examples of our partnership strategy are outlined below:

Market	Partnership Strategy
South Carolina	We actively participate in the State's birth outcome initiative and prohibit payment for elective C-sections prior to the 39th week of gestation.
Louisiana	We have worked with the March of Dimes to implement 17-P educational training with all OB providers. Web-based and onsite trainings focused on the appropriate use of 17-P and the initiative to reduce elective deliveries before the 39th week of gestation.
Nebraska	We work in conjunction with the Nebraska Medical Association and March of Dimes to support the implementation of hospital policies and review procedures to limit elective C-sections prior to 39 weeks to situations where the health of the mother or fetus is in jeopardy. Additionally, one of our largest provider groups, South East Rural Physicians Alliance Network (SERPA) ACO uses C-section rate as an internal quality indicator and they are incentivized for low prematurity rates.

Example outcomes

Results for our five largest health plans, displayed below, outline the percent change in C-section deliveries (2013 – 2014), with strong progress across our plans.

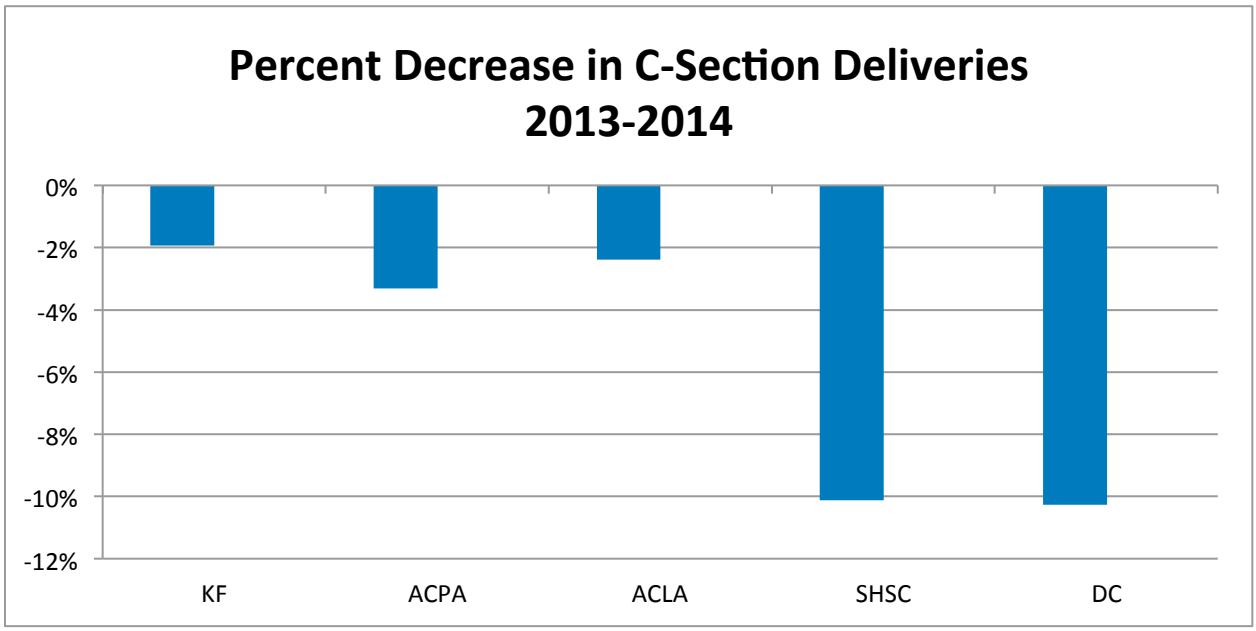


Exhibit 10.1-C: Percent Decrease in C-Section Deliveries (2013 – 2014)

EPSDT and pediatric preventive healthcare

Pediatric preventive care is another key focus for AmeriHealth Caritas. Our various programs have positively impacted EPSDT-related measures, including improvements in adolescent access, children's access and Immunization rates, as shown in the following graphics:

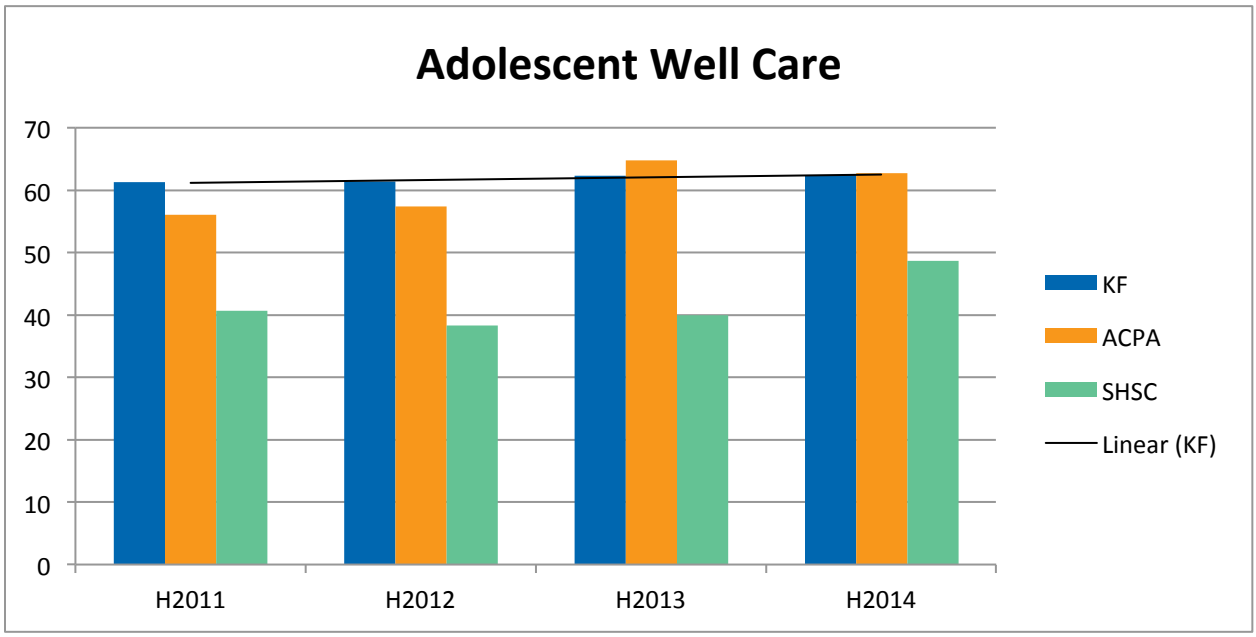


Exhibit 10.1-D: Adolescent Well-Care Access Outcomes — All three plans above Medicaid national average, with two plans in the 75th percentile

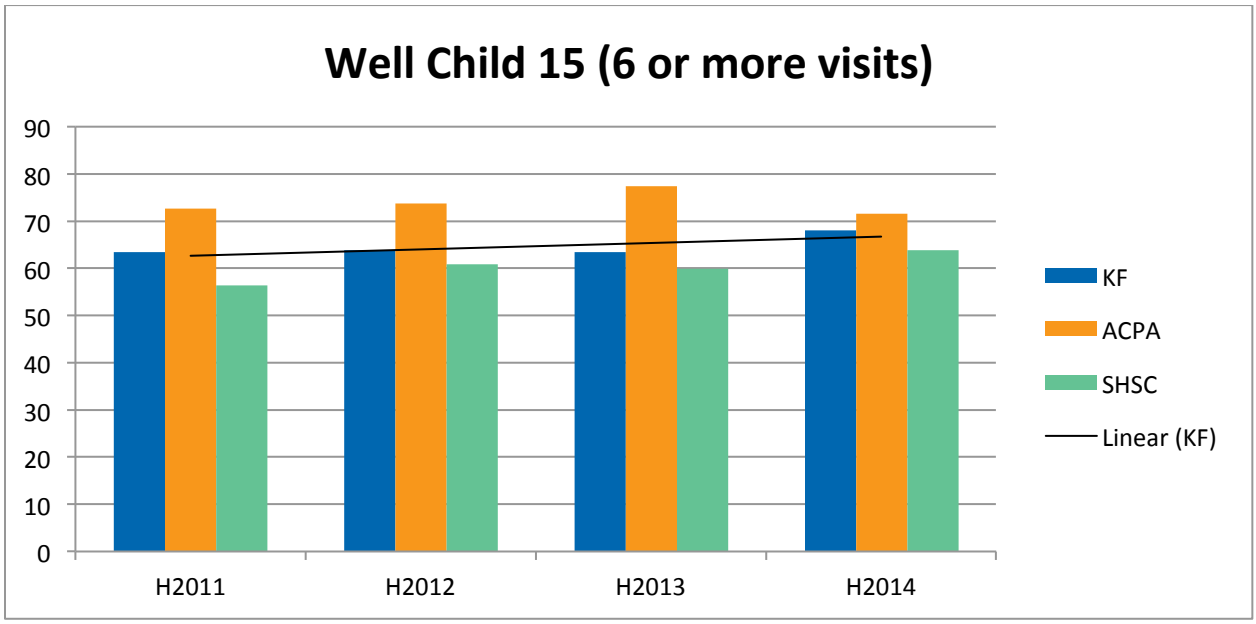


Exhibit 10.1-E: Well-Child 15 (6 or more visits) Outcomes — All three plans above Medicaid national average, with two plans in the 75th percentile

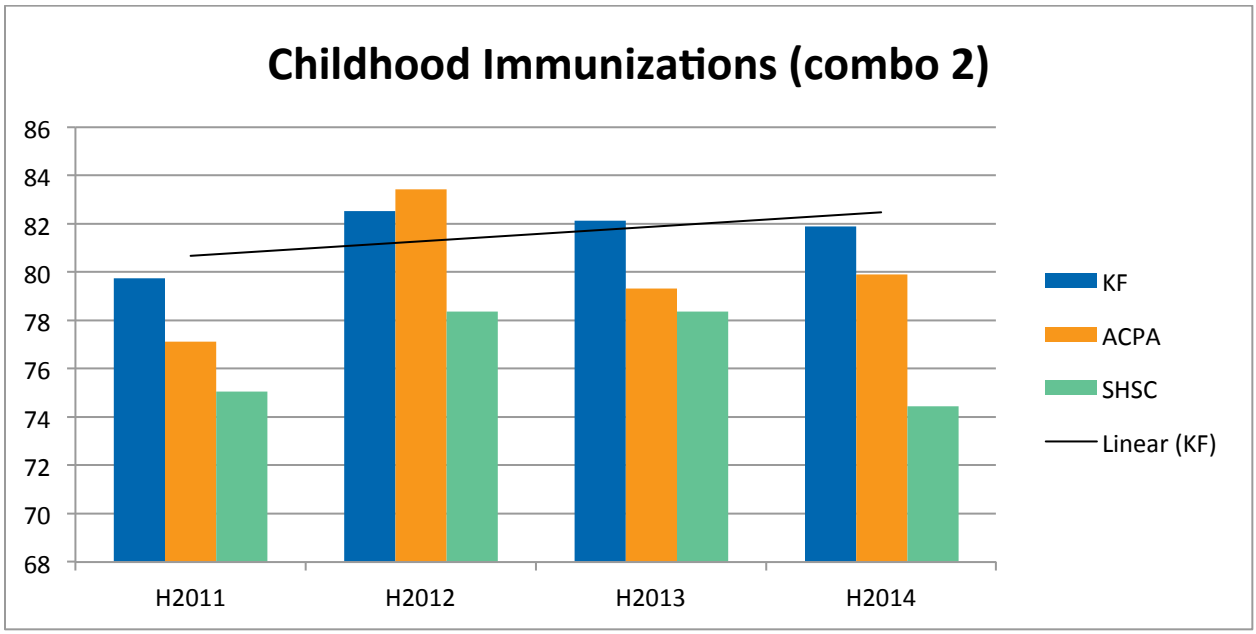


Exhibit 10.1-F: Childhood Immunizations Outcomes — All three plans above Medicaid national average, with two plans in the 75th percentile

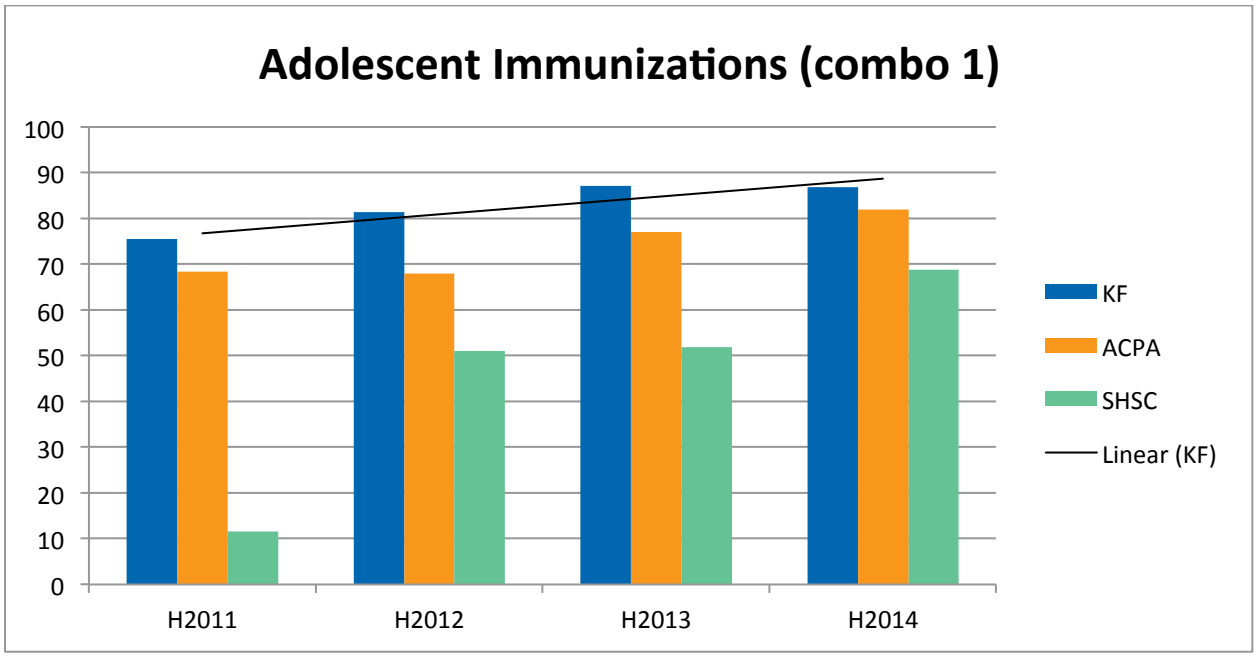


Exhibit 10.1-G: Adolescent Immunization Outcomes – Keystone First in 90th percentile, AmeriHealth Caritas Pennsylvania in the 75th percentile, Select Health showing strong progress

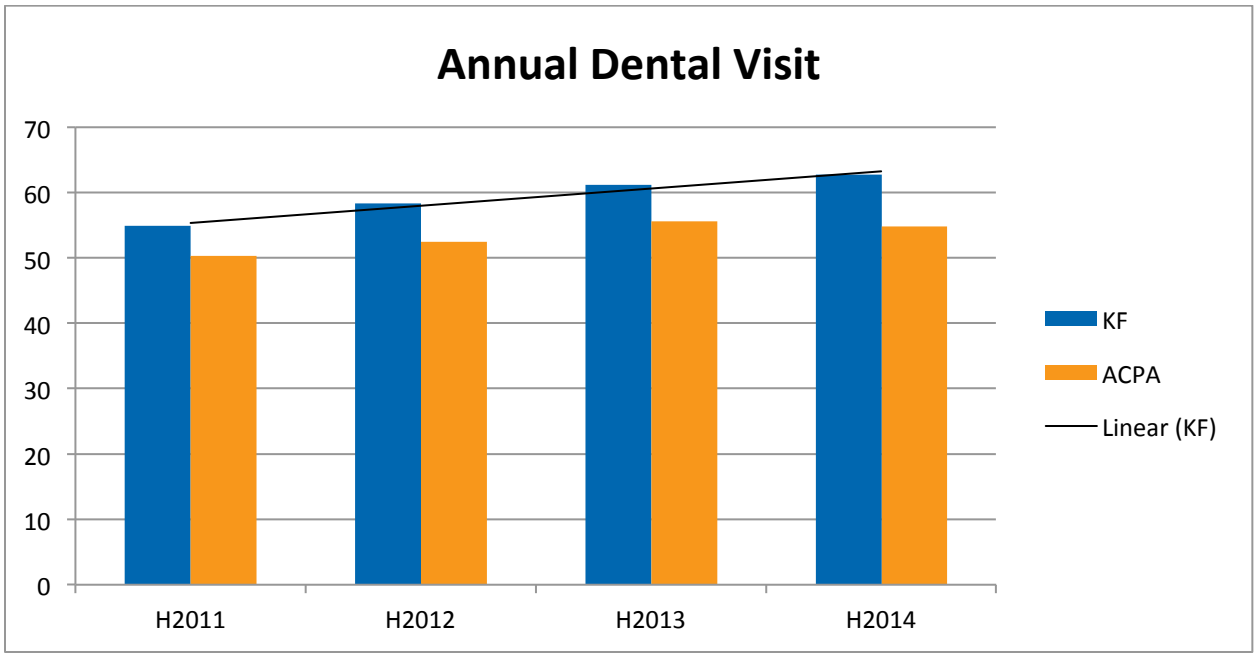


Exhibit 10.1-H: Dental visits (offered in AmeriHealth Caritas' PA plans), with one in 75th percentile; both in 50th percentile of Medicaid national average

2. Describe how you will utilize program data to support the development of the Quality Management and Improvement Work Plan.

AmeriHealth Caritas Iowa will analyze available data to identify baseline measurements for clinical indicators associated with high-prevalence chronic conditions and overall health status. Quality performance improvement initiatives will be developed for low-performing indicators as appropriate, as AmeriHealth Caritas Iowa's affiliates have done across the country. We continuously improve and innovate our services based upon data and feedback to ensure members are receiving optimal care and outcomes.

Use of program data

AmeriHealth Caritas Iowa will identify key measures and results for ongoing monitoring from various internal and external sources. Performance goals and benchmarks, where available, are identified for each measure based on performance targets, industry trends, state experience and quality committee recommendations. Using SAS-based and other analytical tools, AmeriHealth Caritas Iowa's Medical Economics team will perform a more detailed drilldown analysis to understand the drivers of different results.

AmeriHealth Caritas Iowa's robust data infrastructure – described below – allows us to collect, clean, analyze and incorporate data from a variety of sources into our program evaluation and refinement cycles.

- **HEDIS/CHIPRA results —** We use Inovalon's Quality Spectrum Insight software, an NCQA HEDIS-certified product to create a HEDIS/CHIPRA reporting repository that allows us to run monthly reports on progress toward HEDIS goals, identify low performing measures, and drill down to the member and provider level. This dataset serves as the backbone for our care gap infrastructure, allowing us to provide alerts and reports on overdue or missing recommended services to providers and AmeriHealth

Caritas Iowa staff working with members. Provider-level data from this system also feeds our provider performance programs.

- **CAHPS results (adult and child versions) —** We partner with NCQA-certified vendors to collect and analyze member satisfaction using the CAHPS survey tools. Results are analyzed at the individual question level and at the composite score levels. Annually, we add approved questions to the survey to collect data on special areas of focus.
- **Participant experience survey (PES) —** AmeriHealth Caritas Iowa will partner with the State to conduct the participant experience survey for members receiving home and community based services (HCBS). The family version of the PES tool will be used for interviews with children and their families and for adults who are unable to participate independently.
- **Provider satisfaction survey results —** AmeriHealth Caritas Iowa will use an outside vendor to objectively collect and analyze data on practitioner and provider satisfaction with our utilization management, care management, quality, credentialing and provider service programs. The data collection tool is refined each year to collect data on areas of importance to the provider network.
- **Medical and pharmacy claim data —** Data from medical and pharmacy claim transactions are fed from our TriZetto Facets® claim/eligibility system to AmeriHealth Caritas' data warehouse. We will use data from AmeriHealth Caritas Iowa claim transactions, as well as historical claim data provided by DHS, as a starting point in our analyses of utilization rates, chronic care and maternity incidence and outcomes, clinical guideline performance and gaps and health outcome measurement.
- **Care management assessment data —** Data collected through the care management process is stored in our ZeOmega Jiva® care management system. Specific elements, including new member assessment responses, comprehensive and condition-focused assessments and barrier identification will be used to identify non-claim related areas of focus and member response to interventions.
- **Eligibility and Demographic Data —** Eligibility feeds and updated demographic information collected by the Member Service team is entered into our Facets® claim/eligibility system. Member race, ethnicity, language and ZIP code/census block data will be used to identify important sub-populations and geographic pockets with specific needs. Information on Medicaid category and length of enrollment with AmeriHealth Caritas Iowa is used to augment clinical risk score analysis.
- **Member disenrollment surveys —** The reason for disenrollment, along with specific question response for members who disenroll voluntarily, will be collected by the Service Operations department. Information from member disenrollment surveys will be used to identify potential areas of dissatisfaction and/or gaps in plan services.
- **Utilization data —** Utilization data will be collected through our clinical care management system Jiva® and through analysis of claim information. Data on requested and incurred services is used as the basis for analysis of utilization management processes, such as prior authorization, as well as in evaluating health outcomes and clinical guideline adherence.
- **Provider access and availability data —** We use GeoAccess reporting tools and data collected from provider assessments to evaluate network adequacy and provider adherence to appointment and availability standards.
- **Internal service data —** AmeriHealth Caritas' systems and processes are set up to enable collection of performance data for all key service areas. Data related to AmeriHealth Caritas Iowa service levels, including phone performance (speed of answer, abandonment rate, hold time); transaction time

(authorization and claim timeliness); and performance quality (claim accuracy, encounter acceptance, denial processing) are used to identify areas of weakness and opportunities to improve performance.

- **Delegate subcontractor reports —** Monthly subcontractor report data will be reviewed by staff overseeing delegate performance and aggregated to identify trends and potential areas for service improvement. Key areas of focus, as appropriate to the subcontractor's scope of service, include phone performance (speed of answer, abandonment rate, hold time), transaction time (authorization and claim timeliness), and performance quality (claim accuracy, encounter acceptance, denial processing, trip timeliness).
- **Clinical Risk Groups:** AmeriHealth Caritas Iowa will license Clinical Risk Groups (CRGs) algorithms from 3M. CRGs are a risk-adjustment tool and clinically-based classification system used to measure a population's burden of illness through longitudinal analysis of medical and pharmacy claim data. Each individual is assigned to a single, mutually exclusive risk group. CRGs use the historical, clinical and demographic characteristics of the member to predict the amount and type of healthcare resources that the member will use in the future.
- **Potentially preventable events:** AmeriHealth Caritas Iowa will also license algorithms and software to identify and measure potentially preventable events (PPEs) from 3M. PPE analysis is used to allow AmeriHealth Caritas Iowa the ability to target interventions to members whose utilization patterns are most likely to be positively impacted through improved access and coordination of healthcare services. Conversely, a reduction in the level and number of PPEs indicates more appropriate utilization of healthcare services and a member's ability to better manage his/her condition.
- **Member medical records:** AmeriHealth Caritas Iowa will collect data directly from member medical records to support analysis of health outcomes.

We incorporate internal performance targets, standards and external benchmarks into our internal key indicator monitoring and reporting as we work with the State and provider partners to identify areas for additional analysis and, as necessary, implement quality improvement activities and corrective actions.

Data Source and Findings	Action Taken	Health Plan
Pharmacy claim data: low medication adherence rates (proportion of days covered [PDC]) for oral hypoglycemic, anti-hypertensive and cholesterol-lowering (statin) medication.	Implemented 90-day refill program, allowing member to receive a 90-day supply of the targeted medication classes. Members incurred a single copay (where copay applied) and pharmacies were paid two dispensing fees as an incentive (the health plan saved by reimbursing two dispensing fees versus what would have been three 30-day supply fees).	AmeriHealth Caritas Louisiana AmeriHealth Caritas Pennsylvania Select Health of South Carolina Florida True Health Keystone First
Inpatient utilization data and member medical records: length of stay in the neonatal intensive care unit (NICU) was extended for members in need of ongoing apnea monitoring; network durable medical equipment (DME) providers not willing to provide the equipment.	Identified new network provider for home apnea monitoring services; changed payment policy to provide enhanced reimbursement for the service; engaged services of NICU consultant to participate in case discussions with health plan staff and educate treating providers, as needed.	AmeriHealth Caritas Louisiana

Data Source and Findings	Action Taken	Health Plan
Utilization data and claim data: sharp increase in claims for speech therapy services after removal of prior authorization requirement.	Reviewed records associated with submitted claims and re-instituted requirement for prior authorization for speech therapy services.	Select Health of South Carolina
Utilization data: frequent requests for out-of-network service agreements for medically necessary skilled nursing facility services and cochlear implants.	Added to health plan network through change in payment policy to provide enhanced reimbursement for the service to qualified providers.	AmeriHealth Caritas Louisiana
Interim HEDIS results for health outcome measures: Significant volume of members missing or overdue for recommended services.	Implemented provider bonus campaign to incent providers to arrange for members in need of recommended services to receive the clinically recommended care.	AmeriHealth Caritas Louisiana AmeriHealth Caritas Pennsylvania AmeriHealth Caritas District of Columbia Keystone First Arbor Health Plan

Exhibit 10.1-I: Example Findings and Quality Improvement Actions across AmeriHealth Caritas

Race, ethnicity and language data collection

Each plan routinely analyzes health outcomes for race, ethnicity and language (REL) sub-populations. Through this analysis, we identified that both member and provider REL 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 REL 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 REL data capture, storage and retrieval. Since a high percentage of members’ REL data found on the States’ enrollment files are incomplete and or inaccurate, it was determined that a mechanism was needed to obtain REL data directly from the member and provider.

During the new 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.

Annually, providers are surveyed for their own REL 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, in order to ensure we are meeting the language needs of our members. In areas with opportunities, the Provider Network Management team puts a plan in place to address any gaps or identified needs.

Reduction in racial and ethnic healthcare disparities to improve health status

AmeriHealth Caritas' goal is to deliver care that respects the uniqueness of each member and directly benefits the communities we serve. Each AmeriHealth Caritas health plan has a distinct composition of REL. Review of the REL data for each plan confirmed that within our diverse population, many members in linguistic, racial and ethnic minority groups continue to have poorer health and lower-quality healthcare.

Member and provider feedback

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

Member satisfaction surveys

AmeriHealth Caritas will conduct a member satisfaction survey using the CAHPS® and the Iowa PES tool annually. CAHPS is designed to collect information on consumers' experiences with health plans. The PES is used for members receiving home and community based services (HCBS). The family version of the PES tool will be used for interviews with children and their families and for adults who are unable to participate independently. Results of the surveys will be analyzed and compared against available benchmarks, our health plan goals and other health plan results.

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

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

Member focus groups and targeted surveys

In addition to a formal annual CAHPS-driven member satisfaction survey, AmeriHealth Caritas Iowa will systematically monitor members' patterns of accessing healthcare with a variety of qualitative surveys and focus groups for all of our programs. For example, seven AmeriHealth Caritas plans ran postpartum focus groups in the first quarter of 2015 to improve our understanding of member perceptions and behavior drivers for postpartum visits, and field-test some of the messaging we use to communicate about perinatal health activities. Data analsysis is still underway, however early learnings indicate many members believe they had a postpartum visit, despite the absence of a claim or physician visit note during the postpartum visit window.

Analysis of dissatisfactions and grievances

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

Member Feedback Examples

Source	Feedback/Discussion	Action Taken
Feedback from Member Advisory Group (AmeriHealth Caritas Pennsylvania) following a presentation to the group on dental issues.	Members of the group suggested that the plan compile a list of participating dentists that could be given to medical providers so that they can relay this information to the members needing dental service.	Lists of dentists for each geographic area created and distributed to PCPs by network account executives. The PCP can hand the list to members needing preventive or other dental care.
Feedback from Member Advisory Group break-out session on improving HEDIS measures related to diabetes A1C testing.	Provide mobile phlebotomy to collect labs in home with a gift card incentive. Provide mobile phlebotomy at community events with gift card incentive.	Contracts for home phlebotomy services expanded and used for members in need of HgbA1c measurement and nephropathy monitoring. Gift card incentive added for members completing the needed care.
Feedback from members on the "Living Well" program for members with heart failure.	Members indicated that the name was being confused with "living wills."	The program was renamed/branded as "HeartFirst."
Member focus group feedback on postpartum care visits and Bright Start offerings after the birth of the child.	Members identified that there was not enough information provided on breast feeding.	Additional member education material on breast feeding is in the development/state approval process and will be added to the program.
Feedback solicited from parents of pediatric members who missed behavioral health appointments after their hospitalization.	Members reported that they did not keep the appointments because they did not want to have their kids miss any more school time after being hospitalized.	A program was implemented that uses home health agencies to go to a member's home and provide therapy in the home in the afternoon.
Feedback from Member Advisory Group on educational materials addressing anti-violence.	The group felt the topic was important and requested to have direct input on material development.	A sub-team was formed consisting of Member Advisory Committee members, health plan community education staff and health plan communication staff to develop additional content and formats.

Source	Feedback/Discussion	Action Taken
Feedback from members received through community events and other interactions.	Many members request that programs are delivered directly in their neighborhoods.	In the past eight months, requested educational programs were delivered in more than 50 locations throughout the health plan's service area, including local churches, FQHCs, YMCAs, Boys and Girls Clubs and other community locations.

Provider surveys

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

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

Provider service interactions

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

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

Provider feedback examples

Source	Feedback/Discussion	Action Taken
Medical director visit to Geisinger Center for Autism to solicit input on medical genetic testing; additional meetings held between the medical director and a local autism advocacy group.	The policy did not address specific testing indications and required a specific level of counseling.	Clinical policy adjusted to add specific indications for genetic testing and required counseling appropriate to the individual.
Quality team (medical director, pharmacist, quality director) visit to leading suboxone practice to solicit information on best practices.	Need to restrict providers prescribing suboxone to those who meet quality practice criteria.	Added requirements for prescribing policies and adherence monitoring to criteria for providers to be able to prescribe suboxone.

Source	Feedback/Discussion	Action Taken
Request from network surgeons to add coverage for gastric sleeve surgery.	Bariatric surgeons recommend gastric sleeve surgery over gastric bypass based on short- and long-term complication rates; however, the procedure was not covered by the state Medicaid fee schedule.	Agreed that the health plan would cover the sleeve surgery procedure and permit the use of a miscellaneous code. Joined with a group of surgeons to petition the State Medicaid agency to add coverage for the procedure to the fee schedule, so that it would be available for other Medicaid recipients in that State.
Request from plan providers through network account executive interactions to revise care gap alert time frames.	Care gap alerts for breast cancer and cervical cancer screening were displayed annually for members even though the preventive care recommendations indicated the service could be received every two or three years, respectively.	The logic to trigger the care gap alert was changed to align with HEDIS specifications, looking for a mammogram every two years and a cervical cancer screen every three years. Providers were notified via a fax blast.
Feedback from providers collected during focused outreach on discharge follow up.	PCPs identified that it was difficult for them to provide timely appointments for members after discharge from the hospital as they often were not aware that the member was admitted.	An automated fax was developed that is sent to the PCP office.
Call from provider in response to denials for Crinone® gel (for high-risk pregnant women with shortened cervix).	The physician reported that some prior authorization requests that she deemed appropriate use of the medication had been denied. We pulled data on these requests and did find that some appropriate requests were being denied as requests for fertility (an excluded category) when, in fact, they were being requested for pregnant women with short cervix. In addition, there was a claim edit that was alerting with the message "fertility drugs are excluded."	We re-educated prior authorization staff to be more attentive to the need and to differentiate between a request for a pregnant woman with a short cervix and one seeking to become pregnant. We removed the configuration for the claim error code. We revised our review criteria for the medication to specifically identify the appropriate use of the medication for at-risk populations.
Feedback from providers to the network account executive.	The plan added coverage for two albuterol (rescue) inhalers for school-age children when the second inhaler is requested by the physician. The providers felt the process was burdensome.	The plan revised the payment configuration to automatically permit payment for two inhalers for school-age members.

Source	Feedback/Discussion	Action Taken
Feedback from providers during a provider symposium meeting.	One provider mentioned that the office did not have anything to give a member to reinforce the importance of a postpartum physician visit.	The health plan's Bright Start and communication teams developed a brochure and made it available to providers.
Medical director outreach to leading infectious disease physicians at Drexel University (also member of the AASLD national guideline committee) and University of Pennsylvania to solicit input on clinical policy for hepatitis C management.	Draft policy did not acknowledge that in some populations up to one-third of people with hepatitis C are co-infected. Since HIV can make the person more susceptible to the hepatic damage of the hepatitis C virus, the guidelines on whom to treat needed an adjustment.	The guidelines were adjusted to recommend a lower threshold for treatment for people co-infected with HIV and hepatitis C than those with hepatitis C alone.

3. Detail your experience in and strategies for improving quality indicators, including HEDIS measures, CAHPS measures and satisfaction surveys. Describe how you will apply that experience in Iowa.

AmeriHealth Caritas understands how critically important ongoing measurement and evaluation are to the evolution of quality care delivery. Our rich heritage of performance for Medicaid populations is founded, in large part, on the development and implementation of quality measures and improvement processes — both grounded by our comprehensive data aggregation and analysis processes.

We will leverage the experience and best practices we have developed in other markets to create and implement successful initiatives to improve quality indicators (e.g., HEDIS, CAHPS, satisfaction) in Iowa.

Identifying performance improvement projects

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

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

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

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

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

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

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

Focused work teams

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

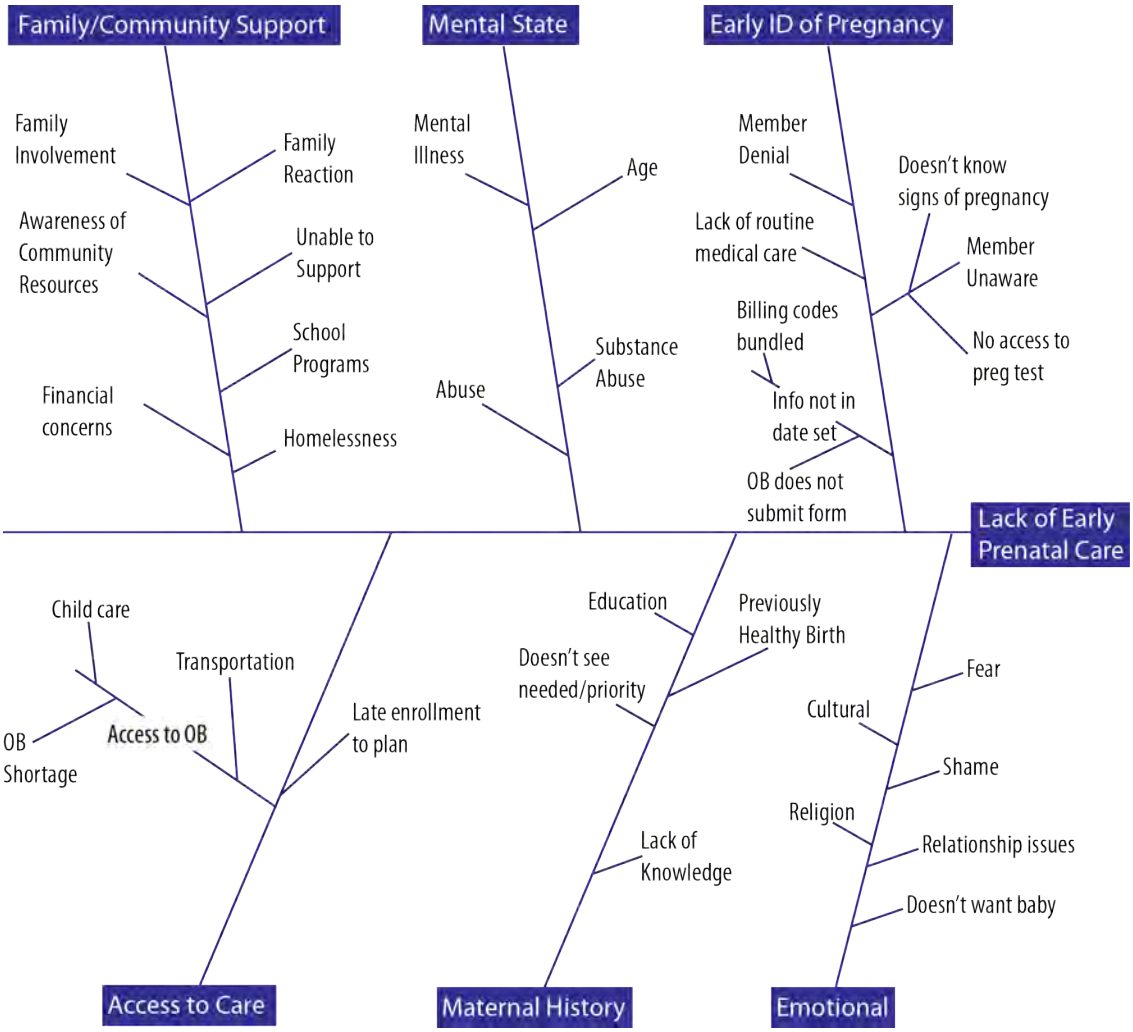


Exhibit 10.1-J: Drivers Behind Low Performance on Early Prenatal Care Metrics

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

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

Evaluation

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

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

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

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

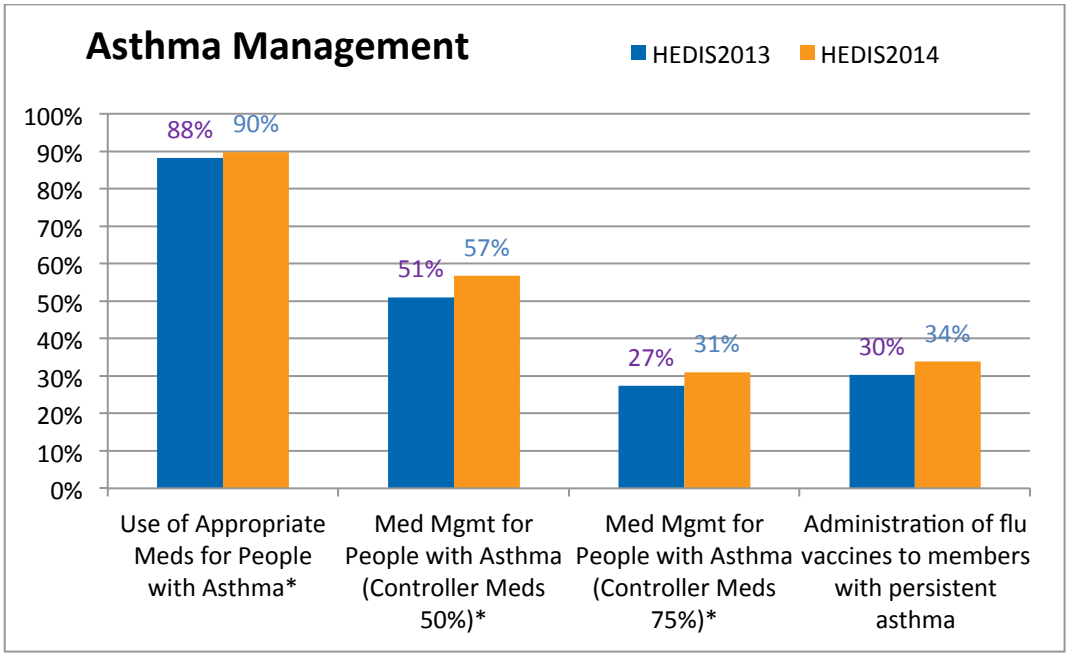
Track record of success

In addition to the several examples of improved quality indicators discussed throughout this section, two additional examples of focused quality improvement efforts from AmeriHealth Caritas Iowa affiliates are provided below.

Example #1 — Select Health of South Carolina

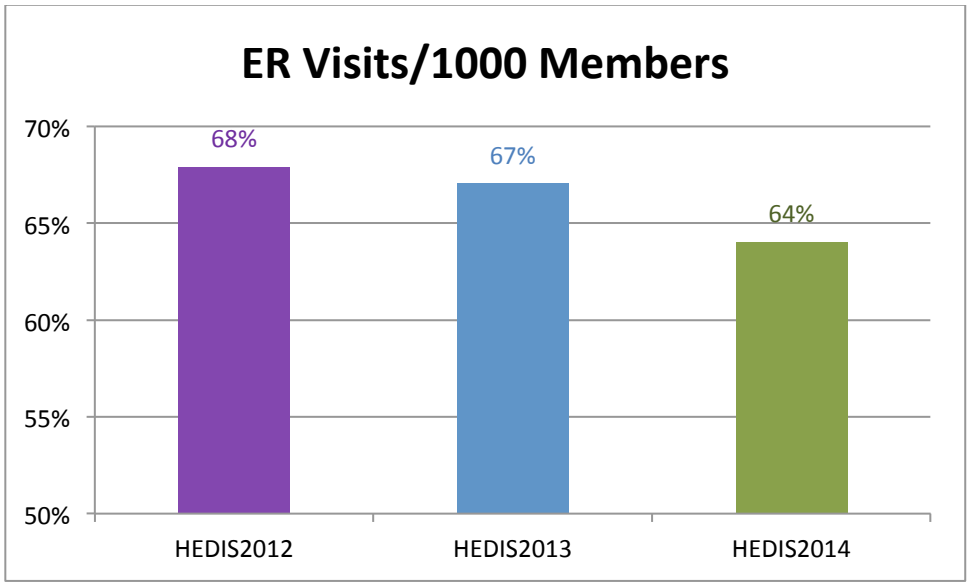
SHSC	Asthma Medication Management	Clinical
Goal	To improve asthma management in members with persistent asthma, including appropriate medication use (by 2 percent), medication management and administration of Influenza vaccines (by 5 percent each).	
Time frame	Baseline January 1, 2012 to December 31, 2012	M1 January 1, 2013 to December 31, 2013

SHSC	Asthma Medication Management	Clinical
Identified Barriers	Member education regarding the importance of receiving an annual flu vaccine. Provider practice variation in adherence to recommended asthma guidelines. Member education regarding asthma, self-management and treatment of asthma. Education of asthma care to caregivers in school and/or community settings. Member age may be a factor for compliance with asthma controller medications.	
Key Interventions	October – November — auto message ("sound bite") to identified high-risk members reminding them to follow-up with their PCPs to obtain an annual flu vaccine. October – January — customer service reminders (CSRs) after completion of inbound and outbound calls. (Member service CSRs will provide education on the importance of receiving flu vaccines and encourage members to follow up with their PCPs to obtain vaccine.) Promotion of clinical alerts on Provider Portal — alerts provide health-related information to providers that can be used to improve adherence to care guidelines and prompt the provision of recommended clinical services to members. HEDIS Year-to-date incentive offered to providers who scheduled an office visit with a member that has asthma to discuss their healthcare needs. Release of Clinical Summary Reports through the Provider Portal — this summary report provides information on members for medications, chronic conditions, gaps in care, ER visits, inpatient admissions and office visits. Health fairs to distribute asthma education information; added two additional community events for children with asthma. A process was added to case management outreach efforts for those with medication non-compliance for referral to a community outreach team for home visits to those that could not be reached by phone. Coordination with Family Connections/Project Breathe Easy for referrals of members with suboptimal medication compliance. A specific outreach effort was made to members who self-identified as having Spanish as their primary language. Case management staff presented communication with local pharmacies as on ongoing barrier for this population. Members (or their responsible party) were educated on how to receive translator services, were advised of Spanish speaking providers in their area and were offered educational materials and information for a mail order pharmacy in Spanish. Members of the quality staff attended state and district school nurse events to provide asthma related educational materials for schools and to assess and address any barriers to students asthma care. The team was subsequently invited to two school-based events to further assist students in the community with asthma care. Targeted outreach to providers with members below the threshold for compliance with appropriate controller medication. The members were identified via pharmacy data for being at risk for lack of controller fills.	

SHSC	Asthma Medication Management	Clinical
Results		
Analysis	The 5 percent goal for appropriate medication management for members with persistent asthma was met for controller medication: 50 percent for all age groups (including combined) except for ages 51 – 64, and for all age groups (including combined) without exception for controller medication 75 percent. The goal of a 5 percent annual increase in administration of influenza vaccine was met. The appropriate use of asthma medications has had a statistically significant upward trend for all age groups except for the 19 – 50 year olds (4.21 percent increase) for the 2014 HEDIS year. Select Health falls above the 75 percent NCQA benchmark for all but the 19 – 50 year age group (above 50 percent). This progress for the majority of age groups may be attributable to increased outreach efforts to the new member population along with the established asthma population. The health plan recognizes an opportunity to institute new interventions specific to the 19 - 50 age group members to overcome barriers and access appropriate medications and care.	

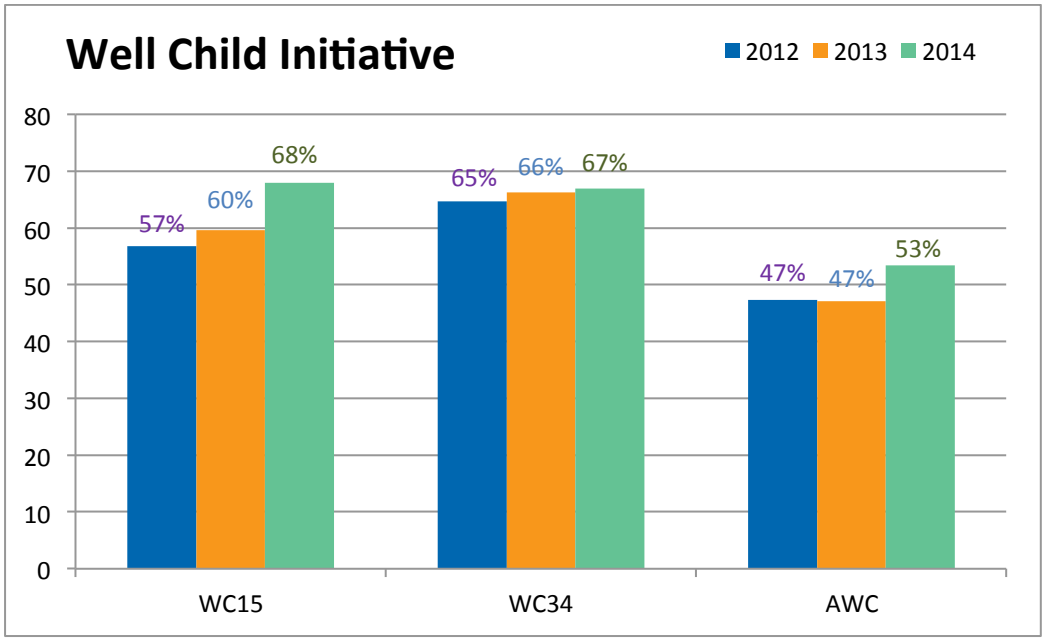
Example #2 — Keystone First

KF	Reducing Emergency Room Admissions		Clinical
Goal	To reduce the rate of emergency room (ER) utilization where other more effective and cost-efficient alternatives exist.		
Time frame	Baseline January 1, 2011 to December 31, 2011	M1 January 1, 2012 to December 31, 2012	M2 January 1, 2013 to December 31, 2013 2012
Identified Barriers	Members unaware of available ER alternatives. Parents of small children anxious when faced with a sick child. Unmet care needs related to underuse of primary care.		

KF	Reducing Emergency Room Admissions	Clinical
Key Interventions	During the measurement years, education was provided to providers and parents, including the following: 4 Your Kids Care program (facilitated over 100 classes in 2013, over 508 head of households attended; referred 67 children members to care management). Daily ER admission data from largest children's hospital (1,347 outreach calls made). Letters explaining the proper use of ER sent to members who utilize the ER for a potentially ambulatory diagnosis. Promoted availability of 24-hour Nurse Call Line through mailing of refrigerator magnets. Acute care transition nurse met with members in the ER (two facilities). Urgent care center listing posted on member and provider websites. Chester-based programs that include comprehensive health and social service for high-risk and high-ER utilizer members (30 members engaged in program). Community Outreach Solutions team outreach — in-person outreach to members who have not been seen by PCP to re-engage them in care and minimize ER use (1,538 total home visits made by COS team, 1,929 appointments made with 50 percent success rate).	
Results		
Analysis	Over the last two years, Keystone First experienced a steady decline in ER visits per 1,000 member months. The health plan's Provider Network Management department continues discussions with providers on issues of access to care for members and ER utilization. Furthermore, Keystone First utilizes the 4 Your Kids Care program as a member education tool to better educate members and parents of child members on the availability of the 24/7 Nurse Call Line, urgent care centers and proper ER utilization.	

Example #3 — MDwise Hoosier Alliance

MDHA	Well-Child Initiative		Clinical
Goal	To improve the rate of annual well-child visits to network providers by 5 percent over two years		
Time frame	Baseline January 1, 2012 to December 31, 2012	M1 January 1, 2013 to December 31, 2013	M2 January 1, 2014 to December 31, 2014

MDHA	Well-Child Initiative	Clinical
Identified Barriers	Member awareness of the importance of well-care visits. Members that were "no-shows" routinely scheduled appointments. Many provider offices lack adequate staff to make outbound well visit calls to their patients.	
Key Interventions	High-volume, low-performing provider groups were identified for assistance with member outreach. Health plan rapid response staff contacted members and used three-way calling to schedule appointments. "Everyone Needs a Check-up Day" events held at targeted provider offices with 200 or more non-complaint members. Well-child member reference cards were created to be used at outreach events to promote well-child visit schedules, immunization schedules and 24/7 nurse line. Members associated with small-provider offices (10 or less members) were sent a member incentive letter offering a gift card to complete the well-visit. Intensive medical record reviews were completed throughout 2014 to identify well-visits for members in the W15 measure completed in the first 30 days of life requirement. Intensive medical record reviews were completed throughout 2014 to identify well-care visits completed for members who may have other primary (TPL) insurance that paid for well-visit in full. Account executives coordinated block scheduling events "Healthy Hoosier Days" for smaller-provider offices (with less than 200 panel members) which offered a gift card to members who completed a well-visit on the event day. Members in the adolescent well-care denominator who may be entering high school were sent a reminder letter to have a state required immunization before October that encouraged a well visit at the same time.	
Results	 W15 - The percentage of members who turned 15 months old during the measurement year and who had a minimum of six well-child visits prior to turning 15 months. W34 and AWC - The percentage of members 3 – 6 and 12 - 21 years of age who had one or more well-child visits with a PCP during the measurement year.	

MDHA	Well-Child Initiative	Clinical
Analysis	Rates for WC15 improved by 5 percent each year, exceeding the goal. Rates for WC34had a statistically significant increase over the two years, but were one percentage point below the goal. Rates for AWC exceeded the goal of a 5 percent increase over two years.	

4. Describe your experience and strategies in working with network providers to improve outcomes.

We work collaboratively with network providers, aligning incentives and sharing information, to improve health outcomes for our members. Our approach incorporates an active Network Account Executive team, dedicated clinical educators, a robust portfolio of value-based contracting models (PerformPlus®), embedding staff in provider offices and facilities and actionable information sharing.

Network account executives

As described in Section 6, our state-wide Network Account Executive (AE) team is a critical component of our strategy to partner with providers to improve outcomes. AEs work directly with providers and their office staff to communicate quality goals, ensure provider access to performance data, gather feedback on provider barriers and leverage additional health plan resources to assist the provider to impact our members. AEs provide training to office staff on accessing member- and panel-level information for the practice, so that the provider knows which members are missing recommended services (such as a well-care visit) or have conditions that require monitoring, such as hgbA1c screening for members prescribed antipsychotic medications.

The AEs also keep providers' offices informed of planned quality activities and priorities for the health plan. For example, AEs alert the offices to bonus campaigns run during the year, which pay additional monies to the providers for targeted services, such as adolescent well-care visits. The AEs will also work with the providers to identify ways that AmeriHealth Caritas Iowa can assist the providers to meet quality outcome goals. For example, the AEs may organize outreach campaigns for the offices to have members in need of screenings or other services schedule an appointment.

Clinical educators

AmeriHealth Caritas Iowa's clinical educators will provide additional support and education to providers and office staff on key topics that drive important member outcomes. The initial focus for the AmeriHealth Caritas Iowa clinical educators will be on management of depression in the PCP office and cholesterol management. Additional planned topics include management of anxiety disorder and trauma-informed care principles. Clinical educators will schedule time convenient for the provider and the office staff.

Each topic presented will include a provider tool kit containing additional information, desk-top resources and additional assistance available from AmeriHealth Caritas Iowa. For example, the depression management tool kit includes information on PHQ9 and PHQ9a screening, first-line treatment regimens for depression, guidelines for evaluating treatment response and the mechanism to refer the member for additional therapy if the first-line treatment is not successful. The goal is to give the provider the tools necessary to successfully manage the member's needs.

Value-based programs

AmeriHealth Caritas Iowa recognizes that best practice occurs when goals are aligned between the State and the supplier. By incorporating the goals that are defined by the State's Value-based Program (VBP) into our contracting and incentive programs, AmeriHealth Caritas Iowa is able to present these goals to the provider and ultimately the member to make Iowa a healthier State.

AmeriHealth Caritas has over 30 years of managed care experience, and has learned that providers are more actionable when pay-for-performance drivers are in place to incent behaviors, and that value-based purchasing can be a catalyst for continual improvement. AmeriHealth Caritas Iowa will regularly monitor provider performance to ensure the tools and resources provided via the PerformPlus shared savings programs are leading to persistent improvements in quality of care.

AmeriHealth Caritas Iowa will use our data collection, analysis and reporting capabilities to drive improvements and cost effectiveness in our provider network. As best practices are identified, they will be shared with our providers. VBP trends will be used to guide investment decisions and program modifications. Provider performance will be used to steer members to higher-performing providers while eliminating the lowest performers from our provider network.

Regular trend analysis and annual assessments

Our Quality and Provider Network Management teams will regularly collect data about provider performance to identify trends indicating that quality of care may be at risk. This includes utilization patterns, HEDIS measures, claims submission/billing issues and even litigation activities against providers. As appropriate, corrective actions will be taken to rectify provider behaviors. These trends and activities will be considered during AmeriHealth Caritas Iowa's contracting and rate setting processes. Individual cases may also be peer reviewed by our Quality of Clinical Care Committee.

In addition to ongoing analysis, an annual provider performance assessment will be conducted to derive insights about the network. The assessments will help Quality staff identify providers who:

- Serve the largest number of members.
- Use the most effective condition management methods.
- Create best practices.
- Leverage patient centered medical home (PCMH) capabilities to best effect.

By identifying these providers, AmeriHealth Caritas Iowa will be able to better support them in innovating further. We will also work to circulate the innovations or best practices throughout the network so that our providers can deliver the best care possible to our Iowa members.

Provider report cards

One of the primary ways we will accomplish this is through provider report cards, which will be created for network providers, notably those participating in PerformPlus shared savings programs mentioned in section 10.3. The report cards will outline the provider practice's performance on specific quality indicators, including comparisons against previous years, as well as peers, and will be available via the Provider Portal at the end of a performance period. The goal of the report cards is to present meaningful feedback and identify causes and other contextual information so that providers have the intelligence they need to make changes within their practices/groups.

Provider network account executives will hand-deliver report cards and checks for any incentive payments the practice has earned at the end of the performance period. The account executive will sit down with

each provider to walk through the findings, including the practice's potential versus actual earnings. For providers who have demonstrated improvements, the chief medical officer will accompany the account executive on the provider visit. In addition to reviewing the report card results, the chief medical officer will have clinician-to-clinician discussions with the provider about the interventions used to achieve the change.

Embedded staff

We also partner with providers to embed care management staff at their locations. Each of these partnership arrangements is slightly different, depending on the needs and goals of the provider. Through these arrangements, we currently have care managers placed in hospital ERs and inpatient settings, primary care provider offices, community mental health centers and state behavioral health treatment sites. We are actively working on a partnership to place a Bright Start care manager in a high-volume maternity office providing care to many of our high-risk members in southeastern Pennsylvania.

We also embed our community care connectors in high-volume practices. The care connector meets with at-risk members identified by the practice while the member is in the office for the office visit. The care connector then follows up with the member at home to ensure that the member is able to successfully implement recommended treatment steps and medication regimens. The care connector will assist the member to access additional community and health plan resources to address identified barriers and treatment goals.

The care connector brings feedback on the member's progress and barriers identified during home visits back to the practice's clinical team. Weekly team meetings — called huddles — are led by the practice's clinical staff to review all of the high-risk members followed by the care connector. During the huddle, team members share information on their interactions with the member, review current information on the member's utilization and medication refills and strategize on next steps to assist the member to meet his/her goals.

The Keystone First, AmeriHealth Caritas Iowa's southeastern Pennsylvania affiliate, Community Case Management team has been instrumental in the management of the most medically and social-economically complicated patients of our practice. The opportunity to collaborate with nurses, social workers and community care workers from Keystone First, and more closely work with the patients themselves, allows us to better exchange information and combine resources. The results are expanded services and improved coordination of care for our challenging patients."

George Valko, M.D.
The Gustave and Valla Amsterdam Professor of Family and Community Medicine
and Vice Chair for Clinical Programs and Quality
Thomas Jefferson University Hospitals

Actionable information sharing

In addition to the dashboards and rich information sets available through the PerformPlus model described above, AmeriHealth Caritas Iowa will provide actionable information to providers at the point of care and as aggregate reports. When a provider office enters a member ID number into AmeriHealth Caritas Iowa's secure Provider Portal, the staff will see a pop-up alert if that member has a missing recommended service (gap in care).

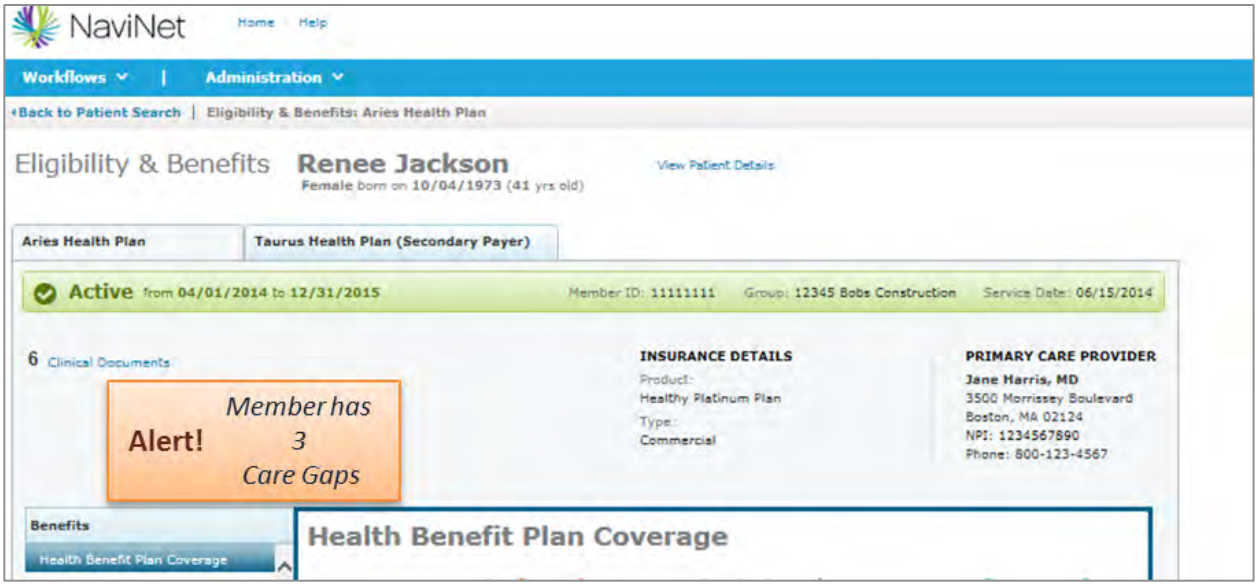


Exhibit 10.1-K: Care Gap Alerts Display on the Provider Portal

Clicking on the alert displays a member-specific care gap worksheet that identifies the missing or overdue service, along with a list of up-to-date care gaps for the provider's reference. The care gap worksheet is formatted to allow for easy printing and inclusion in the member's chart.

PCPs will be also able to access the information at the panel level, allowing them to use population management techniques within their practice. This panel-level information will be available as a printable report or a comma separated value (CSV) file for compatibility with other electronic systems.

AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa - Member Roster for May 2015

AmeriHealth Caritas Iowa PO. Box 307 Ackworth, IA 50001 Phone: Provider Services (800) 111 3312 Pharmacy Rx (866) 221 4412	Group Information*	Primary Care Physician*	Payer ID Number:
	HOUSE CALL GROUP PC [80017814] 1110 213th Ave Ames, IA 50010 Phone: 515-112-3322	JORT, SHARON [80017815] 1110 213th Ave Ames, IA 50010 Phone: 515-223-4433	01234

AmeriHealth Caritas Iowa

Member Name	DOB	Effective Date	Member ID	Address	Phone	Gender	Age	Language	New Member
Mack, Joseph	03/18/06	04/01/2015	000001111	15 Main St Ackworth, IA 50001	515-331-5512	M	8	English	Yes
Madison, Jessica	01/12/85	05/01/2012	000002222	230 South St. Apt B Ames, IA 50010	515-441-6612	F	30	English	
Martinez, Luz	07/13/12	03/20/2015	000003333	7 Orange St Adair, IA 50002	641-551-7712	F	2	Spanish	Yes
Mendoza, Marie	03/12/99	04/01/2015	000004444	2013 Pine St Baxter, IA 50028	641-661-8812	F	16	Unknown	Yes
Miller, Yassan	09/15/90	06/01/2014	000005555	17 East St Washington, IA 50022	712-771-9912	M	24	English	
Moore, Ann	02/28/74	02/01/2015	000006666	31 Alley Way Davis City, IA 50065	660-881-0012	F	41	English	

(*) If any of Provider Demographic Information shown is inaccurate or incomplete, please contact your Provider Account Executive immediately to update your records.

AmeriHealth Caritas Iowa. Notification or Authorization may be required. Please reference online resources for access to care rules & limitations as well as contracted providers, networks, and pharmacies.

Exhibit 10.1-L: Provider Panel Report

5. Outline the proposed composition of your Quality Management and Improvement Committee, and demonstrate how the composition is interdisciplinary and appropriately represented to support the goals and objectives of the Quality Management and Improvement Committee.

The Quality Assessment Performance Improvement Committee (QAPIC) oversees AmeriHealth Caritas Iowa's efforts to measure, manage and improve quality of care and services delivered to AmeriHealth Caritas Iowa's members as well as evaluate the effectiveness of the QAPI program. The QAPIC directs and reviews AmeriHealth Caritas Iowa's quality improvement and utilization management activities. The QAPIC reports through AmeriHealth Caritas Iowa's market president to the regional president and, ultimately, to the AmeriHealth Caritas Iowa board of directors.

The composition of the QAPIC, detailed below, includes representatives from the AmeriHealth Caritas Iowa network. Five subcommittees report in to the QAPIC: Quality of Service (QSC), Quality of Clinical Care (QCC), Culturally and Linguistically Appropriate Services (CLAS), Credentialing and Pharmacy and Therapeutics (P & T).

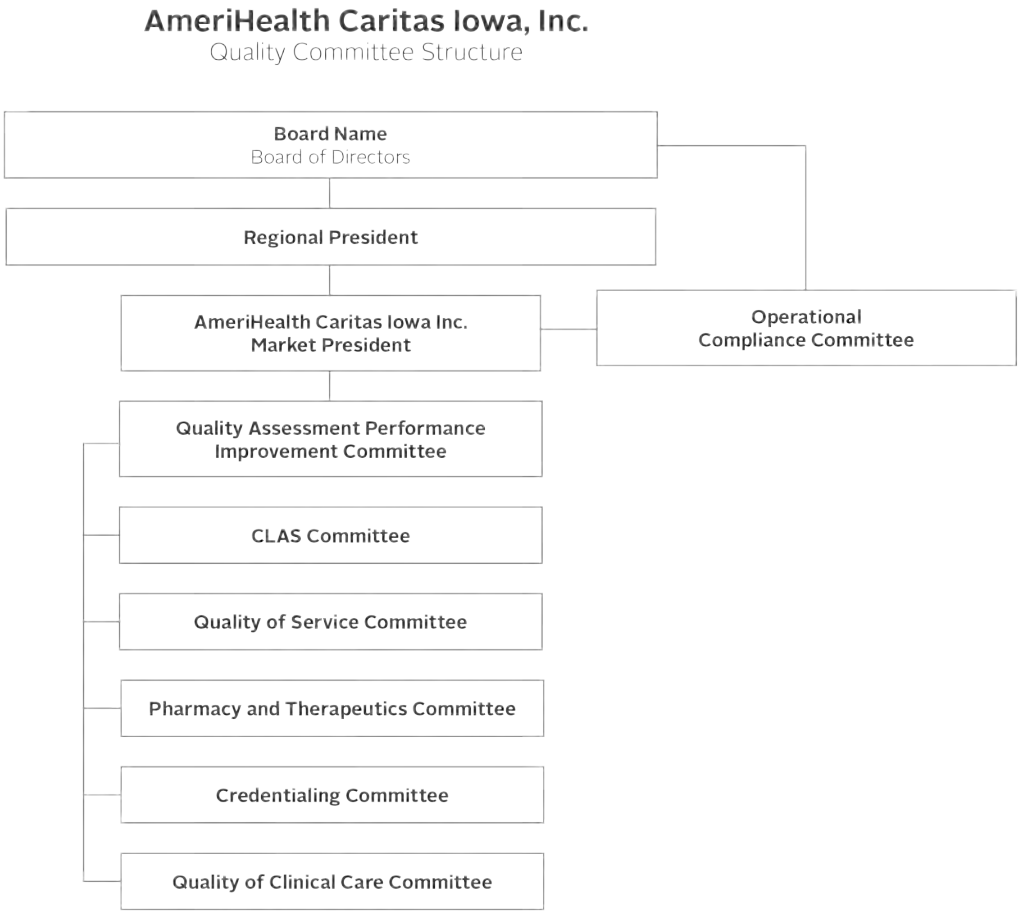


Exhibit 10.1-M: AmeriHealth Caritas Iowa Quality Committee Structure

QAPI Committee membership

The QAPIC will comprise a combination of AmeriHealth Caritas Iowa leadership and participating providers in the AmeriHealth Caritas Iowa network. The chairperson of the QAPIC is the AmeriHealth Caritas Iowa medical director. Additional AmeriHealth Caritas Iowa committee members include:

- Director of Quality Management.
- Director of Utilization Management.
- Director of Integrated Healthcare Management.
- Manager of Long Term Services and Supports.
- Director of Rapid Response and Outreach.
- Director of Provider Network Management.
- Director of Service Operations.

In addition, the QAPIC has voting members from the AmeriHealth Caritas Iowa provider network. The AmeriHealth Caritas Iowa medical director and Provider Network Management team will recruit interested providers to participate as committee members. Every effort will be made to recruit the following provider types:

- Two to three primary care providers, ideally including representation from a federally qualified health center (FQHC) or FQHC-like practice and a smaller practice.
- Two to three specialty physician providers, ideally including an OB/GYN.
- Two LTSS providers, ideally including an in-home service provider.
- One to two ancillary providers, ideally including a therapist.

By including the above mix of providers and health plan representatives, AmeriHealth Caritas Iowa will create representation to support the quality goals and activities important for the AmeriHealth Caritas Iowa member population. To encourage external provider participation, AmeriHealth Caritas Iowa will offer providers a stipend for meeting participation, provide light refreshments and schedule meetings at a time convenient to the external providers. For example, in our Pennsylvania-affiliate health plans, the QAPIC meets at 6:00 p.m., to meet the needs of providers participating on that committee; in our South Carolina- affiliate, the QAPIC meeting occurs at 7:30 a.m. We have begun conversations with providers in Iowa to introduce ourselves and our programs.

Stakeholder Advisory Council

The primary goals of the Stakeholder Advisory Council will be to improve the health status of members and to enhance service delivery to providers and members. The council will provide input and feedback to the QAPIC. Information gathered from the council will provide AmeriHealth Caritas with direction, feedback and the necessary support for our member outreach and quality improvement initiatives. We will use this forum to promote the medical home, develop policies and procedures, share best practices, establish priorities, evaluate findings and implement action plans as needed.

As described in Section 8.12 of our response, Stakeholder Advisory Council members will range in experience and will incorporate members (consumers), agencies (service providers) and advocates representing healthcare, the community-at-large and social issues impacting health equity. Insight and feedback from the Stakeholder Advisory Council will be used to make enhancements to programs and processes that may lead to improved customer service (members and providers) and health outcomes. We are committed to developing a robust membership roster for our Stakeholder Advisory Council. The following is a representative list of organizations we plan to recruit from:

- Central Iowa Shelter and Services.
- Child & Family Policy Center.
- Coalition for Family and Children's Services.
- Disability Rights of Iowa.
- Iowa Community Action Association.
- Iowa Health Care Association/Iowa Center for Assisted Living.
- Iowa Public Health Association.
- Leading Age Iowa.
- Lutheran Services in Iowa.
- Mainstream Living.
- The Arc of Story County.

Additional information on the Stakeholder Advisory Council can be found in Section 8.12.

10.2 State Quality Initiatives

1. Describe how you propose to work with the Healthiest State Initiative.

As discussed in Section 8.7, AmeriHealth Caritas Iowa applauds the Healthiest State Initiative, which supports addressing the "health of the whole person," and looks forward to partnering with DHS to promote this initiative as we move toward delivering the next-generation of healthcare in Iowa and help Iowa reach the #1 spot in the Gallup-Healthways Well-Being Index®. When selected, AmeriHealth Caritas Iowa will meet with DHS as soon as possible to identify and launch activities to support and achieve the goals of Iowa's Healthiest State Initiative. We share your belief that health is a state of complete physical, mental and social well-being and not merely the absence of disease or illness. We also believe that Medicaid beneficiaries should be provided the same tools available to all Iowans to help them learn how to make lifestyle changes to improve their health status. In addition to the programs previously provided that will support Iowa's health and wellness goals, AmeriHealth Caritas Iowa is ready to help promote Iowa's Healthiest State Initiative directly with members as well.

AmeriHealth Caritas Iowa's will offer a broad selection of community education programs and educational mobile applications that support Healthiest State program goals. These programs are open to all members of the community, and delivered in partnership with community agencies and faith-based organizations.

Several topics we plan to offer to support Iowa's Healthiest State Initiative:

- Before, During and After: Steps to a Healthy Pregnancy.
- Healthy You Healthy Me (childhood weight management, smart snacking and activity levels).
- Heart Health (separate curricula address children and adults).
- Many Tips for Healthy Living (health and wellness for men, including tobacco cessation).
- Outdoor Safety (summer safety tips for children).
- Stay Strong, Live Healthy (health and wellness for women, including tobacco cessation).
- Taking Care of Yourself, Healthy Tips for Teens (Health and wellness for teenagers, including tobacco cessation).
- Youth Sports Safety (reducing risks for sports-related injury for children ages 6 to 14).

AmeriHealth Caritas affiliates have partnered with government agencies on similar initiatives in the past. As an example, our affiliate health plan in Washington, DC, developed the "I am healthy" campaign to promote healthy living to members and the general public.

Exhibit 10.2-A: "I am healthy" campaign example

2. Describe how you propose to work with the Mental Health and Disability Services Redesign.

The Mental Health and Disability Services Redesign is a remarkable accomplishment for the state of Iowa in providing local services while also expanding choice for Iowans regionally and supporting better, integrated care. AmeriHealth Caritas Iowa is ready and able to support the state in making this transition.

The move to an MCO model including all populations and conditions is a natural next step in the Iowa Mental Health and Disability Services Redesign is supported by an integrated managed model of care. We focus on holistic care and empowering consumers to self-direct their recovery process, while keeping consumers in their communities and assisting them to live productive lives. AmeriHealth Caritas does not subcontract management of behavioral health services out to another company to manage and will directly and actively partner with Iowa and the Mental Health and Disability Redesign to meet its goals.

Integrated care support

- Facilitate behavioral health (BH)/physical health (PH) integration through our integrated model and medical record. We are a resource to the providers to see the bigger picture of their patient as we keep records of a member's pharmacy, PH and BH information. We can inform them regarding the other providers the member is seeing, what medications they are on and when they last got their prescriptions filled. We notify PCPs when one of their patients/our members has been treated in a mental health hospital setting to ensure that the PCP knows the aftercare plans and medications on discharge. Details on our information sharing capabilities and processes are outlined in Section 9.
- Hire clinical trainers to train PCPs about common behavioral health conditions, how to screen for them, first level treatment strategies and referral pathways for positive screens. We also ensure the PCP is paid for any behavioral health work they do.
- Address the stigma of mental health through the integration of services on the provider level. AmeriHealth Caritas' co-location models and telehealth offerings allow members to receive all of the services they need at the setting of their choice. For example, members who are comfortable receiving care at a local community mental health center should be able to receive physical healthcare in the same setting. We will work to have behavioral health service options available sites where members have connected with the PCP and are in need of behavioral healthcare.

Collaborate with current systems

- Collaborate with the regions to identify gaps specific to that region, then help design and implement a solution to fill the gap. Help the regions provide expanded core services and other innovative treatments.
- Work with the established integrated health homes to develop a model to specialize in care for the intellectually disabled (ID) population.

Supporting member choice

- Support the concept of keeping members in their communities and not in institutions/facilities (as discussed within Section 4 of this response). Our IHM model is based on empowering members to self-direct their treatment and self-manage their chronic conditions. We work with members to develop natural support resources and safety plans to enable them to be productive citizens and achieve recovery. We engage our members in planning and oversight of our programs. Our model involves supporting the member in developing their individualized plan of care; they choose who

participates in planning and intervening, they prioritize goals and they monitor progress with support from the health plan IHM.

- We will be flexible with providers of HCBS to allow them to provide the right amount of service at the right time. We will not dictate that services be provided a minimum of X hours per day; we will manage it at the aggregate level by applying some upper limits based on medical necessity (i.e., X hours per month) and allow the consumer and provider to determine the best times and ways to use those hours. If they need additional hours, the provider can request them with a medical necessity justification. Also, establish expected outcomes for providers and monitor for them. Hold providers accountable for providing quality care.
- Partnering with vendors to empower consumers to hire their own HCBS workers. Available platforms we are researching allow the members to create a profile of their needs and wants. The platform matches the member with available workers who meet those needs. The member is able to consider several choices and determine the best fit.

3. Propose strategies to incorporate the Value Index Score (VIS) as a tool to drive system transformation, and other strategies to support the State Innovation Model (SIM).

Value Index Score (VIS)

AmeriHealth Caritas has partnered with 3M since 2008 and has scaled the platform of preventable services and clinical risk grouping software to all states in which we operate. Components of the Value Index Score (VIS) have already been incorporated into our PerformPlus value-based programs and have proven successful in our historical and current partnerships. Specific VIS domains currently in use include:

- **Primary and secondary prevention measures —** included in our Quality Enhancement Program (QEP) PCP shared savings program and women's health program.
- **Tertiary prevention —** included in our PerformPlus shared savings program, QEP, cardiology program, oncology program and community partner's program for FQHCs.
- **Panel health status change —** currently provided via our Web Portal to all our PerformPlus shared savings program partners. We have been utilizing Clinical Risk Groupers (CRGs) in all markets for both clinical stratification and risk adjustment for several years.
- **Chronic and follow-up care —** a key component, potentially preventable readmissions (PPRs), is included in our PerformPlus shared savings program, cardiology, oncology and FQHC community partners program
- **Efficiency —** the relative efficiency of physicians is calculated by the total CRG risk-adjusted score in our QEP PCP model. Additionally, the total preventable services are a key component of both our internal clinical and external value-based strategy. Generic prescribing rates are provided, via our Web-based dashboards, on a monthly basis to all our value-based partners.
- **Continuity of care and patient experience —** tracked and reported in our quality initiatives and in several of our value-based initiatives via our patient attribution methodologies.

AmeriHealth Caritas is well positioned to adopt the 3M VIS, which uses the same metrics that are already part of our PerformPlus programs. We have implemented the full 3M platform in our affiliate health plans in Pennsylvania, South Carolina, Louisiana, Indiana, Nebraska and Washington, D.C., over the past seven years and are able to rapidly and accurately launch this as well as the accompanying value-based programs and transparency portals in Iowa.

State Innovation Model (SIM)

The goal of the State Innovation Model (SIM) grant is to transform Iowa's healthcare economy so that it is affordable and accessible for families, employers and the state and achieves higher quality and better outcomes for patients. Iowa is working to achieve this goal by implementing multi-payer Accountable Care Organizations (ACOs) and incorporating population health, health promotion and member incentives into the delivery system. Iowa received a model design grant in 2013 from the Centers for Medicare and Medicaid Services (CMS), and has applied for a testing grant to continue the work on transforming Iowa's healthcare delivery system.

In support of the Iowa State Innovation Model (SIM), AmeriHealth Caritas Iowa will leverage the enhanced payment models and information sharing capabilities of our PerformPlus portfolio. We will actively participate in the design of multi-payer arrangements, and contribute our expertise in payment modeling, risk adjustment and program design. The information we currently share through our PerformPlus dashboards can also be distributed through other channels, including a Health Information Exchange (HIE)-powered multi-payer information system.

4. Describe your experience in supporting a State authority in meeting the requirements of the Department of Health and Human Services Substance Abuse and Mental Health Services Administration Substance Abuse Prevention and Treatment Block Grant.

AmeriHealth Caritas currently supplies data to support New Jersey's state submissions for the substance abuse prevention treatment block grant through the Department of Health and Human Services (DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA). Additionally, we supply data for the community mental health block grant to the New Jersey Division of Child Behavioral Health Services (DCBHS).

Our systems can be configured to collect and report a wide variety of data, depending on the reporting needs associated with the grant. We have a strong track record of on-time accurate delivery of reporting information. Additional information on our reporting capabilities can be found in Section 14.

5. Submit a project plan describing your specific approach and timetable for addressing this section.

Healthiest State Initiatives

Iowa's Healthiest State Initiatives are based on more than five key milestones intended to improve Iowa's 2014 score of #16 in United States to #1 by 2016. To support this effort, AmeriHealth Caritas Iowa will integrate key program components designed to increase the consumption of fruit and vegetables and to increase physical activity.

To spearhead this plan, AmeriHealth Caritas Iowa will identify a core team to focus on the key intersections between AmeriHealth Caritas Iowa's programs and Healthiest State goals. Success in this area hinges on communications. To address this we will leverage communications to our members via our community-based staff. We will also enhance provider communications to include key information on these initiatives. A detailed marketing campaign will be created.

Ensuring that information is distributed effectively, a feedback mechanism focused on participant surveys will be created. Information collected via these surveys will be collected, compiled and used to understand program penetration and identify ways to improve programs going forward.

Mental Health and Disability Service Redesign (MHDS)

In support of the Mental Health and Disability Service Redesign (MHDS), AmeriHealth Caritas will create an ongoing working team to review elements of the redesign and incorporate them in our approach. We will identify specific tasks to integrate MHDS In our QAPI work plan. The team will include representatives from different functional areas and external representatives from the behavioral health, LTSS and advocacy communities. Moving forward the team will create Year 1 strategies which will include the following: information sharing, LTSS/BH gap analysis, LTSS approver flexibility and primary care network training. A plan to address service gaps will also be created.

State Innovation Model (SIM)

Implementation of our support for the Iowa State Innovation Model (SIM) will be somewhat dependent upon the state's continued plans for that effort. We will actively pursue ACO-like agreements with willing providers in the state of Iowa and stand ready to assist with design elements and information sharing for multi-payer contracting efforts.

Value Index Scores (VIS)

To support the addition of the VIS capability to our existing array of Treo 3M modules, AmeriHealth Caritas Iowa will enhance our relationship with 3M to fully implement VIS calculation capability. We will educate internal staff on the use of VIS so that we can use the output in meaningful ways for our internal provider performance evaluation and as we assist providers to understand their performance in the context of the VIS output.

Substance abuse prevention and treatment block grant

To facilitate data in support of the substance abuse prevention and treatment block grant, AmeriHealth Caritas Iowa will map data submission requirements against currently available data, develop a data capture and reporting strategy for any missing data and test the output. If possible, we will send test files for validation, prior to submitting program data.

Project plan

A project plan that addresses the elements above, including a time table is outlined below.

Task Name	Duration	Start	Finish	Resource Names
IOWA RFP Section 10.2				
10.2.1 Healthiest State Initiatives (HSI)	**414 days**	**Mon 2/1/16**	**Thu 8/31/17**	
IDENTIFY TOPICS - Initiation				
Identify focused team to coordinate integration with HIS	3 days	Mon 2/1/16	Wed 2/3/16	Iowa/AmeriHealth Caritas teams

Task Name	Duration	Start	Finish	Resource Names
Identify and document key points from Iowa HIS	5 days	Thu 2/4/16	Wed 2/10/16	Iowa/AmeriHealth Caritas teams
Formulate plan to deploy and drive AmeriHealth Caritas initiatives in support of HIS	15 days	Thu 2/11/16	Wed 3/2/16	AmeriHealth Caritas deployment team
DEPLOYMENT APPROACH	**93 days**	**Thu 2/11/16**	**Mon 6/20/16**	
Focus on the consumption of produce	**35 days**	**Thu 3/3/16**	**Wed 4/20/16**	
Integrate promotion and use of produce coupons to members	15 days	Thu 3/3/16	Wed 3/23/16	Quality Director
Develop coupon distribution method(s)	20 days	Thu 3/24/16	Wed 4/20/16	Quality Director
Focus on Walking	**20 days**	**Thu 3/3/16**	**Wed 3/30/16**	
Identify and promote walking groups	20 days	Thu 3/3/16	Wed 3/30/16	Project Team, Quality Director
PLANNING	**93 days**	**Thu 2/11/16**	**Mon 6/20/16**	
Utilize community outreach teams	20 days	Tue 3/1/16	Mon 3/28/16	AmeriHealth Caritas deployment team
Collect information on partnership task	15 days	Tue 3/29/16	Mon 4/18/16	AmeriHealth Caritas deployment team
Review information for partners decision, plan leaders, market president, medical director	15 days	Tue 4/19/16	Mon 5/9/16	AmeriHealth Caritas deployment team
Integrate program availability with staff, care managers, Community Outreach, Care Management Teams	30 days	Tue 5/10/16	Mon 6/20/16	AmeriHealth Caritas deployment team
Develop marketing plan	90 days	Thu 2/11/16	Wed 6/15/16	Marketing Team
COMMUNICATIONS	**75 days**	**Thu 3/3/16**	**Wed 6/15/16**	
Provider Communications	**75 days**	**Thu 3/3/16**	**Wed 6/15/16**	
Create information	20 days	Thu 3/3/16	Wed 3/30/16	Communications Team
Complete internal review	5 days	Thu 3/31/16	Wed 4/6/16	Client facing team
State review of provider information	30 days	Thu 4/7/16	Wed 5/18/16	Iowa Team, Communications Team

Task Name	Duration	Start	Finish	Resource Names
Distribute information	20 days	Thu 5/19/16	Wed 6/15/16	Provider Communications
Internal Communications	**75 days**	**Thu 3/3/16**	**Wed 6/15/16**	
Create information	20 days	Thu 3/3/16	Wed 3/30/16	Communications Team
Complete internal review	5 days	Thu 3/31/16	Wed 4/6/16	Communications Team
Distribute information	20 days	Thu 5/19/16	Wed 6/15/16	Communications Team
REPORTING	**110 days**	**Thu 2/11/16**	**Wed 7/13/16**	
Establish reporting guidelines to measure increased population penetration	40 days	Thu 2/11/16	Wed 4/6/16	Project team
Develop workflow training to collect data	20 days	Thu 4/7/16	Wed 5/4/16	Trainers
Generate/review test reports	30 days	Thu 4/7/16	Wed 5/18/16	Quality Director
Launch reporting into production	30 days	Thu 5/19/16	Wed 6/29/16	IT
Confirm data meets defined requirements	10 days	Thu 6/30/16	Wed 7/13/16	Information Services
TRAINING	**120 days**	**Thu 2/11/16**	**Wed 7/27/16**	
Define training requirements	60 days	Thu 2/11/16	Wed 5/4/16	Training Manager
Create Training documentation	30 days	Thu 5/5/16	Wed 6/15/16	Training Material Staff
Deploy training internal staff and providers as necessary	30 days	Thu 6/16/16	Wed 7/27/16	Trainers
LAUNCH - AmeriHealth Caritas in compliance and supporting Iowa HIS	1 day	Mon 8/1/16	Mon 8/1/16	Project Team
FEEDBACK	**113 days**	**Thu 4/7/16**	**Mon 9/12/16**	
Develop plan to collect participant surveys	30 days	Thu 4/7/16	Wed 5/18/16	Quality Director
Begin collecting responses	20 days	Tue 8/2/16	Mon 8/29/16	Client facing team
Review responses	20 days	Mon 8/8/16	Fri 9/2/16	Quality Director
Create response report	3 days	Mon 9/5/16	Wed 9/7/16	IT, Quality Director
Distribute response reports	3 days	Thu 9/8/16	Mon 9/12/16	Quality Director
IOWA RFP Section 10.2				

Task Name	Duration	Start	Finish	Resource Names
10.2.2 2 Mental Health and Disability Service Redesign (MHDS)	**289 days**	**Tue 12/1/15**	**Fri 1/6/17**	
IDENTIFY TOPICS - Initiation	**15 days**	**Tue 12/1/15**	**Mon 12/21/15**	
Coordinate with Iowa team to understand all services associated with the Redesign	15 days	Tue 12/1/15	Mon 12/21/15	Iowa/AmeriHealth Caritas Teams
DEPLOYMENT APPROACH	**103 days**	**Tue 12/22/15**	**Thu 5/12/16**	
Map gaps between current AmeriHealth Caritas service offerings and redesign specified	20 days	Tue 12/22/15	Mon 1/18/16	AmeriHealth Caritas Deployment Team
Identify specific tasks to integrate MHDS to QA/QI plan representatives	15 days	Tue 1/19/16	Mon 2/8/16	Quality Director
Create sub team across function areas, BH provider community and LTSS	20 days	Tue 2/9/16	Mon 3/7/16	Quality Director
Create Year 1 Strategies	**48 days**	**Tue 3/8/16**	**Thu 5/12/16**	
Information Sharing	20 days	Tue 3/8/16	Mon 4/4/16	Information Services
LTSS/BH gap analysis	10 days	Tue 4/5/16	Mon 4/18/16	AmeriHealth Caritas Deployment Team
LTSS approver flexibility	10 days	Tue 4/19/16	Mon 5/2/16	AmeriHealth Caritas Deployment Team
Primary care network training	30 days	Fri 4/1/16	Thu 5/12/16	Trainers
Develop plan to address service gaps	30 days	Tue 3/8/16	Mon 4/18/16	AmeriHealth Caritas Deployment Team
COMMUNICATIONS	**65 days**	**Fri 1/1/16**	**Thu 3/31/16**	
Provider Communications	**65 days**	**Fri 1/1/16**	**Thu 3/31/16**	
Create information	10 days	Fri 1/1/16	Thu 1/14/16	Communications Team
Complete internal review	5 days	Fri 1/15/16	Thu 1/21/16	Quality Director
State review of provider information	30 days	Fri 1/22/16	Thu 3/3/16	Iowa Team, Quality Director
Distribute Information	20 days	Fri 3/4/16	Thu 3/31/16	Information Services
Internal Communications	**45 days**	**Fri 1/1/16**	**Thu 3/3/16**	

Task Name	Duration	Start	Finish	Resource Names
Create information	20 days	Fri 1/1/16	Thu 1/28/16	Communications Team
Complete internal review	5 days	Fri 1/29/16	Thu 2/4/16	Quality Director
Distribute information	20 days	Fri 2/5/16	Thu 3/3/16	Information Services
REPORTING	**90 days**	**Mon 2/1/16**	**Fri 6/3/16**	
Establish reporting guidelines	40 days	Mon 2/1/16	Fri 3/25/16	Quality Director
Generate/review test reports	20 days	Mon 3/28/16	Fri 4/22/16	Client-facing Team, Information Services
Launch reporting into production	10 days	Mon 4/25/16	Fri 5/6/16	Information Services
Based on reporting develop methodology to determine improvement	20 days	Mon 4/25/16	Fri 5/20/16	Quality Director
Forward report to QA/QI teams	10 days	Mon 5/23/16	Fri 6/3/16	Quality Director
TRAINING	**30 days**	**Mon 5/9/16**	**Fri 6/17/16**	
Define training requirements	30 days	Mon 2/1/16	Fri 3/11/16	Training Manager
Create training documentation	30 days	Mon 3/14/16	Fri 4/22/16	Trainers
Deploy training internal staff and providers as necessary	20 days	Mon 4/25/16	Fri 5/20/16	Trainers
Production date	1 day	Mon 6/20/16	Mon 6/20/16	Iowa/AmeriHealth Caritas Teams
FEEDBACK	**45 days**	**Wed 6/1/16**	**Tue 8/2/16**	
Develop plan to collect participant surveys	10 days	Wed 6/1/16	Tue 6/14/16	IS/Quality
Begin collecting responses	20 days	Wed 6/15/16	Tue 7/12/16	Information Services
Review responses	10 days	Wed 7/13/16	Tue 7/26/16	Quality Director
Create response report	3 days	Tue 7/26/16	Thu 7/28/16	Project team
Distribute response reports	3 days	Fri 7/29/16	Tue 8/2/16	IT
State Innovation Model (SIM)	**289 days**	**Tue 12/1/15**	**Fri 1/6/17**	
IDENTIFY TOPICS - Initiation	**20 days**	**Tue 12/1/15**	**Mon 12/28/15**	
Identify and review SIM requirements	20 days	Tue 12/1/15	Mon 12/28/15	AmeriHealth Caritas Deployment Team

Task Name	Duration	Start	Finish	Resource Names
DEPLOYMENT APPROACH	**140 days**	**Tue 12/29/15**	**Mon 7/11/16**	
Implement SIM to support medical homes and ACOs	30 days	Tue 12/29/15	Mon 2/8/16	Quality Director
Implement incentives to support healthy behaviors	30 days	Tue 12/29/15	Mon 2/8/16	Information Services
Identify targeted healthy behavior per grant	30 days	Tue 12/29/15	Mon 2/8/16	Quality Director
Map healthy behavior identify gaps	60 days	Tue 2/9/16	Mon 5/2/16	Quality Director
Deploy solution to address identified gaps	30 days	Tue 5/3/16	Mon 6/13/16	Information Services
Add healthy behaviors to CAREcard	20 days	Tue 5/3/16	Mon 5/30/16	Information Services
Gather current information on quality measures used for reporting	20 days	Tue 6/14/16	Mon 7/11/16	Information Services
Complete review and gap analysis	60 days	Tue 12/1/15	Mon 2/22/16	Quality Director
Implement build out of missing data per gap analysis	60 days	Tue 2/23/16	Mon 5/16/16	Information Services
Incorporate data into our provider network via Navinet Portal	60 days	Tue 5/17/16	Mon 8/8/16	Information Services
Develop and deploy contracting strategy with participating ACOs	120 days	Fri 1/1/16	Thu 6/16/16	AmeriHealth Caritas deployment team
Develop contract(s)	60 days	Fri 1/1/16	Thu 3/24/16	Vendor Management
Review fees for service(s)	30 days	Fri 3/25/16	Thu 5/5/16	Vendor Management
Negotiate agreements as necessary	30 days	Fri 5/6/16	Thu 6/16/16	Vendor Management
COMMUNICATIONS	**130 days**	**Tue 3/1/16**	**Mon 8/29/16**	
Provider Communications	**130 days**	**Tue 3/1/16**	**Mon 8/29/16**	
Create information	30 days	Tue 3/1/16	Mon 4/11/16	Communications Team
Complete internal review	30 days	Tue 4/12/16	Mon 5/23/16	Communications Team
State review of provider information	40 days	Tue 5/24/16	Mon 7/18/16	Communications Team, Iowa Team
Distribute Information	30 days	Tue 7/19/16	Mon 8/29/16	Communications Team, Information Services

Task Name	Duration	Start	Finish	Resource Names
Internal Communications	**90 days**	**Tue 3/1/16**	**Mon 7/4/16**	
Create information	30 days	Tue 3/1/16	Mon 4/11/16	Communications Team
Complete internal review	30 days	Tue 4/12/16	Mon 5/23/16	Communications Team
Distribute information	30 days	Tue 5/24/16	Mon 7/4/16	Communications Team
REPORTING	**97 days**	**Mon 7/4/16**	**Tue 11/15/16**	
Establish reporting guidelines	30 days	Mon 7/4/16	Fri 8/12/16	AmeriHealth Caritas Deployment Team
Develop reporting workflow	25 days	Tue 8/9/16	Mon 9/12/16	AmeriHealth Caritas Deployment Team
Train Staff to collect data for reporting	25 days	Tue 9/13/16	Mon 10/17/16	Trainers
Generate/review test reports	10 days	Tue 10/18/16	Mon 10/31/16	Information Services
Confirm data meets identified requirements	10 days	Tue 11/1/16	Mon 11/14/16	Quality Director
Launch reporting into production	1 day	Tue 11/15/16	Tue 11/15/16	Information Services
TRAINING	**70 days**	**Mon 8/1/16**	**Fri 11/4/16**	
Define training requirements	20 days	Mon 8/1/16	Fri 8/26/16	Training Manager
Create training workflow	10 days	Mon 8/29/16	Fri 9/9/16	Trainers
Create training documentation	20 days	Mon 9/12/16	Fri 10/7/16	Trainers
Deploy training internal staff and providers as necessary	20 days	Mon 10/10/16	Fri 11/4/16	Trainers
Production date	1 day	Mon 12/5/16	Mon 12/5/16	Iowa/AmeriHealth Caritas Teams
FEEDBACK	**70 days**	**Mon 10/3/16**	**Fri 1/6/17**	
Develop plan to collect participant surveys	30 days	Mon 10/3/16	Fri 11/11/16	Quality Director
Begin collecting responses	10 days	Tue 12/6/16	Mon 12/19/16	Information Services
Review responses	10 days	Tue 12/20/16	Mon 1/2/17	Quality Director
Create response report	3 days	Tue 1/3/17	Thu 1/5/17	IS/Quality
Distribute response reports	1 day	Fri 1/6/17	Fri 1/6/17	Information Services

Task Name	Duration	Start	Finish	Resource Names
10.2.3 Substance Abuse Prevention and Treatment Block Grant.	146 days	Fri 1/1/16	Fri 7/22/16	
IDENTIFY TOPICS - Initiation	**10 days**	**Fri 1/1/16**	**Thu 1/14/16**	
Create working core team, Iowa/ AmeriHealth Caritas	10 days	Fri 1/1/16	Thu 1/14/16	AmeriHealth Caritas Deployment Team
DEPLOYMENT APPROACH	**46 days**	**Fri 1/15/16**	**Fri 3/18/16**	
Identify 17 targeted goal areas	15 days	Fri 1/15/16	Thu 2/4/16	AmeriHealth Caritas Deployment Team
Complete gap analysis, current data available versus requirements	10 days	Fri 2/5/16	Thu 2/18/16	AmeriHealth Caritas Deployment Team
Establish plan to collect missing data	10 days	Fri 2/19/16	Thu 3/3/16	Quality Director
Create workflows	10 days	Fri 3/4/16	Thu 3/17/16	Project team
Begin data collection	1 day?	Fri 3/18/16	Fri 3/18/16	Information Services
COMMUNICATIONS	**55 days**	**Mon 2/1/16**	**Fri 4/15/16**	
Provider Communications	**55 days**	**Mon 2/1/16**	**Fri 4/15/16**	
Create information	10 days	Mon 2/1/16	Fri 2/12/16	Provider Communications
Complete internal review	10 days	Mon 2/15/16	Fri 2/26/16	Quality Director
State review of provider information	30 days	Mon 2/29/16	Fri 4/8/16	Iowa Team, Quality Director
Distribute information	5 days	Mon 4/11/16	Fri 4/15/16	Information Services
Internal Communications	**35 days**	**Mon 2/1/16**	**Fri 3/18/16**	
Create information	15 days	Mon 2/1/16	Fri 2/19/16	Communications Team
Complete internal review	10 days	Mon 2/22/16	Fri 3/4/16	Quality Director
Distribute information	10 days	Mon 3/7/16	Fri 3/18/16	Information Services
REPORTING	**51 days**	**Mon 2/1/16**	**Mon 4/11/16**	
Establish reporting guidelines	5 days	Mon 2/1/16	Fri 2/5/16	Quality Director
Develop reporting workflow	10 days	Mon 2/8/16	Fri 2/19/16	Project team
Train Staff to collect data for reporting	20 days	Mon 2/22/16	Fri 3/18/16	Training Manager

Task Name	Duration	Start	Finish	Resource Names
Generate/review test reports	10 days	Mon 3/21/16	Fri 4/1/16	Information Services
Confirm data meets identified requirements	5 days	Mon 4/4/16	Fri 4/8/16	Quality Director
Launch reporting into production	1 day	Mon 4/11/16	Mon 4/11/16	IS/Quality, Quality Director
TRAINING	**60 days**	**Tue 2/2/16**	**Mon 4/25/16**	
Define training requirements	10 days	Tue 2/2/16	Mon 2/15/16	Training Manager
Create training workflow	10 days	Tue 2/16/16	Mon 2/29/16	Trainers
Create training documentation	20 days	Tue 3/1/16	Mon 3/28/16	Trainers
Deploy training internal staff and providers, as necessary	20 days	Tue 3/29/16	Mon 4/25/16	Trainers
Production date	1 day	Mon 5/2/16	Mon 5/2/16	Iowa/AmeriHealth Caritas Teams
FEEDBACK	**146 days**	**Fri 1/1/16**	**Fri 7/22/16**	
Develop plan to collect participant surveys	1 day	Tue 5/3/16	Tue 5/3/16	IS/Quality
Begin collecting responses	1 day	Wed 5/4/16	Wed 5/4/16	Information Services
Review responses	1 day	Thu 5/5/16	Thu 5/5/16	Quality Director
Create response report	1 day	Fri 5/6/16	Fri 5/6/16	IS/Quality
Distribute response reports	1 day	Mon 5/9/16	Mon 5/9/16	Information Services
10.2.3 Value Index Scores (VIS)	**146 days**	**Fri 1/1/16**	**Fri 7/22/16**	
IDENTIFY TOPICS - Initiation	**20 days**	**Fri 1/1/16**	**Thu 1/28/16**	
AmeriHealth Caritas current review of VIS	20 days	Fri 1/1/16	Thu 1/28/16	AmeriHealth Caritas Deployment Team
DEPLOYMENT APPROACH	106 days	Fri 1/29/16	Fri 6/24/16	
Load historical and current data and map to Treo inputs	30 days	Fri 1/29/16	Thu 3/10/16	Information Services
Load and test data historical data form the state to AmeriHealth Caritas data warehouse	29 days	Fri 3/11/16	Wed 4/20/16	Information Services

Task Name	Duration	Start	Finish	Resource Names
Map current AmeriHealth Caritas data from data warehouse to Treo	15 days	Fri 3/11/16	Thu 3/31/16	Information Services
Send test data feed for historical and current data and test data transmission	1 day	Fri 4/1/16	Fri 4/1/16	Information Services
Evaluate test data feed	**10 days**	**Mon 4/4/16**	**Fri 4/15/16**	
Informatics team review test data feed with Treo	5 days	Mon 4/4/16	Fri 4/8/16	Quality Director
Provide recommendations for modifications/retests	5 days	Mon 4/11/16	Fri 4/15/16	Quality Director
Correct as necessary	10 days	Mon 4/18/16	Fri 4/29/16	IS/Quality
Retesting	10 days	Mon 5/2/16	Fri 5/13/16	Information Services
Production Launch	**30 days**	**Mon 5/16/16**	**Fri 6/24/16**	
Prepare and send 1st monthly feed	5 days	Mon 5/16/16	Fri 5/20/16	Information Services, Project Team
Treo Solutions load data and perform data intake QA	10 days	Mon 5/23/16	Fri 6/3/16	Information Services
Informatics review data intake QA results with Treo	5 days	Mon 6/6/16	Fri 6/10/16	Quality Director
Treo launch VIS dashboard into production	10 days	Mon 6/13/16	Fri 6/24/16	Information Services
COMMUNICATIONS	**30 days**	**Mon 4/4/16**	**Fri 5/13/16**	
Internal Communications	**30 days**	**Mon 4/4/16**	**Fri 5/13/16**	
Prepare internal communications as necessary	10 days	Mon 4/4/16	Fri 4/15/16	Communications Team
Internal communications review	10 days	Mon 4/18/16	Fri 4/29/16	Communications Team, Quality Director
Distribute internal communications as appropriate	10 days	Mon 5/2/16	Fri 5/13/16	Information Services
External Communications	**35 days**	**Mon 4/4/16**	**Fri 5/20/16**	
Prepare external communications as/if necessary	10 days	Mon 4/4/16	Fri 4/15/16	Communications Team
Create documentation	10 days	Mon 4/18/16	Fri 4/29/16	Communications Team

Task Name	Duration	Start	Finish	Resource Names
Review external communications	10 days	Mon 5/2/16	Fri 5/13/16	Quality Director
Distribute external communications as appropriate	5 days	Mon 5/16/16	Fri 5/20/16	Information Services
REPORTING	**56 days**	**Tue 3/1/16**	**Tue 5/17/16**	
Identify additional reporting	15 days	Tue 3/1/16	Mon 3/21/16	Project Team
Create reporting workflow	10 days	Tue 3/22/16	Mon 4/4/16	IS/Quality
Generate test reports	20 days	Tue 4/5/16	Mon 5/2/16	IS/Quality
Review results from test reports	10 days	Tue 5/3/16	Mon 5/16/16	Quality Director
Add reporting to production environment.	1 day?	Tue 5/17/16	Tue 5/17/16	Information Services
FEEDBACK	**38 days**	**Wed 6/1/16**	**Fri 7/22/16**	
Develop plan to collect participant survey's	1 day	Wed 6/1/16	Wed 6/1/16	IS/Quality
Begin collecting responses	1 day	Fri 7/1/16	Fri 7/1/16	Information Services
Review responses	5 days	Mon 7/4/16	Fri 7/8/16	Quality Director
Create response report	5 days	Mon 7/11/16	Fri 7/15/16	IS/Quality
Distribute response reports	5 days	Mon 7/18/16	Fri 7/22/16	Information Services

10.3 Incentive Programs

1. Describe your proposed provider incentive programs.

PerformPlus® (value-based contracting models)

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.

PerformPlus is AmeriHealth Caritas' 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 or more of PerformPlus' 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 will be customized to align with Iowa's value-based purchasing goals, as well as the needs of individual practices.

We use both peer- and trend-based performance metrics to determine incentive payments, which come from an established bonus pool of dollars based on a percentage of total volume of claims payment. PerformPlus' risk-adjusted quality metrics include, but are not limited to:

- Potentially preventable hospital admissions.
- Potentially preventable hospital re-admissions.
- Low-acuity emergency room 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 to finalize which programs and which value-based incentives will be offered to providers. AmeriHealth Caritas currently offers the following PerformPlus programs in our health plans:

Quality Enhancement program

AmeriHealth Caritas designed the Quality Enhancement Program (QEP) to reward PCPs, including pediatrics, internal medicine, OB/GYN if participating as a PCP and general/family practice, who deliver:

- High-quality and cost-effective care.
- Member service and convenience.
- Accurate and complete health data.

Performance on the plan's quality indicators is the most important determinant in the program. These quality indicators target specific opportunities for meaningful health improvement, using state quality goals and performance measures as a starting point; they are further refined through analysis of the health plan's data and discussions with health plan PCPs. The QEP is currently live in AmeriHealth Caritas' Pennsylvania and Louisiana plans, which serve more than 600,000 members. The QEP programs in these states use quality indicators such as such as well-child visits, adolescent well-care visits, adult access to preventive and ambulatory health services, maternity care and effective management of patients with

diabetes. Cost-efficiency measures are focused on avoidance of inappropriate use of emergency room services.

We anticipate aligning QEP quality indicators with DHS's performance targets, and leveraging the QEP model to share value-based purchasing incentive payments with Iowa providers. To further support these measures, DHS's performance targets will also be aligned with the member incentives AmeriHealth Caritas Iowa will provide through our CARE Card. AmeriHealth Caritas Iowa will reward members with cash incentives, up to $50 per year, using the reloadable CARE Card. Rewards are accrued as members receive targeted services.

PerformPlus shared savings

AmeriHealth Caritas' 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 members 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 members 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, 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 Valley Health Network in Pennsylvania, as well as Palmetto Health and the Medical University of South Carolina (MUSC) in South Carolina.

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 impactful to our FQHC partners, such as clinically preventable events.

AmeriHealth Caritas launched the Community Partners program in January 2015 with three FQHCs who serve more than 8,200 members in Pennsylvania and South Carolina. We are currently negotiating with another four potential FQHCs in South Carolina and the District of Columbia.

FQHC Providers Currently Participating	FQHC Providers Currently in Discussion
Quality Community Health Care (PA)	Mary's Center (DC)
Spectrum Health Services (PA)	Care South Carolina, Inc. (SC)
Sumter Family Health Center (SC)	Sandhills Pediatrics (SC)
	Palmetto Pediatrics and Adolescent Clinic (SC)

"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."

Marcella Lingham, M.D., Executive Director, Quality Community Health Centers (PA)

Cardiology program

Built on ACO and medical home concepts, the PerformPlus cardiology shared savings program is designed to promote high-quality care, improve health outcomes and reduce unnecessary/redundant care. The program's quality measures focus on interventions that reduce the risk factors for heart attacks, as well as complications from hypertension and coronary artery disease. Currently, two large cardiology practices in Pennsylvania are participating in the Cardiology program.

Perinatal program

Recognizing that Medicaid plays a key role in child and maternal health, AmeriHealth Caritas has developed a perinatal quality enhancement program that will be implemented in our affiliate health plan in Louisiana and other existing markets in 2015. The program is designed to reward qualifying obstetric practices for improving quality and outcomes measures that support healthy, full-term deliveries, therefore lowering neonatal intensive care unit utilization as well as the rates of medically unnecessary C-sections. Program metrics include pre- and postnatal care, antenatal progesterone administration and sexually transmitted disease screenings, among others.

Women's health program

In addition to the perinatal program, AmeriHealth Caritas is currently developing the women's health program to encourage providers to make timely preventive screenings and preventive care more accessible to female members of one of our Pennsylvania plans. The program will reward providers for screening members for cervical cancer, breast cancer and chlamydia, as well as for improving prenatal care rates.

Custom programs

AmeriHealth Caritas Iowa's advantage is our ability to customize programs based on the needs of each 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

Accountable care organizations (ACOs) are an increasingly popular approach to achieve the triple aim of improved health, better outcomes and lower per-capita healthcare costs. We understand ACO models are

the basis of the SIM program and AmeriHealth Caritas Iowa is ready to partner with the state in supporting this program to bring the next generation of highest-quality care to Iowa's Medicaid population. As a mission-driven managed care organization, our experience in case management, quality reporting and innovative payment design positions AmeriHealth Caritas as a uniquely qualified leader in Medicaid ACO implementations. 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 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 in Iowa 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

Our strategy includes a behavioral health (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 behavioral health and physical health providers.
- Well care for Serious Mental Illness (SMI) population, includes screenings for diabetes and well-care visits.
- Innovative dashboarding/transparency tools.

When it comes to behavioral health, a member's success is rarely the result of the work done by one doctor or the effectiveness of one procedure. It is a full 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. Members 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 behavioral health providers is based on services provided, so payment comes per individual treatment session or doctor's appointment. This is a structure that does not encourage the continuum of care that may best suit these individuals.

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 during outpatient therapy.

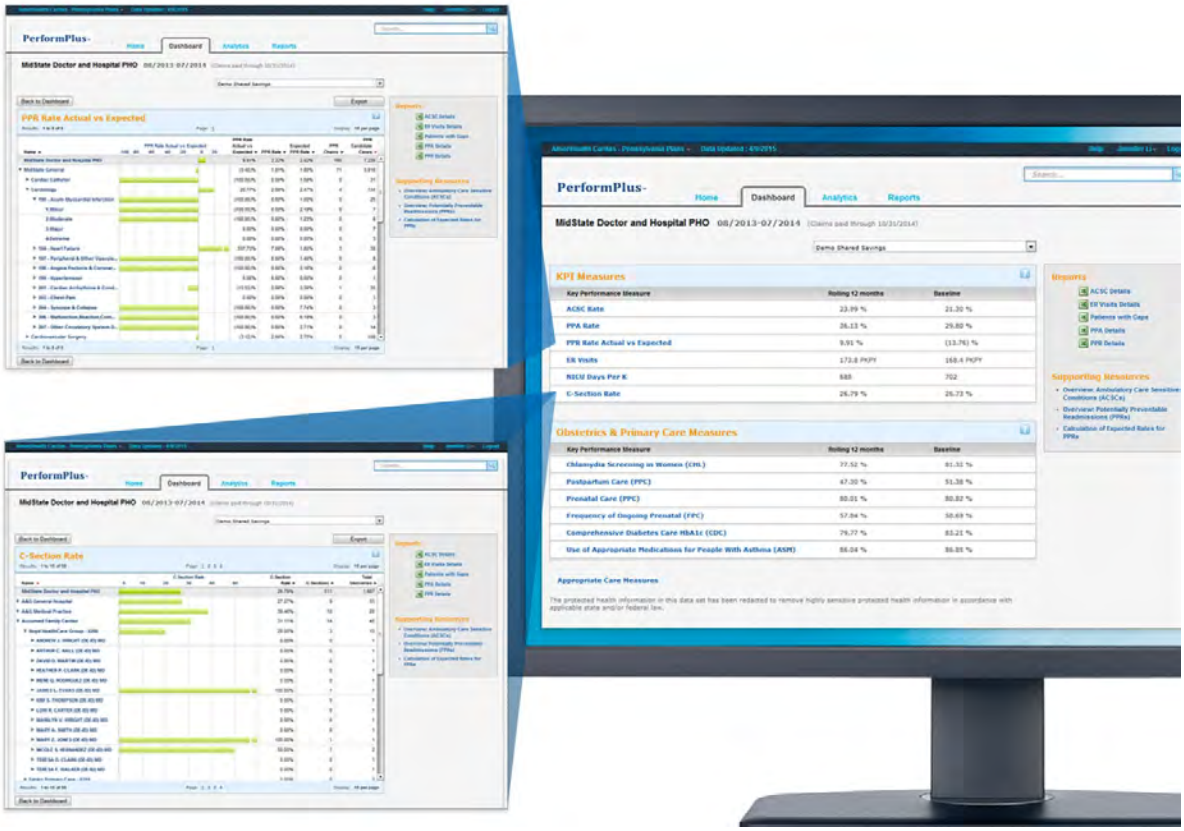
Access to PerformPlus dashboards - moving performance measurement closer to real time

PerformPlus provides a variety of Web-based dashboards to participating providers, enabling them to track their progress for each metric.

Three different dashboards currently exist for our provider partners:

- Shared savings.
- Quality Enhancement Program (QEP).
- Clinical stratification (3M).

Partners participating in the PerformPlus model can access a Web-based dashboard to track their progress for each metric and produce self-service reports and drill-down data mining. The dashboard also allows identification of frequent emergency room utilizers, readmissions, HEDIS results, care gaps, clinical risk and other member-centric data to foster collaboration and meaningful member outreach. 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.



"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

A key feature of the dashboard reports is the display of population-level data for all key performance indicators with drill-down capabilities to the facility level, provider level and member 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 members. This facilitates prompt identification of variation from program goals and will enable the Iowa medical team to meet with individual providers to discuss results, review barriers and assist via brainstorming sessions.

Currently the data reports are based on administrative claims data. We have recently partnered with a cardiology practice to exchange electronic medical record (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. Through our participation in health information exchanges in Philadelphia, Washington D.C. and in South Carolina, we will receive additional electronic health record "point of service" quality data over the next 12 to 24 months. This year 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.

2. Describe your proposed member incentive programs.

As discussed in Section 3, The AmeriHealth Caritas CARE Card is an innovation AmeriHealth Caritas Iowa is ready to offer its members in Iowa. We have designed this program to incentivize members for healthy behaviors, which will compound by offering these financial incentives to be focused on elements that will further promote member health and improved outcomes (e.g., CARE Card 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 their cost. The system wins by rewarding for behavior that reduces cost."8

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.

8 John Nosta. Be Healthy and Get Rewarded--Incentives Driving Engagement. Forbes. April 9, 2014.

- Idaho's Behavioral Preventative 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, 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.

10.4 Critical Incidents

1. Describe your critical incident reporting and management system.

AmeriHealth Caritas Iowa will implement the robust critical incident reporting and management system used across other AmeriHealth Caritas health plans. Our system includes a list of triggers and required reporting elements along with time-specific processes for investigation and outcome determination, tracking and reporting.

Critical incidents include but are not limited to adverse, sentinel, never events and/or other circumstances and medical outcomes as described below:

Unexpected mortality	Event resulting in an unanticipated death not related to the natural course of the patient's illness or underlying condition.
Unexpected morbidity	Event resulting in a significant loss of function or further impairment not related to the natural course of the patient's illness or underlying condition.
Fetal demise > 24 weeks gestation	Only those occurring at 24 or greater weeks gestation.
Medication error	Event resulting in an unanticipated death or serious disability associated with a medication error (e.g., wrong drug, dose, patient, time, rate, preparation or wrong route of administration)
Inpatient re-admission ≤ 30 days from an inpatient discharge	Readmission with same or similar DRG/diagnosis that may have resulted from premature discharge or inadequate discharge planning.
Surgical events	• Unplanned removal of organs, injury to organs or body parts during surgery or delivery. • Unintended retention of a foreign object in a patient after surgery, procedure or delivery. • Situations which require return to the operating room or delivery for further operative or delivery procedures. • Any surgical procedures performed on the wrong side, wrong site, wrong body part or on the wrong person. • Intra-operative myocardial infarction/cardiopulmonary arrest.

Unexpected event leading to an increase in the LOS or inpatient stay in hospital	Event that occurred while the patient was being cared for in a healthcare facility that leads to an emergency inpatient admission or additional inpatient days which was reasonably preventable through the application of appropriate evidence-based protocols.
Event related to appropriateness of clinical care	Occurring in any clinical care setting that was related to the failure to follow general practice guidelines.
Facility incidents	Patient death or serious disability associated with a healthcare facility acquired injury from trauma, falls, fracture or burns.
Prolonged fluoroscopy with cumulative dose >1500 rads	To a single field or any delivery of radiotherapy to the wrong body region or >25 percent above the planned radiotherapy dose.
Facility acquired decubitus ulcers stage III or IV	Not present on admission.
Other never events	Event resulting in a patient death or serious disability that occurred while being cared for in a healthcare facility and associated with one of the following: • Patient elopement (disappearance). • A hemolytic reaction due to the administration of incompatible blood or blood products. • An electric shock or elective cardioversion. • Use of contaminated drugs, devices or biologics provided by the healthcare facility. • Use or function of a device in patient care, in a manner in which it was not intended. • Intravascular air embolism occurring while being cared for in a healthcare facility. • Patient suicide or attempted suicide resulting in serious disability. • Hypoglycemia occurring while patient is being cared for in a healthcare facility. • Failure to identify and treat hyperbilirubinemia in neonates. • Patient death or serious disability due to spinal manipulative therapy. • A line designated for O2 or other gas containing the wrong gas or contaminated by toxic substances.

Hospital acquired conditions (HAC) as defined by CMS	• Unintended retention of a foreign object in a patient after surgery, procedure or delivery. • Intravascular air embolism. • A hemolytic reaction due to the administration of incompatible blood or blood products. • Facility acquired decubitus ulcers stage III or IV – not present on admission. • Patient death or serious disability associated with a healthcare facility-acquired injury from trauma, falls, dislocations, intracranial injuries, fractures, or burns. • An electric shock or elective cardioversion. • Surgical site infection following: o Coronary artery bypass graft (CABG) – mediastinitis. o Bariatric surgery: - Laparoscopic gastric bypass. - Gastroenterostomy – open gastric bypass. - Laparoscopic gastric restrictive surgery – lap band. o Orthopedic procedures: - Spinal. - Neck. - Shoulder. - Elbow. o Deep vein thrombosis (DVT) pulmonary embolism (PE): - Total knee replacement. - Hip replacement. - Partial hip. - Hip resurfacing. o Manifestation of poor glycemic control: - Hypoglycemia. - Hypoglycemic coma. - Diabetic ketoacidosis. - Non-ketotic hyperosmolar coma. o Catheter-associated urinary tract infection (UTI). o Vascular catheter-associated infection.

2. Describe strategies for training staff and network providers on critical incident policies and procedures.

All AmeriHealth Caritas Iowa staff who interface with members and providers receive training on critical incident reporting as part of their initial orientation. Additionally, appropriate referral for suspected critical incidents is an audit element for Care Management, Utilization Management and Member Service staff. Our ongoing audit processes for these teams continually reinforce the need to take action when an encounter with a member or provider indicates the possibility that a critical incident occurred. Annually, staff from the Quality Management department attend departmental staff meetings to reinforce critical incident scenarios that should be reported and the reporting process.

Provider network account executives train providers on critical incident reporting during provider orientation. Information on the reporting process is also contained in the Provider Manual.

3. Describe processes for implementing corrective action when a provider is out of compliance with critical incident reporting.

Providers who are out of compliance for critical incident reporting are reminded of their responsibilities by the AmeriHealth Caritas Iowa medical director and given a period of 30 days to submit a corrective action plan. The corrective action plan is reviewed by the AmeriHealth Caritas Iowa medical director and a peer-review subcommittee of the QAPIC. The corrective action plan must directly address the finding and offer potential to satisfactorily correct the issue. Updates to the corrective action plan are reviewed through the same process.

Each month the provider involved is reviewed for additional issues or activities related to the finding. Review is ongoing for the following 12 months.

If the provider does not respond to the request for a corrective action plan — or does not follow through on corrective action plan activities — the AmeriHealth Caritas Iowa medical director contacts the provider to explain that continued non-compliance may result in termination. If the provider still does not respond, the AmeriHealth Caritas Iowa medical director initiates AmeriHealth Caritas Iowa's process to terminate the provider in accordance with the provider agreement provisions.

4. Describe how critical incidents will be identified, tracked and reviewed and how data gathered will be used to reduce the occurrence of critical incidents and improve the quality of care delivered to members.

Notification of susptected critical incidents occur through claim review or reports from AmeriHealth Caritas Iowa staff, providers or members. All suspected critical incident notifications are sent to the Quality Management (QM) staff for tracking and investigation. Upon receipt of a suspected cirtical incident notification, the QM staff person opens a secure quality case in the AmeriHealth Caritas Iowa population health management system. A letter is sent to notify the person making the notification that the incident will be investigated and that the outcome is protected by peer-review requirements. Only AmeriHealth Caritas Iowa staff with security privledges to review quality cases have access to quality case type in the system. Information on the date, time and name of the person making the notification are recorded, along with the substance of the report. Critical incident notifications that are sent by mail are scanned and electronically attached to the quality case.

A QM nurse performs the initial review, beginning with the information reported in the notification and other available information in the population health management system. For example, for a critical incident related to an inpatient admission, the QM nurse will review available clinical information collected during the concurrent review and discharge planning process. The QM nurse will request specific additional medical records to conduct a full review.

If it is determined that the delivery of care in the situation led to a potential quality issue, the case and all supporting documentation is reviewed by the AmeriHealth Caritas Iowa medical director or behavioral health clinician. The AmeriHealth Caritas Iowa medical director determines whether the case requires additional follow-up or action, such as provider education or corrective disciplinary action up to and including termination. As warranted or required, AmeriHealth Caritas Iowa also initiates reporting to state and federal regulatory and oversight agencies, such as the National Practitioner Databank in according with AmeriHealth Caritas Iowa's policy on provider sanctioning.

Critical incident reports are monitored, tracked and trended by facility and provider. If a pattern emerges at any hospital, provider office or ancillary provider, our network staff and medical management staff

meet to discuss the findings and plan appropriate action. Results of critical incident review activity and trends are reported to the QAPIC. Additionally, critical incident information associated with individual providers is incorporated in the information gathered during the re-credentialing process.

The outcome of critical incident reviews is also used to drive educational initiatives and program improvements. For example, at AmeriHealth Caritas Iowa's South Carolina affiliate, smaller OB-GYN offices brought a quality of care concern to the health plan concerning sub-optimal use of Tetnus-Diptheria-Pertussis (Tdap) vaccinations for their pregnant adult patients. Under South Carolina state Medicaid policy, the administration of Tdap vaccine to females between the 27th and 36th weeks of pregnancy, had to be performed using vaccine obtained from the physician office. Vaccines obtained from a pharmacy were not covered. This meant that the Obstetrician office had to keep Tdap vaccine in stock for their pregnant Medicaid members. Along with leading to waste when expired vaccines had to be discarded, the providers were not equipped to meet strict state regulations for vaccine oversight and storage. Many of the smaller providers were administering the vaccine at the time of delivery, which provided suboptimal protection for the mother and her child.

To address this issue, the health plan implemented policies at variance with state directives to provide coverage for the Tdap vaccine when dispensed at the pharmacy with a prescription from the physician. A provider communication is in development to promote this new option to the plan's OB-GYN offices. The health plan medical director discussed this initiative with state/regional representatives of several major pharmacy chains who have agreed to distribute information to all state pharmacies.

10.5 Provider Preventable Conditions

1. Describe how you will ensure payment is not made for provider preventable conditions.

Per AmeriHealth Caritas standard operating policies and procedures, healthcare acquired conditions (HCAC) and other provider-preventable conditions (OPPC) diagnoses claims are automatically reviewed prior to any payment. If a billed service is found to be HCAC or OPPC, providers are not paid and the claim is denied. If a subsequent review identifies a HCAC or OPPC that may not have been coded as such, an internal claims team that specializes on these types of claims executes a take-back to have the funds deducted from the next provider payment. AmeriHealth Caritas Iowa's payment policy with respect to provider preventable conditions (PPC) complies with the Patient Protection and Affordable Care Act of 2010 (ACA).

Ensuring non-payment for claims involving an OPPC

In addition to broadening the definition of OPPCs, the ACA requires payors to make pre-payment adjustments. That is, an OPPC must be reported by the provider at the time a claim is submitted. There are some circumstances under which an OPPC adjustment will not be taken, or will be lessened. For example:

- No payment reduction will be imposed if the condition defined as an OPPC for a particular member existed prior to the initiation of treatment for that member by the provider. Please refer to the "Reporting a Present on Admission" section for details.
- Reductions in provider payment may be limited to the extent that the identified PPC would otherwise result in an increase in payment; and AmeriHealth Caritas Iowa can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to the PPC.

Example of policy: In-patient facility

When an OPPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital-acquired**.** When submitting a claim which includes treatment as a result of an OPPC, facility providers are to include the appropriate ICD-9 diagnosis codes, including applicable external cause of injury or E codes on the claim in field 67 A – Q.

For per-diem or percent of charge based hospital contracts, claims including a PPC must be submitted via paper claim with the member's medical record. These claims will be reviewed against the medical record and payment adjusted accordingly. Claims with OPPC will be denied if the medical record is not submitted concurrent with the claim.

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11. Utilization Management

Please explain how you propose to execute Section 11 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) Utilization Management (UM) program is designed to ensure that members receive appropriate, evidence-based care. We collaborate with providers, members and others involved in healthcare delivery, to provide quality, cost effective physical health, behavioral health and long-term services and supports (LTSS) in the most appropriate setting for the intensity of services required.

> Our UM program ensures that the intensity and duration of services requested and provided are consistent, medically necessary and clinically appropriate to the individual, and match the member's health status and current needs.

AmeriHealth Caritas' UM program objectives include:

- Facilitating the reduction of inappropriate and duplicative healthcare services.
- Promoting collaborative practice among all disciplines to assure continuity of care and high-quality services over the course of illness and recovery.
- Fully integrating physical health, behavioral health and LTSS services so as to minimize fragmentation in service delivery.
- Ensuring that medically necessary care and services are provided in the most appropriate clinical mix, intensity and duration, consistent with the member's condition and needs.
- Ensuring that physical health, behavioral health and LTSS are medically necessary and delivered to the member at the least restrictive and most appropriate level with a length of stay that is clinically indicated.
- Promoting appropriate interventions, alternatives and care management programs as healthcare services are rendered.
- Facilitating the identification and management of high-risk cases, with appropriate referral of high-risk management cases to the Integrated Healthcare Management (IHM) department.
- Reviewing and evaluating member and provider satisfaction with AmeriHealth Caritas Iowa's UM program.
- Assessing utilization practices and patterns to identify over- or under-utilization of services by providers and members and review outliers.
- Reviewing and rendering determinations for provider and member appeals of medical necessity determinations.

AmeriHealth Caritas Family of Companies (AmeriHealth Caritas) uses InterQual® criteria and employs a rigorous clinical policy development and evaluative process to support UM activities. Additionally, AmeriHealth Caritas will publish its evidence-based clinical policies on AmeriHealth Caritas Iowa's public

website to demonstrate the transparency of its standards to members and the provider network. Public comment opportunities are available for these clinical policies.

AmeriHealth Caritas Iowa's UM programs ensure that the intensity and duration of services requested and provided are consistent, medically necessary and clinically appropriate to the individual, and match the member's health status and current needs. Efforts are made to obtain all necessary information to appropriately review the member's condition and to make determination for authorization of care. Reasons for decisions are clearly documented and provided to the member. All components of UM are monitored and evaluated for continuous quality improvement.

AmeriHealth Caritas mines administrative data to identify new opportunities for UM activities and to evaluate the effectiveness of its programs. For example, when new medications were introduced to treat Hepatitis C, AmeriHealth Caritas implemented American Association for the Study of Liver Disease (AASLD) guidelines, then developed stricter evidence-based guidelines and obtained state approval to implement them. Our guidelines have been revised five times in the last year as the science and recommendations changed. Improvement in adherence to guidelines is near 100 percent and the costs of medications have declined by over 80 percent.

UM activities and results are reported to committees in the Quality Assessment and Performance Improvement Committee (QAPIC) structure and include utilization monitoring activities as described in the Quality Assessment Performance Improvement (QAPI) work plan. UM program policies and procedures meet National Committee for Quality Assurance (NCQA) standards and are reviewed and updated as needed and at least annually. As in all of our markets, externally practicing Iowa physicians will sit on the AmeriHealth Caritas Iowa Quality of Clinical Care Committee (QCCC) Committee and QAPIC, so that external Iowa physicians will have a voice in providing oversight for these activities.

AmeriHealth Caritas consistently meets the timeliness standards for UM review as required by each of the states in which we operate and by NCQA. AmeriHealth Caritas Iowa will comply with all requirements stated within this section and any new technical requirements established by the State of Iowa and developed through the collaborative process outlined in the Scope of Work.

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

11.1 Utilization Management Programs

1. Describe in detail your utilization management program, including how you will operate and maintain the program.

AmeriHealth Caritas successfully operates UM programs for all of our health plans that incorporate evidence-based policies and procedures in a comprehensive, systematic approach to ensuring delivery of the right service at the right time in the most cost-effective manner. The AmeriHealth Caritas Iowa UM program will incorporate nationally recognized InterQual guidelines, regular and ongoing evaluation and comprehensive associate training, and inter-rater reliability (IRR) testing to ensure that our membership in Iowa receives high-quality, medically necessary care. For new technologies and certain high-cost/high-volume services, AmeriHealth Caritas Iowa will also incorporate a disciplined, evidence-based process to decide which procedures require prior authorization, and implement supplemental evidence-based clinical policies, as needed, to address them.

Access to UM staff

A registered nurse and physician will be immediately available by phone 24 hours a day, seven days a week, to render UM determinations for providers and members. For routine utilization-related inquiries, AmeriHealth Caritas Iowa UM staff will be accessible to members and providers via mail, toll-free phone, online portal and fax Monday through Friday, with the exception of recognized and agreed-upon holidays. Plan business hours will be 8:30 a.m. to 5:00 p.m. CST.

An AmeriHealth Caritas Iowa medical director and behavioral health medical director are available within one business day (or immediately in urgent/emergent cases) to discuss a medical necessity determination with the attending physician or other ordering provider.

UM resources

The AmeriHealth Caritas Iowa medical director, an Iowa-licensed physician, is responsible for the development, implementation and oversight of all aspects of the AmeriHealth Caritas Iowa UM program. Day-to-day operations for the UM program are managed by the director of UM.

The roles of each of the staff members in the UM program are clearly delineated to ensure all aspects of the UM process work in harmony and promote access to high quality, medically necessary healthcare services. Specific roles and responsibilities are documented in role-specific job description documents.

Requests for benefit coverage or medical necessity determinations are made through staff supervised by a registered nurse or licensed behavioral health clinician. Decisions to approve coverage for care may be made by the UM staff when they fall within AmeriHealth Caritas Iowa's written guidelines.

Licensed physicians and psychologists support the nurses and behavioral health clinicians within the UM department. AmeriHealth Caritas Iowa medical directors provide clinical review of medical information and/or direct peer-to-peer contact with attending physicians when there is conflicting medical information or if there are questions on the application regarding medical necessity criteria related to requests for coverage of medical services. All AmeriHealth Caritas Iowa medical directors, behavioral health physicians and psychologists involved in medical necessity decisions will be licensed in Iowa.

Medical necessity decision making

Any request that is not addressed by, or does not meet, medical necessity guidelines is referred to the medical director or behavioral health physician/psychologist for a decision. Any decision to deny or limit coverage for an admission, service, procedure or extension of stay, based on medical necessity, is made by a medical director, behavioral health physician or psychologist or another designated physician under the clinical direction of the medical director.

Medical necessity decisions made by a medical director, behavioral health physician or psychologist are based on the Iowa Department of Human Services' (DHS') definition of medically necessary services, in conjunction with the member's benefits, medical expertise, medical necessity criteria and/or published peer-reviewed literature. At the discretion of the medical director, a behavioral health physician or psychologist, participating board-certified physicians or behavioral health clinicians from an appropriate specialty may provide input to the decision. The medical director, behavioral health physician or psychologist makes the final decision.

AmeriHealth Caritas Iowa will not retroactively deny reimbursement for a covered service provided to an eligible member by a provider who relied on written or oral authorization from AmeriHealth Caritas Iowa or an agent of AmeriHealth Caritas Iowa, unless there was material misrepresentation or fraud in obtaining

the authorization. Upon request by a member or participating provider, the criteria used for medical necessity decision making in general, or for a particular decision, is provided in writing by the medical director, behavioral health physician or psychologist.

The UM associates and medical directors, behavioral health physicians or psychologists involved in medical necessity decisions are assessed annually for consistent application of review criteria. Variances among associates in each functional group are identified and corrective action is implemented.

Technology assessment and clinical policy development

AmeriHealth Caritas Iowa will use a disciplined, evidence-based process to evaluate new technologies and medical services, and to decide which procedures require prior authorization. Our clinical policy development process is based on in-depth review of the medical literature using the criteria for strength of evidence employed by the federal Agency for Healthcare Research and Quality (AHRQ). The clinical policy review process recognizes the strength of evidence and the potential for bias in the evaluation of the medical literature. These clinical policies are reviewed annually or more frequently as new scientific knowledge emerges. The Clinical Policy Committee reviews the draft reports over a two-month period before approval. The Iowa DHS will have the opportunity to review the clinical policies prior to their adoption. Additionally, the draft clinical policies will be posted to the AmeriHealth Caritas Iowa provider website for public comment prior to the effective date. The approved clinical policies are employed during the course of UM as a key tool in the evaluation of requests for new technologies and medical services. AmeriHealth Caritas Iowa monitors the cost of new technologies and medical services while reviewing the quality of care impact to members, such as complication rates and reduced hospitalizations resulting from these new technologies and services.

As an example, AmeriHealth Caritas Iowa's affiliate in South Carolina was approached by two bariatric surgeons to add coverage for gastric sleeve surgery. At the time, the procedure was not eligible for payment on the State's Medicaid fee schedule. The surgeons explained that the procedure had lower short- and long-term complication rates. After investigating available evidence, including input from the practicing providers, the health plan agreed to cover the procedure and facilitate billing through a miscellaneous code. The plan also assisted the surgeons in successfully lobbying the State to add the procedure to the Medicaid fee schedule.

Integration of AmeriHealth Caritas Iowa programs within UM

AmeriHealth Caritas Iowa will use a streamlined process that leverages prior authorization information as an inspection point in situations of high-cost services and wide variations in the medical community of service utilization. Our approach includes a move toward more algorithms to automate predictable decisions through fewer required prior authorizations. Our Medical Economics department will monitor data for outliers. Additionally, we have implemented a combined Pharmacy and Therapeutics Committee with representation from all of our health plans that will monitor the pharmacy review process. Using corporate analytic support, the AmeriHealth Caritas Iowa team will integrate areas of utilization focus with AmeriHealth Caritas Iowa's other IHM and value-based payment programs. Examples of such integration include:

1. PerformPlus® enterprise-wide value-based contracting solutions for primary care, specialty care, facilities and accountable care organizations (ACOs) that demonstrated the effectiveness of taking a metrics driven, collaborative approach to network contracting. AmeriHealth Caritas' experience demonstrates that when data-driven information is given to providers, the providers' recognize

opportunities for improvement and find ways to improve the efficiency of appropriate medical services utilization.

2. Numerous embedded care manager initiatives, including care managers in office sites, care managers in emergency rooms (ER) (Acute Care Transition program), community-based care connectors and care managers, identify unmet member needs and facilitate needed services. We successfully use this approach in all of our markets to decrease episodes of avoidable care.
3. In New Jersey, PerformCare is an advocate and active participant with the New Jersey Children's System of Care (CSOC). As the administrative service organization (ASO) for the State of New Jersey's Division of CSOC since 2009, PerformCare utilizes significant expertise and integrated technologies to register, authorize and coordinate services for children, youth and young adults who are experiencing emotional and behavioral challenges or are developmentally and intellectually disabled. PerformCare provides UM for all authorizations of clinical services for youth in the New Jersey CSOC.

The programs implemented by PerformCare New Jersey decreased out-of-state behavioral health placements from a total of 327 in 2006 to zero in 2015. At one time, 53 percent of youth involved in out-of-home placements through the child welfare system were out -of -state, complicating opportunities for family engagement. By expanding community-based and intensive in-home therapeutic services, including care management, youth have been successfully treated in less restrictive settings. The number of youth served by care management has grown from nearly 7,000 youth in 2000 to over 44,000 youth in 2013, an increase of more than six-fold.

Similarly, the total number of youth treated in out-of-home behavioral health settings in New Jersey has decreased from a total of 3,749 youth in 2007 to 3,100 youth in 2013, a decrease of 17 percent. The decrease in out-of-home treatment from 2009 to 2013 has been 9 percent. The number of admissions to out-of-home settings has decreased between 2012 and 2014 by 16 percent.

The average length of stay in out-of-home behavioral health (residential) treatment settings has decreased 27.5 percent between 2012 and 2014. The decrease in length of out-of-home stay is a positive outcome, indicating that the youth are returning to community settings sooner. Also, nearly 80 percent of youth remained in community settings during the first year after discharge from out-of-home treatment based on 2013 discharge data.

PerformCare clinical coordinators approve authorizations for mobile crisis dispatches after a highly structured telephonic triage process with the youth and family. Mobile crisis arrives to the home of the youth and family typically within one hour of the authorization. When the care coordinator identifies a more emergent crisis, police are dispatched and/or youth are referred directly to the local ER or psychiatric screening center. Through the initial authorization of mobile crisis (for 72 hours), as well as authorization for mobile crisis stabilization services (up to eight weeks), 96 percent of the youth served remain in the community, avoiding costly hospitalization, and 98 percent of the youth served remain in the home setting, avoiding costly out-of-home residential treatment. Clearly, the outcomes for youth accessing mobile crisis services are extremely positive.

Outcome monitoring and ongoing evaluation

Evaluation of our UM program is conducted through retrospective statistical analysis and ongoing, consistent evaluation and monitoring. Program components are evaluated retrospectively to both identify positive outcomes and to identify “markers” of success that are incorporated both in future UM initiatives and monthly care management identification algorithms. Evaluation is conducted using sophisticated statistical techniques applied to a combination of medical, pharmacy, survey data, HEDIS measure results, risk stratification scores, eligibility and other data points critical for meaningful population health study.

Propensity matched cohorts are identified to isolate the true statistical impact relative to the program study group. Trend improvement is also studied for different services managed through UM techniques and statistical significance is calculated to ensure that each program studied is evaluated for true positive impact, normalized for the trend effect of the larger, non-study population.

Using the tools and resources of its corporate parent, AmeriHealth Caritas Iowa will continually refine its approach to outcome monitoring and program evaluation. We employ a "proactive analytic learning model" to consistently monitor, evaluate and refine programs. Utilizing this approach, we are able to systematically evaluate disparate metrics in a meaningful way to assess the success of UM activities, thereby building a more refined UM program based on predicted attributes of success. As specific metrics are identified to be more or less predictive of high levels of success, the proactive analytic learning model scoring algorithm is modified to reflect these learnings. New data may be added while other less outcome-driven information may be removed as the model is enhanced and refined over time. This constant feedback loop of information yields an effective, dynamic process for ongoing refinement our activities.

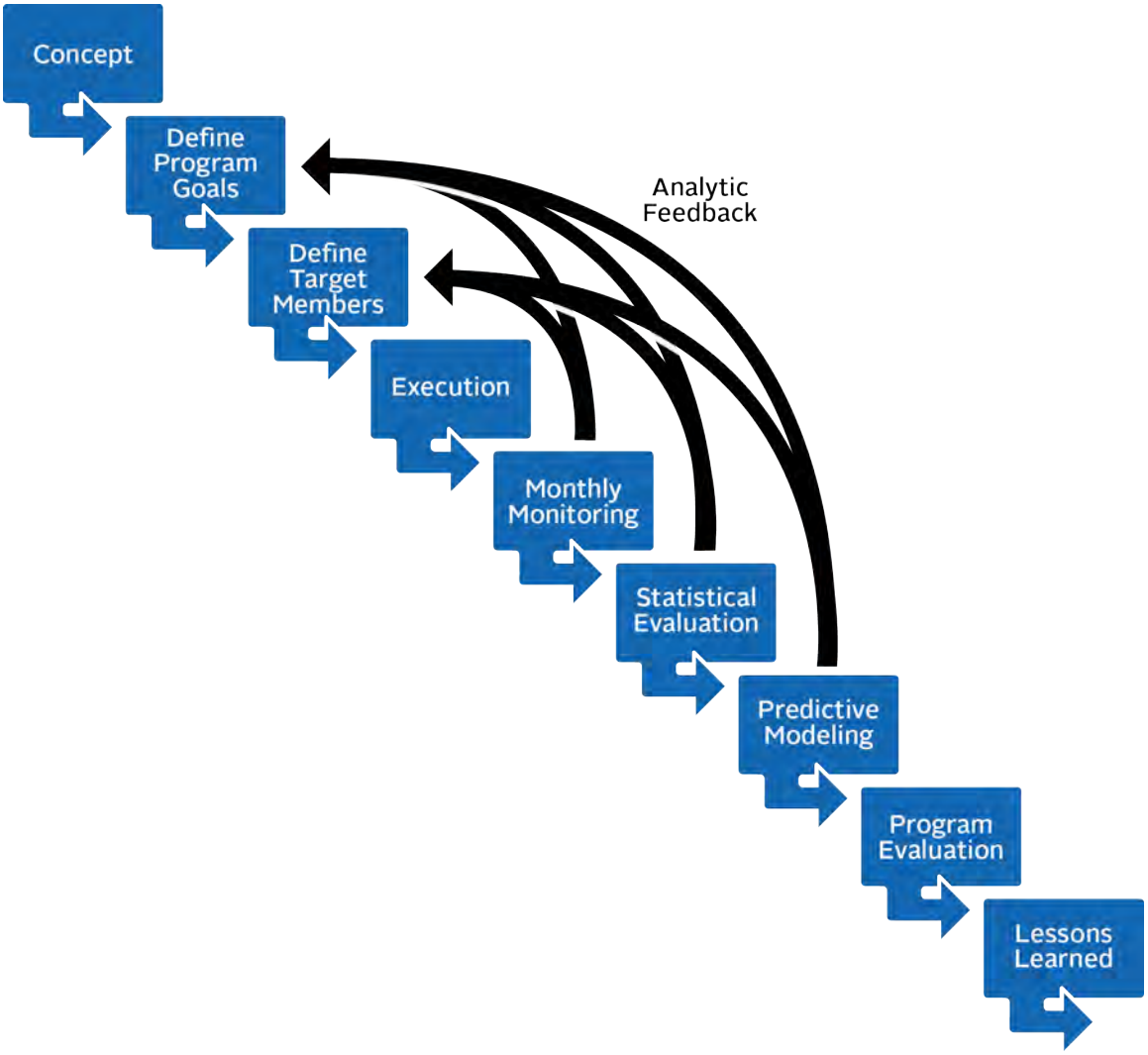

Exhibit 11.1-A: UM Feedback Loop

We are currently using this approach with our Community Care Management Team (CCMT) program to refine how we engage members into the program to have greater success of effective management and early intervention of "super utilizers." When the program began in 2013, members were identified based on over-utilization analysis (high-volume inpatient and ER utilization), physician referrals, care manager referrals and the presence of multiple chronic conditions. The member engagement rate was 15 percent. In 2014, using the learning model, we refined how members were identified for the program by using historical data to rank key attributes, such as total medical spend, number of inpatient admissions, number of ER visits, and so forth, to target members by subsets for intervention. With this approach, the member engagement rate increased to 53 percent. The program lead immediately changed how members are targeted for outreach. The CCMT program results are promising with reductions in average per-member-per-month total medical spend, inpatient claims and ER claims. Our next step is to develop predictive models based on trends to further refine member target population. The learning model is an iterative process, and one which we believe will produce actionable data and continuous refinement of our programs. We will continue to use this model because we understand the value of efficient front-end performance in reducing costly and inefficient back-end work and reducing the administrative burden on providers.

2. Describe your policies, procedures and systems to:

a. Assist utilization management staff to identify instances of over- and under-utilization of emergency room services and other healthcare services;

AmeriHealth Caritas Iowa will utilize AmeriHealth Caritas' proven methods to assist staff in the identification of over- and underutilization of healthcare services, including ER services. We use a variety of techniques, including care gap alerts, a 360-degree view of all member care through our population health platform and training on the identification of potential fraud, waste and abuse cases. We have a strong focus on ensuring members are connected to integrated primary care so that their needs can be addressed without the need for an ER visit.

Care gap alerts

Care gaps occur when members do not receive (or there is no documentation that they received) services recommended by evidence-based clinical practice guidelines. AmeriHealth Caritas analyzes claims data against evidence-based algorithms monthly to identify gaps in care. Care gap algorithms exist for a full range of preventive services and chronic disease states. Connecting the member with needed care identified through the care gap process can avoid under-utilization of critical healthcare services.

Care gap alerts, are available to associates performing UM, quality management, care management and member services activities. Associates see a system flag when the member's identification (ID) number is entered.

Providers also receive care gap reports, both as alerts during an eligibility check, and as full panel reports through the Provider Web Portal. When the member's ID number is entered in the Provider Web Portal, a pop-up alert appears notifying the provider that a care gap exists. When the provider clicks on the alert, a member-level report appears, identifying missing and overdue services, care gaps and up-to-date services. The provider can also access a report of all care gaps for his assigned members, either as a printable document or as a comma-separated values (CSV) file that can be incorporated into other systems.

Complete view of member's services through "Member 360"

We have built our data infrastructure in a way that allows our staff a complete view of all available clinical information and services a member has a received. Data available through our population health management system include information on prescription refill dates, ER visits, inpatient admissions, laboratory results and other physician and outpatient services the member is currently receiving or has received in the past. This allows easy identification of potential over-use and under-use of services.

Through ongoing claim analysis, Jake, a 15-year-old boy, was identified for an in-depth care management assessment. Diagnosed with hypertrophic cardiomyopathy, Jake had three hospital admissions since his diagnosis in 2013 and was not getting regular refills of his medications. After unsuccessful attempts to contact Jake's parent via phone, searches for alternate contact information and a follow-up letter, the care manager sent a care connector from the Community Outreach Solutions (COS) team to connect with Jake at his home. The COS associate found Jake's mother at home and connected Jake and his mother with the AmeriHealth Caritas care manager.

The care manager quickly identified that Jake was supposed to be re-evaluated by his cardiologist but had not made an appointment. Using a three-way call, the care manager and mother called the cardiologist office together and set up the appointment. The care manager also contacted the pharmacy to have Jake's spironolactone refilled.

After addressing Jake's initial needs, the care manager administered the PHQ9A to screen for depression. Jake's results indicated potential mild depression. In reviewing the results with Jake, he indicated that he would like to talk with someone about how he was feeling and the care manager provided information on behavioral health resources in Jake's area. The care manager also helped Jake's mother find a new dental provider near their home to address Jake's routine dental care gap and provided information to get Jake connected to the state transportation vendor to give Jake an alternative to the public transportation currently used for medical appointments.

Additionally, proprietary analytics are able to mine our data sets for unmet member needs and potential duplicative care or overuse. Information on member needs is fed back into our population health management system and queued as a work list activity for a member of the care management team to address. For example, a member who is identified as pregnant through analysis of claim data is flagged for outreach by a Bright Start® pregnancy management care connector to ensure that all needed prenatal care is delivered.

Developing innovative solutions to address underutilization

AmeriHealth Caritas recognizes that laboratory test results drive many health care decisions, but the process in obtaining the results can be scary, intimidating, inconvenient and expensive. It is estimated that between 40-60 percent of laboratory tests are not completed, which means that individuals and their health care providers likely do not have all the right information at the right time to make important health care decisions or develop comprehensive care plans.

Typically, health care innovation and technology is first available to individuals who are most advantaged. Our partnership with Theranos provides an opportunity for us to bring an innovative solution to those who are least advantaged first, giving them a health care experience that reinforces our approach to treating all members with dignity and respect.

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. Their revolutionary laboratory service platform uses dramatically smaller samples than traditional labs, with samples collected from both capillary draws and traditional methods. Results are returned much faster than industry averages, with the overwhelming majority of results reported within 24 hours of sample collection. 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.

Removing barriers to health care and services for those most in need is a top priority for our family of companies. 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. It is important that our members and their health care providers have the information they need, when they need it, to develop personal health care plans and make health care decisions, and so members can fully engage in their health care.

Our partnership with Theranos is aligned with our mission, consistent with our commitment to offer solutions to assist our clinical partners, and supports our forward-thinking approaches to developing innovative solutions for our members and providers.

Fraud, waste and abuse investigations

All of our associates receive training on fraud, waste and abuse (FWA) to identify potential over-use and misuse of healthcare services. Our training program includes didactic material and competency testing to ensure that associates understand the content. UM associates routinely report identified concerns to the Special Investigations Unit (SIU) for investigation and action. We also maintain a FWA hotline and reporting capability through our internal Web portal.

We are armed with FWA software and reporting that also helps identify issues. The SIU routinely analyzes utilization data to identify provider and member patterns potentially indicating overuse, misuse or underuse of services. For example, a provider billing for in-office laboratory services for every patient seen in the office may indicate over-use of services.

Case studies:

Overutilization

We monitor utilization patterns at the member level and then aggregate them to look for patterns on the provider level. Through this review process we identified a new provider whose payments from us had increased over 1,000 percent from 2012 to 2014 in one of our Midwest states. Based on this information, we scheduled a visit with the provider to ascertain the services being provided and understand the significant increase. The visit demonstrated that the services being provided were medically necessary the majority of the time. However, it was also determined that the provider was conducting educational activities during that time and billing them as clinical program time. This finding resulted in a referral to the FWA unit where the investigation is continuing.

Underutilization

In a Midwest state, we determined that many members were not being seen by a mental health professional within seven days of discharge from a mental health inpatient hospitalization. This resulted in a low HEDIS Follow-Up after Hospitalization for Mental Illness (FUH) score and a high readmission rate. One of the many interventions we implemented involved contracting with mental health professionals to provide this follow-up visit in the member's home within one to two days of discharge. This intervention resulted in a significant increase in our HEDIS FUH rate, reduction in readmissions and confirmation that our members are now being safely maintained in the community.

b. Analyze emergency department utilization and diversion efforts.

AmeriHealth Caritas has developed a comprehensive strategy to avoid unnecessary use of the ER, using a variety of interventions to address the unique socioeconomic and cultural characteristics that influence how our members access care. Through initiatives such as outreach to members with high ER utilization and proactive member education, we have worked to curtail the rise of ER overuse in our membership. We will implement these programs in Iowa.

Overuse of the ER is a well-documented national problem that transcends all demographic groups and is particularly acute within the Medicaid program. In the 16-year period ending in 2011, the number of ER visits in the United States increased over 41 percent from 96.5 million to 136.3 million, according to the Center for Disease Control and Prevention. The number of visits by Medicaid recipients is almost two-fold those seen in the Commercial population and most of the visits are for urgent issues, which suggests many have health needs that are not being adequately addressed in lesser care settings910.

Inappropriate visits continue to rise sharply. Visits made to the ER for a condition that does not require emergency treatment is a concern across the country. According to Health Leaders, only 29 percent of patients presented with an emergent condition that was not avoidable. Conversely, 24 percent presented with no emergent medical need at all. Among those who showed up in the ER and had an emergent condition, 42 percent could have been treated in a primary care setting and six percent could have avoided the ER trip with timely outpatient care. Diversion of just 10 percent of patients who did not have an unavoidable emergent medical need could result in a net savings of $18.68 in total allowed costs per-member per-year, totaling over $7.6 million for a population of 400,000.

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

Our approach is aligned with Iowa's priority of establishing a true medical home for members, aligning provider reimbursement with desired health outcomes and moving from an episodic care model to a comprehensive chronic care model to address the needs of members with chronic illness. Our experience

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9 Garcia et al. 2010. Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007? CDC, NCHS Data Brief No 38.

10 Sommers et al. 2012. Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are for Urgent or More Serious Symptoms. Center for Studying Health Systems Change.

has shown that such measures, in combination with appropriate care management for those with chronic conditions, drive reductions in inappropriate ER use.

Emergency room initiatives

Reduction of inappropriate utilization of the ER is a key focus of AmeriHealth Caritas UM activities. We will tailor our interventions to fit with Iowa's healthcare delivery resources and complement existing programs. We will concentrate our initiatives on identification of frequent ER users, building strong care management relationships in that population, educating all members on when to use the ER versus the primary care physician (PCP) or an urgent care center and encouraging self-management of non-emergent issues.

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

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

- **Data-driven Outreach —** AmeriHealth Caritas uses claim data to identify frequent ER users. Our Rapid Response team contacts identifies members by phone to offer education and assistance in finding appropriate primary and specialty care and reinforce appropriate use of ER services. We also receive daily reports from the nurse triage vendor detailing members who called the service in the previous 24 hours, the problem identified and the advice given. Rapid Response care connectors contact the member to check the outcome of the advice they received, assess for unmet needs and connect the member back to the PCP through an appointment.

  Our affiliate in Louisiana used this approach with the top 100 ER utilizers in that plan. The chart below demonstrates the results for the cohort of identified members we started in January of 2014, and by February, the number of ER visits for the cohort declined drastically. Despite a slight increase noted in March, the trend continued to show a consistent decline in the April, May and June. 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 team.

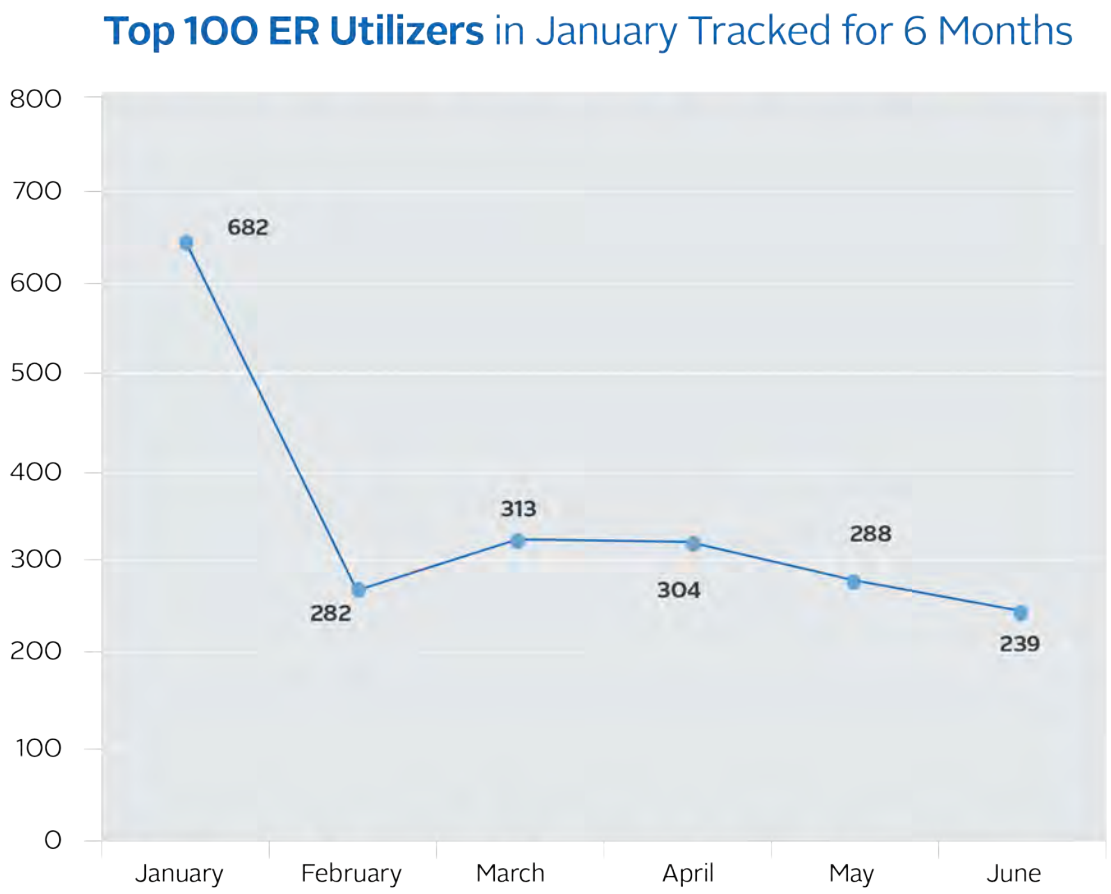


Exhibit 11.1-B: ER Utilization Example

- **Acute Care Transition Managers** — We place care management resources in the ERs of our high-volume facilities. Through personal contact with ER users during the ER event, we are able to confirm the member's contact information for post-ER follow-up. We are able to conduct an onsite assessment of the barriers and drivers that led the individual to the ER. We also use the opportunity to strengthen the care management relationship with the member, make an appointment with the PCP and forward the ER discharge summary to the PCP's office.
- **Quality Incentive Programs for Providers** — Our quality incentive programs include metrics on ER use, specifically focusing on Potentially Preventable Visits (PPVs). Provider performance is risk-adjusted and compared to a cohort of peer providers and historic performance, and influences quality of incentive payments to providers.
- **For Your Kids Care** — We run community education programs to educate parents of young infants on how to care for sick children, effective home treatments and when to seek medical or emergency care. Interested participants can become lay instructors for the program. Each participant is given an easy-to-read reference book outlining symptoms and recommended care for common childhood illnesses. We also supply thermometers to those participants who don't have them. We learned early in the program that the advice regarding fever in the book will not help a parent who has no means to take the child's temperature.

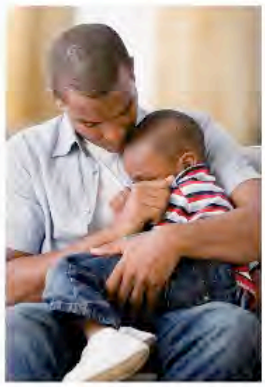
Is This an Emergency?

4 Your Kids Care

Is This an Emergency?

A 3-year-old boy's father touched his forehead and it felt warm. He took the child's temperature. It was 101.2 degrees. The boy complained that his head hurt. The dad made him breakfast but the child didn't feel like eating. The dad also gave the boy some juice and children's Tylenol. The following morning, the fever was 101.0 degrees. The boy was still tired, aching and not interested in playing with his toys.

What should the father do?



Member Services
1-XXX-XXX-XXXX
TTY 1-XXX-XXX-XXX

The Nurse Call Line is available to answer questions about your health. Call 1-XXX-XXX-XXXX or TTY XXX to talk to a trained nurse 24 hours a day, 7 days a week.

AmeriHealth Caritas Iowa

Exhibit 11.1-C: For Your Kids Care Education Example

Outcomes of our For Your Kids Care program:

To evaluate the effectiveness of this intervention, we conducted a one-year controlled pre/post matched-control analysis. Specifically, we investigated whether hands-on training and education of the parents/caregivers of pediatric Medicaid health plan members who have had prior non-emergent visits to the ER could reduce the subsequent incidences of these visits resulting in improved home-based care at significant cost savings. The study population analyzed consisted of 585 pediatric members with at least one ER claim for treating non-emergent conditions during the prior year whose parent/caregiver

participated in the classes. The matched control group consisted of 1,189 and 1,153 pediatric members with non-participating parents/caregivers in the pre- and post- periods, respectively. Statistical significance was set at P=0.05.

The average number of ER visits for non-urgent conditions decreased significantly in a six-month and 12-month period after members attended at least one class (p<0.0001). While the average number of ER visits for non-urgent conditions decreased significantly in a 12-month period for nonparticipants as well (p=0.0097), the mean reduction for study group participants was over three-fold greater than control group nonparticipants (-46.3 percent vs. -14.6 percent) over the same time period. Similarly, the amounts paid for ER claims for non-urgent visits during both six-month and 12-month periods decreased by over twice the amount for members after they attended at least one class than for non-participating members (-27.4 percent vs. -13.7 percent at six months; -37.8 percent vs. -17.4 percent at 12 months) over the same time period.

Additionally, a post-program survey of 705 program participants found that respondents were significantly less inclined to take a child with a fever or earache to the ER as a result of participating in the program.

Additional initiatives include:

- Automated discharge outreach surveys to support successful discharge plan implementation, ensure follow–up with the PCP and avoid a post-discharge trip to the ER.
- Targeted mailings for ER utilizers based on common non-emergent diagnoses, i.e., otitis media, or frequent usage of the ER.
- Increased visibility of urgent care centers and PCP offices that offer after-hour appointments.
- Asthma home assessments/educational visits in collaboration with the National Nursing Centers Consortium's Asthma Safe Kids program.
- New member assessment ER question — Has anyone in the household been to the ER four times or more in the last six months? Members who respond "yes" receive assessment and follow-up through the Rapid Response team.
- Monthly medication adherence reminders to members who are prescribed asthma, heart failure and diabetes medications.

We also offer all members access to our 24/7 Nurse Call Line. Daily information on member calls to the 24/7 Nurse Call Line, including the reason for the call and the advice given, is sent to the member's PCP and to the Rapid Response team. Care connectors in the Rapid Response team contact the member to assist the member to access care recommended during the call, including facilitating a PCP appointment. We will employ this approach in Iowa.

Across all of our Medicaid markets in 2014, between six percent and 15 percent of members who thought they needed to go to the ER or call 911 at the time they called the 24/7 Nurse Call Line were able to have their concerns addressed and healthcare needs met without an ER visit. Data for each of our affiliates is provided in the table below:

24/7 Nurse Call Line Diversion Summary 2014	
Plan	% of Triaged Members diverted from ER
AmeriHealth Caritas Pennsylvania	9%
AmeriHealth Caritas Northeast	10%
AmeriHealth Caritas District of Columbia	14.7%
AmeriHealth Caritas Louisiana	12%
Arbor Health Plan	5.9%
Blue Cross Complete of Michigan	6.8%
Keystone First	12%

Exhibit 11.1-D: 24/7 Nurse Call Line Diversion Summary (2014)

c. Identify aberrant provider practice patterns

In Iowa, we will utilize the robust analytic systems and resources of AmeriHealth Caritas to monitor service utilization at the member level and aggregate the results to look for patterns at the provider level. Individual member needs identified through this process are referred to the Integrated Healthcare Management (IHM) team program for outreach, assessment and coordination of additional supports.

Below we have included recent examples of aberrant provider practice patterns that we have identified and addressed:

Case study 1: Thoracic-Lumbar-Spinal Orthotic claim analysis

An analysis of claims for thoracic-lumbar-sacral orthotics (TLSO) identified an increase in TLSO claims over a three-year period, with a significant increase in claim submissions from one durable medical equipment (DME) company (Company X). The claim analysis also identified a clustering of claims paid just below $500, which was driving the total increase in TLSO claim volume.

The graph below shows that expenditures took off in 2013-2014 and that Company X accounted for all of the increase over the baseline. We found that Company X was exploiting a loophole in our authorization system that allowed all DME less than $500 to pay without prior authorization. We closed that loophole mid-2014, implementing prior authorization requirements for TLSO requests (many of which were found to be not medically necessary). The decline in medical costs for TLSOs in the second half of 2014 was entirely explained by a reduction in claims from the one identified company.

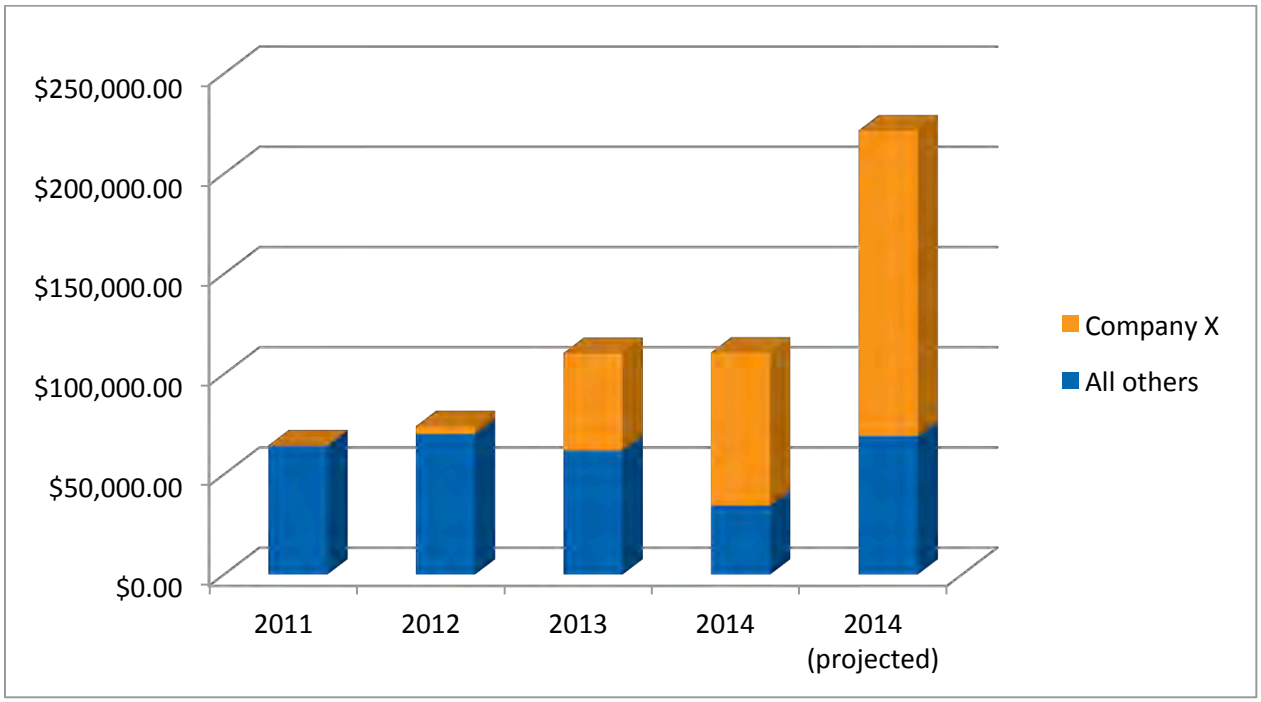


Exhibit 11.1-E: Total TSLO Claims

Case Study 2: Suboxone misuse

Analysis of controlled substance prescribing patterns in in our affiliate plan in Pennsylvania identified that many members were receiving prescriptions for Suboxone from out-of-network providers. Many of these providers were managing more than the 100-patient limit established by the Drug Enforcement Administration (DEA) for Suboxone prescribing. Moreover, site visits to high-volume Suboxone prescribers in the health plan network found that some were requiring cash payments — a practice that violates state and health plan rules. Project staff referred these cases to AmeriHealth Caritas' SIU and sent a fax blast to all Suboxone prescribers in the network to remind them of the health plan's prohibition on requiring cash payments.

To address the existing problems and create the infrastructure needed for evidence-based Medication-Assisted Treatment (MAT) with Suboxone, AmeriHealth Caritas decided to create a network of Suboxone prescribers who meet best-practice standards. AmeriHealth Caritas identified evidence-based standards for quality, documentation and member visits for Suboxone treatment that would be required to be contracted in a "preferred Suboxone network." Due to the fact that no formal credentialing process exists for Suboxone providers, we developed a provider office audit tool to track compliance with the identified standards for the initial and renewal certification to participate in the preferred Suboxone network. Some of the key items being integrated into the program are listed below:

- Confirming the provider's Controlled Substance Drug Enforcement Administration (XDEA) number and the absence of disciplinary action at the state and federal level.
- Evaluating the number of patients seen per hour to ensure appropriate attention is given to the member.
- Reviewing the provider's written policies and procedures for the induction and maintenance of patients on Suboxone therapy, including:

- The number of refills authorized on a Suboxone prescription.
- The procedures are in place to address reports of lost or stolen prescriptions.
- The presence of a comprehensive treatment agreement between the member and the provider.
- The process to refer members for a behavioral health evaluation and ensure that this visit occurs.

Currently, our Pennsylvania affiliate only has a single provider office in the Philadelphia market that has met these standards. As they continue to evaluate offices to join their preferred Suboxone Network they will evaluate member access to these providers. Once a critical mass of preferred Suboxone providers are contracted with the plan, they will remove the ability for Suboxone prescriptions from all other current Suboxone prescribers to be filled. At this point, any additional provider wishing to prescribe Suboxone for AmeriHealth Caritas members needs to complete a successful audit in accordance with AmeriHealth Caritas - Suboxone prescribing standards. Pharmacy point-of-service dispensing edits will only allow prescriptions from providers who meet the Suboxone prescribing standards, as evidenced by an onsite audit review, to be filled.

Providers that do not pass the audit will receive a deficiency notice that delineates the audit items the provider did not pass, provides education on the required standard and establishes a timeline for resolution. Those providers that are unable to achieve compliance will not be eligible to join the network. Providers that had previously been in the network and receive a deficiency notice on a repeat audit must become compliant within the timeframe allotted or they will automatically become ineligible to prescribe Suboxone for AmeriHealth Caritas members until such time as they are compliant and successfully complete a follow-up audit.

This evaluation process is currently underway and will continue throughout the remainder of 2015. Our Pennsylvania affiliate anticipates that by the first quarter of 2016, it will have evaluated a sufficient portion of contracted providers dispensing Suboxone to effectively close the network to only include providers were evaluated. This will also allow sufficient time for offices that received deficiency notices to become compliant.

To launch this new audit system, AmeriHealth Caritas will mail letters to all current and past Suboxone prescribers to explain that they must complete a quality audit and meet AmeriHealth Caritas standards to remain eligible to prescriber Suboxone to AmeriHealth Caritas members. The provider communication will detail the key components of the program listed in the bullets above as well as the expectations and timeline for correcting items deemed deficient. AmeriHealth Caritas' provider account executive will be available to the provider to discuss questions or concerns regarding the new credentialing requirements. In addition, the health plan's network medical director will be working in tandem with the account executive to enable a true peer-to-peer collaboration between the medical director and the prescribing physician. The ability to speak directly with a medical director has been received favorably by the provider network and provides a high-touch approach to the program. Finally, any prescriber who meets the best-practice standards will be included in the network, and AmeriHealth Caritas will conduct periodic audits to ensure compliance.

d. Monitor patient data related to length of stay and re-admissions related to hospitalizations and surgeries;

AmeriHealth Caritas of Iowa will use several methods to monitor length of stay and readmission data related to hospitalizations and surgeries. Through our robust data analytic capabilities, we produce

monthly reports on length of stay by type of admission and readmission rates. We also review the data by facility and diagnosis, to identify drivers of the results. Our UM team identifies previous admissions for current inpatient events, allowing us to proactively strengthen our discharge planning and follow-up activities for members with previous admissions. We also use Potentially Preventable Readmission (PPR) data in our predictive modeling algorithms, targeting members with PPRs for individual care management outreach and engagement.

Monthly key indicator reports and analysis

Our key indicator reports compare inpatient and outpatient services that were authorized and requested from the current period to the corresponding prior period, both on a monthly and year-to-date basis. In addition to serving as a forecaster of future claim activity, they allow the UM team to identify trends and variances from prior performance periods.

Report data includes separate results by admission type, breaking out specialty services such as neonatal intensive care unit (NICU) admissions, behavioral health admissions and maternity admissions. This allows the UM team to identify drivers for the identified trends. Length of stay data is also available by admission type. This is especially critical in markets where the majority of the contract arrangements pay a flat rate for the diagnosis-related group (DRG) or all patient refined diagnosis-related group (APDRG) for most admissions. Trend results by type of admission allow the UM team to focus on critical admission types, such as NICU, where the length of stay translates directly to the cost of the admission and is a proxy indicator of newborn health.

Diagnostic level reports use clinical classification software (CCS) to group admissions for like conditions to identify trends at the condition level. Drill-down data is used to identify specific diagnoses clusters driving the results, such as influenza, heat-related conditions and pregnancies. Using inpatient and outpatient authorization results, we monitor for unusual changes between specific periods of time.

Reduction of inappropriate inpatient admissions with lengths of stay two days or less

A statistical review of inpatient admissions with a length of stay less than or equal to two days was performed using 3M analytics and strict application of medical necessity criteria. A significant number of admissions were identified where the care provided could have been safely administered in the outpatient setting. Almost half of those cases presented with conditions that were ambulatory sensitive and potentially preventable admissions (PPAs), suggesting gaps in outpatient care. Specific PPAs identified in the data included:

A List of PPAs, Based on 3M APR DRGs		
• 053 – Seizure • 054 – Migraine & other headaches • 113 – Infections of upper respiratory tract • 137 – Major respiratory infections & inflammations • 138 – Bronchiolitis & RSV pneumonia • 139 – Other pneumonia • 140 – Chronic obstructive pulmonary disease • 141 – Asthma • 191 – Cardiac catheterization with circ disord exc ischemic heart disease	• 192 – Cardiac catheterization for ischemic heart disease • 194 – Heart failure • 198 – Angina pectoris & coronary atherosclerosis • 199 – Hypertension • 203 – Chest pain • 244 – Diverticulitis & diverticulosis • 249 – Non-bacterial gastroenteritis, nausea & vomiting • 251 – Abdominal pain • 383 – Cellulitis & other bacterial skin infections	• 420 – Diabetes • 422 – Hypovolemia & related electrolyte disorders • 463 – Kidney & urinary tract infections • 465 – Urinary stones & acquired upper urinary tract obstruction • 662 - Sickle cell • 722 – Fever

Exhibit 11.1-F: List of Potentially Preventable Admissions (PPAs)

To reduce this inappropriate inpatient utilization and improve outpatient management of these conditions, we implemented a mandatory medical director review of requests for inpatient admission for any of the above conditions. Requests for inpatient level of care for admissions not meeting medical necessity criteria were denied for and were approved for an observation level of care. This revision to our process has decreased the number of short inpatient stays for PPA-related diagnoses.

Readmission monitoring

We also monitor readmission data monthly and through real-time identification during the UM process. We track 30-day all - cause readmission rates by health plan and by facility. Separate analyses are performed to identify diagnoses related to readmissions. For example, in 2014, we identified that members with sickle cell disease accounted for a high-volume of readmissions for members in three of our affiliate health plans. Additional analysis identified many of these members were not receiving prescriptions for Hydroxyurea, an evidence-based treatment potentially helpful in preventing sickle cell pain crisis. We implemented educational outreach to the providers treating these members on the benefits of Hydroxyurea (and Penicillin in pediatric patients) for management of sickle cell disease. As part of the discussion, we shared the names of our members they were treating to whom the guidelines might apply.

We also implemented a member education campaign to reinforce healthy behaviors associated with sickle cell disease management, including hydration. As part of the campaign, members with sickle cell disease were sent a reusable water bottle and educational material encouraging them to talk with their doctor about available treatment options. A full analysis of the impact is in process; however, we have already seen an increase in the number of members receiving Hydroxyurea therapy.

Patient readmission data is also monitored real-time through our UM process. When an inpatient case is created (based on phone, Web portal, fax or admission/discharge/transfer data feed), the member's

history is reviewed to identify any previous admissions. Automated rules in the population health management system create alerts on member records when a new inpatient case is added to the system for a member with a previous discharge within 30 days. This functionality alerts the UM team to the need for enhanced discharge planning and follow-up.

Recognizing that readmission rates are highest in members with chronic conditions, we set a goal during 2014 to decrease the 30-day readmission rate for members with dominant chronic conditions or asthma. Dominant chronic conditions are conditions that are expected to result in continued health deterioration over time. To meet the goal, we strengthened all of our discharge planning processes and touch points. We also implemented targeted initiatives to address readmission drivers, including the behavioral health and sickle cell disease programs discussed above. Each health plan developed specific partnerships and initiatives, using data analysis, population health management system capabilities and core outreach common across all of our health plans to customize an approach specific for that health plan's members and providers. The result was an 11.5 percent decrease in 30-day readmissions for members with chronic conditions (including asthma).

e. Assure the appropriateness of inpatient care

AmeriHealth Caritas conducts medical necessity review of all inpatient hospitalizations, with the exceptions of maternity admissions for childbirth. We assess the appropriateness of inpatient care using clinical information from the facility related to the member's severity of illness, and the treatment planned and delivered. In addition, inpatient review provides information to facilitate the discharge plan and allows for peer consultation between the attending facility physician and the health plan's medical director as needed. The inpatient review process also identifies and facilitates transition to alternate levels of care when appropriate.

f. Ensure active participation of a utilization review committee

The Quality of Clinical Care Committee (QCCC), which reports in to the Quality Assessment Performance Improvement Committee (QAPIC), serves as the Utilization Review Committee for AmeriHealth Caritas Plans. AmeriHealth Caritas Iowa will actively solicit participating providers to serve as voting members on the committee. AmeriHealth Caritas Iowa's medical director will chair the QCCC.

AmeriHealth Caritas Iowa will take several steps to ensure the active participation of external physicians on our committee and to ensure that committee meetings serve as a forum for meaningful dialogue and activity. We are cognizant of the needs of the contracted community practitioners participating on the committee. We will schedule committee meetings outside of normal business hours to allow practitioners to more readily attend without disrupting their practice schedules. AmeriHealth Caritas holds meetings in the morning and evening, depending on the needs of the committee participants. As an example, QCCC meetings for AmeriHealth Caritas Iowa's affiliates in Pennsylvania are held at 6:00 p.m., while meetings for the South Carolina and Louisiana affiliates are held early in the morning at 7:30 a.m.

The QCCC participants are provided an agenda and meeting documents prior to the date of the meeting to allow them time to review and note any questions related to the information being presented. The QCCC chair solicits feedback on topics of discussion from the health plan QCCC participants and community providers.

As discussed in Section 10, we have already had introductory discussions with representatives of several potential sources of external members for the QCCC in QAPIC structure, including the QCCC. We will contact the following organizations to solicit representation for the QCCC:

- I4A (Iowa Association of Area Agencies on Aging).

- Iowa Association of Community Providers.
- Iowa Behavioral Health Association.
- Iowa Community Action Association.
- Iowa Health Care Association/Iowa Center for Assisted Living.
- Iowa Medical Society.
- Iowa Primary Care Association.
- Mercy Health Network.
- University of Iowa Health Alliance.

g. Evaluate efficiency and appropriateness of service delivery

Evaluating the efficiency and appropriateness of service delivery is a core tenet of the AmeriHealth Caritas Iowa UM program. Several programs and initiatives designed to evaluate efficiency and appropriateness with respect to medical necessity, practice patterns and under-/overutilization of services were discussed above. AmeriHealth Caritas Iowa will perform ongoing evaluation of the efficiency and appropriateness of services delivered by the UM team and program. In addition to a comprehensive annual evaluation of all program components, AmeriHealth Caritas Iowa will conduct daily, weekly and monthly evaluation of key service metrics.

Average speed of answer

UM supervisors monitor the wait times for calls in queue throughout the day, and adjust resource allocation to meet call demand. AmeriHealth Caritas Iowa will use the workforce monitoring platform used across all AmeriHealth Caritas health plans to understand call volume patterns, forecast demand and adjust resources accordingly. We monitor performance results for all UM teams against industry best-practice goals to ensure that the average call answer time is 30 seconds or below, and the average abandonment rate is less than five percent.

UM decision timeliness

Daily aging reports alert staff to cases that are approaching their decision due date. Weekly reports on the timeframe for decisions confirm that medical necessity determinations are made within the allotted timeframe for the type of decision. Monthly, each team reports their results, challenges and actions taken to address issues at a corporate-wide meeting. This meeting provides a forum for UM teams across the organization to share best practices and collaborate on solutions.

Case audits

In addition, routine case audits are performed to evaluate the appropriateness of steps taken in processing authorization requests, discharge planning and identification of additional needed actions. Audit elements address documentation of the receipt and process steps taken to make the determination and communicate the outcome. Additional elements focus on the application of criteria and the appropriateness of decisions made during the case. Several audit elements also evaluate connections the UM associate made for the member, including referrals to care management, identification of potential quality of care concerns, discharge planning and initiation of post-admission activities, where appropriate.

Audit results are shared with the individual handling the case and the team supervisor. Individuals with low scores (below 95 percent) are given additional training and coaching. For audit elements with negative findings for several team members, team-based refresher education is conducted.

Satisfaction results

Results of member, practitioner and provider satisfaction surveys are used to evaluate the efficiency and appropriateness of our UM program services. Consumer Assessment of Healthcare Providers and Systems (CAHPS) questions on Getting Care Quickly, along with feedback gathered during Stakeholder Advisory Committee meetings and analysis of provider dissatisfaction data, will provide insight into members' perceptions of UM program services. Annual practitioner and provider satisfaction surveys will be conducted using a third-party vendor to gather information on provider perceptions. This data will be combined with input from providers participating on our Stakeholder Advisory Council, QAPIC and QCCC, as well as feedback gathered during discussions between practicing providers and AmeriHealth Caritas Iowa medical directors and behavioral health medical directors.

Comprehensive annual evaluation

In addition, AmeriHealth Caritas will conduct a comprehensive evaluation of all aspects of its UM program annually to evaluate how well the program meets AmeriHealth Caritas Iowa goals for the delivery of efficient and effective services. The evaluation includes performance data for the entire program year. Results of the evaluation are used to develop recommendations for improvement, and propose goals and objectives for the following year.

h. Incorporate subcontractor's performance data

AmeriHealth Caritas Iowa retains full accountability and responsibility for the provision of services delivered to members through delegated relationships. As part of our robust program for delegation oversight, including pre-delegation assessment of capabilities, ongoing performance monitoring, and a comprehensive annual capability and performance audit, we evaluate and incorporate subcontractor performance data into our program operations and assessment.

Each delegate performing UM services will provide monthly performance data to the AmeriHealth Caritas Iowa QCCC and Quality of Service Committee (QSC). Performance standards for each contractor mirror the internal and external standards as AmeriHealth Caritas. All data presented is specific to performance related to AmeriHealth Caritas Iowa members, even for delegates who serve more than one AmeriHealth Caritas health plan. As part of the delegate oversight monitoring process, delegates who miss a performance goal are required to provide an explanation and planned action. If metric goals are missed for three months in a row, a formal action plan is required.

Prior to the delegation of any activity, a comprehensive pre-delegation assessment will be conducted to evaluate the delegation candidate's ability to perform the services in question according to AmeriHealth Caritas Iowa requirements. AmeriHealth Caritas Iowa reserves the right to investigate/audit the delegate at any time and to terminate the delegation agreement if the delegate's performance does not meet AmeriHealth Caritas' standards.

In addition, AmeriHealth Caritas Iowa will receive ongoing data feeds from delegates performing UM activities. These data feeds will take the form of authorization data in delegation arrangements where AmeriHealth Caritas Iowa retains the responsibility for claim payment. In arrangements where the delegate performs UM activities and claim payment functions, the data feeds will take the form of encounter files. These data sets are incorporated in our Facets® claim/eligibility system and/or data

warehouse, making them accessible to our Medical Economics teams. In this manner, subcontractor data is incorporated into analyses of utilization rates, over-/under-utilization, care gap identification and prior authorization requirements.

i. Facilitate program management and long-term quality

The UM program is one component of AmeriHealth Caritas Iowa's quality infrastructure and business processes that will allow AmeriHealth Caritas Iowa to achieve high-quality outcomes and service delivery. It is an integral part of the way AmeriHealth Caritas Iowa does business. In addition to providing an interface to the AmeriHealth Caritas Iowa Quality Assessment/Performance Improvement Program, the UM program employs systemic monitoring and evaluation of UM processes and services against objective criteria and tools. UM activities are monitored on the individual team and program level. Data used for quality monitoring includes, but is not limited to: average speed of answer, call volume, abandonment rate, IRR review outcomes and functional processes, including:

- Intake/triage.
- Prior authorization.
- Concurrent review.
- Discharge planning.
- Medical review.
- Provider appeals.
- Member appeals.
- Decision timeliness.

Action plans are developed to address identified variances. Performance results and action plan results are communicated to staff via individual sessions, team meetings and department communications. The results are also reported to the QAPIC.

j. Identify critical quality of care issues

AmeriHealth Caritas Iowa's UM program will serve as a window into the quality of care and services received by the individual member, and the population as a whole. Data collected through the performance of UM activities is used to identify critical quality of care issues, including:

- Potential quality of care issues on an individual member basis.
- Access issues and gaps in healthcare service availability.
- Aggregated data related to provider practice patterns.
- Areas for medical policy development and/or revision.
- Opportunities to improve processes to enhance provider and member experience with UM activities.

Potential quality of care issues will be investigated by the AmeriHealth Caritas Iowa Quality Management staff. The AmeriHealth Caritas Iowa clinical leadership team, led by the medical director, will take action to address access issues, gaps in healthcare service availability and medical policy changes. Data on provider practice patterns are reviewed by AmeriHealth Caritas Iowa leadership, with action taken under the direction of the AmeriHealth Caritas Iowa quality program. Opportunities to improve member and provider satisfaction are reviewed by the UM program medical leadership at least annually.

AmeriHealth Caritas Iowa staff report suspected fraud and abuse to the AmeriHealth Caritas Iowa compliance coordinator and the SIU for investigation and related actions. The AmeriHealth Caritas Iowa compliance coordinator will report the investigations, findings and actions taken, as appropriate, to the DHS Program Integrity Unit.

3. Provide a sample UM Work Plan

Purpose/Scope		Frequency	Responsible Party	Action Needed	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Comments
Program Documentation																	
1	UM program Description + annual review and approval. Goal: Annual review and update of the UM program consistent with achieving the health plan's mission of improving health outcomes.	Annual	UM Director or Designee	Review and Approve			X	Submit for DHS Approval									
2	UM work plan updates. Goal: Monitor and review planned UM activities; add additional activities as needed.	Quarterly	UM Director or Designee	Review and Approve	X			X			X			X			

Purpose/Scope		Frequency	Responsible Party	Action Needed	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Comments
3	UM program Evaluation. Goal: To provide an annual evaluation and report on the overall effectiveness of the UM activities and identify opportunities for updates and revisions to the program.	Annual	UM Director or Designee	Review and Approve				Submit for DHS Approval									
4	UM Work Plan (following year). Goal: Prepare UM work plan for following year.	Annual	UM Director or Designee	Review and Approve												X	Submit for DHS Approval
5	Review of UM Criteria and Revisions. Goal: Annual review and revision to UM medical necessity criteria/guidelines. Goal: Annual review and approval of the plan's criteria for medical necessity.	Annual	UM Director or Designee	Review and Approve				X									

Purpose/Scope		Frequency	Responsible Party	Action Needed	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Comments
Clinical Initiatives																	
6	ER Utilization Quality improvement initiative. Goal: Monitor ER rates and identify and review effectiveness of initiatives implemented to reduce unnecessary ER utilization.	Annual	UM Director or Designee	Review and Approve									X				
7	Consistency between UM criteria, disease management programs and clinical practice guidelines. Goal: Review UM criteria for consistency with disease management and clinical practice guidelines.	Annual	UM Director or Designee	Review and Approve							X						

	Purpose/Scope	Frequency	Responsible Party	Action Needed	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Comments
Continuity of Care Reports																	
8	Inpatient discharge to outpatient setting. Goal: Review results and approve interventions for percentage of members with a PCP encounter within 30 days of being discharged to home from an acute inpatient admission.	Quarterly	UM Director or Designee	Review and Approve			X			X			X			X	
Utilization Reports																	
9	Inpatient/Outpatient Utilization. Goal: Review monthly inpatient and outpatient utilization reports; identify trends/opportunities.	Monthly	Medical Economics	Review and Approve	X	X	X	X	X	X	X	X	X	X	X	X	
10	Inpatient Readmissions. Goal: Review monthly inpatient readmission report; identify trends/opportunities.	Bi-Annual	Medical Economics	Review and Approve													

	Purpose/Scope	Frequency	Responsible Party	Action Needed	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Comments
11	Preventive Care. Goal: Review reports comparing utilization of key clinical and preventive services to expected levels and external benchmarks; identify opportunities for improvement.	Quarterly	Medical Economics	Review and Approve		X			X			X			X		
12	Over-under-Utilization. Goal: Review results of routine and targeted investigations comparing utilization of key clinical services to expected levels and external benchmarks; identify opportunities for improvement.	Quarterly	Medical Economics	Review and Approve			X			X			X			X	
13	Provider Practice Patterns. Goal: Review outcome of provider level process and outcome data against expected levels and external benchmarks; identify opportunities for improvement.	Quarterly	Medical Economics	Review and Approve	X			X			X			X			

	Purpose/Scope	Frequency	Responsible Party	Action Needed	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Comments
14	Drug Utilization Review. Goal: Assess drug utilization review (DUR) activity and outcomes.	Quarterly	Pharmacy	Review and Approve			X			X			X			X	
Appeals																	
15	Member Complaint and Grievances. Goal: Report member complaint and grievance timeliness, outcomes and data trends; implement initiatives in response to identified opportunities.	Semi-Annual	UM Appeals Manager	Review and Approve				X						X			
16	Member Appeals. Goal: Report member appeal timeliness, outcomes and data trends; implement initiatives in response to identified opportunities.	Quarterly	UM Appeals Manager	Review and Approve	X (4th Quarter prior year)			X (1st Quarter prior year)			X (2nd Quarter prior year)			X (3rd Quarter prior year)			

Exhibit 11.1-G: Sample UM Workplan

4. Describe if any UM functions will be delegated: If any functions will be delegated, describe proposed ongoing monitoring strategies of the delegated entity

AmeriHealth Caritas Iowa will delegate UM activity associated with medical necessity review of high-tech radiology services to National Imaging Associates (NIA). Under this arrangement, NIA will process prior authorization requests for computerized tomography (CT), computerized tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission

tomography (PET) and nuclear cardiology services. AmeriHealth Caritas uses NIA services in a similar fashion in several of our other health plans.

As part of the process to implement NIA services for AmeriHealth Caritas Iowa, results of a comprehensive review of NIA policies, processes and performance will be reviewed by the AmeriHealth Caritas Iowa QAPIC as part of the process to approve delegation of medical necessity review for high-tech radiology services. The criteria used by NIA for medical necessity determinations will also be reviewed through AmeriHealth Caritas Iowa's quality process, including review and approval by practicing physicians on the QCCC.

Once implemented, AmeriHealth Caritas Iowa will review monthly performance data outlining NIA's compliance with AmeriHealth Caritas Iowa and NCQA processes. Performance data from NIA will be reviewed by the AmeriHealth Caritas Iowa QCCC and QSC. All data presented will be specific to NIA's performance related to AmeriHealth Caritas Iowa members. As part of the delegate oversight monitoring process, NIA will be required to provide an explanation and planned action when performance goals are missed. If NIA misses a performance goal for three months in a row a formal action plan is required. If performance deficiencies remain unresolved in accordance with the time frames set forth in the corrective action plan, AmeriHealth Caritas Iowa will exercise its right to withdraw delegation consistent with the terms of the delegation agreement with NIA.

AmeriHealth Caritas also reserves the right to investigate/audit NIA at any time. Complaints concerning service provided by NIA are reviewed and handled through the AmeriHealth Caritas Iowa Grievance System (for member complaints) and Provider Service team (for provider complaints). This provides a mechanism to track and trend the volume, topic and resolution of issues reported.

Annually, AmeriHealth Caritas Iowa will conduct a comprehensive review of NIA policies, processes and performance. We will audit prior authorization requests that resulted in an approval and requests that resulted in a denial to ensure that NIA continues to perform in accordance with AmeriHealth Caritas and NCQA standards. The results of the review are presented to the AmeriHealth Caritas QAPIC, who makes the determination whether to continue or terminate delegation.

5. Describe the process for developing and updating practice guidelines

Adherence to consistent evidence-based national standards has been demonstrated to improve the health of the population. Clinical practice guidelines are critical to setting the standards for delivering high-quality healthcare and reducing risk. They establish protocols for providing consistent evidence-based care to all members. Adopting best practices established by AmeriHealth Caritas in all of its markets, AmeriHealth Caritas Iowa will identify and adopt clinical practice guidelines based on clinical evidence or a consensus of healthcare professionals in a particular field.

In choosing clinical guidelines for adoption, AmeriHealth Caritas Iowa will focus on clinical areas that are important to the healthcare needs of its members, subject to variation in the delivery of service and where the use of evidence-based practice has been shown to improve health outcomes. We consider and select guidelines based on the following criteria:

- Incidence of the identified disease state in the target population.
- Ability of guideline adherence to improve the health state of the affected member.
- Current professional standards, supported by scientific evidence and research.
- Approval and support by relevant professional medical organizations.

With the participation of AmeriHealth Caritas Iowa's medical director, all new clinical guideline recommendations will be reviewed by the AmeriHealth Caritas National Clinical Policy Committee. Once approved by the enterprise committee, the clinical guideline recommendation will be submitted to AmeriHealth Caritas Iowa's QAPIC for review with suggestions for ways to increase adoption within the health plan's network. Recommended guidelines will also be reviewed by participating providers in the AmeriHealth Caritas Iowa network to identify additional considerations based on local practice patterns as well as ideas on ways to remove barriers to adoption in the market.

AmeriHealth Caritas reviews existing guidelines at a minimum of every two years and more frequently as new information becomes available. The guidelines in the table below will be presented to AmeriHealth Caritas Iowa's QAPIC for review, approval and discussion of ways to improve adherence to these evidence-based standards of care during its first committee meeting.

Guideline Topic	Guideline Source and Location
Asthma	• General Principles in the Management of Asthma. • http://mqic.org/pdf/mqic_general_principles_for_the_diagnosis_and_management_of_asthma_cpg.pdf. • GINA 2014. • http://www.ginasthma.org/local/uploads/files/GINA_Report_2014_Aug12.pdf. • The National Heart, Lung, and Blood Institute (NHLBI) Guidelines for the Diagnosis and Management of Asthma, 2007. • http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/full-report.
Attention Deficit Hyperactivity Disorder (ADHD)	• American Academy of Pediatrics Clinical Practice Guideline for Diagnosis, Evaluation and Treatment of ADHD in Children and Adolescents. • http://guideline.gov/content.aspx?id=36881&search=adhd. • CDC. • http://www.cdc.gov/ncbddd/adhd/diagnosis.html. • American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 2013.
Cardiac Disease	• 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2014; 129:S49-S73. • http://circ.ahajournals.org/content/129/25_Suppl_2/S49. • 2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk: A Report of the American Heart Association/American College of Cardiology Task Force on Practice Guidelines. Circulation. 2014; 129:S76-S99. • http://circ.ahajournals.org/content/129/25_Suppl_2/S76.
Cholesterol Management	• 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. • https://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a .
COPD	• Global Strategy for Diagnosis, Management, and Prevention of COPD, 2014. • http://www.goldcopd.org/uploads/users/files/GOLD_Pocket_2014_Jun11.pdf . • American College of Physicians Guidelines on Diagnosis and Management of Chronic Obstructive Pulmonary Disease. • http://www.keystonefirstpa.com/pdf/provider/resources/cpg/copd-guideline.pdf.

Guideline Topic	Guideline Source and Location
Depression (Adult)	• Michigan Quality Improvement Consortium Guideline. • Primary Care Diagnosis and Management of Adults with Depression. • http://mqic.org/pdf/mqic_primary_care_diagnosis_and_management_of_adults_with_depression_cpg.pdfhttp://mqic.org/pdf/mqic_primary_care_diagnosis_and_management_of_adults_with_depression_cpg.pdf. • ICSI, Adult Depression in Primary Care Guideline, 2013 https://www.icsi.org/_asset/fnhdm3/Depr-Interactive0512b.pdf.
Diabetes	• Michigan Quality Improvement Consortium Guideline. • Management of Diabetes Mellitus. • http://mqic.org/pdf/mqic_management_of_diabetes_mellitus_cpg.pdf. • American Diabetes Association, 2014 http://care.diabetesjournals.org/content/37/Supplement_1/S14.full.pdf+html.
Hypertension	• Michigan Quality Improvement Consortium Guideline Medical Management of Adults with Hypertension. http://mqic.org/pdf/mqic_medical_management_of_adults_with_hypertension_cpg.pdf. • 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8). JAMA. 2014; 311(5): 507-520, doi:10.1001/jama.2013.284427.
Maternity: Routine Prenatal and Postpartum Care	• Michigan Quality Improvement Consortium Guideline Prenatal and Postnatal Care. • http://mqic.org/pdf/mqic_routine_prenatal_and_postnatal_care_cpg.pdf. • ICSI 2012 Health Care Guideline Routine Prenatal Care. https://www.icsi.org/_asset/13n9y4/Prenatal-Interactive0712.pdf.
Maternity: Primary Care Interventions to Promote Breastfeeding	• USPTF recommendations. • http://www.uspreventiveservicestaskforce.org/uspstf08/breastfeeding/brfeedsum.html. • .AAFP • http://www.aafp.org/afp/2004/0115/p354.html.
Obesity (Adult)	• Michigan Quality Improvement Consortium Guideline Management of Overweight and Obesity in the Adult. • http://mqic.org/pdf/mqic_management_of_overweight_and_obesity_in_the_adult_cpg.pdf. • NHBLI, Obesity. • http://www.nhlbi.nih.gov/guidelines/obesity/prctgd_c.pdf. • ICSI, Prevention and Management of Obesity for Adults, 2013. https://www.icsi.org/_asset/s935hy/Obesity-Interactive0411.pdf.
Obesity (Child)	• Michigan Quality Improvement Consortium Guideline Prevention and Identification of Childhood Overweight and Obesity. • http://mqic.org/pdf/mqic_prevention_and_identification_of_childhood_overweight_and_obesity_cpg.pdf. • CDC Childhood Overweight and Obesity Guidelines. • http://www.cdc.gov/obesity/childhood/index.html.

Guideline Topic	Guideline Source and Location
Sickle Cell Disease	• National Heart, Lung, and Blood Institute: Division of Blood Diseases and Resources: Evidence-Based Management of Sickle Cell Disease: Expert Panel Report, 2014. • http://www.nhlbi.nih.gov/health-pro/guidelines/sickle-cell-disease-guidelines/. • http://jama.jamanetwork.com/article.aspx?articleid=1902235.

Exhibit 11.1-H: Example Quality Guidelines and Sources

AmeriHealth Caritas Iowa will adhere to state and NCQA guidance on practice guideline dissemination. AmeriHealth Caritas Iowa will notify providers of new or changed practice guidelines via fax blasts, our provider email service ("Network News"), and hard copy mail. Fax blasts are used to notify providers that clinical practice guidelines are posted on the AmeriHealth Caritas Iowa website and can be accessed by providers, members and other interested parties. Active practice guidelines will be stored and retained on AmeriHealth Caritas Iowa's website for at least two years. Providers can request a hard copy of the guidelines by contacting their Provider Network account executive.

6. Describe how your UM program will integrate with other functional units as appropriate and support the Quality Management and Improvement Program

The American healthcare system is undergoing unprecedented change with the goal of delivering better care through an enhanced customer experience, better quality and lower cost. AmeriHealth Caritas Iowa promotes teamwork among departments with different yet complementary knowledge and skills. Our UM team works closely with care management), Rapid Response team, medical directors, provider network management, quality management, pharmacy, behavioral health and operations to develop internal and external relationships. Our collaboration achieves better outcomes and supports, improves provider engagement and satisfaction and integrates utilization management, care management, provider network management, quality management and medical director’s efforts to close gaps in needed services for members touched through UM activity. This integrated approach will incorporate the goals and strategies driving AmeriHealth Caritas Iowa’s QAPI program and efforts.

Examples of AmeriHealth Caritas Iowa UM program activities that are integrated with other functional units in support of quality management and improvement goals include:

- **Discharge planning:** UM associates coordinate needed services for members transitioning from the inpatient setting to home, including arranging for in-home follow-up from care coordinators in the Rapid Response team or AmeriHealth Caritas Iowa’s COS team. Our seamless process to task members of these teams to perform critical post-discharge follow-up, including ensuring needed medications are available, facilitating a post-discharge physician appointment and reinforcing warning signs that indicate the need to contact a physician, promotes access to appropriate care and reduction of preventable care events which are key tenets of our QAPI program.
- **Care gap dissemination:** Through AmeriHealth Caritas Iowa’s robust technology infrastructure, providers authorized to deliver in-home services for members, including skilled nursing and therapy services, will have access to information on recommended services the member has not received. These care gaps will be identified on the Member Clinical Summary accessible to the home health team through the AmeriHealth Caritas Iowa Provider Portal. This capability allows providers receiving authorizations for in-home care to develop a comprehensive approach to the member’s needs and supports QAPI program goals related to the use of evidence-based practice guidelines.

- **Care management member identification:** Several activities and systems within the UM program facilitate the identification of members in need of additional care management support. All UM associates are trained in the internal process to create an activity in the population health management system to initiate a care management assessment. In addition, case audits, performed for all UM associates, review and score appropriate referral for care management as an audit element. This referral process is one mechanism AmeriHealth Caritas will use to address unmet member needs.
- **Out of network requests:** AmeriHealth Caritas Iowa medical director and Provider Network Management team will review requests to have covered services delivered by providers that are not part of the AmeriHealth Caritas Iowa network to identify whether there is an available provider in the network that can deliver the requested service. Cases where an appropriate provider does not exist are reviewed to see whether additional network recruitment and contracting efforts are needed. This integration will help AmeriHealth Caritas Iowa provide appropriate access to care for its members.

7. Describe how the UM program will encourage health literacy and informed healthcare decision-making

Several AmeriHealth Caritas Iowa core practices, designed to encourage health literacy and informed healthcare decision making, are utilized in the UM program. These include a foundation of cultural competency, use of plain language in written and oral communication, use of interpretation and translation services for members with limited English proficiency and use of alternate communication modalities for members with vision and hearing disabilities. In addition, AmeriHealth Caritas Iowa encourages open discussion between the treating provider and member to review all available treatment options, and will disseminate information from trusted sources to aid members in making informed healthcare decisions. Member materials used to reinforce healthcare services related to transitions of care provide clear, easy to read guidance on recommended next steps.

Cultural consideration

AmeriHealth Caritas Iowa fully recognizes the importance of addressing the needs of members in a culturally competent and linguistically appropriate manner. This is an integral part of our overarching strategy to promote health equity, deliver person-centered care and reduce health disparities. AmeriHealth Caritas Iowa will continue the successful and consistent practices used by AmeriHealth Caritas to ensure that services are provided to all members in a manner that values, affirms and respects their worth, in addition to protecting and preserving their dignity.

All AmeriHealth Caritas Iowa associates are trained upon hire and annually thereafter in Culturally and Linguistically Appropriate Services (CLAS) standards and health equity. This helps reinforce our philosophy throughout the organization so that all associates are empowered to help members receive equal access to care. We also provide this training to our physician and dental communities as well.

Use of plain language

Whenever possible, our UM associates use non-clinical terms when discussing requested healthcare services with members. We understand the relationship between low health literacy and poor health outcomes, and the associated impact on healthcare costs. Members with low health literacy, specifically those who cannot read, understand or act on health information and instructions, face multiple health risks. Confusion about, or lack of, healthcare information may result in poor control of chronic illnesses such as diabetes, more hospitalizations and longer lengths of stay and improperly taken medications.

All of our written materials adhere to literacy and plain - language guidelines. We follow a documented process to produce all communication materials in accordance with cultural competency and literacy requirements. Materials are available in alternative formats to members with specialized needs. Strategies that help us accomplish this include:

- Using simple vocabulary to convey information and minimizing the use of medical jargon.
- Using language that is at or below a sixth grade reading level.
- Choosing appropriate design formats that maximize white space and include easy-to-read fonts and layouts.
- Translating materials into Spanish, German, French and other alternate languages.
- Making materials available in alternate formats (large print, Braille, compact disc and audiotape).
- Testing our materials with member focus groups.
- Using diverse graphics on materials to engage members.

Members with disabilities

For members who are unable to communicate their needs through spoken words, we use a variety of techniques to ensure they have information needed to access the UM process. For members who are hearing-impaired, sign-language interpreters or TTYD systems can be used to conduct the conversation.

Members with limited English proficiency

For members who are not proficient in English, interpreters or bi-lingual UM staff are used to communicate UM decisions. For language needs that are not common in the population, AmeriHealth Caritas Iowa will employ the services of Language Services Associates (LSA) to provide real-time language interpretation. LSA is able to provide interpretation services in over 200 languages.

In addition, AmeriHealth Caritas Iowa will translate written materials, including UM Notice of Action into needed languages. We will contract with a translation service capable of translating materials into over 100 languages.

Encouraging informed decision making

AmeriHealth Caritas Iowa includes language in provider agreements outlining our position to encourage a comprehensive and frank discussion of treatment options with members. We will not penalize a practitioner or provider for advocating on behalf of a member, including in the context of a UM appeal or other dispute over appropriate medical care. Specifically, the below contract language exemplifies our position and supports informed decision making:

- **Provider Discrimination Prohibited.** AmeriHealth Caritas Iowa may not, with respect to provider compensation or indemnification under this Agreement, discriminate against provider to the extent that the provider is acting within the scope of his, her or its license or certification under applicable State law, solely on the basis of that license or certification. Without limiting the foregoing, AmeriHealth Caritas Iowa shall not discriminate against provider for serving high-risk populations or specializing in conditions that require costly treatment. Nothing herein shall be construed to: (i) require AmeriHealth Caritas Iowa to contract with provider if not necessary to meet the needs of members; (ii) preclude AmeriHealth Caritas Iowa from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (iii) preclude AmeriHealth

Caritas Iowa from establishing measures that are designed to maintain quality of services and control costs and are consistent with AmeriHealth Caritas Iowa's responsibilities to members 42 CFR §438.12.

- **Provider-Member Communications.** Nothing in this Agreement shall be construed to prohibit, restrict or impede a provider's ability to freely and openly discuss with members, within the provider's lawful scope of practice, all available treatment options and any information the member may need in order to decide among all relevant treatment options, including but not limited to the risks, benefits and consequences of treatment or non-treatment, regardless of whether the services may be considered Covered Services in accordance with this Agreement. Further, nothing in this Agreement shall be construed to prohibit, restrict or impede provider from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a member, including: information regarding the nature of treatment options, risks of treatment, alternative treatments or the availability of alternative therapies, consultation or tests that may be self-administered and the member's right to participate in decisions regarding his or her care, including the right to refuse treatment and to express preferences about future treatment decisions 42 CFR §438.102(a).

We provide members with access to actionable information on healthcare outcomes for physicians, hospitals and other providers from trusted sources to enable members to make informed healthcare decisions. The primary method of access to this data will be through the Member Portal. Data sources we plan to provide include:

- **NCQA - PCMH:** http://recognition.ncqa.org/PSearchResults.aspx?state=IA&rp=6
- **NCQA - recognized physicians in diabetes:** http://recognition.ncqa.org/PSearchResults.aspx?state=IA&rp=3 and in heart disease and stroke: http://recognition.ncqa.org/PSearchResults.aspx?state=IA&rp=2
- **CMS Physician Compare:** http://www.medicare.gov/physiciancompare/
- **CMS Hospital Compare:** http://www.medicare.gov/hospitalcompare/results.html#dist=25&state=IA&lat=0&lng=0

Additionally, information on board certification status is contained in our online Provider Directory.

These credible sources of information have demonstrated impacts upon selection of physicians and hospitals which may translate into better member outcomes and experiences of care.

Finally, member materials used to educate members at key transition points, such as returning home from after an inpatient stay, are developed using the health literacy and plain language processes described above. These materials assist members to understand the importance of receiving timely follow-up care, adhering to medication schedules and watching for signs and symptoms that should be reported to their physician.

8. Describe strategies to monitor member access to preventive care and strategies to increase member compliance with preventive care standards. Describe how you will identify and address barriers which may inhibit a member's ability to obtain preventive care

AmeriHealth Caritas Iowa will employ the successful strategies and initiatives used by its affiliate health plans to monitor member access to preventive care, increase member compliance and resolve member barriers members to preventive care. Our approach will focus on three core components of our IHM model: a robust population health management infrastructure to identify and disseminate gaps in care,

alignment of member and provider incentives, and proactive outreach and screening for barriers to receiving recommended care.

Preventive care gaps

Care gaps occur when members do not receive (or there is no documentation that they received) services recommended by evidence-based clinical practice guidelines. On a monthly basis, AmeriHealth Caritas Iowa will analyze available data sets, including claims information, immunization registries and electronic medical record data, against evidence-based algorithms for preventive health services to identify gaps in care. Care gap algorithms exist for a full range of preventive services, including child and adolescent wellness measures, immunizations and cancer screenings.

Preventive Care Gaps	
• Well Visits	• Well-child visit (all ages). • Adolescent well-visit. • Adult well-visit.
• Early Prevention Screening Diagnosis Treatment (EPSDT)	• Developmental screening. • Hearing screening. • Lead screening. • Vision screening.
• Immunizations	• Chicken Pox vaccination. • Diphtheria, Tetanus and Pertussis Vaccination. • Haemophilus Influenza Type B Vaccination. • Hepatitis B Vaccination. • Measles, Mumps and Rubella Vaccination. • Pneumococcal Conjugate Vaccination.
• Cancer Screening	• Breast cancer screening. • Cervical cancer screening. • Colorectal cancer screening.
• Other Services	• Annual dental visit. • Chlamydia screening.

Exhibit 11.1-I: Preventive Care Gaps

Care gap alerts are integrated into our population health management platform, visible to associates performing UM, quality management, care management and member service activities. The associates see an alert in the member's record when the member's ID number is entered in the system. This will allow AmeriHealth Caritas Iowa staff to proactively address the need for recommended preventive health services while the member is on the phone. Through one approach of making every member contact count, AmeriHealth Caritas Iowa Member Service and Care Management staff review the recommended preventive health service with the member, assist the member to schedule an appointment and screen for any barriers to obtaining the service. Our associates will also check the preventive healthcare needs for other family members through the family link functionality in our population health management system. This allows an AmeriHealth Caritas representative talking with a mother of four children to review and assist with scheduling the services needed for all four of the children during the same call.

Providers will receive preventive healthcare gap information through our Provider Portal, both as a member-specific alert during an eligibility check and through on-demand reports containing preventive health needs for all of their assigned members. When the member's ID number is entered in the portal, a pop-up alert appears notifying the provider that a care gap exists. When the provider clicks on the alert, a member level report appears, identifying missing and overdue services, care gaps and up-to-date services. The provider can also access a report of all preventive healthcare gaps for assigned members, either as a printable document or as a CSV file that can be incorporated into other systems.

Preventive healthcare gap information is also present on the Member Clinical Summary (MCS), available to all providers through the member eligibility screen in the Provider Portal and to members through the secure Member Portal. The MCS can be viewed online, printed for inclusion in a paper medical record or downloaded as a continuity of care document (CCD) for integration into an electronic medical record. Members can print the MCS to bring with them to the physician's office. An expanded MCS is delivered for children, including information on all EPSDT wellness visits, screening and immunizations received.

Members using the AmeriHealth Caritas Iowa mobile application will receive information on recommended preventive health services through screens in the application and as text reminders. The text reminder will provide a call to action, offering the member the ability to touch the screen and connect to the AmeriHealth Caritas Contact Center of Excellence for assistance in scheduling.

Aligning member and provider incentives

To drive members and providers to take action to address identified gaps in preventive health services, AmeriHealth Caritas Iowa will include key preventive healthcare services in the respective member and provider incentive programs. To drive member behavior, AmeriHealth Caritas Iowa will implement the CARE Card program using a reloadable card to deliver cash incentives to members who receive recommended preventive health services. Metrics base on preventive health services will also be included in the Quality Enhancement (pay for performance) program for PCPs.

Proactive outreach and barrier identification

To facilitate the delivery of timely preventive health services to members, AmeriHealth Caritas will implement ongoing phone and text message outreach programs designed to alert members to needed preventive care services and facilitate a one-touch connection to obtain assistance. Our text reminder program will leverage feedback loops that allow us to validate the response to each message delivered. Through these mechanisms we continually refine the language used to drive desired member behavior.

During outreach calls, we will review recommended services and offer real-time assistance, through a three-way call, to facilitate scheduling an appointment. We will proactively ask the member about common barriers that may arise, including child care and transportation. As needed, we will assist the member to explore options for child care and make arrangements with available transportation services. We will also reinforce the importance of keeping scheduled appointments and contacting the office if something does arise that impacts the member's ability to attend the appointment. For members who are overdue for recommended services, we will set a date-reminder on the member's record to trigger a call to the member the day before the scheduled visit to remind the member of the visit and reassess for any potential barriers.

Innovations in removing barriers to health care

AmeriHealth Caritas believes that every individual has the right to quality healthcare and services and to benefit from healthcare innovation and technology, regardless of socio-economic status. We proactively

seek out partnerships with like-minded organizations that share our passion for equipping individuals with the information they need to make informed decisions about their overall health and wellness, and that share our passion for caring for the whole person through a fully integrated model of care and services.

An 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 soon to be announced strategic partnership with Theranos. Aided by cutting-edge Theranos technology, AmeriHealth Caritas is 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. Theranos' revolutionary laboratory service platform uses dramatically smaller samples than traditional labs, with samples collected from both capillary draws and traditional methods. Results are returned much faster than industry averages, with the overwhelming majority of results reported within 24 hours of sample collection. 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.

AmeriHealth Caritas recognizes that laboratory test results drive many healthcare decisions, but the process in obtaining the results can be scary, intimidating, inconvenient and expensive. It is estimated that between 40-60 percent of laboratory tests are not completed, which means that individuals and their healthcare providers likely don't have all the right information at the right time to make important healthcare decisions or develop comprehensive care plans. Our new strategic partnership with Theranos provides an opportunity for us to quickly, and more actively, engage all new members in Iowa in their overall health and wellness.

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. We expect to publicly announce our strategic partnership with Theranos shortly and intend to bring this innovative solution to all of the markets and Medicaid Members we serve.

9. Describe your UM Committee, including proposed committee composition and tasks

The QCCC will provide direct monitoring, oversight, and direction for the UM program, and reports into the QAPIC, AmeriHealth Caritas Iowa medical director and, ultimately, the AmeriHealth Caritas Iowa board of directors. The chairperson of the QCCC is an AmeriHealth Caritas Iowa medical director. QCCC members will include participating AmeriHealth Caritas Iowa providers and a cross-section of leadership from AmeriHealth Caritas Iowa departments.

Over the past few months, we have initiated conversations with providers in Iowa to introduce ourselves and our programs. We have identified the following organizations we will recruit from for our quality committees:

- I4A (Iowa Area Agency on Aging).
- Iowa Association of Community Providers.
- Iowa Behavioral Health Association.
- Iowa Community Action Association.
- Iowa Health Care Association/Iowa Center for Assisted Living.

- Iowa Medical Society.
- Iowa Primary Care Association.
- Mercy Health Network.
- University of Iowa Health Alliance.

The QCCC is responsible for the following:

- Reviewing and approving clinical and preventive practice guidelines.
- Adoption of utilization review criteria (new and revised).
- Monitoring and evaluating utilization of health services (including overutilization, underutilization and outliers) and the effectiveness of UM activities.
- Monitoring the medical appropriateness and necessity of healthcare services provided to members.
- Reviewing, approving and ensuring conformance with NCQA and industry standards of policies and procedures, including the method, timelines and individuals responsible for each task, related to the UM process and making changes, as needed.
- Monitoring providers' requests for delivery of healthcare services to members.
- Monitoring and evaluating performance related to appeal processing and service indicators.
- Reviewing results of program clinical outcome collection, clinical practice guideline adherence, medical record review outcomes, and utilization results to identify opportunities for improvement and oversee related improvement plans.
- Monitoring and evaluating consistent application of medical necessity criteria, and overseeing related improvement plans.
- Reviewing the effectiveness of the UM program and processes, and making changes as needed.
- Reviewing results of member and provider satisfaction surveys and appeal data to identify opportunities for improvement.
- Monitoring the process to have an AmeriHealth Caritas Iowa provider or medical director available at all times to respond to ER providers within one hour.
- Reviewing and approving the UM program description and UM program evaluation.
- Monitoring performance of program delegates and vendors, and recommending interventions as appropriate.

The QCCC review set results of overutilization and underutilization monitoring, prior authorization activity, decision timeliness, IRR and medical necessity appeal determinations to identify opportunities for improvement in program operations. Decisions to remove or institute authorization requirements or revise UM policies are made by the QCCC. The inclusion of participating providers as voting members in the QCCC ensures that policies and decisions reflect local practice patterns and provider needs.

10. Describe any benefits which are proposed to require PCP referral and what services would be available on a self-referral process

AmeriHealth Caritas Iowa does not propose to require the member to obtain a PCP referral as a precursor for accessing any covered services. AmeriHealth Caritas Iowa will actively encourage members to form a

close relationship with a PCP for coordination of care and holistic management of their needs. We provide PCPs with several tools to track the care a member is accessing, including the Member Clinical Summary (MCS), which lists the names, specialties, visit dates and visit reason for all specialist encounters. Additionally, the MCS identifies all prescriptions the member is receiving, giving the PCP a comprehensive overview of medications prescribed by other treating providers. We also require specialists to provide visit summaries to the PCP, outlining the specialist's findings and treatment plan. In our experience, these mechanisms provide more value to achieving a coordinated approach to healthcare delivery than a PCP referral program.

At AmeriHealth Caritas Iowa, our goal is to reduce the barriers to appropriate and necessary care while improving the healthcare experience for our members. For that reason we do not propose any PCP referral requirement.

11.2 Prior Authorization

1. Describe policies and procedures for processing authorization requests including when consultation with the requesting provider will be utilized

AmeriHealth Caritas Iowa's policies and procedures for processing authorization requests meet NCQA standards and 42 CFR 438.210(d) requirements and related rules and regulations. AmeriHealth Caritas Iowa will not employ, and will not permit any of our providers or others acting on our behalf to employ, utilization control guidelines or other quantitative coverage limits that are not based on an individualized determination of medical necessity based upon the needs and medical history of the member.

Processing prior authorization requests

Requests for prior authorization can be submitted by phone, fax, mail or through the AmeriHealth Caritas Iowa Provider Portal. Prior authorization requests may be submitted by the practitioner/provider ordering the service or performing the service or by the member. Information gathered for use in a prior authorization determination includes some or all of the following:

- Clinical history.
- History of present illness.
- Presenting symptoms.
- Prior treatment outcomes.
- Current clinical status.
- Plan of care.
- Prior utilization, including inpatient and ER history.
- Current treatment.

Prior authorization is performed by UM staff who are supervised by a registered nurse or licensed behavioral health clinician, and supported by Iowa-licensed physicians including psychiatrists and psychologists. Prior authorization decisions are based on the clinical indications in the member's individual situation with guidance from AmeriHealth Caritas Iowa medical necessity/psychosocial necessity criteria (described in detail in section 11.2.1, below). For the purposes of this section, medical necessity criteria

and psychosocial necessity criteria will be referred to as "medical necessity criteria." UM staff can approve requested services when UM medical necessity criteria have been met.

Any decision to deny, alter or approve coverage for an admission, service, procedure or extension of stay in an amount, duration or scope that is less than requested will be made by an AmeriHealth Caritas Iowa medical director, behavioral health medical director or physician designee with appropriate clinical expertise in treating the member's condition or disease. In the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services will be responsible for the decision. AmeriHealth Caritas Iowa will make these decisions only after evaluating the individual clinical history and health needs of the member, characteristics of the local delivery system and, as needed, consultation with the treating physician or provider. For requests for covered psychosocial services, such decisions will also include the impact of previous treatment and service interventions, services being provided concurrently by other delivery systems, the potential for services and supports to allow the member to maintain functioning improvement attained through previous treatment, unique circumstances which may impact the accessibility or appropriateness of particular services for the individual member, and the member's choice of provider or proffered treatment location.

Tammy is a 16-year-old with a history of childhood obesity (500 lbs.), sleep apnea and clinical depression secondary to her obesity. She is the oldest of three children residing with her mother with no active involvement from her father. The mother has a history of substance abuse and was not very supportive in previous plans of care.

Tammy was hospitalized three times in the previous year for sleep apnea complicated by her obesity. During her multiple hospitalizations, Tammy increasingly demonstrated signs of depression and suicidal thoughts. She was identified for care management. A care manager at our affiliated Pennsylvania health plan began working with the mother, PCP and behavioral health provider.

Interdisciplinary meetings with the behavioral health provider revealed that Tammy 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, the team planned to send Tammy to a highly specialized out-of-network facility that would concentrate on losing weight, monitoring and treating sleep apnea and providing psychological interventions for her depression.

Tammy is now 17 years old. She spent 14 months in the facility, losing over 250 pounds and stabilizing her sleep apnea. She is now attending ongoing outpatient treatment for weight management and depression. Tammy returned to school in a traditional setting and has not had any further hospitalizations for sleep apnea or depression.

At the request of the AmeriHealth Caritas Iowa medical director or behavioral health medical director, board-certified physicians from an appropriate specialty may participate in the decision. However, the AmeriHealth Caritas Iowa medical director will make the final decision. AmeriHealth Caritas Iowa will maintain a documented process to request board certified consultant involvement and include the recommendations in the review process.

Consultation with the requesting provider

Consultation with the requesting provider will be used in cases where the information available to support the medical necessity determination does not provide a clear picture of the member's clinical situation,

and needs or the requested treatment does not appear to match the member's needs. In these situations, an AmeriHealth Caritas Iowa medical director/behavioral health medical director will contact the requesting provider to review the information received and planned treatment. This interaction provides for a complete view of all of the member's medical and psychosocial needs related to the requested service.

Additionally, the notification process used to inform the member and requesting provider of a determination to deny authorization for a requested service, or to authorize the service in an amount, duration or scope that is less than requested, includes information on the ability of the requesting provider to discuss the determination with the AmeriHealth Caritas Iowa medical director/behavioral health medical director who made the decision. This process provides another mechanism to ensure that a full picture of the member's needs is reviewed as part of the authorization process. This discussion is offered in addition to the ability for either the member or provider acting on behalf of the member to file a formal appeal and does not take the place of any of the appeal levels and processes available to the member.

Prior authorization timeframes

Requests for prior authorization are completed as expeditiously as required by the member's health condition, and will not exceed the timeframes outlined below:

Review Type	Timeframe	Extension Timeframe
Pre-service standard (Non-urgent)	Seven calendar days from the date the request was received.	14 calendar days if requested by member or provider; or if AmeriHealth Caritas Iowa justifies that it is in the best interest of the member.
Pre-service expedited (Urgent)	As expeditiously as the member's health condition requires and no later than three business days after receipt of the request for service.	14 calendar days if requested by member or provider; or if AmeriHealth Caritas Iowa justifies that it is in the best interest of the member.
Post- service	30 calendar days from receipt of the request for service.	N/A

Exhibit 11.2-A: Prior Authorization Timeframes

Documenting prior authorization requests and determinations

AmeriHealth Caritas Iowa UM staff will document all prior authorization requests in our population health management system. Documentation will include the case number, requestor name, date, time and submission method associated with receipt of the request; the substance of the request, including an electronic copy of any faxed or mailed documents; the steps taken to review the request; the determination made, including the time, date, name and title of the person making the determination and rationale for the decision; and the time, date and name of the person notified of the determination. All notes will contain the name of the person making the entry, and for licensed staff, the appropriate suffix (e.g., RN, MD, PhD, RPh). For prior authorization requests that result in a denial or approval of a lesser amount or scope of service, documentation will also include a synopsis of the member's illness or condition, associated diagnoses, the treatment plan and the clinical guidelines and/or rationale used to make the determination.

Monitoring prior authorization processes

Daily aging reports alert staff to cases that are approaching their decision due date. Weekly reports on the timeframe for decisions confirm that medical necessity determinations are made within the allotted timeframe for the type of decision. Monthly, each team reports their results, challenges and actions taken to address issues at an enterprise-wide meeting. This meeting provides a forum for UM teams across the organization to share best practices and collaborate on solutions.

In addition, routine case audits are performed to evaluate the appropriateness of steps taken to process authorization requests. Audit elements address documentation of the receipt, and process steps taken to make the determination and communicate the outcome. Additional elements focus on the application of criteria and the appropriateness of decisions made during the case. Audit results are shared with the individual handling the case as well as the team supervisor. Individuals with low scores (below 95 percent) are given additional training and coaching. For audit elements with negative findings for several team members, team-based refresher education is conducted.

Continuous improvement

AmeriHealth Caritas is implementing new efforts to improve efficiency and effectiveness of the prior authorization process that will be in effect by January 1st, 2016. The goals of this effort are to:

1. Reduce the number of current procedural terminology (CPT) codes requiring authorization, which will:
   A. Reduce the number of calls and faxes received.
   B. Allow for redeployment of UM associates to perform other roles that may increase our “touch rate” with members.
   C. Reduce the administrative burden associated with prior authorization for providers.
2. Perform a process improvement analysis to see where we may be able to improve timeliness, accuracy and minimize redundancies.

AmeriHealth Caritas is committed to being an effective partner and will continuously strive to improve our policies and processes in an effort to improve outcomes efficiently.

2. Describe mechanisms to ensure consistent application of review criteria for prior authorization decisions

AmeriHealth Caritas Iowa will ensure consistent application of review criteria for prior authorization decisions through proven comprehensive staff training and IRR testing programs, supplemented by individual and team-training to address identified areas of inconsistency.

Staff training

Training staff instructing UM associates on the use of AmeriHealth Caritas Iowa medical necessity criteria complete the InterQual Certified Instructor program to certify them to train and re-train AmeriHealth Caritas Iowa UM staff, physicians and behavioral health doctors on appropriate use of AmeriHealth Caritas Iowa's medical necessity criteria. All associates involved in UM determinations receive initial InterQual certification training as part of their initial orientation. Annually, all staff receive refresher training to update their skills and receive education on any new aspects of the criteria.

In addition, medical directors convene educational sessions quarterly. Topics of discussion include:

- Cases that were denied and overturned on appeal, or dispute by another medical director.

- Cases associated with inconsistencies in determinations.
- Problematic or instructive cases.
- Appeal and dispute cases with special interest to network needs and provider relations.
- Criteria, including those from InterQual, local sources or the corporate clinical policy committee that may have variation in interpretation or application.
- Special reports by medical directors, based on their education, training and experience.
- New information, including:
  - InterQual and health plan-specific criteria.
  - Nationally-recognized guidelines, such as those from the American College of Cardiology/American Heart Association, American Diabetes Association, and National Heart, Lung and Blood Institute.
  - Relevant peer-reviewed medical literature.
  - Clinical policies written using evidence-based literature.

Inter-rater reliability testing

All clinical UM staff involved in the application of medical necessity criteria will participate in an IRR process twice a year.

The inter-rater reliability testing is a written assessment based on specific case examples. Questions are created that test the individual's use of appropriate IQ criteria selection and specific criteria points. Separate assessments are created and administered for staff involved in medical necessity determinations and psychosocial necessity determinations to ensure cases presented during the assessment apply to the request types handled by the associate being assessed.

The inter-rater reliability process involves reviewing blinded actual case examples to ensure non-physician staff are selecting the appropriate criteria and are either approving or pending the cases to a physician reviewer or behavioral health provider for approval if criteria appear to have not been met. Physician reviewers and behavioral health providers also participate in an inter-rater reliability process twice per year.

The inter-rater reliability process helps identify how well and consistently users apply the criteria, whether clarification or recommendations for modifying criteria are needed or whether additional individual or group training is indicated. Action plans are developed to address identified variances. Performance results and action plan results are communicated to staff via individual sessions, team meetings and departmental communications. The results are then reported to the QCCC.

3. Describe processes for retrospective utilization monitoring for IDPH population services

AmeriHealth Caritas Iowa will monitor utilization patterns for the Iowa Department of Public Health (IDPH) substance abuse population through the data and analytical systems used to support our medical expense and trend reporting. The report will be based on paid claims and membership data. It will outline the expense, utilization, and unit cost trends for treatment categories including inpatient, outpatient, professional and retail pharmacy services. Additional data levels will be available to view utilization in the context of age, gender, race, ethnicity, ZIP code, treating provider and diagnosis group, among others.

4. Describe required staff qualifications for UM staff

AmeriHealth Caritas will employ a combination of non-clinical staff and clinical staff including physicians, pharmacists and psychologists, to support the UM program. All staff are regularly trained and tested in cultural competency to ensure that all of our members can receive effective care.

Clinical staff

Our clinical staff will include registered nurses and licensed behavioral health clinicians with varied clinical backgrounds. We often hire UM staff directly from the provider setting. These staff members bring unique knowledge of the processes and practices used in physician offices, hospitals and outpatient healthcare settings. This gives them additional insight to the provider's perspective and needs.

To ensure appropriate expertise in handling requests for psychosocial medical necessity, clinical associates handling behavioral health requests will be experienced behavioral health professionals including registered nurses, licensed clinical social workers, licensed social workers, licensed marriage and family therapists, certified addictions counselors and/or licensed professional counselors. Behavioral health UM associates have a minimum of two years of experience in a clinical psychiatric or chemical dependency setting and may have UM, care management or quality improvement/assurance experience. Behavioral health utilization associates have expert knowledge of managed care concepts and practices have demonstrated the ability to maintain professional relationships and have effective communications with providers, families and facilities.

Non-clinical staff

Our non-clinical and intake staff will answer phones, begin the documentation process for authorization requests and answer basic questions. When hiring, we seek candidates who have a minimum high school diploma/GED, previous call center experience and medical terminology knowledge. All staff also undergo rigorous training and ongoing auditing.

Medical directors and behavioral health medical directors

AmeriHealth Caritas Iowa will hire physicians and behavioral health physicians/psychologists as medical directors and behavioral health medical directors, respectively. In addition to licensure in the state of Iowa, we will seek individuals with a minimum of five years of clinical practice experience, clinical expertise related to the delivery of healthcare services to those most in need and a desire to improve health outcomes in that population. Where appropriate, based on the training and licensure available, we will seek board-certified professionals in these roles.

5. Describe proposed utilization management clinical standards, including the use of any nationally recognized evidence based practices

AmeriHealth Caritas Iowa's UM program will employ nationally - recognized clinical criteria and guidelines that are reviewed by local practitioners for applicability to Iowa. Recommended criteria and guidelines are reviewed upon initial adoption and at least annually thereafter. The QCCC, including practicing Iowa practitioners as members with voting privileges, will be responsible for the annual review and approval of AmeriHealth Caritas Iowa's medical necessity and psychosocial necessity criteria as part of the QAPI program. Practitioners who serve on this committee will provide input in the development and revision of these criteria. Formal approval is obtained from the QAPI Committee, which includes community-based

practicing physicians in primary and specialty care. After internal approval, the criteria will be forwarded to the Iowa DHS for review and approval.

AmeriHealth Caritas Iowa proposes to use the following criteria for medical necessity and psychosocial necessity decision making:

- InterQual Level of Care Acute Adult Criteria.
- InterQual Level of Care Acute Pediatric Criteria.
- InterQual Level of Care Outpatient Rehabilitation and Chiropractic Criteria.
- InterQual Home Care Criteria.
- InterQual Care Planning Procedures Adult Criteria.
- InterQual Care Planning Procedures Pediatric Criteria.
- InterQual DME Criteria.
- InterQual Level of Care Rehabilitation Criteria.
- InterQual Level of Care Subacute and Skilled Nursing Facility Criteria.
- InterQual Level of Care Criteria Behavioral Health Psychiatry Geriatric.
- InterQual Level of Care Criteria Behavioral Health Psychiatry Adult.
- InterQual Level of Care Criteria Behavioral Health Psychiatry Adolescent.
- InterQual Level of Care Criteria Behavioral Health Psychiatry Child.
- InterQual Level of Care Criteria Behavioral Health Residential & Community Based Treatment.
- American Society of Addiction Medicine (ASAM) Criteria.
- NIA Radiology Guidelines.
- AmeriHealth corporate clinical policies.

As needed, AmeriHealth Caritas Iowa will develop internal criteria to supplement InterQual. We will use the following information sources during the development process for our clinical policies:

- Results of the Hayes Incorporated (Hayes, Inc.) technology assessment report.
- Information from appropriate government regulatory bodies, such as the Food and Drug Administration (FDA) or the Department of Community Health.
- Published scientific evidence.
- Publicly available reference information (including Web/online resources).
- Information from a board-certified consultant(s) familiar with the specialty or technology area under review.

The Clinical Policy department is responsible for the production of evidence-based clinical policies which:

- Supplement InterQual criteria for utilization review.
- Are evidence-based, using the hierarchy of evidence provided by the AHRQ.
- Are publically accessible so members, providers and suppliers can be informed on the reviews by AmeriHealth Caritas Iowa.
- Allow for input from providers, members and the public.

The Clinical Policy department receives requests for research on clinical topics internally from UM, Claims, and Provider Network departments, or externally from providers and suppliers. Topics are researched by the writers of the Clinical Policy department using resources such as PubMed, Cochrane Reports, National Institute for Health and Care Excellence (NICE), AHRQ reports, and broad-based literature reviews such as from Hayes, Inc. The clinical policy drafts are reviewed twice by the Clinical Policy Committee (CPC). That committee will include the medical director of AmeriHealth Caritas Iowa along with the medical director from across AmeriHealth Caritas. Representatives from AmeriHealth Caritas' Government Affairs, Compliance, Legal and Pharmacy departments sit on the CPC in an advisory capacity. External comment is encouraged, and both the American Academy of Pediatrics and the American College of Radiology are regular contributors. Beyond that, individual providers and professional associations frequently submit comments and recommendations to the CPC which are considered during the review.

Changes in medical science and technology occur on a rapid basis. All clinical policies are reviewed on an annual basis, but when there is a significant change in medical evidence clinical policies have been reconsidered on a more frequent basis.

The CPC meets monthly to review submitted policies and quality guidelines. Once approved, the clinical policies for Iowa will be modified based upon Iowa Medicaid fee schedule, regulations and Medicaid benefits so that what is displayed on the Provider Portal of the AmeriHealth Caritas Iowa Website is reflective of evidence-based medicine and Iowa Medicaid benefits. This individual tailoring of the clinical policy to Iowa is a unique feature of the AmeriHealth Caritas Iowa policy display. Please see the clinical policy manual and current list of clinical policies on the websites of AmeriHealth Caritas health plans.

The CPC reviews the medical evidence behind requested clinical services to ascertain if they meet the standards of care and state requirements. Currently, AmeriHealth Caritas has nearly two hundred clinical services which have been reviewed using the protocols for evidence evaluation as recommended by the AHQR in determining coverage. This CPC performs annual reviews of existing clinical policies and evaluates new clinical policies. Approved policies are posted publicly on the Provider Web Portal. This transparency makes clinical policies accessible to the physician network and members.

6. Describe how you will identify those services that will be reviewed for medical necessity determination. Provide a list of services for which prior authorization would be required

AmeriHealth Caritas Iowa believes that prior authorization should be used as an inspection process for services that are high-cost and/or have wide variations in how they are used in the community. We are continuously evaluating our prior authorization requirements to reduce the administrative burden the prior authorization process can cause for providers. For services that we see very few denials of care, we lift prior authorization requirements and review utilization through claims data.

Members identified with high utilization patterns are referred to the IHM program for outreach, education and support. Providers that have patterns of care delivery outside of their peers or outside of evidence-based guidelines are contacted by a medical director or behavioral health medical director to review the findings and provide education, as appropriate. When indicated, we refer the provider and/or member to the SIU for additional evaluation.

AmeriHealth Caritas collaborates with our government customers as well as network providers on policies and procedures around authorizations and monitoring for medical necessity. For those services where authorization is required, AmeriHealth Caritas strives to make the process as streamlined and timely as possible to avoid delays in the provision of medically necessary services.

Identifying services that will be reviewed for medical necessity

AmeriHealth Caritas uses a disciplined, evidence-based process to decide which procedures require prior authorization. We review claim and authorization data to understand the services utilized, the variation in service utilization and evidentiary basis available to support the need for the identified service. These processes are also applied to new technology and new uses for existing technology. Based on the outcome of that analysis, services with high cost impact and variable utilization in the population are added to the prior authorization list. Note: All requests for services will be subject to Iowa Medicaid coverage guidelines and limitations.

Services requiring prior authorization

AmeriHealth Caritas Iowa will require medical necessity determination for the following list of services:

- Waiver services:
  - 1915(C) services.
  - 1915(I) habilitation services.
- Elective/non-emergent air ambulance transportation (emergency air ambulance will be reviewed for medical necessity before payment of the claim).
- Diagnostic genetic testing.
- All out-of-network services.
- All inpatient hospital admissions (including medical, surgical, behavioral and rehabilitation).
- Obstetrical admissions/newborn deliveries (exceeding 48 hours after vaginal delivery and 96 hours after caesarean section).
- Elective transfers (for inpatient and/or outpatient services between acute care facilities).
- Long-term acute care.
- Long-term care.
- Home-based services
  - Home healthcare.
  - Skilled nurse visits (SNV) - after six visits per calendar year.
  - Occupational therapy (OT)/physical therapy (PT)/speech therapy (ST) after six visits per calendar year.
  - Home health agency (HHA) authorization from start of care.
  - Nursing services.
- Private duty nursing and personal care services — authorization is required from initiation of service (covered as a benefit under EPSDT as provided through a HHA for up to 16 hours per day).
- Therapy and related services (outpatient).
  - ST, OT and PT (after 12 visits for each modality).
  - Cardiac and pulmonary rehabilitation require authorization from first visit.
- Transplant surgery — organ and tissue.

- All DME rentals
- DME Purchases (for billed charges $500 and over, including prosthetics and orthotics when covered).
- Repairs for member-owned DME items/equipment.
- Hearing services and devices that exceed $500 purchase price may include but are not limited to hearing aids, FM systems and cochlear implants/devices.
- Replacement of hearing aids that are less than four-years-old, except for children under the age of 21.
- Diapers/pull-ups (ages three and above):
  - For quantities over 200 per month (for either or both).
  - For brand-specific diapers.
- Hyperbaric oxygen.
- Gastric restrictive procedures/surgeries.
- 17-P infusion for pregnancy-related complications.
- Gastroenterology services — codes 91110 and 91111 only.
- Surgical services that may be considered cosmetic, including but not limited to:
  - Blepharoplasty.
  - Mastectomy for gynecomastia.
  - Mastoplexy.
  - Maxillofacial.
  - Panniculectomy.
  - Penile prosthesis.
  - Plastic surgery/cosmetic dermatology.
  - Reduction mammoplasty.
  - Septoplasty.
- Inpatient hysterectomy.
- Elective terminations of pregnancy.
- Services related to the diagnosis and treatment of Infertility (coverage as identified by the member's benefits).
- Pain Management — external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radiofrequency ablation and nerve blocks.
- Select radiological exams — EXCLUDES radiological studies that occur during Inpatient, ER and/or observation stays.
  - Positron emission tomography (PET).
  - Magnetic resonance imaging (MRI)/Magnetic resonance angiography (MRA).
  - Nuclear cardiology diagnostic testing.
  - Computed axial tomography (CT/CAT scans) and CT angiography.

- All miscellaneous/unlisted or not otherwise specified codes.
- All services that may be considered experimental and/or investigational.
- All services not listed on the Iowa Medicaid fee schedule.
- Select medications — see formulary.
- Behavioral health
  - Mental health partial hospitalization program.
  - Mental health inpatient admissions.
  - Neuropsychological testing.
  - Psychological testing.
  - Developmental testing.
  - Behavioral health day treatment.
  - Residential treatment (including crisis residential).
  - Electroconvulsive therapy.

Services that do not require prior authorization

The following services will not require prior authorization from AmeriHealth Caritas Iowa:

- Emergency services.
- Women's health specialist (to provide women's routine and preventive healthcare services).
- Diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and human immunodeficiency rendered by county health departments.
- OB/GYN services for one annual visit and the medically necessary follow up care for a condition(s) detected at that visit (the recipient must use a plan provider for these services).
- Podiatry for diabetics.
- Immunizations by county health departments and participating PCPs.
- Imaging procedures related to ER services, observation care and inpatient care.
- Dialysis.

Services that require notification

Providers will be asked to notify AmeriHealth Caritas Iowa when the following services are delivered:

- Maternity obstetrical services (after the first visit) and outpatient care (includes 30-hour observations).
- Normal newborn deliveries.
- Inpatient hospital detoxification admissions (within 24 hours of admission).
- Behavioral healthcare management.
- Peer support.

7. Describe your prior authorization request tracking system

UM uses a member-centric population health management system to enter and track all authorizations. With this application, we are able to assign users a specific role or roles that control access to types of episodes with additional confidentiality and sensitivity requirements such as behavioral health services and quality investigations.

When a request for service comes in via phone, fax or mail, images of all documents associated with the request are attached to the episode of care, creating a single source of information and providing efficiency in the review process. Each authorization episode contains the diagnosis code and description, service type, service start dates and end dates, requesting/referring provider, the treating or servicing provider and when applicable service codes including CPT, HCPC, ICD9 (the application is ICD-10 ready),.

The system allows us to easily record and track utilization by provider, as we use one episode per treating provider for outpatient services. The single episode will contain all associated documents and notes for the initial request for service and each extension request. This approach helps us keep all of the history related to the episode of care in the same place, reducing the need for the provider to resubmit prior documentation when requesting an extension.

The notes entered into each episode are date and time stamped. They include the user ID, name, role and title of the person who entered the note. Note templates are used to assist with ensuring all required documentation is included with the entry. Templates include areas that identify how and who made the request for service, what service is requested, past medical history and supporting clinical information. Each user signs their note with their name, credentials (if applicable) and title/role.

Inpatient requests are processed in a similar manner; however, instead of one episode per provider, it is one episode per inpatient stay.

Medical necessity reviews are accomplished by utilizing InterQual criteria which is seamlessly accessed through the system while completing the workflow to document the coverage request. The InterQual review is interactive. The criteria elements selected to complete the review are saved. Separate InterQual records are created for the initial request and each extension or continued stay request.

The application also supports tracking of timeliness by capturing the time each step is completed and calculating the elapsed time against the requirement for that type of request (standard, expedited or retrospective). In addition, AmeriHealth Caritas Iowa uses activities and/or alerts that remind individual users to complete reviews within the timeliness requirements.

A variety of episode types are available including inpatient, outpatient, appeals, behavioral health, care management and physician review. Through the use of assessment tools, AmeriHealth Caritas Iowa will be able to gather specific information related to reviews, notification and/or a member's individual needs as part of the care management referral process. This allows AmeriHealth Caritas Iowa to address of all the member's needs in one application, improving communication between functional areas and supporting our IHM model.

UM associates can also generate correspondence associated with a service or stay request, and/or care management activities. Some examples of letters used include: admission notification letters to PCPs, approval letters and notice of action/denial letters.

AmeriHealth Caritas Iowa is able to obtain reporting from our medical management application using any of the collected data elements. The reporting capabilities allow AmeriHealth Caritas Iowa to monitor utilization and make adjustments to the prior authorization processes and program based on the trends that are noted.

8. Provide sample notices of action as described in Section 11.2.7

If a request for service is completely denied and/or not approved exactly as requested, AmeriHealth Caritas Iowa sends a notice of action to the member and requesting provider. The notice of action provides information to the member at a fifth grade reading level. The written notice of action will include the following information:

- What action was taken or will be taken which will include information regarding why the request was not approved as it was requested. If the request was completely denied, the notice of action will also include information regarding when the action will take effect.
- Rationale or the reason for the action.
- The member's right to file an appeal and the process to file an appeal.
- Information regarding the member's right to request external review or state fair hearing once all levels of internal appeal have been exhausted, along with information on how to request an external review or state fair hearing.
- Expedited appeal information is necessary when an expedited appeal is available and how to file the expedited appeal.
- Information regarding the member's right to continue services during the appeal process pending the appeal decision, how to request the continuation of covered services and in what circumstances the member may have to pay for the cost of the services.

A sample notice of action is provided as Attachment 11.2-A (at the end of this section). AmeriHealth Caritas will provide the notice of action letter template to DHS for review and approval prior to its use.

9. Indicate if your organization elects not to provide, reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds

AmeriHealth Caritas Iowa will provide all covered counseling and referral services.

10. Describe your program for ongoing training regarding interpretation and application of the utilization management guidelines

As discussed in Section 11.2.2 above, AmeriHealth Caritas Iowa will provide ongoing training for associates involved in medical necessity and psychosocial necessity determinations on the interpretation and application of UM guidelines.

Certified InterQual instructors

Staff providing ongoing training on the use of, and updates to, the InterQual criteria will complete the InterQual Certified Instructor program for certification to train and re-train AmeriHealth Caritas Iowa UM staff, physicians and behavioral health doctors on appropriate use of the criteria. Annually, all staff receive refresher training to update their skills and receive education on any new aspects of the criteria. As part of the training process, different case examples are reviewed and discussed as a group to ensure common understanding of criteria application.

Medical director shared learning

In addition, medical directors hold quarterly educational sessions to work through other cases of interest in the group setting. Topics of discussion include:

- Cases that were denied and overturned on appeal or dispute by another medical director.
- Cases associated with inconsistencies in determinations.
- Problematic or instructive cases.
- Appeal and dispute cases with special interest to network needs and provider relations.
- Criteria, including those from InterQual, local sources, or the corporate CPC, that are may have variation in interpretation or application.
- Special reports by medical directors, based on their education, training and experience.
- New information, including:
    - InterQual and plan-specific criteria.
    - Nationally-recognized guidelines, such as those from the American College of Cardiology/American Heart Association, American Diabetes Association, and National Heart, Lung, and Blood Institute.
    - Relevant peer-reviewed medical literature.
    - Clinical policies written using evidence-based literature.

Inter-rater reliability testing follow-up

As discussed previously, individual and group training is conducted based on the results of bi-annual IRR testing. The IRR testing is a written assessment based on specific case examples. Questions are created that test the individual's use of appropriate IQ criteria selection and specific criteria points. Separate assessments are created and administered for staff involved in medical necessity and psychosocial necessity determinations to ensure that cases presented during the assessment apply to the request types handled by the associate being assessed.

The IRR process helps to identify how well and consistently users apply the criteria, whether clarification or recommendations for modifying criteria are needed, or whether additional individual or group training is indicated. Action plans are developed to address identified variances. Performance results and action plan results are communicated to staff via individual sessions, team meetings and departmental communications, and are reported to the QCCC.

Attachment 11.2-A: Draft Denial Letter

200 Stevens Drive
Philadelphia, PA 19113-1570

|TODAY|
|TRANSLATE TO LANGUAGE|{RBL}
Reference/Tracking Number: |CASE_NUMBER|
LOB UMBDEN {RBL}
{ADDRESS} {RBL}

Provider:	|ref/att/treat|
Member ID Number:	|PATIENT_ID|
Medicaid ID Number:	|PATIENT_MEDICAID_NO|
Admission/Service Date:	|LTR37|
Effective Date:	|LTR22|
Service(s):	|LTR36|

Dear [MBR/PG SAL}:

Based upon the medical information provided to our physician reviewer, {Physician Reviewer}, it has been determined that beginning {LTR22}, the request for **{LTR36}** is denied/cannot be certified.

The reason(s) for this determination is (are) as follows: {LTR161}

This determination was based on: {Reference to applicable criteria (LTR18):}

(All references in this letter to the term "you" or "your" refer solely to the named member.)

You may obtain copies (at no charge) of the medical and other documents on which this decision was based by contacting Member services at {MSPH#} or by sending a request to AmeriHealth Caritas Iowa:

AmeriHealth Caritas Iowa
Attention: Member Advocate
Member Appeal Department
200 Stevens Drive
Philadelphia, PA 19113-1570

If your provider would like to discuss this case with a reviewer, please have him or her call the Medical Management Department at 1-800-XXX-XXXX or XXXXXXXXXXX (TTY).

If you disagree with this decision, you have the right to appeal it. There are two ways in which you may appeal: an expedited appeal or a standard appeal.

Expedited Appeal

If you or your provider believes your appeal is an emergency and that it would be harmful or painful to you if you had to wait for a standard appeal to be decided, you or your provider may request an expedited appeal by AmeriHealth Caritas Iowa. If you want your provider to represent you, you must give your provider written permission to do so.

An expedited appeal can be requested by calling AmeriHealth Caritas Iowa Member Services department at |MSPH#|. You or your provider can fax documents to support your appeal to AmeriHealth Caritas Iowa Appeal department at 1-888-XXX-XXXX. You will be notified of AmeriHealth Caritas Iowa's decision as soon as possible, but no later than three (3) calendar days after AmeriHealth Caritas Iowa receives your request for an expedited appeal.

Standard Appeal

You or your provider have the right to appeal this decision to AmeriHealth Caritas Iowa within 30 calendar days of the date at the top of this letter by calling Member Services at |MSPH#|, by faxing your request to 1-888-XXX-XXXX or by sending a written notice to:

AmeriHealth Caritas Iowa
Attention: Member Advocate
Member Appeal Department
200 Stevens Drive
Philadelphia, PA 19113-1570

You may receive assistance from Member Services at |MSPH#| in filing your appeal or may contact the Iowa Department of Human Services directly.

If you file your appeal by telephone, you must follow up your call with a written, signed appeal letter. AmeriHealth Caritas Iowa will help you by writing this appeal letter and sending it to you for your signature.

If you want your provider to represent you, you must give your provider written permission.

If you wish to have your benefits continue during the appeal, you must file your request within the later of:

- **Ten days from the postmark on the envelope this letter came in; or**
- **The effective date above.**

You may submit medical information and documents that support your appeal and written comments for review to AmeriHealth Caritas Iowa. You will be notified of the decision in writing within 45 calendar days after AmeriHealth Caritas Iowa receives your appeal.

State Fair Hearing

If you disagree with this decision, you, your provider or other representative (such as a family member or a lawyer) have the right to request a State Fair Hearing before the Department of Human Service Appeals Section. You must request a State Fair Hearing within 90 days of the date at the top of this letter.

12. Program Integrity

Please explain how you propose to execute Section 12 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Overview

As a people-to-people organization, AmeriHealth Caritas Family of Companies (AmeriHealth Caritas) is built on a foundation of trust earned through the commitment to ethics and honor with which we conduct our business. Our operational practices are measured by the highest standards, and we comply fully with all applicable federal and State requirements.

> Our next generation model of healthcare relies not just on integrity of thought and care, but also on integrity of process and structure.

Throughout AmeriHealth Caritas, we have adopted a compliance program to encourage collaborative participation at all levels and to stimulate a culture of compliance, which will include the designation of an AmeriHealth Caritas Iowa compliance officer and Compliance Committee accountable to senior leadership. The compliance program fosters an environment that requires associates to comply with all relevant laws and regulations and appropriately report any concerns about business and operational practices. In addition to focusing on compliance from associates, AmeriHealth Caritas has an established, comprehensive Fraud and Abuse Operations program to prevent, detect, investigate and mitigate fraud, waste and abuse (FWA) by providers and members, which will be implemented by AmeriHealth Caritas Iowa.

Our program is developed in accordance with 42 CFR 438.608, 42 CFR 455, Section 12 of this RFP, 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). Our program includes adequate staffing to carry out our integrity plan. In addition, a Program Integrity manager — dedicated to the oversight and coordination of program integrity efforts — will be located in Iowa and along with the compliance officer will partner directly with the State to meet all the requirements.

A draft of AmeriHealth Caritas Iowa's Compliance Program , is attached (Attachment 12.0-A: Draft AmeriHealth Caritas Iowa Compliance Program).

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

1. Describe your procedures for avoiding, detecting and reporting suspected fraud and abuse to the State.

Organization and tools

Program Integrity Department architecture

The Program Integrity Department (PID) uses external vendors and subcontractors, as well as internal methods, to detect FWA. The diagram below illustrates the overall architecture of the PID and operates as

part of cost avoidance, retrospective recovery and investigation and reporting by the Special Investigations Unit (SIU).

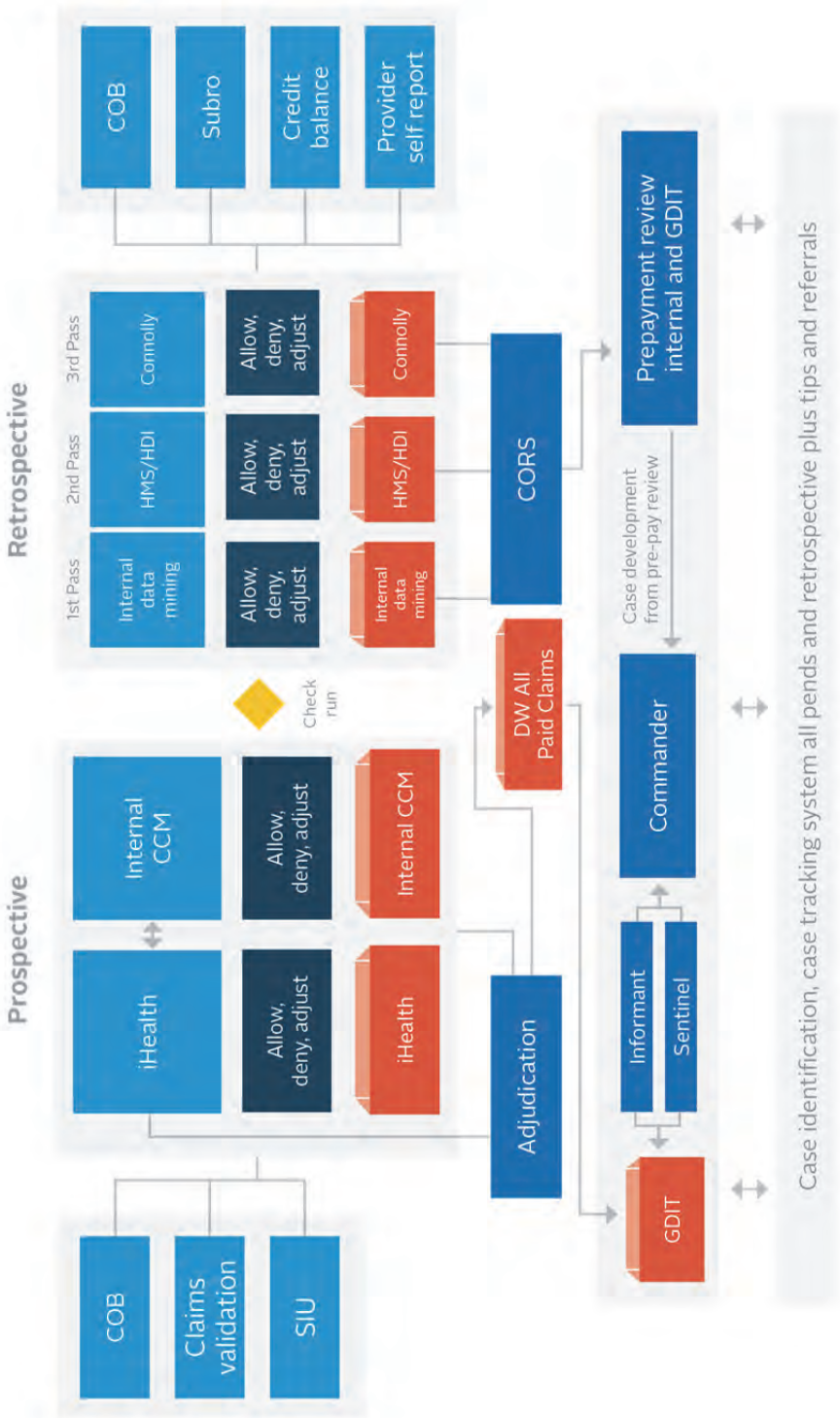


Exhibit 12.1-A: PID Architecture

Prospective cost avoidance operations

The Payment Integrity department utilizes an internal process and an external vendor to perform claim editing before check runs to increase the accuracy of paying claims. Medical directors, as well as provider network management (PNM) associates, review and approve all clinical cost avoidance edits prior to deployment. The process includes high-priority claim tagging to ensure timely and accurate payments to providers.

Internal claims cost management

The internal claims cost management (CCM) process includes an internal data mining system that runs a post-adjudication, pre-check run for all of our health plans. The edits are developed to maintain compliance with provider contract language, individual state Medicaid and CMS reimbursement methodologies, system configuration issues and detect provider billing errors. As part of the process, AmeriHealth Caritas has certified clinical coders who review claims and medical records to provide new areas for prepay algorithm development, affording continuous improvements and innovation to the process.

iHealth Technologies

All outpatient, professional and durable medical equipment (DME) claims pass through iHealth Technologies (iHT) analytics engines post-adjudicated and pre-check run on a daily basis. This first-pass, external vendor process denies, reduces or allows claims to be paid. As part of the process, and on a monthly basis, all denied and reduced claims are reviewed. Included in this process is the introduction of new clinical edits that are reviewed by AmeriHealth Caritas Family of Companies medical directors and PNM associates.

Retrospective data mining and recovery operations

The Payment Integrity department utilizes both internal and external sources to perform data mining for FWA. Data mining and recovery operations use distinct processes, performed by internal staff, with queries focused on the following potential overcharges targeted for recovery:

- Outpatient charges during inpatient stay.
- Payment greater than billed charges.
- Duplicates.
- Incorrect coordination of benefits (COB) payment.

Health Management Solutions coordination of benefits identification and recovery

On a weekly basis, claims, member eligibility, provider and third-party liability (TPL) files are sent to Health Management Solutions (HMS) to identify additional TPL information for our Medicaid members. Additionally, HMS will bill liable, primary and third-party carriers to recover claim payments.

HMS data mining and recovery

Utilizing the files referenced above, HMS uses sophisticated analytics to identify potential overpayments from professional, outpatient, facility and DME claims. These overpayments are posted into the AmeriHealth Caritas Claims Overpayment Recovery System (CORS). Providers receive overpayment request letters with descriptions of the overpayments and information regarding how to dispute the findings — a majority of the overpayments are recovered by offsetting future claims.

Connolly data mining and recovery

Connolly Data Mining and Recovery (Connolly) operates similarly to HMS. Connolly reviews claims using additional sophisticated analytics and is referred to as our third-pass vendor.

Claims Overpayment Recovery System

CORS is an internally-developed, desktop-software application that serves as the record system for a majority of the Payment Integrity department's retrospective recovery activity. It is also used to complete the following claims recovery-related functions:

- Internal generation of project recovery letters to providers.
- Communication and tracking of vendor identified projects.
- Vendor invoicing process.
- Overall internal and external project reporting.

Prevention/cost avoidance

FWA prevention is managed through clinical editing during claims processing and prepayment correct coding edits. The prepayment correct coding edits avoid claims cost that supports FWA reduction. AmeriHealth Caritas has comprehensive systems in place to conduct claims editing for professional and outpatient encounters. Applicable clinical edits are added on a regular basis to the claims processing system, based largely upon National Correct Coding Initiative (NCCI) and American Medical Association (AMA) standards. Inpatient claims are evaluated using a multiple-pass data mining screening to identify overpayments. In addition, predictive scoring models are used on all facility-paid claims to select medical records to be reviewed for claims validation and potential overpayment recoveries.

The medical claim payment policies are based on guidelines from established industry sources, such as CMS, AMA, state regulatory agencies and medical-specialty professional societies. In making claims payment determinations, AmeriHealth Caritas also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, Current Procedural Terminology (CPT®) codebook, International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC).

In addition to the above, the Special Investigation Unit (SIU) utilizes a prepayment review process to validate services prior to payment, which requires providers suspected of fraud and/or abuse to submit medical records in conjunction with claims. This targeted process ensures accurate payments during SIU investigations.

Detection and investigation

AmeriHealth Caritas' SIU is responsible for detecting FWA throughout our claims payment processes. The scope of the SIU's activities encompass all contracted/non-contracted providers, specifically including the authority to investigate allegations of FWA involving members or other persons, as well as allegations related to the business practices of vendors, contractors and subcontractors. The SIU establishes, distributes, enforces and revises written policies and procedures used by the SIU staff to detect, investigate and fully document allegations of FWA. SIU staffing includes experienced investigative analysts, Certified Professional Coders (CPC), Certified Fraud Examiners (CFE) Accredited Healthcare Fraud Investigators and dedicated legal support to help guide the SIU staff throughout case development. Additionally, AmeriHealth Caritas is a corporate member of the National Health Care Anti-Fraud Association. Through this membership, SIU staff receives multiple training opportunities to keep current on certifications and FWA trends and schemes.

The SIU proactively identifies potential incidents of suspected fraud and abuse as part of its program for ongoing monitoring and auditing. The SIU has procedures in place designed to prevent and detect potential or suspected fraud and abuse in the administration and delivery of services for this Contract. They include the following:

- Ongoing evaluation of claims data to detect abnormalities in provider billing, prior authorizations and member utilization patterns.
- Post-processing review of claims to include participating and non-participating providers.
- Periodic sampling of claims to determine propriety of payments.
- Requirement that providers and subcontractors agree to adhere to program standards regarding FWA as a condition of contracting.
- Dissemination of information to members and providers concerning FWA.
- Encourage reporting of potential FWA through the provider handbook, member handbook and newsletters.
- Pre- and post-payment medical record reviews accompanying claims for SIU identified providers.
- Using peer-to-peer comparisons.
- Using predictive scoring models that identify suspicious providers.
- Searching for scheme-outcome scenarios.

The SIU efforts are supported by industry-leading anti-fraud technology. The SIU utilizes a lead detection and pattern analysis tool providing automated early-warning fraud and abuse detection and overpayment protection capabilities. Rules, algorithms and pattern detection capabilities evaluate, identify, compare and rank providers and members who generate qualified leads for investigation. A case-tracking system provides support for day-to-day investigation coordination, management of dedicated resources and reporting capabilities to ensure compliance with contractual reporting requirements of suspected and/or confirmed fraud or abuse. Ad hoc claims-query capabilities are another important proficiency within the scope of the SIU technological capacity. The SIU also accesses an internal data warehouse, which includes all claims processed, to identify patterns that may indicate FWA. Combined, these tools are used to identify potential FWA, such as:

- Overutilization.
- Upcoding.
- High-dollar claims.
- Unusual patterns by members, providers or facilities.
- Unusual dates of service.
- Excessive time units for time-based codes.
- Unusual claims volume by providers.
- Unbundling of services.
- Incorrect reimbursement to providers, facilities and/or pharmacies.
- Incongruous procedure code, prescription and diagnostic code combinations.

The SIU uses General Dynamics Information Technology (GDIT) STARSSolutions as part of an integrated solution for detection, investigation and prevention of FWA. These solutions, as depicted in the PID architecture, are defined below:

- STARSInformant enables the SIU to export ad hoc claims data to fully support the investigative process.
- STARSSentinel is an outsourced fraud and abuse lead generation solution. AmeriHealth Caritas Iowa's claims will be run through this analytics engine on a monthly basis. The output is based upon statistics and provides the SIU with suspicious providers and members.
- STARSCommander is the case management system used by the SIU. It enables the SIU management team to manage workload/caseload throughout the case lifecycle. Case reporting and status is monitored weekly and monthly with internal management.

The workflow starts with all paid claims. We send up to three (3) years of historical claims to GDIT, where the claims are managed in their data warehouse. The SIU analysts and investigators have the ability to perform ad hoc data mining on STARSInformant to identify abnormal patterns, peer-to-peer comparisons, research tips and referrals. Independently, GDIT runs our claims data through STARSSentinel on a monthly basis. STARSSentinel provides the following information to the SIU:

- Peer-to-peer comparison.
- Predictive scoring for suspicious providers.
- Scheme outcome scenarios.
- Billing rule violations.
- Claims submission frequency comparator.

All cases — through ad hoc data mining, tips and referrals, or STARSSentinel — are logged and tracked in STARSCommander from case initiation through referral and/or closure.

Provisions for prompt response to a detected offense includes a process that ensures a timely referral to appropriate state oversight agencies according to individual state contract requirements, development of an investigative timeline, provider flagging, beneficiary flagging and specific procedure code flagging for verifying service delivery. This may include requiring submission of medical records to validate and justify claim(s) submission prior to payment. The prepayment review process affords the plan the opportunity to pay the claim(s) accurately versus paying and chasing.

The SIU may refer members to AmeriHealth Caritas Iowa's lock-in process when the results of a preliminary investigation reveal pharmacy and medical claims utilization patterns appear abnormally high. Responsive decision-making exists in the clinical judgment of AmeriHealth Caritas Iowa's medical director.

State agency reporting

AmeriHealth Caritas Family of Companies and AmeriHealth Caritas Iowa will follow state-mandated reporting requirements and establish a cadence for monthly reporting, including payment integrity (cost avoidance and recoveries) and SIU provider case identification, planning and action plans. In addition, the state has requested reporting of suspected fraud or abuse within two (2) days of identification. AmeriHealth Caritas Iowa's SIU is prepared to meet this timeframe in a manner and format deemed appropriate by the state.

This organizational alignment provides transparency for all PID and SIU activities and findings. The Program Integrity manager ensures timely reporting and ongoing updates to the Medical Fraud Control Unit (MFCU) and DHS in accordance with the Medicaid Managed Care Organization (MCO) Contract, and will bring forward investigation summaries to the Compliance Committee. The Program Integrity manager reviews and addresses requests for information relating to FWA, including losses, recoveries and provider terminations. Reporting will include, but is not limited to:

- The name and national provider identifier (NPI) of reviewed provider.
- The reason for the review, including data source and/or referral.
- Review outcome.
- Provider referrals to MFCU.
- Providers suspended and reason for suspension.
- Providers terminated and reason for termination.
- Provider recoupment amount and reason for recoupment.
- Provider payment reductions and reason for payment reduction.
- Providers who were denied enrollment or reenrollment pursuant to 42 CFR 455, including provider name, NPI and reason for denial.
- State fiscal year-to-date summary information of contractor program integrity activity.

Referral to law enforcement

The primary goal of referring a case to a law enforcement agency is to obtain a conviction. In the prosecution of fraud cases, the SIU pledges full cooperation with local, state and federal law enforcement agencies, as well as with state insurance fraud departments, state Medicaid fraud control units and state Medicaid program integrity units. If the prosecution is successful, restitution will be consistently pursued as an element of judgment in coordination with state and federal victim protection boards.

The SIU will refer law enforcement to any transaction where the facts and circumstances create a reasonable belief that a person or entity may have committed or is committing fraud and/or abuse. Such referrals will be submitted in a standardized format or as mandated by a particular law enforcement agency.

The SIU will refer suspected or confirmed fraud or abuse, in addition to suspected neglect/abuse (mistreatment) of a member, to appropriate oversight agencies within the required timeframes. AmeriHealth Caritas Iowa will also monitor all communications from DHS and suspend payment to any provider that is on payment hold under the authority of DHS or its authorized agent(s).

2. Provide examples of outcomes achieved in other states regarding program integrity efforts.

The focus of the PID is on prospective savings, cost-avoidance opportunities and retrospective overpayment recoveries. In 2014 alone, for the AmeriHealth Caritas PID activities in Indiana, Louisiana, Nebraska, Pennsylvania, South Carolina, and Washington D.C, our program integrity efforts delivered savings of over $274 million. A high-level summary of some the prospective and retrospective outcomes and results from our PID services we provide to other states is set forth below:

- Prospective coordination of benefits cost avoidance – $132.3 million
- Claims cost management cost avoidance - $13.1 million
- Complex/medical record review cost avoidance - $1.6 million
- Prepay clinical editing cost avoidance - $38.6 million
- Special Investigations Unit prepay review cost avoidance - $1.2 million

At the end of calendar year 2013, prospective savings for Medicaid plans totaled $132.4 million. For 2014, the total was $186.8 million, as shown in Exhibit 12.2-A.

- Retrospective COB overpayment recoveries - $15.9 million
- Subrogation overpayment recoveries - $3.3 million
- Facility Credit balance overpayment recoveries - $4.4 million
- Provider self-reports overpayment recoveries - $5.7 million
- Data mining/audit recoveries - $52.9 million
- Complex/Medical Record Review and claim validationoverpayment recoveries - $4.3 million
- Special Investigations Unit overpayment recoveries - $1.1 million

Retrospective recoveries for AmeriHealth Caritas totaled $74.2 million at the end of calendar year 2013, and a total of $87.5 million for 2014, as shown in Exhibit 12.2-A.

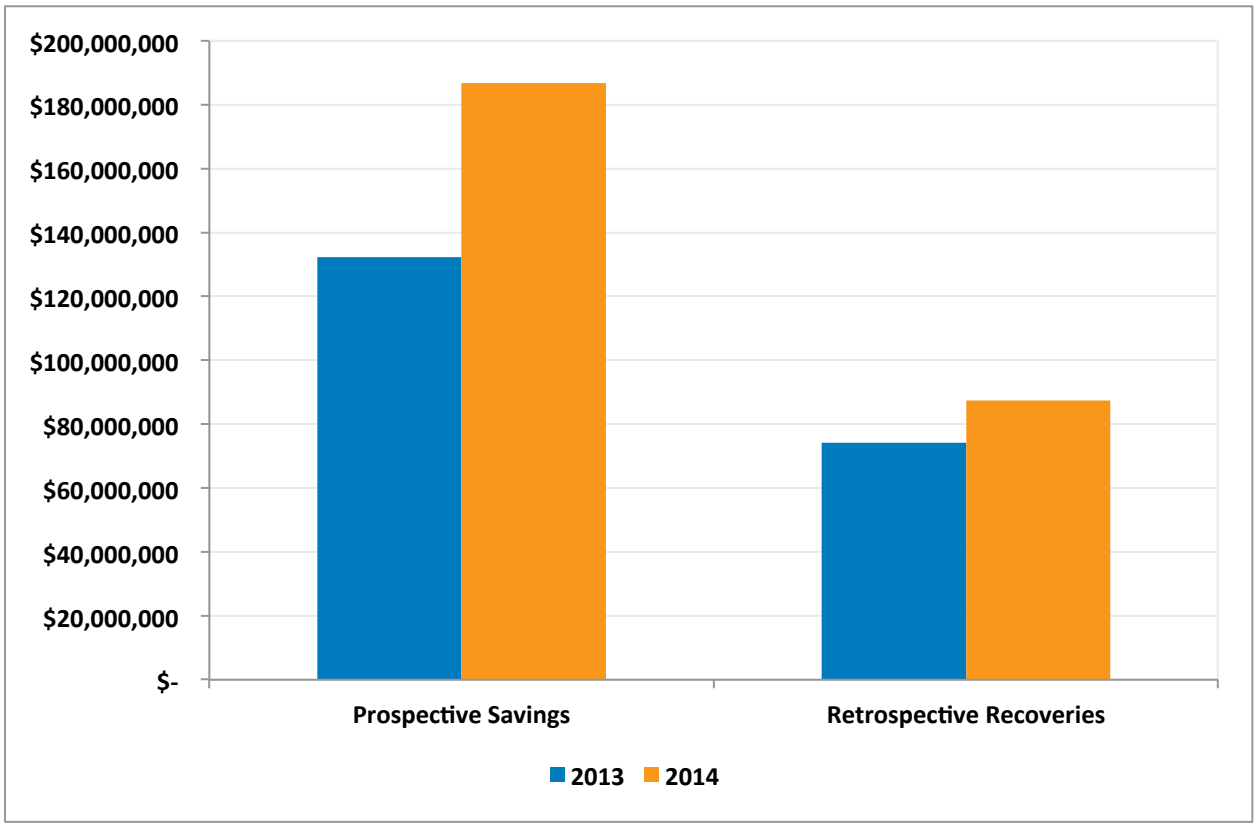


Exhibit 12.2-A: Prospective and Retrospective savings 2013-2014

Examples of recent case studies currently in investigation within AmeriHealth Caritas

Example 1: PCP

Primary care providers (PCPs) were identified as outliers for billing diagnostic testing (radiology and lab tests), as well as a high frequency upcoding of evaluation and management (E/M). The initial data analysis reflected similar billing patterns for members at each visit and identified duplicate tests being performed

at unexpected intervals. A probe record review confirmed the allegation of excessive diagnostic testing and upcoding, as well as a lack of documentation to support the necessity or practicality of the services. A referral was sent to the state Medicaid Program Integrity and Fraud Control departments. The investigation was expanded to include medical record review using a statistically valid random sample (SVRS). Additional records were requested from the provider. A certified nurse coder received and reviewed the records, which confirmed the results of the probe sample. An addendum to the initial referral was forwarded to the state, and the provider was placed on prepayment review. The case is currently in active investigative status and awaiting mediation/arbitration. A final overpayment demand was forwarded to the provider for $503,000.

Example 2: OB/GYN

An OB/GYN provider was identified through SIU data mining as an outlier for the billing of 99215 E/M code. A SVRS sample was pulled from the provider's 99215 claims and a request for records was sent to and received by the provider. Clinical review of the records confirmed 1) the allegation of upcoding; 2) the documentation did not support the billing of the 99215 services; 3) 40 out of 41 claims were not supported by the documentation; and 4) no documentation was received for one (1) out of 41 claims. The case was referred to the state Medicaid Program Integrity department and MFCU. A final identified overpayment of $42,000 was recovered.

Example 3: Pain management provider

A pain management provider was identified through SIU data mining as an outlier for billing excessive urine drug screens (UDS). An SVRS was pulled for a two-year period. Records were received and reviewed. An onsite visit revealed the provider office had opened its own lab, and was performing unnecessary quantitative testing simultaneously with the initial qualitative screening without regard to the initial results. The case was referred to the state Medicaid Program Integrity department and MFCU, which is currently in an active investigative status. An identified overpayment of $715,000 is being pursued.

Example 4: Physical therapist

A physical therapist was identified through SIU data mining as an outlier for billing excessive physical therapy (PT) services. An SVRS of the provider's claims was pulled. Records were requested and received. Review of the records revealed the provider's documentation did not contain necessary elements for the billed CPT codes, including direct one-on-one patient contact, stated time per modalities, orders and plan of care. The case was referred to the state Medicaid Program Integrity department and MFCU. Final overpayment demand of $100,000 was forwarded to the provider. The case remains active and the SIU is pursuing the overpayment.

3. Describe methods for educating employees, network providers and members on fraud and abuse identification and reporting.

AmeriHealth Caritas Iowa's training systems will include education and guidance on our ethics and legal compliance policies; the Code of Conduct; fraud, waste, and abuse (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 will have a policy concerning disciplinary action for noncompliance with the Code of Conduct.

Employees will complete new hire training within 30 days of the beginning date of employment in the following areas:

- Code of Ethics and Conduct.

- Privacy and Security, including the Health Insurance Portability and Accountability Act.
- FWA.
- Procedures for timely, consistent exchange of information and collaboration with DHS.
- Organizational chart, including the compliance organization and the program integrity management and investigators.
- Provisions that comply with 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures and guidelines issued by the Iowa DHS, US Department of HHS, CMS and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by Iowa or its departments.

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

The training program includes the SIU's mission and purpose, identification of suspicious fraud, waste and/or abuse scenarios and the SIU referral process. The provisions of the targeted FWA and other related training are provided by the SIU upon request, or otherwise as necessary. Annually, as a condition of continued employment, every associate (including fulltime, part-time and temporary associates) undergoes training on the Code of Conduct. The Code of Conduct instructs associates to report suspected FWA to the SIU.

AmeriHealth Caritas Iowa is committed to combatting FWA. As with other AmeriHealth Caritas plans, AmeriHealth Caritas Iowa will provide additional training to its associates via mandatory educational sessions and quarterly compliance newsletters. Topics include compliance, FWA reporting and DHS contract requirements. For SIU associates, they are provided training opportunities to enhance their skill set and knowledge base. Investigators attend in-person and online education sessions and training provided through the National Health Care Anti-Fraud Association.

Training information is available on-demand to providers via our plan website as well as through the provider manual, which includes information on how to stay compliant with state and federal laws combating FWA. This information is reviewed in depth with new providers. Providers are also directed to our website to become familiar with the broad range of educational topics we offer. At any time, providers are able to contact their assigned Provider Network Management account executive for education, follow-up questions and concerns. Information available through the website is reviewed and updated regularly.

In addition to our robust associate and provider training, AmeriHealth Caritas Iowa members will be educated regarding fraud and abuse through their initial enrollment, onboarding materials and regular communications with AmeriHealth Caritas Iowa.

Our provider manual is available electronically on our plan website and can be downloaded for those who prefer a hard-copy version. The provider manual and all provider-related materials, including the provider section of our website, are reviewed regularly to ensure information is current and concise. As an example of our policies and training, please refer to the provider manual information contained in Section 6 of this response.

4. Describe internal controls to ensure claims are submitted and payments are made properly.

AmeriHealth Caritas Iowa's contracts with providers require prompt notification to AmeriHealth Caritas Family of Companies if the 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 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 terminates its contractual relationship with the provider. Compliance is also assured through the credentialing and re-credentialing process.

The SIU has an excluded and sanctioned provider process across the enterprise. The SIU has established a screening process to review all participating and nonparticipating providers. On a monthly basis, AmeriHealth Caritas Family of Companies provides all provider files to two Payment Integrity vendors (Optum and Provider Trust) that screen for all federal (OIG LEIE and GSA SAM) and state exclusions and sanctions.

All practitioners and facilities identified by these vendors are immediately configured within the AmeriHealth Caritas Family of Companies' adjudication platform to deny their submitted claims. Additionally, excluded practitioners and facilities that submitted claims that were denied after the effective date of the exclusion are transferred to the SIU for investigation.

Any new non-participating provider (practitioner or facility) submitting a claim goes through a validation process to ensure the provider is not on the excluded/sanctioned provider list. This is accomplished during the initial steps of claims adjudication, where claims processors access Optum and ProviderTrust validation portals to validate the provider. AmeriHealth Caritas Iowa will also screen new participating and non-participating providers using the websites listed in the section above.

AmeriHealth Caritas Iowa also coordinates with DHS Program Integrity to maintain member and provider data integrity and remove incarcerated, deceased or incorrectly enrolled members or providers. In order to support the maintenance of accurate and complete provider data and to support the efforts described above, AmeriHealth Caritas Iowa is also developing an internal mechanism to monitor providers on an ongoing basis.

Provider suspension

AmeriHealth Caritas Iowa shall comply with 42 CFR 455.23 by suspending all payments to a provider after the Agency determines a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity, unless the Agency or law enforcement (included but not limited to the MFCU) has identified cause not to suspend payments, in part or in full, in writing.

Upon notification, AmeriHealth Caritas Iowa shall issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 CFR 455.23(b) and maintains the suspension for the period set forth in 42 CFR 455.23(c). In addition, the notice of payment suspension shall state that payments are being withheld in accordance with 42 CFR 455.23. AmeriHealth Caritas Iowa will not suspend payments until consulting with the MFCU and the Agency.

AmeriHealth Caritas Iowa will afford a grievance process to providers for whom payments have been suspended by the Contractor, which adheres with all state requirements.

AmeriHealth Caritas Iowa will maintain all materials related to payment suspensions for a minimum of five (5) years in compliance with the obligations set forth in 42 CFR 455.23(g).

Service verification

On a monthly basis, AmeriHealth Caritas Iowa mails service verification letters to a group of members for whom claims are received. Using state-approved sampling methodology, AmeriHealth Caritas Iowa generates notices, which include a description of the service provided, the provider of said service, date on which the service occurred and the amount of payment made. AmeriHealth Caritas Iowa ensures that a minimum of one (1) percent of all paid claims in a given month are represented in this sample. AmeriHealth Caritas Iowa tracks all complaints received by the Member Services department, as well as any actions taken as a result of an inquiry. We will report the results to DHS on a quarterly basis or as required, and utilize the results to target high-risk provider types and/or services. In cases where survey results indicate unreceived paid services, AmeriHealth Caritas Iowa will forward all required information to SIU and DHS for review

Ensuring completeness of claims data

AmeriHealth Caritas Iowa will implement defined processes to ensure all claims submitted by providers are processed appropriately and that claim acknowledgements are returned to providers. AmeriHealth Caritas Iowa will accept claims submitted via electronic data interface (EDI) methods or on paper claim forms, which are converted to electronic format for processing through our adjudication system.

Provider claims reconciled upon receipt

AmeriHealth Caritas Iowa's clearinghouse will validate submitted claims to identify missing and invalid required fields. Claims lacking HIPAA compliant data fields will be rejected and returned to the provider. Claim acknowledgements will be returned to providers via the clearinghouse for EDI submitted claims. A control process will acknowledge all claims received.

For our paper clearinghouse, a similar validation is performed to identify any missing or invalid data fields. A rejection letter will be generated informing the provider of all the reasons for the rejection(s), and be accompanied by a copy of the claim form submitted. A copy of both the rejection letter and claim will be sent by AmeriHealth Caritas Iowa via an XML file for storage in the SunGard EXP MACESS tool. EXP MACESS is an imaging-based operations management, workflow management, enterprise content management and customer-service solution that has been standardized for managed healthcare organizations.

Once processed through the clearinghouses, the claims will then be loaded into Facets, which will verify the completeness and accuracy of provider numbers, member ID numbers, diagnosis codes and procedure codes.

Reconciling pended, paid or denied claims to remittance advices

The claims processing system will set the claim to a status of pend, deny or ready for payment. Pended claims require a manual review before adjudication can be finalized, and will be routed to claims examiners via an automated workflow system. The workflow system will track each pended claim until adjudication is finalized. If a claim is denied because the provider did not submit required information or documentation with the claim, then the remittance communication will identify all missing information and documentation. The resubmission of a claim with further information and/or documentation will not constitute a new claim for purposes of timely filing. The remittance advice (RA) will include information on all claims paid, denied and adjusted during the claim payment cycle. The associated payment to the provider will consist of the net of all debits and credits.

Support for electronic data interface

AmeriHealth Caritas Iowa will maximize claims submission via EDI, encouraging providers to utilize electronic claims submission, use electronic funds transfer (EFT) for payment and adopt electronic remittance advice. These electronic claims will be submitted through secure, web-based portals, such as Emdeon's Provider WebConnectSM. These portals enable providers to improve practice efficiency and reduce expenses through real-time access to key administrative transactions, such as:

- Claim inquiries.
- Electronic referrals.
- Eligibility inquiry, including benefit verification.

Optical character recognition of paper claims

AmeriHealth Caritas Iowa's paper claims will be converted into electronic data by a vendor that uses optical character recognition (OCR) and performs a character repair function. Claims that do not pass OCR will be keyed through a data-capture application. The vendor and AmeriHealth Caritas Iowa's quality auditors will separately pull a sample of keyed claims monthly to validate quality and accuracy.

Enforcing accuracy of claims data

We will use several strategies to ensure accurate claims data submissions. This will include testing payment configurations, automated editing against a full suite of clinical and administrative rules, maintaining up-to-date system rules and edits and regularly monitoring quality through audit programs.

Claims payment testing strategy

AmeriHealth Caritas Iowa will use a robust testing strategy to ensure the accuracy of claim payments. Payment configuration will be tested when one of the following triggers occurs:

- Initial set-up of providers in a new market.
- Loading of a new provider agreement.
- Introduction of a new payment methodology.
- Identification of trends in claim payment errors.
- Fee-schedule updates.

AmeriHealth Caritas Iowa will utilize the Claim Test Pro application to test claims data and verify that correct claim totals are being paid prior to system updates and changes. Claim Test Pro is a TriZetto solution that greatly reduces the need for manual creation of test data, by electronically converting system data to applicable testing data sets to create a robust and applicable testing environment. The application also automates the management and reconciliation of results, tracks and documents test projects and cases, and creates testing result reports.

Claims processing rules

AmeriHealth Caritas Iowa will develop standard claims-processing rules used during the adjudication process. The standard rules will be tailored to meet state-specific requirements and our provider agreements. Claim examiners will have access to the processing rules to aid them during the adjudication process through our online help software. Processing rules will be updated when new rules are identified and/or when the quality-auditing process has identified specific areas for enhancement.

Compliance with industry standards, state and federal requirements

Claim payment policies will be updated regularly, and updated code files will be loaded into the claim adjudication system generally quarterly or annually, as published.

These updates will be derived from standard industry sources, such as:

- NUBC.
- HCPCS.
- CPT.
- ICD-10 guidelines.
- CMS NCCI manual.
- NCCI facility and professional procedure to procedure edits.
- CMS manuals.
- Outpatient Professional Payment System (OPPS) guidelines.
- Integrated Outpatient Code Editor (I/OCE) guidelines.
- Iowa state regulatory guidelines.

Quality monitoring programs

AmeriHealth Caritas Iowa will use several approaches to ensure claims and encounters are accurate and timely. Our dedicated Quality Auditing department will be accountable for reviewing adjudicated claims for financial, procedural and claim accuracy.

AmeriHealth Caritas Iowa will track encounter performance, as well as the performance of our subcontractors and providers. Our monitoring programs will help us achieve compliance with DHS encounter data reporting requirements, and highlight when follow up is required to resolve issues regarding encounter reporting by subcontractors or providers.

Reports will be regularly generated through our monitoring and audit programs and distributed to appropriate leadership and workgroups for review or necessary remediation activities. We will also perform a monthly internal credibility audit to validate the accuracy of auditing statistics.

Stratified health plan audit program

Every month, we will complete a stratified health plan audit, which consists of a random sample of at least 385 electronic and paper claims processed in the previous month. The payment strata will be adjusted depending on claims volume and then divided into three payment stratum, with a fourth stratum used for adjusted claims, and a fifth stratum for zero-paid claims. Parameters will be based on the previous year's historical data.

Claims pulled for stratified audits will consist of manually adjudicated and system adjudicated claims, as well as those handled by HP Quick Test Pro, a claims testing tool that processes routine claims that fall outside of our auto-adjudication process. The quality scores achieved for each plan will serve as the official score, which include financial, procedural and payment accuracy percentages. See Exhibit 12.4-A for an illustration of audit program results for one of our affiliate health plans.

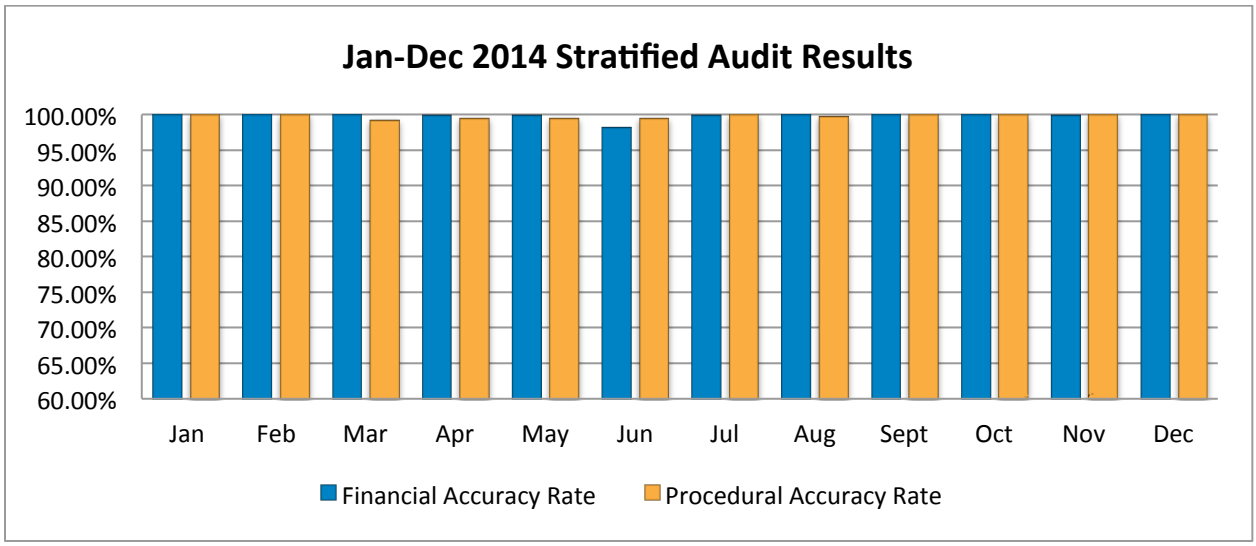


Exhibit 12.4-A: Stratified Audit Results from a Similar Plan We Manage

Monthly encounter status reports

Monthly status reports pulled from the encounter audit table will validate the integrity of the encounter data and overall system. Analysts will monitor the rejections on each error file received and use cumulative encounter error reports to identify trends.

Manually adjudicated audit program

On a daily basis, the selection for this audit will consist of a random sample of at least three percent of each claim examiner's processed work. Audits will be performed on a pre- or post-disbursement basis. The quality scores achieved for each claim examiner will serve as a performance management analysis for the claims operations management team. If a claims examiner needs further assistance, the claims management team will direct the auditor to pull a higher percentage of the individual's processed claims for an agreed-upon period.

Assisted adjudicated audit program

On a daily basis, a selection for this audit will consist of a random sample of at least one percent of claims processed through the HP Quick Test Pro. AmeriHealth Caritas Iowa utilizes an automated tool for batch claims reprocessing. This tool enables us to perform systematic payment updates to multiple claims when necessary, e.g., retro changes to updated fee schedules. This audit reviews processing of claims against specific adjustment criteria and plan-specific processing rules, and is also used to address provider claim payment issues (e.g., retrospective fee schedule adjustments) when multiple claims are impacted. Audit results are also used to identify process improvement opportunities.

Cost containment/Claim Reconciliation Recovery Unit audit program

For this daily audit, we will choose a random sample of at least 10 percent of monthly claims adjusted by the Claim Reconciliation Recovery Unit (CRRU) and at least three percent of monthly claims adjusted by the Cost Containment team. Audits will be performed on a pre- or post-disbursement basis. The quality scores of each examiner will serve as a performance management tool for the Cost Containment and CRRU management teams. Upon request from the CRRU/Cost Containment management teams, a higher percentage of an individual's processed claims can be pulled and audited for an agreed-upon period.

System adjudicated target audit program

The sample criteria for this audit will be based on claims management team requests, which may include previously identified quality auditing errors and recent configuration changes to the claim system (Facets). The sample will be focused on specific claim types and calculated to meet a minimum of a 95 percent confidence level and five percent precision level. Target audits will be performed on a pre- or post-disbursement basis as requested by the claims management team. Errors assessed during the target audit will be sent by the Quality Audit (QA) department to the Configuration and Claims Operations management teams for review.

High-dollar, pre-disbursement audit program

The criteria for this audit will be claims with total billed charges equal to or greater than $50,000. These claims will be reviewed by the QA team for procedural, financial and payment accuracy. Any identified discrepancies will be resolved prior to claim adjudication/payment.

New hire quality onboarding audit program

The selection for this audit will consist of a random sample, between five and 30 percent of the claims processed daily for each new associate, to identify performance gaps. The training program will be broken into three (3) modules for new associates to learn to process one type of claim and gain experience before moving on to another type. Modules exist for medical, hospital and COB claims. As each module of the training program concludes, the associate will begin processing that claim type in the production environment and the auditing periods begins. The first module is medical claim processing training. Subsequently, there is an audit period of three weeks, with a two-week period following the hospital and COB modules. The Quality Auditors may review errors with an associate up to two to three times per week, and with the trainer/supervisor at least once per week.

The quality scores achieved for each associate will serve as a performance management tool for the trainer and the claims management team. Upon completion of the “new hire” claims training and audit period, the associate will be monitored through the manually adjudicated audit program.

Claims payment subcontractor audit

AmeriHealth Caritas Iowa will collect “accuracy percentage” from the monthly delegation performance report submission required of all delegates. Additionally, we will ensure the delegate has approved procedures that include a process for reviewing claims for accuracy and acceptability. These policies will be reviewed by AmeriHealth Caritas Iowa during the annual delegation audit.

Local AmeriHealth Caritas Iowa review audit processes

In order to address errors in a timely manner, AmeriHealth Caritas Iowa will utilize a local quality auditor. This auditor will be responsible for the review of the lifecycle of all claims, contracting, configuration updates, fee schedule updates, provider maintenance, member reassignments and the monitoring of statutory reports/performances metrics from the Network Operations department. Audited information will be tracked and any discrepancies or identified claims issues will be reported at weekly meetings between Provider Network Operations (PNO) and the Claims Unit team. If updates or corrections are identified, the appropriate steps will be taken to address the issues as soon as possible. Additional staff within the PNO department will also audit the recoveries efforts, clinical editing and billing issues to ensure we are following standard Medicaid guidelines.

Documentation and reporting of audit results

The documentation of the audit results will reside in a dedicated database. The results for the monthly Stratified Plan Audit will be distributed to the Claims Operations management team on a monthly basis. The results for the manually adjudicated claim audit will be available to the Claims Operations management team in real-time, as the management team will have the access to pull quality audit results at any time, either by individual examiner or department. For both audits, the QA department will issue a claim summary report with the financial, procedural and claim accuracy scores for the month and a claim detail report to support claim errors identified in the audit.

Claim Detail Report for LOB 2100

Record Number	Claim Number	Paid Date	Paid Time	Paid Incorrect	Date Reviewed	Comments
		7/9/2014	Over Payment	$478.95	8/5/2014 6:34:18 AM	

Error Description	Error Comments	Error Type	Dispute Status	Dispute Level	Dispute Decision	Decision Comments
CLAIM Inappropriately Paid-Other	Claim paid incorrectly frequency code & submitted on claim. Per the Adjusted Claims Hospital rules, Void/Cancel of Prior Claim (this bill type is used for retractions), Deny all frequency 8 claims- X53, even if an EOB is attached to the claim	Financial				

Figure 12.4-B: Sample Stratified Plan Audit Report

Once the results are compiled, the Claims Operations team will access the results through a self-service reporting application. Reports will be available on a real-time basis and will include the following:

- Claim detail report by individual.
- Health plan summary report.
- Supervisor summary report.

Audit results will be utilized as a tool for the management staff of each claims team to identify trends and to enact procedures to remediate any identified errors. This will include, but not be limited to, individual coaching, targeted training (e.g., authorization, COB training) and progressive performance management. Results and any associated action plans will be reported to AmeriHealth Caritas Iowa's Quality of Service Committee and to the executive management team responsible for the plan.

Necessary corrective action processes

Claim Operations managers and supervisors will be responsible for reviewing the manually adjudicated (performance management) audit reports and determining if the errors are charged appropriately. If there is a discrepancy, the team lead will follow a formal appeals process to review the audit result. In addition, an internal credibility audit will be performed monthly to validate the accuracy of auditing statistics.

If the final monthly financial or procedural accuracy metrics do not meet our goal, the claims manager will develop an action plan, which will include a detailed analysis of the identified errors and a remediation plan. Action plans, which could include targeted refresher training, amended work aids and/or additional pre- and post-adjudication auditing, will be reviewed monthly and remain active until identified errors are resolved. Any claim payment error identified will be immediately corrected and reprocessed for appropriate payment.

Intervention for accuracy

Quality scores will be shared with the management team on a daily and monthly basis. If error trends are identified, targeted training modules will be developed. Depending on the nature of the errors, the entire claim staff may be required to attend the training. If the errors are isolated, the examiners who committed the errors will be required to attend the training.

Provider-reported payment errors will be handled by the Research and Analysis team, a specially trained unit within the Claims department. The Research and Analysis team will work with the provider to determine the root causes of the payment errors, such as system set-up or provider billing errors. Once the cause is determined, the team will implement appropriate remediation action, which may include education, system enhancements or claim examiner training.

5. Describe methods for verifying whether services reimbursed were actually furnished to members as billed by providers.

AmeriHealth Caritas Iowa will verify that services, for which a reimbursement was made, were provided to members via service verification letters. Service verification letters will be mailed monthly to members who receive claims within 45 days of payment. AmeriHealth Caritas Iowa will ensure that a minimum of one (1) percent of all paid claims in a given month is represented in the sample. If state requirements mandate a larger sample size, this requirement will be adjusted. To the extent that AmeriHealth Caritas Iowa considers a subset of providers or service types to warrant closer scrutiny, AmeriHealth Caritas Iowa will focus on claims received from targeted provider specialties, such as pain management, DME and home health.

On a monthly basis, we will track all service verification responses, related complaints received from members, resultant interventions and actions, and report results. Unreceived paid services will be forwarded to the DHS within the two business days.

Attachment 12.0-A: Draft AmeriHealth Caritas Iowa Compliance Program

Commitment to Compliance

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 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.

The training program also includes our SIU's mission and purpose, identification of suspicious FWA scenarios and the SIU referral process. The provisions of the targeted FWA and other related training are provided by SIU upon request, or otherwise as necessary.

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.

In furtherance of AmeriHealth Caritas Iowa's commitment to FWA, SIU staff members are provided training opportunities to enhance their skill set and knowledge base. Investigators attend in-person and online education and training provided through the National Health Care Anti-Fraud Association.

AmeriHealth Caritas Iowa providers and subcontractors shall agree to conduct their own compliance FWA training for all associates in accordance with Iowa rules and regulations, and shall conduct such training within 30 days of hire and annually thereafter. Additionally, we will make our Compliance and FWA training available to first tier, downstream and related entities, so that it can be used as a resource for meeting the requirement that they provide compliance and FWA prevention training to their associates.

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.

Communication with Iowa State Program Integrity/Medicaid Fraud Units

AmeriHealth Caritas Family of Companies and AmeriHealth Caritas Iowa will establish monthly reporting, including both payment integrity (cost avoidance and recoveries), and SIU provider case identification, planning and action plans. AmeriHealth Caritas Iowa will report possible FWA activity to the Agency. AmeriHealth Caritas Iowa will initiate an immediate investigation to gather facts regarding potential fraud or abuse. Documentation of the findings will be delivered to the Agency within two (2) days of the identification of suspected FWA activity. AmeriHealth Caritas Iowa's SIU is prepared to meet any additional reporting timeframes in the matter and format deemed appropriate by the state.

This organizational alignment provides transparency for all Program Integrity and SIU activities and findings. In addition, the SIU director, in conjunction with the designated AmeriHealth Caritas Iowa compliance officer, ensures timely reporting and ongoing updates to the MFCU through DHS, and in accordance with the state Medicaid contract, also brings forward investigation summaries to the Compliance Committee. AmeriHealth Caritas Iowa will communicate monthly and as required with the Agency Program Integrity Unit, DHS staff, and MFCU staff when necessary.

The SIU Director reviews and addresses requests for information relating to FWA, including, but not limited to losses, recoveries and provider terminations. In accordance with policy and procedure, prior to a FWA provider termination decision being made by AmeriHealth Caritas Iowa, the SIU director and compliance officer may consult with multiple stakeholders, including AmeriHealth Caritas Iowa's leadership, provider network management, operations, credentialing and risk management leaders, to ensure that all affected systems are updated and peer review can take place if it is warranted. Legal Affairs may also provide advice when required.

Reporting will include, but is not limited to:

- The name and NPI of provider reviewed.
- The reason for the review, data source and/or referral.
- Review outcome.
- Provider referrals to MFCU.
- Providers suspended and reason for suspension.
- Providers terminated and reason for termination.
- Provider recoupment amount and reason for recoupment.
- Provider payment reductions and reason for payment reduction.
- Providers who were denied enrollment or reenrollment pursuant to 42 CFR 455, including name, NPI and reason for denial.
- State fiscal year to date summary information of Contractor Program Integrity activity.

Upon request, AmeriHealth Caritas Iowa will provide any and all documentation or information to the Agency, the MFCU, HHS-OIG or the US Department of Justice related to any aspect of the Contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, provider records and report on recoupment actions and receivables.

AmeriHealth Caritas Iowa will not take action to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claim upon the withhold or recoupment meet the criteria outlined by DCH.

Referral to Law Enforcement

Where applicable and permitted, the SIU pledges full cooperation with local, state and federal law enforcement agencies, as well as with state Insurance Fraud Departments, state Medicaid Fraud Control Units and state Medicaid Program Integrity Units in the prosecution of all fraud cases. The primary goal of referring a case to a law enforcement agency is to obtain a conviction. If the prosecution is successful, restitution will be consistently pursued as an element of judgment in coordination with state and federal victim protection boards.

The SIU will refer to law enforcement any transaction where the facts and circumstances create a reasonable belief that a person or entity may have committed or is committing fraud and/or abuse. A referral to a law enforcement agency will be submitted in a standardized format or as mandated by a particular law enforcement agency.

The SIU will refer suspected or confirmed FWA, in addition to neglect/abuse (mistreatment) of a member, to the appropriate agencies within the required timeframes.

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 be completed for the AmeriHealth Caritas Family of Companies' Philadelphia campus, as well as the AmeriHealth Caritas Iowa local office.

Sanction screening

Employees and Providers

All prospective associates are required to undergo pre-employment background check and mandatory drug screens prior to employment. AmeriHealth Caritas screens prospective vendors as well as current vendors and employees by checking the U.S. Department of Health and Human Services (HHS) Office of Inspector General (HHS- OIG) List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration's (GSA) web-based Excluded Parties List System (EPLS), U.S. Treasury Department Office of Foreign Assets List of Specially Designated Nationals and Blocked Persons, and applicable state exclusion lists for names of excluded associates, contractors, providers and vendors barred from participation in Medicare, Medicaid, other federal health care programs, federal contracts and state health care program.

Excluded individuals/entities are not hired, employed or contracted to provide services for AmeriHealth Caritas Family of Companies' product offerings.

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

As described above, the AmeriHealth Caritas Iowa SIU establishes, distributes, enforces and revises, as necessary, written policies and procedures to be used by the SIU staff to detect, investigate, and fully document allegations of FWA. This includes a procedure to report evidence of misconduct or noncompliance to DHS and other agencies. All investigations are performed in a uniform, timely and complete manner.

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

13. Information Technology

Please explain how you propose to execute Section 13 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Overview

AmeriHealth Caritas' management information system is built on best-in-class enterprise solutions to support core business needs and health plan functions. Our core platforms are industry-leading, highly configurable applications that enable us to easily adjust to changes in contract requirements and leverage our experience to provide the best care possible to the Iowa Medicaid population. Our integration framework and data lake technologies enable plug-and-play analysis and data sharing with the Department of Human Services (DHS).

- AmeriHealth Caritas' management information system is built on "best in class" enterprise solutions.
- AmeriHealth Caritas is an industry leader in using innovative technologies to improve patient outcomes and access.

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

13.1 Information Services & System

1. Provide a general systems description and a systems diagram that describes how each component of your information system will support and interface to support program requirements

Implementing an innovative, flexible, scalable management information system

TriZetto Facets

AmeriHealth Caritas uses Facets, TriZetto's industry-leading, core-administration platform. Facets automates business processes, enhances efficiency and provides the flexibility needed to administer and adapt to the Iowa Contract requirements.

Facets serves as the primary source for the health plan's claims, referral, prior authorization, provider network and pricing agreements, and member eligibility data, including third-party liability (TPL) and coordination of benefits (COB) information. This integration enables a high degree of auto-adjudication through standard edits that check claims data against the other data stored in the system, allowing for greater claims processing accuracy and efficiency. The integrated information stored in the Facets databases is readily available to Contact Center of Excellence (CCOE) representatives as they help members and providers with eligibility and enrollment, appeals and grievances, and general inquiries.

AmeriHealth Caritas – Core Administration Transaction Flows

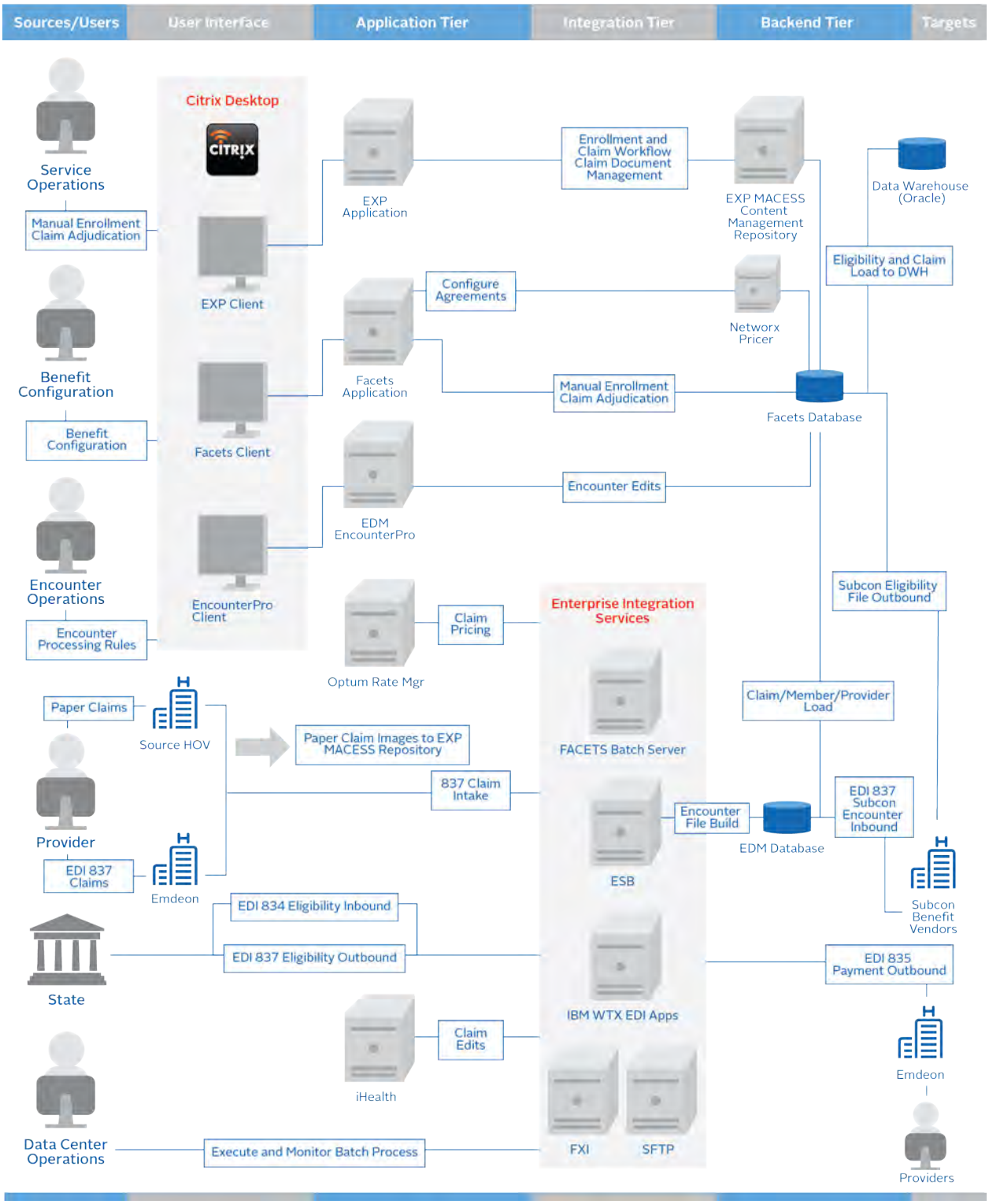


Exhibit 13.1-A: Core administration transaction flows

An enterprise-wide solution with a high degree of automation and data capture, Facets achieves fast, accurate claims processing and high auto-adjudication rates. Medical and hospital claims submitted via paper, online or electronically are processed in an automated fashion, with full support for highly productive electronic adjudication. Facets electronic commerce capabilities are designed to accept and transmit eligibility and claim information in HIPAA-compliant, transaction-set standard formats. AmeriHealth Caritas further enhanced Facets with custom capabilities for auto-adjudication of certain coordination of benefits (COB) claims. COB automation is enabled for all health plans and is calibrated to adhere to each State's processing rules.

We regularly update our claims core administration system with new State and federal requirements, other industry standard code sets and procedure codes. This includes the latest CPT, HCPCS, ICD-9, ICD-10, HCPCS Level II and Category II CPT codes. Whenever federal guidelines are utilized, State legislative or regulatory policy modifies or entirely supersedes federal determinations where applicable.

As our core administration application, Facets will store AmeriHealth Caritas Iowa's member eligibility, benefit parameters, provider network status and pricing agreements, utilization and authorization requirements, and COB information to support the completeness, timeliness and accuracy of our claims processing.

Files sent by DHS will be utilized as follows:

- Enrollment files received are loaded into Facets daily. Records that fail the loading process are reviewed by dedicated enrollment associates. Eligibility information is used during the auto-adjudication process and is available to our claims examiners to manually adjudicate claims that pended through auto-adjudication.
- Prior authorization and referral information from our clinical care management platform, ZeOmega Jiva, is loaded into Facets daily.
- Provider contracts and pricing data from our provider network management application are loaded into Facets daily. Pricing schedules can be customized and configured to varying complexities.
- COB and third party liability information is stored in Facets, and is used to identify liable parties, determine order of benefits and price claims to allow for appropriate processing of applicable secondary payments.
- Claim activity is logged, including but not limited to the date AmeriHealth Caritas Iowa receives the claim as indicated by the date-stamp, the history of actions taken on each claim and the date of payment.

TriZetto Facets Batch Server

Facets Batch Server is one of the core components of the Facets architecture. It provides a platform to execute batch processes such as member enrollment, claims adjudication and capitation required for enabling core administration functionality. Facets Batch Server will allow AmeriHealth Caritas Iowa to process files received from DHS efficiently through parallel processing capabilities. Facets Batch Server also provides for the dynamic reallocation of system resources to batch processing, which will enable AmeriHealth Caritas Iowa to quickly scale to increased demand.

TriZetto Facets eXtended Integration™

The Facets eXtended Integration™ (FXI) application integrates the Facets solution with third-party and custom-developed applications in order to reduce costs, enhance data-sharing and flexibility and improve efficiency. FXI provides real-time integration to Facets through the use of predefined Web services

designed to accomplish common tasks such as enrolling a member, updating provider information and a variety of search capabilities for claims, members and providers.

TriZetto NetworX Pricer and Modeler

TriZetto NetworX Pricer is a Java-based application that integrates with Facets to support greater contract sophistication, specificity and processing speed, while eliminating inconsistencies and errors in pricing of providers' claims. Combined with TriZetto NetworX Modeler (described below), these capabilities position us to model the financial implications of changes during provider negotiations and those driven by regulatory changes, such as the ICD-10 implementation. NetworX Pricer provides an English-like, common-language user interface that allows AmeriHealth Caritas to easily configure complex provider contracts within the Facets system. This method reduces confusion between provider-contracting staff and technical resources to ensure the Contract configuration in the system aligns with the provider's expectations for reimbursement.

NetworX Modeler is a sophisticated Contract modeling application that downloads historical claim data and performs scenario-based, "what if" analysis at the Contract level. NetworX Modeler helps to forecast results, negotiate optimized terms and improve the financial outcome of Contracts. Once new pricing terms and methodologies are entered into NetworX Modeler, historical claims will be adjudicated through this tool, displaying how the same claims would have been priced using the newly entered terms. Once finalized, NetworX Modeler automatically updates the Contract in Facets through seamless integration with the NetworX Pricer application.

Integrated payment integrity and third-party liability

AmeriHealth Caritas' dedicated Payment Integrity department identifies other responsible payer information, including Medicare, commercial insurance and/or accident-related coverage to administer the collection of TPL information. TPL information provided by DHS will be enriched through the use of third-party sources for TPL data. Members are also asked to verify their TPL information when interacting with our Contact Center of Excellence.

After TPL data are loaded into Facets, it is available immediately to all system users including claims examiners, customer service representatives, provider service representatives, enrollment associates, medical management associates and payment integrity/TPL associates.

iHealth Technologies (iHT) analytics

iHT is utilized to enhance clinical and business rule editing for claims. iHT applies a comprehensive, customized library of clinical coding edits to professional and outpatient hospital claims to support accurate coding and payments. In addition to AmeriHealth Caritas' generally accepted clinical edits, AmeriHealth Caritas Iowa will build a library of customized medical policies that comply with Iowa Medicaid requirements.

Provider Services associates use a Web-based tool to access detailed clinical descriptions of the edits applied to every processed claim, including the justification for their application, so they can provide medically appropriate explanations to providers as necessary.

Optum Rate Manager/ECM Pro/Webstrat

Optum™ WebStrat™ is a Web-based application that delivers tools to help payers accurately reimburse providers using prospective payment methodologies. The application provides a wealth of resources, including Prospective Payment System (PPS) knowledgebase, methodologies and tools.

Encounter applications

AmeriHealth Caritas Iowa recognizes that providing Contract-compliant encounters is critical for meeting program requirements. Our integrated encounter solution will produce and submit HIPAA 5010 ANSI X12 837 transactions in professional and institutional formats, as well as National Council Prescription Drug Programs (NCPDP) formats. Encounter files will be built in accordance with Iowa's companion guides and payment rules.

TriZetto Encounter Data Manager (EDM) is a software platform designed to provide a framework for submittal of encounter data and retrieval of response file data. The application provides a wide range of functionality that tracks and reports data throughout the encounter process.

Schedules created in the application define the criteria for the source data to pull, such as paid date ranges and claim lists. When a schedule executes, the application connects to one or more claim sources to download the claim data that is required to generate encounter files. The download process includes a pre-edit process that prevents claims that would generate an encounter error from being submitted and redirects them to pre-edit queues for correction. Claims flagged by the pre-edit process are researched and corrected in the source system. After the download process completes, test files can be generated and reviewed prior to building finalized encounter files for submission to DHS.

Encounter files will be built with settled claims, adjustments, denials and voids from the most recent month and by week for drug encounter data. AmeriHealth Caritas Iowa adjudicated claims will be loaded into the EDM application, along with the most recent member eligibility and provider data files received from DHS. EDM will then build HIPAA 5010 ANSI X12 837 encounter files that include all paid, adjusted and denied claims, including zero-dollar claims from capitated providers. The files will be formatted in the 837-I (institutional) and 837-P (professional) transaction formats. Pharmacy encounters from our pharmacy benefits manager (PBM) will be prepared weekly as HIPAA National Council for NCPDP transactions and include all paid, adjusted, denied or voided claims, including those showing a zero-dollar amount.

All encounter files will be checked for completeness and accuracy, which will include verifying claim counts as well as HIPAA compliance validation using IBM Standards Processing Engine (SPE), to identify potential TA1 or 999 errors. Any encounter that results in an error will be reviewed to identify root causes for the error and adjustments that need to be made for the encounter to process correctly. The review process will be repeated until a compliant file is created. Compliant encounter files will be submitted via secure file transfer protocols (SFTP) in accordance with contractual time frame requirements and any file size limitations, along with a certification attesting to the accuracy, completeness and truthfulness of the information.

When a 999, 824, 277 or 835 response file is received, it is loaded to EDM, where encounter analysts will review each rejected encounter and coordinate its remediation within the required time frames. The AmeriHealth Caritas Encounters team actively manages and tracks error resolution through completion. Corrected encounters will be included in the next encounter build processes and resubmitted as appropriate.

To ensure timely, accurate and complete encounter submissions, AmeriHealth Caritas Iowa will utilize AmeriHealth Caritas' leading practice approach to reconcile encounters data to provider payments. We will use a standard methodology to reconcile claims, encounters and cash monthly. Our dedicated team examines our encounter reconciliation report, comparing total claims processed to submitted encounters. This process is accomplished through a reconciliation of encounters submitted and accepted to the detailed cash disbursement journal (CDJ) related to claims adjudicated, by both dollars and volumes measures.

Provider Network Management

AmeriHealth Caritas' Provider Network Management system will manage and support our Iowa provider

network through platform capabilities to enroll and maintain facilities, groups and practitioner information, address incentives and handle appeals and grievances as well as continued enhancements and growth of the network.

Additionally, our provider enrollment and maintenance processes ensure standard and centralized procedures through business process management (BPM) and master data management (MDM) solutions to provide high data quality and accuracy, as well as cross-functional efficiency for all tasks related to:

- Provider enrollment — recruitment, contracting, credentialing, configuration, Facets loading, data auditing and provider orientation.
- Provider maintenance — data updates and corrections, adding practitioners to a group, re-credentialing, monitoring, terminations, performance metrics and Contract amendments.

The following diagram depicts the transaction flow (Exhibit 13.1-B) for Provider Network Management followed by descriptions of applicable technologies:

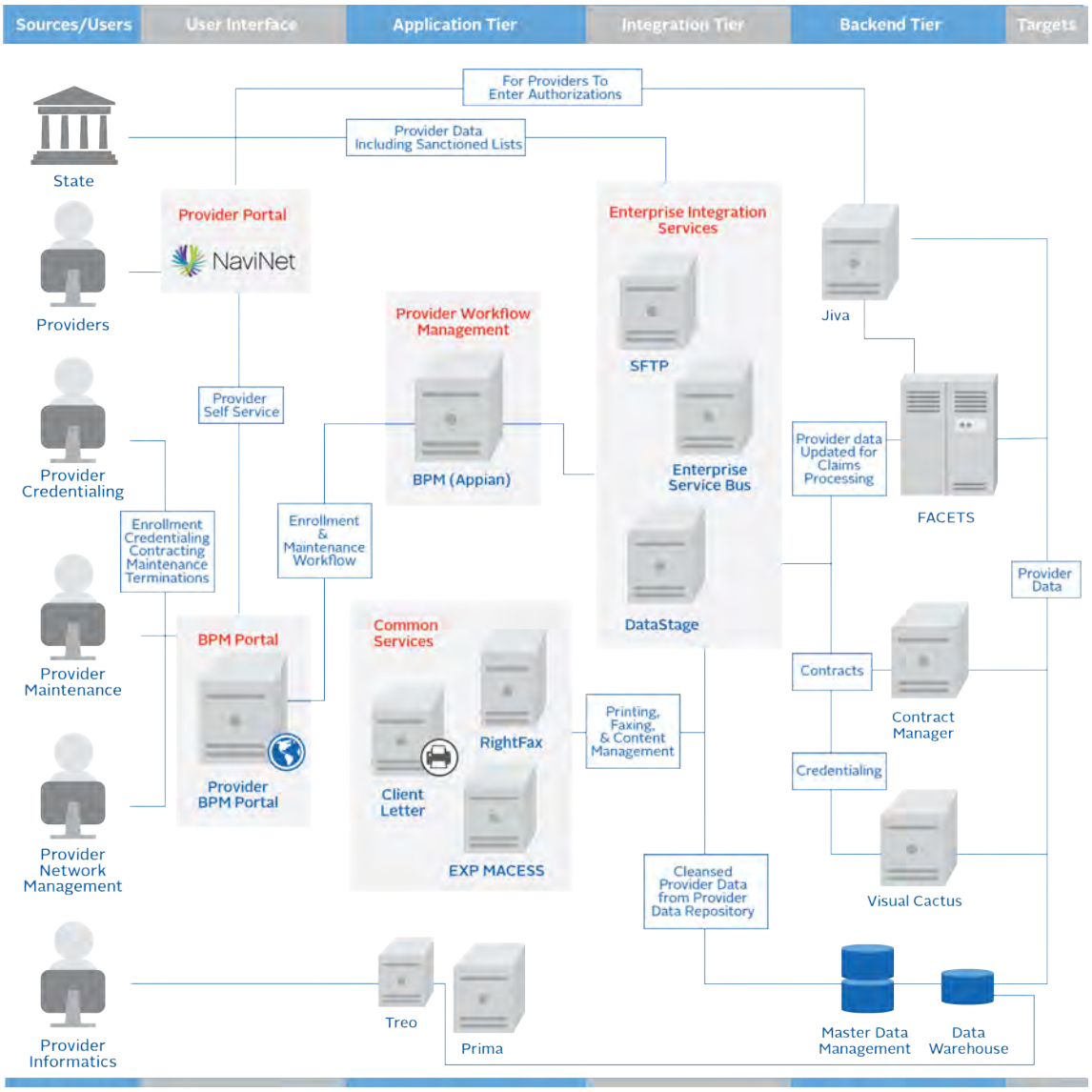


Exhibit 13.1-B: Provider Network Management transaction flow diagram

Appian Business Process Management (BPM)

AmeriHealth Caritas uses the Appian BPM technology to manage the provider lifecycle in a standardized and efficient manner. This solution provides role-specific user interfaces, task routing, queue management, monitoring, reporting, tracking and notification of work items at different status levels to task performers and their supervisors. The user interfaces are populated in real-time from applications and databases across the enterprise.

Provider Master Data Management (MDM)

AmeriHealth Caritas uses MDM to maintain a provider "golden record" that is the single source of truth for all of AmeriHealth Caritas Iowa provider data. This application suite manages the governance, creation, enrichment, delivery and use of master data across the entire organization. MDM is used in the provider domain to ensure quality data is used for all provider business processes. MDM is also used to automate monitoring of all applicable federal and State databases for excluded and sanctioned providers.

Contract Management

AmeriHealth Caritas Contract Management is a single content source for provider contracting. It automates the way Contracts are created, negotiated, amended, viewed, distributed and audited. Utilizing its components, we are able to streamline negotiations, manage provider demographics and provide system-wide visibility into provider network information. Contract Management provides the information transparency and process automation necessary for our affiliates to effectively manage the end-to-end provider contracting process. Some of the key features of Contract Management include:

- Generating provider-specific Contracts and Contract amendments for review and revision.
- Electronically transmitting provider-specific Contracts and Contract amendments for review and revision.
- Tracking revisions as Contracts and Contract amendments are negotiated.
- Acknowledging and tracking all Contracts and Contract amendments as they are finalized for execution.
- Storing executed Contracts and Contract amendments, including all revised iterations and negotiation-related communications.

Visual CACTUS (CACTUS)

Visual CACTUS is an application to maintain provider credentialing and re-credentialing information. CACTUS electronically interfaces with Web-based data repositories and primary verification sources to obtain and update provider credentialing files.

AmeriHealth Caritas implemented an interface between CACTUS and the Council for Affordable Quality Healthcare (CAQH) to download CAQH provider attestations and store the complete attestation. A viewer provides a side-by-side comparison of select CAQH and CACTUS data. Data currently imported into CACTUS include: provider demographics, provider IDs, institutions, licenses, affiliations, insurance, education, specialties, boards, languages, groups and addresses. The import program also creates a credentialing event for the provider if he or she is due for credentialing and an event does not already exist.

GeoAccess Suite

The GeoAccess Suite consists of the following components:

DataCleaner	DataCleanerTM is a data cleansing and preparation tool created by GeoAccess that standardizes our provider and member data. Consistent, standardized data provides the most accurate GeoNetworks reports, DirectoryExpert directories and referral searches.
DirectoryExpert	DirectoryExpert® is the GeoAccess® database publishing application that incorporates process automation, desktop publishing and managed care accessibility capabilities into an integrated system to help us produce healthcare provider directories.
GeoCoder	GeoCoder is an easy-to-use system that geocodes our data files based on the street address of locations within the United States. Geocoding is the process of assigning geographic coordinates — longitude and latitude — to individual points or locations.
GeoNetworks	GeoNetworks® is an easy-to-use, state-of-the-art software system used to analyze the geographic accessibility of healthcare networks. With GeoNetworks we calculate the distance between members and network providers based on actual geographic coordinates — a more accurate method for determining accessibility than ZIP code-based techniques.
ProviderMatch	ProviderMatch is an easy-to-use software application designed specifically for matching network members or prospects to network providers.

GeoAccess is used in the auto-assignment process for primary care providers (PCPs), to monitor network access standards and understand network disruption in the event of a known or threatened provider termination.

3M Treo™ Services

3M's suite of Web-based applications focuses on analyzing information for quality improvement. Using sophisticated algorithms, chains of admission and readmission events are linked to identify opportunities for improvement of care, use in pay-for-performance programs and other care management analytics.

HealthSparq

HealthSparq is a provider and physician online search module that enables consumers to view cost, quality, patient reviews, provider demographics and emergency room (ER) alternative options. AmeriHealth Caritas uses this technology to empower members with this information to make informed decisions regarding their care providers.

Care management information systems

AmeriHealth Caritas' care management platform utilizes ZeOmega Jiva ™ as the backbone for services to support the coordination of care, utilization management, Case Management, disease management, quality management and value-based contracting functions.

The following diagram (Exhibit 13.1-C) shows the care management transaction flow followed by descriptions of applicable technologies:

AmeriHealth Caritas – Care Management Transaction Flow Diagram

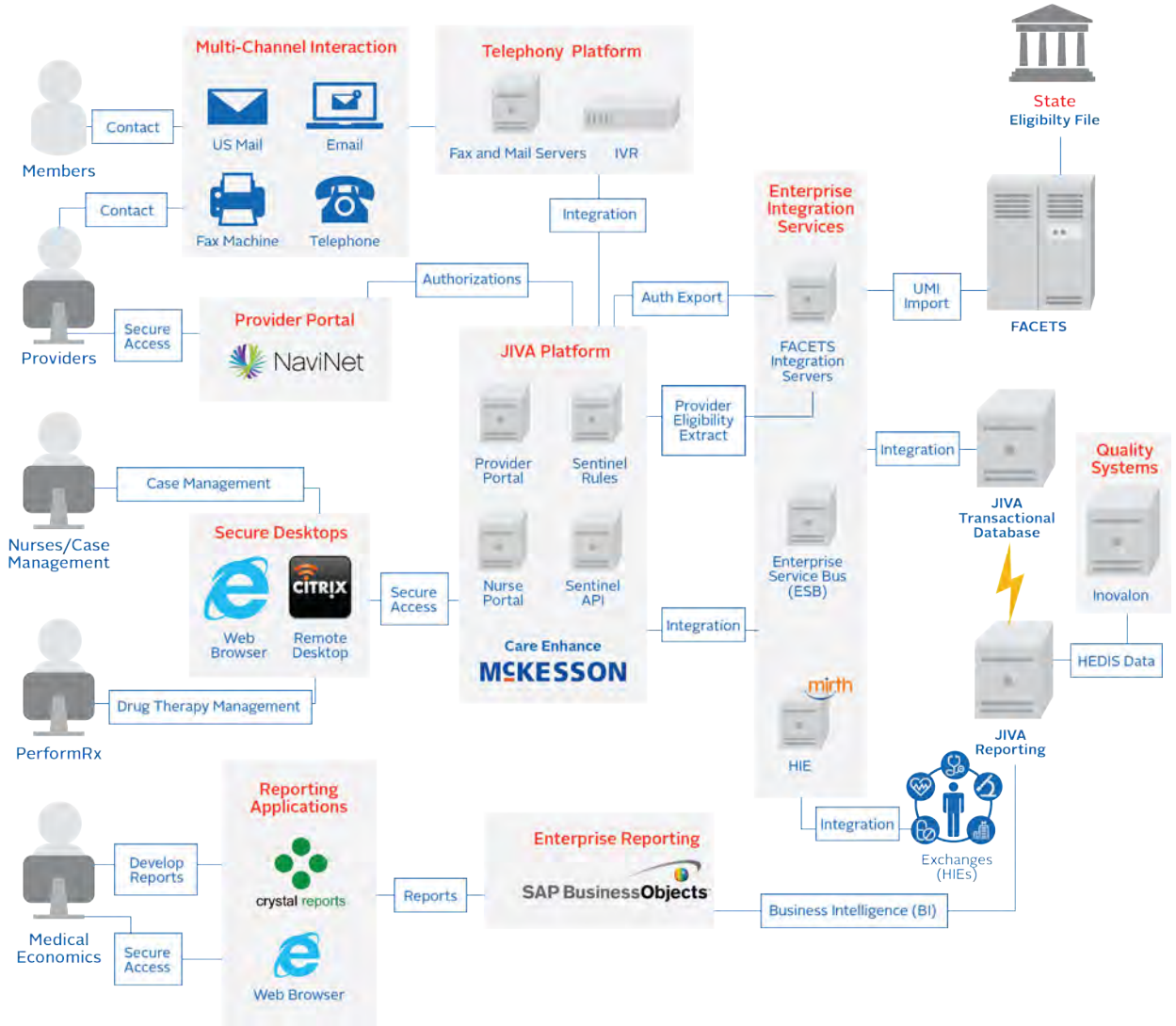


Exhibit 13.1-C: Care management transaction flow diagram

ZeOmega Jiva™

Jiva is AmeriHealth Caritas' core care management platform, which provides a 360-degree view of the member by integrating access to medical, pharmacy, lab and behavioral health data. This information will feed AmeriHealth Caritas Iowa's utilization management, Case Management, disease management and quality management strategies. Jiva's broad range of capabilities will enable AmeriHealth Caritas Iowa to provide quality healthcare to members while strengthening relationships with members and providers, optimizing operational efficiencies and managing healthcare costs.

Jiva stores evidence-based clinical pathways that will enable AmeriHealth Caritas Iowa's Care Management and Rapid Response teams to help members through efficient and holistic management of chronic conditions, pregnancy and pediatric preventive care. The application also enables AmeriHealth Caritas

Iowa's Care Management staff to coordinate and collaborate with providers to improve health outcomes across shared populations, primarily through care gap alerts.

Additional detail on Jiva is provided in section 13.1.7 below.

McKesson CareEnhance

McKesson's CareEnhance® Review Manager Enterprise (CERMe) is a decision-support system that leverages InterQual® Criteria. CERMe is integrated into Jiva and is used as a guideline for medical necessity determinations.

Inovalon

Inovalon HEDIS Advantage™ (formerly Catalyst Quality Spectrum®) is a NCQA-certified platform used for HEDIS reporting, provider profiling and the generation of care gap intelligence.

NaviNet Provider Portal

AmeriHealth Caritas Iowa will use the NaviNet Provider Portal to enable Iowa providers with a single point of access for the clinical insights they need to better care for their patients, as well as a seamless integration of AmeriHealth Caritas Iowa administrative transactions into their existing workflow. This portal is multi-payor, and is already used by 60 percent of Iowa providers. This will enable them to conveniently access information on "day one" with no need to subscribe or enroll for NaviNet. AmeriHealth Caritas Iowa and NaviNet will provide onboarding support for any providers not currently using NaviNet as needed. AmeriHealth Caritas has deep experience with NaviNet and currently uses it with other State Medicaid plans.

In addition to the convenience of accessing its Provider Web Portal, AmeriHealth Caritas has built a set of services in the portal that exceed the capabilities of many other provider portals. These features include a core set of self-service capabilities, a set of advanced services primarily focused on sharing care information with providers to improve quality and several new services for Iowa that will address the specific needs of that market. These services are all accessible through NaviNet, leveraging single sign-on capabilities with a broad set of AmeriHealth Caritas systems.

Provider Portal capabilities include:

- Secure log-in — ensures that the information in the portal is HIPAA compliant and secure.
- Eligibility and benefits inquiry — provides real-time checks against our enrollment system to validate and provide details on the eligibility status for our health plan, including information on the current PCP, copays and other essential information.
- Claim status inquiry — provides real-time inquiry against our claims system to deliver up-to-date information on the status of a claim including where it is in the payment process, detailed information on every claim line and detailed and usable information on the disposition of the claim.
- Authorization submission and inquiry — offers providers the ability to submit, update and look up the status of authorizations as both a requesting and servicing provider. Authorization submission includes the ability to provide all required information, apply rules and auto-adjudicate in real-time.
- Reporting — supports a wide range of reports at the practice level including panel rosters, gaps in care for members in the practice and pay for performance summaries. The reports allow providers to filter and sort the data, pull as PDF files or download in Excel, which the practice can then pull into its EHR system. A wide range of reports have been developed, depending on the requirements of the health

plan, including ER visits, claim status by date range and type, capitation roster, and authorization status.

- Gaps in care alerts — automatically notifies providers when a member has a gap in care such as a missed well-child visit or mammogram.
- Member care profiles — offers providers a comprehensive set of information on the member's medications, encounters, diagnoses, gaps in care, labs and radiology procedures. The profile is particularly useful to providers who are first encountering a member and lack a complete and reliable history. High utilization of this tool has been observed in ERs, specialists and home health.
- Quality dashboards —will enable providers to identify quality gaps and drill down to the individual patient and provider level to address those gaps.
- Care plans and assessments — will offer the PCP and other care team members easy access to, and updating of, the member's assessments and care plans. This capability exists today for plans involved in complex case management and will be extended to AmeriHealth Caritas Iowa.

Member List (limited to 1,000 members)

This list includes all patients who are attributed to the provider and who have had one or more Potentially Preventable Readmissions during the latest 12 months for which data is available.

Export All 36 Members

Search:

Show 10 entries

Member ID	Member Name	Age	Gender	Base Risk Group	Physician Name	PPR Admits
1008720	MARTIN (DE-ID), EDNA U	42	F	Moderate Chronic Substance Abuse and Other Moderate Chronic Disease	PAMELA Y. KING (DE-ID) MD	2
1011236	JONES (DE-ID), KAREN Y	39	F	One Other Dominant Chronic Disease and One or More Moderate Chronic Disease	JOAN P. EVANS (DE-ID) MD	2
1419034	SMITH (DE-ID), SHANNON U.	63	F	Diabetes - 2 or More Other Dominant Chronic Diseases	JOAN P. EVANS (DE-ID) MD	2
164200	LEWIS (DE-ID), SCOTT Y	47	M	Dialysis with Diabetes	CHARLES G. PEREZ (DE-ID) MD	2
190403	SMITH (DE-ID), KEITH O.	65	M	Other Nondominant Malignancy and Other Moderate Chronic Disease	VIRGINIA Z. PEREZ (DE-ID) MD	2
421489	HILL (DE-ID), ALICE S	63	F	Congestive Heart Failure and Dementing Disease	DOUGLAS A. MITCHELL (DE -ID) MD	2
480109	SCOTT (DE-ID), JESSE O	39	M	One Other Dominant Chronic Disease and One or More Moderate Chronic Disease	CHARLES G. PEREZ (DE-ID) MD	2
491409	CAMPBELL (DE-ID), KATHY O	48	F	Other Dominant Chronic Disease and Moderate Chronic Substance Abuse	LISA K. WILLIAMS (DE-ID) MD	2
519080	WILSON (DE-ID),	43	M	Other Nondominant	JOAN J. THOMPSON (DE-ID)	2

Exhibit 13.1-D: Panel summary – patients with preventable events

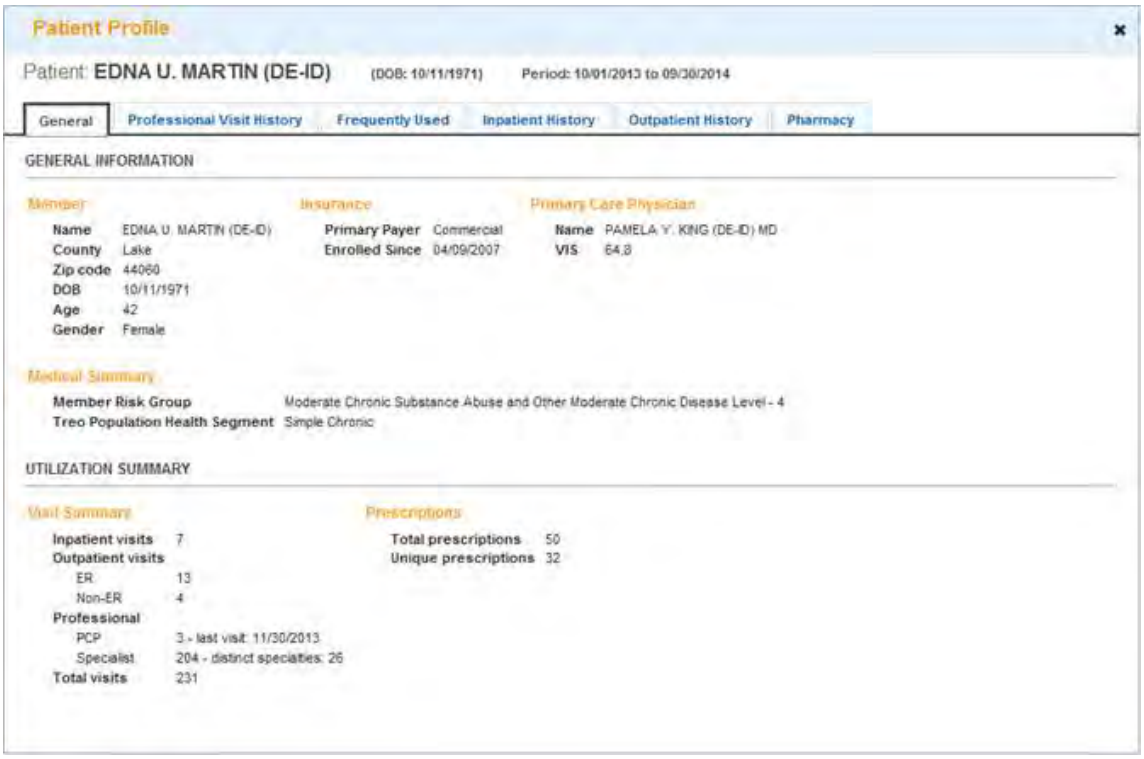


Exhibit 13.1-E: Patient detail via AmeriHealth Caritas Iowa Provider Portal

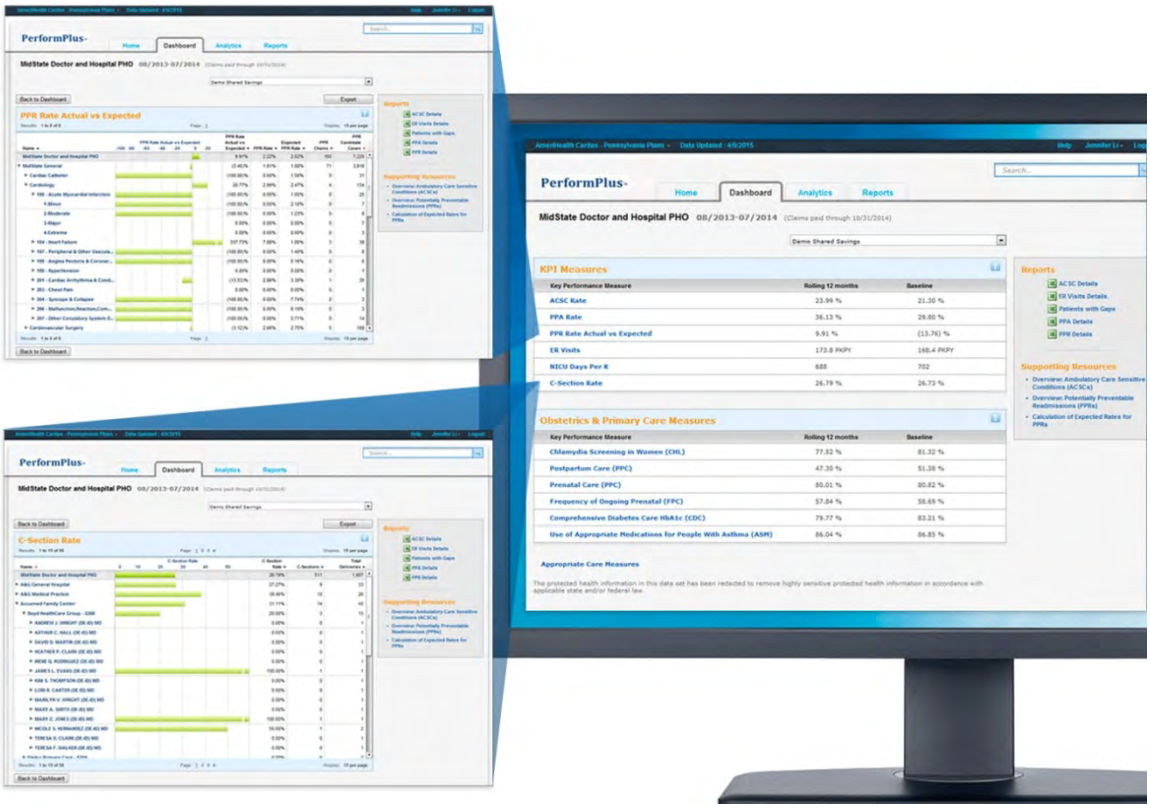


Exhibit 13.1-F: PerformPlus® provider performance management dashboard

Mirth for health information exchange (HIE)

AmeriHealth Caritas has created a scalable and adaptable exchange infrastructure to support enterprise-wide integration with health information exchanges across the nation. AmeriHealth Caritas adopted Mirth as the enterprise's HIE platform. The application is capable of exchanging messages in industry-standard admission, discharge and transfer (ADT), continuity of care document (CCD), and consolidated clinical document architecture (C-CDA) formats. Using Mirth, our affiliate in the District of Columbia connected to the Chesapeake Regional Information System for Our Patients (CRISP) exchange and began receiving messages in 60 days. AmeriHealth Caritas anticipates that a similar time to market can be achieved with the Iowa Health Information Network.

One of Mirth's key functions is the ability to intelligently direct messages to the appropriate care team. For example, routing mechanisms are configured for members with chronic conditions, pregnant members, members classified as super-utilizers or members in lock-in programs.

Race, ethnicity and language (REL)

Our custom module collects race, ethnicity and language (REL) data on our members in addition to and without overwriting the 834 information sent by the enrollment broker. This module is fully integrated with Jiva and Facets and will enhance AmeriHealth Caritas Iowa's ability to help our members access the care they need.

Once collected, the REL data is available in all member services and care management systems. It is analyzed on a bi-annual basis to report race, ethnicity and language trends in our plan membership.

Culturally and linguistically appropriate services (CLAS) coordinators use the collected REL data to identify health disparities and prepare culturally appropriate disease management programs, brochures and services for members. The granular-level data the plan collects enables specific sub-category-targeted interventions for the most vulnerable populations in a general race or ethnicity category.

Additionally, HEDIS and CAHPS results are analyzed by REL data to identify health disparities. To this end, interventions are designed to close any gaps in specific cultural populations. As an example, one of our plans used the REL information from the disparities identified based on the HEDIS REL Reports to develop a brochure targeted to African-American members on the importance of the postpartum visit.

Common business services information systems

AmeriHealth Caritas' common business services information systems and applications provide common functionality to support our business services for providers and members.

The following diagram highlights the common business services transaction flow followed by descriptions of applicable technologies:

AmeriHealth Caritas – Common Business Services Transaction Flows

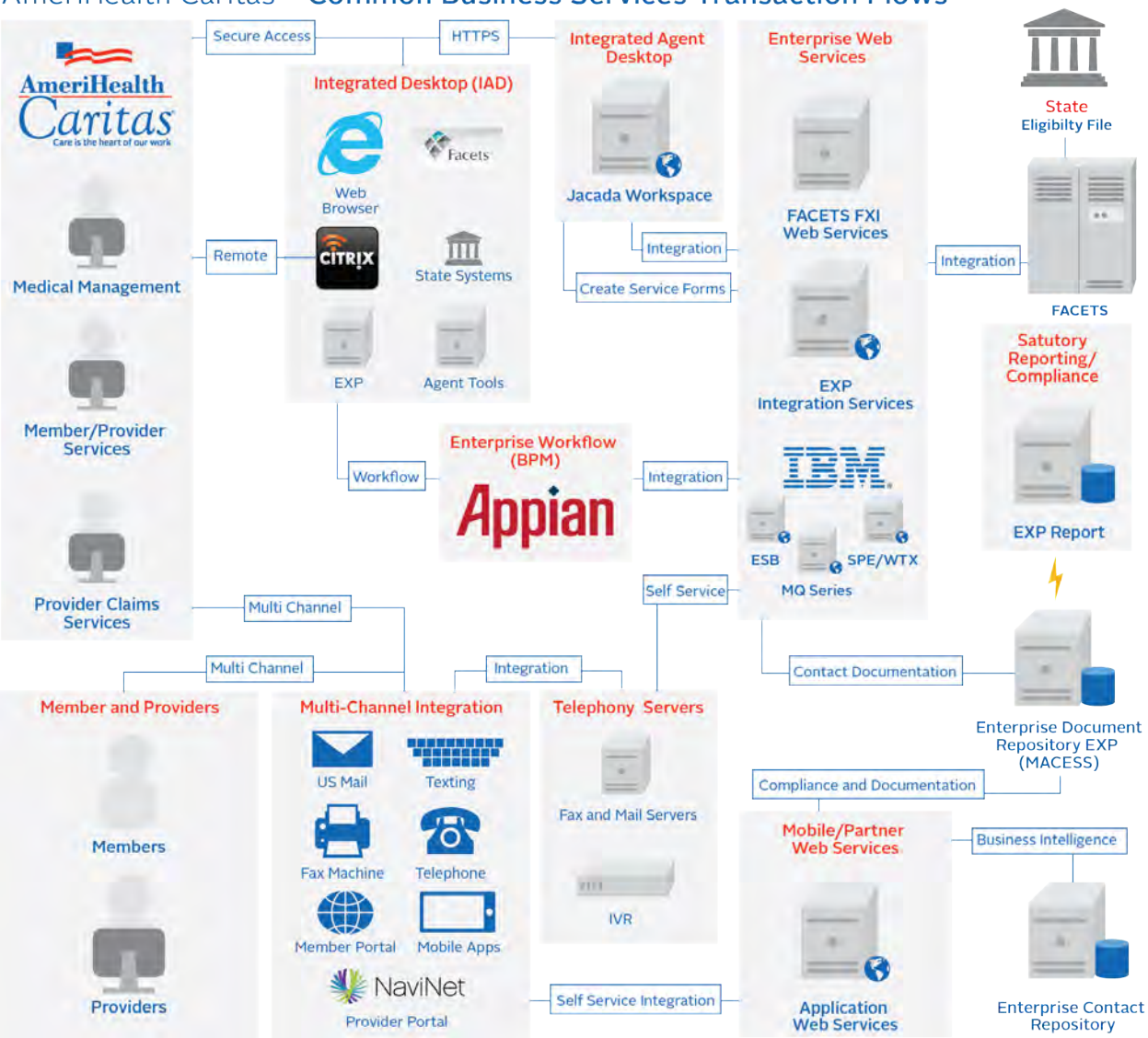


Exhibit 13.1-G: Common business services transaction flow diagram

Enterprise document management — SunGard EXP MACESS™

SunGard EXP MACESS™ is our enterprise document management platform. The platform supports storage and retrieval of documents and images and contains workflows customized for managed healthcare organizations, supporting care management, claims management, provider management and customer service needs. AmeriHealth Caritas uses EXP MACESS to support plan operations and care management staff with automated workflows in managing documents across corporate and regional functions and locations.

EXP MACESS indexes electronic images of documents to facilitate high-performance search functions across all records pertaining to members and providers. The system utilizes an SQL Server database to store logical relationships between key data elements such as member, provider and claim identification numbers. These relationships streamline the process of monitoring particular events, such as transactions or customer service interactions, by enabling staff to easily find, retrieve, update and archive records

across multiple systems. They also directly support reporting tools that enable managers to monitor workflow, identify bottlenecks and increase efficiency.

Appian Business Process Management (BPM)

Appian BPM is a workflow management platform that allows for the automated orchestration of business processes in an optimized and efficient manner. The platform supports Business Process Management Notation (BPMN) to provide a graphical representation that business experts can update directly. The platform also supports Business Process Execution Language (BPEL) to model the behavior of real-world business processes. BPMN and BPEL together define and orchestrate processes that fit into the plug-and-play architecture foundation at AmeriHealth Caritas.

For example, for an "on-site provider visit" business process, the AmeriHealth Caritas provider credentialing team can visit a provider facility, complete an on-site visit and upload the site visit evaluation form along with any pictures of the facility in real time to our credentialing system. The workflow immediately transfers to our Provider Enrollment team to complete the contracting process. BPM supports role-specific user interfaces, real-time news feeds, task routing, queue management, monitoring, tracking and notification of work items at different status levels to task performers and their supervisors.

Jacada Integrated Agent Desktop (IAD)

IAD provides contact center associates the ability to access several enterprise systems (such EXP MACESS and Facets®) from a single, convenient desktop screen. All aspects of member and provider information are displayed for fast reference during calls with members and providers, leveraging computer telephony integration (CTI) capabilities. The IAD product self-documents the contact with the member or provider and stores this information in EXP MACESS. This provides Member Services representatives with a full view of the member's past experience and speeds service for their current needs.

Avaya Call Management and Interactive Voice Response (IVR)

The Avaya Aura Contact Center and Verint Impact 360 Workforce Optimization Suites are configured to ensure optimum performance and high availability of services required to support our 24/7/365 contact center. Features of the contact center include:

- IVR for self-service capabilities that include eligibility inquiry, form faxback, requests for identification cards and provider directory requests.
- Simultaneous recording of call and desktop screen activity for quality auditing purposes.
- Telephonic responses to provider claim status inquiries.
- PCP selections based on multi-point geographic location, preferences for gender, languages spoken and affiliations.
- Automatic Call Distribution (ACD) System, which features member/provider messaging, assignment based on availability and skill set, transfer and detailed measurement and reporting.

Mobile applications

AmeriHealth Caritas Iowa will offer a suite of member engagement tools that leverage mobile technologies as a supplement to traditional forms of communication. These tools are designed to address the member as a "consumer," not a "recipient," and are driven by three key consumer-centric principles:

- Convenience — Members lead busy lives and as a result they look for convenient ways to interact with their health plan. Our mobile tools provide meaningful reminders and real-time information about the entire family unit.
- Informed decisions — Members have many health and wellness options. Our mobile tools help them make better choices about their healthcare from selecting a provider to understanding their medications.
- Choice — Members will respond best if they have a choice in how and what communications they receive. Our mobile tools offer the member choices about how to engage the plan that can be easily changed as their preferences change.

AmeriHealth Caritas' member mobile application provides:

- PCP information and a provider directory with integrated maps allowing members to easily find directions to their PCP or a provider from the directory.
- One-touch dialing making it easy for a member to contact their PCP or a provider from the directory.
- Virtual member ID card that can be displayed having the same format and information as directed by the state agency for the physical ID card.
- Medication list for the member and their family, facilitating a more accurate relaying of medications to caregivers.

AmeriHealth Caritas is currently implementing the next release of this core member mobile application, to be launched in the fourth quarter of 2015, and available for AmeriHealth Caritas Iowa members. It will include new features for enhancing member management of their healthcare and additional self-service capabilities, including:

- Alerts and reminders to members (app-based or text messaging) when certain health actions come due (e.g., medication refill reminders and preventive health screenings such as mammograms and colorectal screenings). Alerts can be selected for the member only or for the entire associated household.
- Expanding the PCP information feature to include the whole care team, along with one-touch calling to the office and directions and maps to the office.
- Self-service alternatives for high-volume phone service requests, for example, new ID cards and PCP changes.
- Access to a community services resource directory that lists important non-health plan services (organization names, contact information and directions), such as housing, food and nutrition, child care and transportation.
- Telehealth integration, providing easy access to appropriate telehealth services for the member.
- Links to specialized mobile apps that focus on specific member conditions. For example, standalone mobile apps that address the needs of pregnant members, diabetics and asthmatics will be available. Furthermore, based on the needs of AmeriHealth Caritas Iowa, AmeriHealth Caritas will provide specialized mobile apps that offer self-management tools and education around the member's specific conditions.
- The Due Date Plus maternity app from Wildflower addresses the needs of low-income women who are pregnant. Due Date Plus enables the member to monitor her pregnancy, offers useful educational tips and supports early detection of at-risk members. Weekly messages are sent to the member to help

her understand the stage of her pregnancy based on her due date. Reminders are provided for physician appointments and other key events. Alerts are delivered with educational content to encourage healthy behavior and activities. Monitoring tools, such as a weight gain calculator, further support the member and are sent to the health plan to alert it to issues and trigger intervention.

Texting

AmeriHealth Caritas recognizes that all mobile phones support texting and members tend to be text-messaging users. Health plan-generated texts offer an effective channel for communicating key information to members to support wellness, manage conditions and enable self-service.

Comprehensive text messaging will be offered to all AmeriHealth Caritas Iowa members, including reminders for preventive health screenings, medication refill reminders, appointment reminders and eligibility redetermination, if required. Through its experience with text messaging, AmeriHealth Caritas has developed highly effective mechanisms for enrollment and consent management.

AmeriHealth Caritas Iowa will offer the following messaging programs:

- Condition management texting programs — are programs that support members with the management of specific conditions such as pregnancy, asthma and diabetes. These programs are typically managed through a vendor product that offers a specific engagement approach, expertise in educational and medical practice information and analytics to monitor members' experiences and progress. AmeriHealth Caritas is currently employing texting for an asthma program and a pregnancy program. The asthma program provides educational content, medication reminders, alerts for environmental condition changes and analytics reported back to the plan. The pregnancy program is testing a new technology that segments members based on receptiveness to particular message styles and customizes messages on that basis. Condition-specific messaging is an evolving discipline and AmeriHealth Caritas will continue to monitor, test and adapt its offerings to achieve the highest level of adoption and impact.
- Keys to Your Care — is a program to improve pregnant member physician visit compliance. This program combines texting around healthy behaviors and member prenatal visit reminders with a rewards program including gift cards and a final reward of a baby crib if the member meets her required number of visits. Texting allows members to track the points they have earned.
- Discharge Alert Program — is an innovative texting program intended to reduce unnecessary ER visits and improve follow-up care. The program leverages real-time hospital discharge notifications that are made available to AmeriHealth Caritas. The immediacy of these notifications allows the plan to text the member within 24 hours of discharge with reminders of the PCP phone number to encourage follow-up care and more appropriate utilization.
- Tracfone free phone program — will be implemented for AmeriHealth Caritas Iowa. It has currently been approved by states for five (5) of AmeriHealth Caritas' affiliates. In less than a year, over 5,000 free phones have been distributed to eligible members. All of these phones are text-capable, making them available for the texting programs.

Exhibit 13.1-H: Sample mobile applications screenshots

Telemedicine

AmeriHealth Caritas has a long history of being a committed partner to State Medicaid agencies and other stakeholders. Throughout our history, we have developed programs that speak to our nimbleness and ability to evolve delivery of services and programs unique to each state and market, rather than applying a corporate solution broadly across all markets and products. This approach allows us to leverage our national presence, while adopting a local perspective in affordably connecting underserved populations with high-quality healthcare. We seek out and partner with local organizations in tailoring customized solutions to foster an integrated approach to care management.

Telemedicine is a top priority for AmeriHealth Caritas. For Iowa, AmeriHealth Caritas will build a telemedicine program in collaboration with our providers that meets the unique needs of Iowa members. This will greatly increase efficiency, efficacy and participation for members, enable providers to deliver quality care and maximize cost effectiveness for members, providers and the State. Our goal is to develop a telemedicine program that both integrates with and enhances the existing Iowa telemedicine infrastructure and supports the future direction for telemedicine in Iowa. 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. Our enhanced telemedicine offering would augment (not duplicate or replace) the current capabilities available through other platforms and would be developed in conjunction with key stakeholders.

Bringing telemedicine innovations to Iowa Medicaid members

Under certain circumstances in which it is determined that a member has a significant barrier to accessing an originating site, AmeriHealth Caritas proposes, as an enhanced benefit, to enable members to have a telehealth visit at home or in a convenient location using their own equipment, such as a desktop computer, standard laptop or mobile phone. By enabling access to telemedicine with a standard computer connection, deploying a telemedicine solution to a new location will be easy and cost-effective.

Our proposed telemedicine expansion will deliver convenient 24/7/365 access to care when and where the participating members need it. These proposed initiatives will provide documented, safe, effective and traceable telehealth programming directly to the participating member and will be capable of linking the member directly to their care team, PCP or specialist for unparalleled collaboration and access to care.

Access will expand to include members and providers previously unable to participate in telehealth initiatives due to equipment costs, technical staff capability or technical hardware access. Members and providers in congested urban areas as well as far-reaching rural areas will be able to speak with healthcare professionals locally or from regional centers of excellence conveniently on their own schedules, using safe and secure technologies and their own equipment.

Our solution will offer the capability to access telemedicine service via phone, Web, kiosk and mobile devices delivering high-quality audio and video connectivity. There will be no need for specialized video equipment, making telemedicine cost effective for providers and allowing for easy set-up and portability.

Providers will receive documentation and training from AmeriHealth Caritas on how to use the application, the proper procedures for conducting a telemedicine visit and how to bill for the service. PCPs will be educated about the availability of various telemedicine options for their consideration when making referral decisions.

Our telemedicine solutions will enable seamless and secure virtual collaboration between medical professionals and members. The platform will be HIPAA compliant and provide access to real-time data.

Telemedicine for physical health visits at the behavioral health office/behavioral health visits at the physical health office

This service will be provided to behavioral health members in rural areas who have large distances to travel to either a physical health provider or behavioral health provider or members who require a collaborative appointment with the provider. Members can schedule a telemedicine visit at the behavioral health site with the physical health provider or vice versa. The member will interact with the provider via video conference equipment that is located at the site. A nurse practitioner or medical assistant at the originating site will be available to help connect the member to the specialists, troubleshoot issues or take diagnostics. If collaboration is required, the provider at the originating site and the member can conference in the other provider. Additionally, the member's care manager or another health professional can simultaneously be conferenced into the telemedicine visit for further collaboration.

Telemonitoring

AmeriHealth Caritas provides telemonitoring in partnership with Physician Preferred Monitoring (PPM). AmeriHealth Caritas care managers identify members with congestive heart failure or poorly controlled chronic diabetes and direct PPM to provide home monitoring equipment. Members receive an in-home monitor to capture their weight, blood glucose and other biometrics. The vendor reports abnormal results to the member's care manager and PCP.

Top Down CLIENT LETTER®

CLIENT LETTER® provides powerful, yet easy-to-use tools for creating, managing and distributing customer correspondence and other multi-channel communications. The CLIENT LETTER application provides the ability to produce correspondence on demand as well as in batch mode. Correspondence can be distributed in several fashions including, but not limited to, print, fax and email. When necessary, letters can be sent to queues to ensure specific correspondence is reviewed at the appropriate level before distribution. Libraries housing an unlimited number of custom templates keep the variation of "like-letters" streamlined for efficient creation and maintenance.

The following common business services support data, reporting and analytics.

Cloudera Hadoop

AmeriHealth Caritas has implemented a data lake approach using Cloudera's Apache Hadoop platform. The Hadoop platform is the core of what is now referred to as big data analytics. Hadoop is an open source software project that enables the distributed processing of large data sets across clusters of commodity servers. It is designed to scale up from a single server to thousands of machines, with a very high degree of fault tolerance. Hadoop offers massively parallel and scalable processing power and disk space at a fraction of the cost of data appliances. Hadoop enables AmeriHealth Caritas to store massive amounts of both structured and unstructured data from unlimited sources. In addition to standard claims and operational data, data from social media sites, biometric sensors (blood glucose monitors, scales, blood pressure cuffs), HIEs and any number of new data streams can be seamlessly imported and made available to the organization quickly.

SAP BusinessObjects Web Intelligence

Web Intelligence (WebI) provides flexible, intuitive reporting tools and interactive analytics through a Web-based platform.

Microsoft Power BI

Microsoft Power BI is used in two ways. First, as a solution integrated with vendor products such as ZeOmega Jiva, our clinical-care management platform. Second, as a self-service analytics solution for reporting on combined enterprise (data warehouse) and departmental (local spreadsheets) data sources.

SAP BusinessObjects Crystal Reports

SAP BusinessObjects Crystal Reports is used to develop standard, formatted reports about claims, membership, provider, authorizations and care management data, such as member service verification letters that include logos and specific formatting requirements.

SAS® Business Analytics and Business Intelligence Software

SAS® Business Analytics and Business Intelligence Software is used for advanced analytics, including data management and predictive analysis. For example, predictive models are being developed specifically around a combination of small geographical zones, such as census tracts, in conjunction with network access information, cultural, ethnic and derived behavioral metrics to enable us to identify care disparity that impacts member health at a neighborhood level. Deployed solutions include:

- SAS® Visual Analytics for data discovery and advanced visualizations.
- SAS® Office Analytics for on-demand, self-service analysis.
- SAS® Enterprise Miner for predictive modeling.

- SAS® Enterprise Guide for standard analysis.

Enterprise integration services

AmeriHealth Caritas enterprise integration services provide the capabilities to support a multi-channel engagement with providers and members. Enterprise integration services enable the AmeriHealth Caritas "no wrong door" member contact capability.

AmeriHealth Caritas maintains a “plug-and-play” architecture to support robust integration on existing technologies and facilitate the ease of integrating new technologies. Plug-and-play leverages readily available, out-of-the-box adapters to integrate with healthcare applications. Functionality being supported by these applications is made available across the enterprise as enterprise services to both internal and external requesting systems, subject to appropriate security mechanisms.

Enterprise service bus (ESB)

A central bus on which everything passes gives opportunity for additional layers of abstraction, which reduces disruption of services due to technology changes.

AmeriHealth Caritas manages ESB capability with IBM Integration Bus (IIB), which is a service-oriented architecture (SOA)-based solution. The ESB provides abstraction built on industry standards to make connecting applications, new services, data sources and clients with disparate needs relatively easy. Interoperability is achieved through protocols supported by IIB such as SOAP/HTTP(S), SOAP/JMS, XML/JMS, XML/HTTP(S) and REST for Web services; SFTP/FTP for batch file transfers; ODBC/JDBC for databases. Additionally, Base-64 compressions on documents and images allow us to manage document transmissions directly through the ESB.

AmeriHealth Caritas platforms for core administration, Provider Network Management, care management, Contact Center of Excellence and portals leverage the services exposed through our ESB.

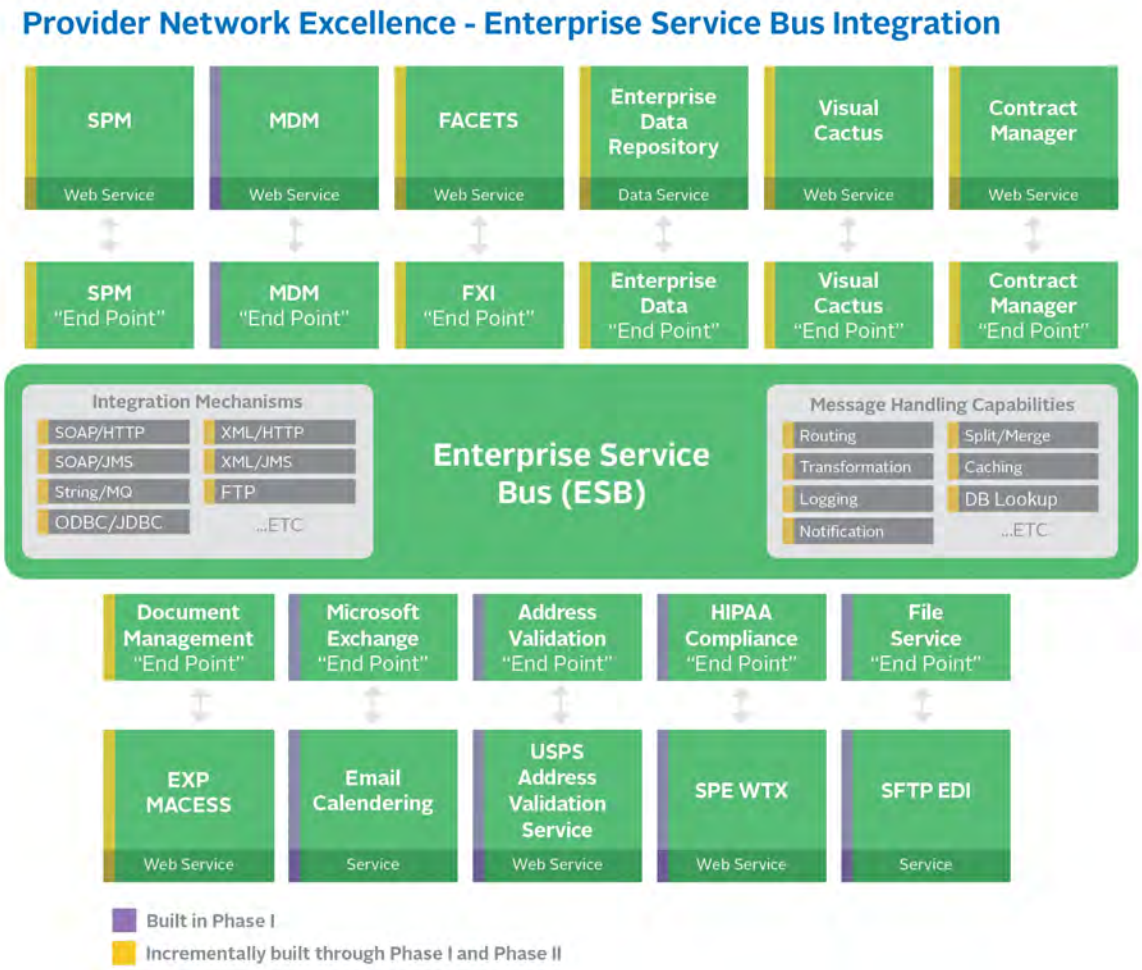


Exhibit 13.1-I:Enterprise service bus

- IBM MQ Series:
  - AmeriHealth Caritas implemented IBM MQ Series as a robust messaging middleware that simplifies and accelerates the integration of diverse applications and business data across multiple platforms. IBM MQ facilitates the assured, secure and reliable exchange of information between applications, systems, services and files by sending and receiving message data via messaging queues, thereby simplifying the creation and maintenance of business applications. It delivers universal messaging with a broad set of offerings to meet enterprisewide messaging needs, as well as connectivity for the “Internet of Things” and mobile devices.
- SFTP/Direct Connect:
  - AmeriHealth Caritas provides a secured file transfer capability for external entities to exchange data files in a batch mode leveraging SFTP or secure virtual private networks (VPNs) across the Internet. These data exchanges include, but are not limited to, eligibility/enrollment data, claims/encounters data for physical health, behavioral health, pharmacy, laboratory results, vision and dental.
- IBM WebSphere Transformation Extender (WTX)/standards processing engine (SPE):

- AmeriHealth Caritas has implemented WTX, a universal data transformation solution to transform large data volumes of any format to a different format efficiently and effectively.
- In addition to WTX, AmeriHealth Caritas has implemented SPE, which operates on WTX, to ensure all EDI files are complete and accurate, which includes verifying claim counts as well as HIPAA compliance validation, to identify potential TA1 or 999 errors.

Corporate services information systems

AmeriHealth Caritas' corporate information system supports the enterprise finance and human resources functions. The following are descriptions of the applicable technologies:

PeopleSoft

Oracle's PeopleSoft Enterprise is an industry-leading software system that supports AmeriHealth Caritas' back-office financial and human resource administrative functions. PeopleSoft Enterprise supports the following capabilities:

- Contracting, purchasing and purchase order management.
- Accounts payable and check processing.
- Bank funds transfers.
- Asset management.
- General ledger accounting.
- Human capital management.

PeopleSoft is the authoritative source for all associate data and interfaces with ancillary internal and third-party systems such as payroll, talent management and associate training portals. Each financial application is integrated with the general ledger system for final consolidated reporting and financial statement generation through the Hyperion financial planning application.

Supplier Contracts & Purchasing

Oracle's PeopleSoft Supplier Contracts & Purchasing provides a method in which supplier contracts can be built using standardized terms and purchase orders, and requisitions generated and approved through appropriate levels of management. Purchasing also serves as the communication tool for suppliers by providing the authorized purchases for the organization to each vendor for fulfillment.

PeopleSoft Payables

Oracle's PeopleSoft Payables provides automated invoice and payment processing to ensure timely and accurate payment for goods and services. We employ best-practice business processes, matching purchase orders, receipts and invoices with online approvals, increasing control over disbursements.

Enterprise Cash Management

Oracle's PeopleSoft Enterprise Cash Management module enables AmeriHealth Caritas to monitor and forecast cash requirements, perform automated bank reconciliations, distribute payments and automatically generate accounting entries. Cash Management's straight-through payment processing feature, Financial Gateway, provides a single platform for seamless communication among banks, financial institutions and corporations to process payments and receipts.

Asset Management

Oracle's PeopleSoft Asset Management is a repository of asset data and provides complete visibility into assets throughout AmeriHealth Caritas. Asset Management facilitates the tasks of adding, transferring, depreciating and retiring assets as they progress through their useful life.

General Ledger Accounting

Oracle's PeopleSoft General Ledger is the system of record for the enterprise chart of accounts and the central repository for all financial data. The General Ledger module is integrated with all other PeopleSoft sub-modules so the financial impact of different transactions is recorded. It is also integrated with the claims system and other external systems that generate financial transactions to track and monitor plan expenditures so that final consolidated reporting can be completed within Hyperion.

Hyperion

Oracle Hyperion Financial Management is a financial consolidation and reporting application. It provides financial managers the ability to rapidly consolidate and report financial results, meet global regulatory requirements and reduce the cost of compliance.

Human Capital Management

Oracle's Human Capital Management is the single source of associate and contractor data. Specific associate data is tracked and managed as well as the benefits provided to each associate. This information is sent to the ADP payroll system to calculate deductions and payroll costs.

Claims clearinghouses

AmeriHealth Caritas accepts claims through a number of clearinghouses, including Emdeon, ZirMed, NaviNet and HDX. We primarily partner with Emdeon, which has a large footprint in provider offices and receives “pass-through” claims from other clearinghouses. As a result, providers who submit electronic claims to payers will find it quick and easy to submit electronic claims to AmeriHealth Caritas Iowa.

Emdeon Provider WebConnect offers real-time transactions, improved efficiency and reduced expenses through a personalized, payer-branded portal. Providers access our secure portal through the Web for direct claim entry submission, real-time eligibility and benefit verification, and claim status inquiries. Provider WebConnect is Web-based, with no requirements for specialized software or management systems, intermediary vendor relationships or transaction fees. This helps promote electronic claim submission, especially among smaller practices and rural providers with low claim volumes, including physical therapists, durable medical equipment and home health providers. Providers simply complete a self-service registration and initial setup process. Online training is offered to assist with the initial setup process and to address any product support inquiries.

Emdeon business services

AmeriHealth Caritas contracts with Emdeon to process electronic fund transfers (EFTs). Emdeon’s ePayment enables providers to sign up once and connect to all payers in Emdeon’s network. This eliminates the time and effort needed to set up multiple EFT connections to providers’ banks.

AmeriHealth Caritas promotes EFT services to our provider community through our communication channels, including links on the Provider Web Portal, newsletters, inserts into paper remittance advices and IVR messaging.

Maximizing collaboration through shared data

As AmeriHealth Caritas Iowa works in partnership with DHS, information sharing will be critical in maximizing efficiency and maintaining high quality of care to our members. This can be accomplished through a variety of media including electronic file transmissions, fax or real-time application program interfaces with State systems. Some of the methods AmeriHealth Caritas has implemented with other State agencies to reduce duplication of efforts include:

- Providing a return member file containing updated member demographic, address, contact and primary care data. This data allow for better synchronization across systems and less data maintenance.
- Providing a return TPL file to DHS which will contain updated TPL and carrier data identified through third parties or from the member.
- Providing 837 encounter files to DHS.
- Providing enhanced data files in accordance with the CMS program for the Transformed Medicaid Statistical Information System (T-MSIS). Our Louisiana affiliate has worked closely with its State agency and vendors to build and test T-MSIS revisions, including the delivery of a supplemental provider registry file.

2. Describe data back-up processing plans including how data is stored at an off-site location.

AmeriHealth Caritas uses redundancy, resiliency and scalability as central design principles in our physical infrastructure, network topology, databases and application servers to ensure the availability of all our data and data processing systems. Redundancy ensures everything operates through a secondary path, should the primary path become nonfunctional.

Our high level of resiliency results in system availability and the ability to quickly recover.

AmeriHealth Caritas maintains primary and secondary data centers that feature disk-based data replication of all business critical data as well as hot-standby infrastructure and application components. Both the primary and secondary data centers are Tier 3 certified. The primary and secondary data center configuration ensures recoverability, guaranteeing minimal disruption to critical member and business functions in the event of a disaster.

AmeriHealth Caritas employs high-availability, state-of-the-art monitoring and systems management applications and strategies to support 24/7 systems availability for all core platforms and business applications. This includes member and provider portals and phone-based functions and information, such as eligibility inquiries (confirmation of Care Management Organization Enrollment [CCE]) and the healthcare benefits administration platform (electronic claims management [ECM]). Member Services and Provider Services are available to users 24 hours per day, seven (7) days per week, except during periods of scheduled system unavailability as will be agreed upon by DHS and AmeriHealth Caritas Iowa.

Ensuring availability of core systems

AmeriHealth Caritas has addressed increased demand for availability, performance and reliability from information and telecommunication systems by developing comprehensive Service Level Agreement (SLA) policies and procedures that are supported by staff dedicated to each core domain, such as network, database and security.

Critical application performance and availability metrics are tracked and maintained in accordance with contracted SLAs. Network and Systems SLA performance is maintained at consistently high levels by dedicated technical experts that select, maintain and upgrade infrastructure components in their domain. These experts continuously monitor the performance and stability of their information and technology systems to identify and proactively address issues before they impact plan functions or customer experiences. This results in improved levels of availability, performance and reliability.

AmeriHealth Caritas leverages these staffing and monitoring strategies to ensure that we exceed all of the availability and business continuity/disaster recovery standards set forth by the State. During AmeriHealth Caritas' most recent disaster recovery test, AmeriHealth Caritas restored and validated critical applications and infrastructure, meeting all of our contractual obligations. Systems essential to communications with members and providers, including base telephony, IVR and member and provider portal services, are available 24/7/365. Periodic system maintenance typically does not impact these essential communications functions, but any planned maintenance that could will be communicated in advance and completed with mutual agreement between AmeriHealth Caritas Iowa and the State.

Information Systems Architecture

AmeriHealth Caritas' approach to high-availability infrastructure design includes collaboration with experts from our infrastructure and applications teams working with our business users and customers. This ensures that the technologies work together to provide an integrated, secure and reliable technology environment to support our business. The following strategies and technologies ensure high availability of core AmeriHealth Caritas' systems.

Data Center Architecture, including off-site backup

AmeriHealth Caritas's primary and secondary Tier 3 certified data centers are built with power, cooling and monitoring redundancies. The architecture is designed to continually monitor for potential failures and automatically mitigate their effects.

Two different power feeds come into both data center buildings at separate entry points. Redundant, inline Uninterrupted Power Supplies (UPS) measure and condition (balance and mitigate any spikes/drops) the incoming power. In the event of a power loss, the UPS batteries hold the data center load while a generator is brought online to ensure uninterrupted processing. Additionally, two separate power distribution units provide power to each cabinet/server rack. Power strips are metered to ensure that power load is not exceeded in each server rack.

Maintaining appropriate temperature in our data center environments is critically important to ensure hardware function. AmeriHealth Caritas' primary and secondary data centers are designed to provide uninterrupted and balanced cooling. Our server and network racks are built with alternating cold and hot aisles that allow cold air to enter through the front to cool the equipment, and hot air to exhaust to the air compressor to be re-cooled and circulated back through the equipment. Each cooling unit is internally redundant, with multiple compressors and fan kits, so they continue to operate even if part of the unit fails.

Secondary Data Center

As mentioned, our secondary data center has the same Tier 3 availability characteristics as our primary data center with a redundant network ring topology that enables the following redundancy and recovery characteristics between the primary and secondary data centers:

- Scalable computer network that links the primary data center with the secondary data center with built-in redundancy.

- Staged server solutions to support recovery in the event of a loss of the primary data center.
- Disk-to-disk recovery for all Tier 1 applications.
- Full control over enhancements and testing of the technical environment.
- Full control of the disaster recovery environment.
- Routine maintenance consistent between the primary and secondary data centers.
- Network latency of only four (4) ms between the primary and secondary data centers.

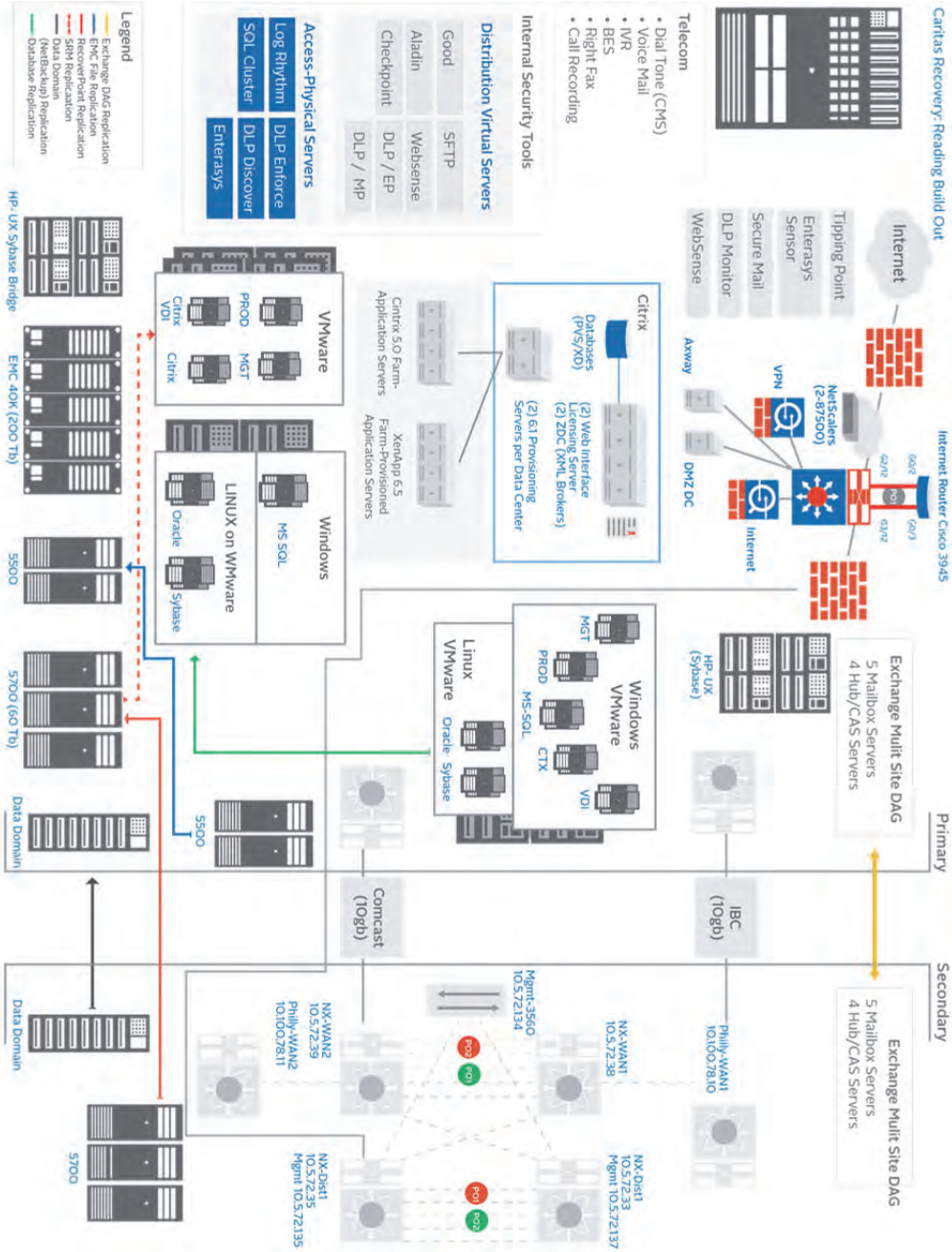


Exhibit 13.1-J:Data Center Architecture

Storage Architecture – EMC VMAX and VPLEX

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. It supports storage configuration in a highly tolerant Mirror or Raid level of protection, capable of absorbing physical disk failures. The multipath approach of cache holding data in memory engineered by EMC not only provides data protection but also improves storage performance.

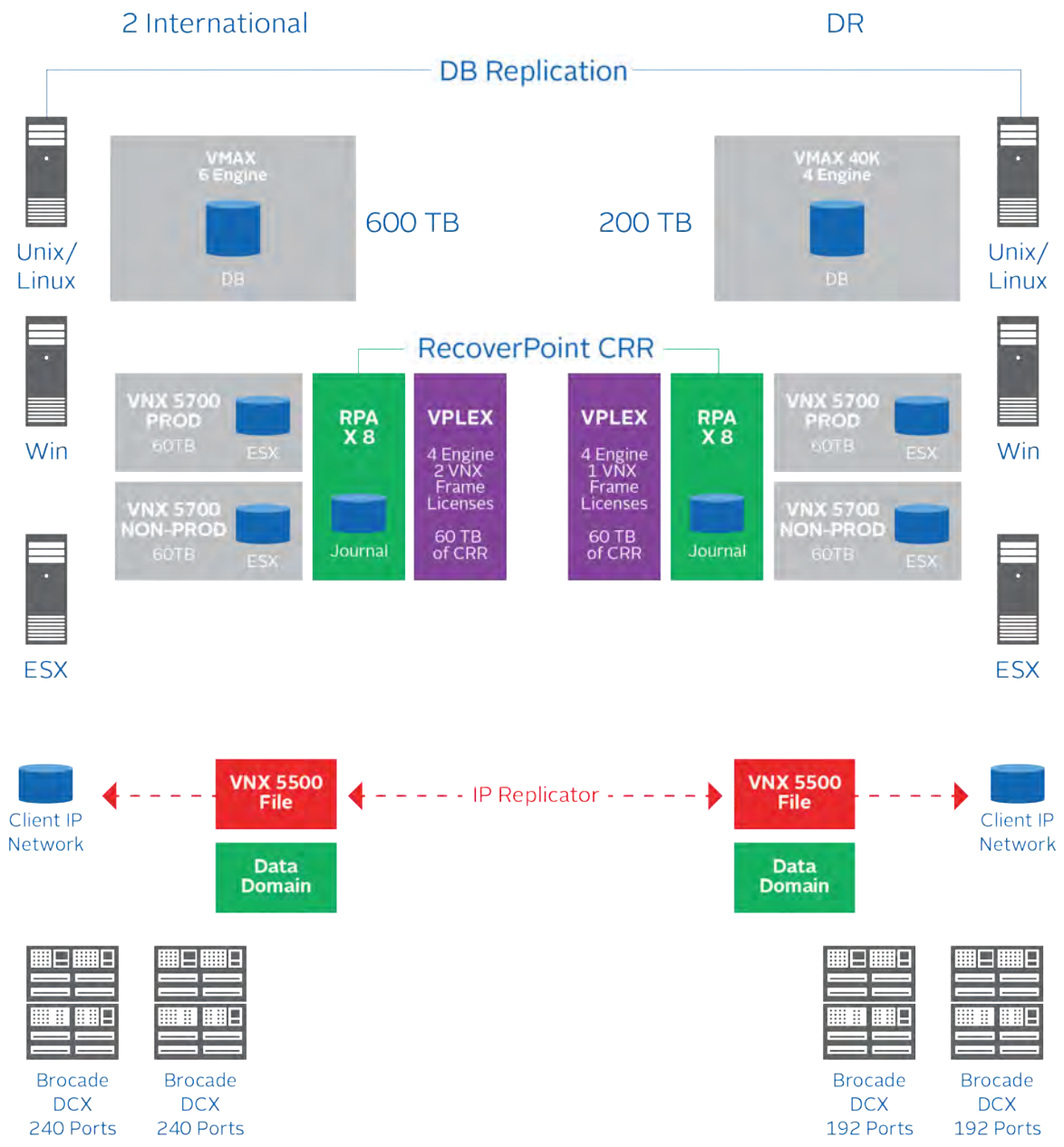


Exhibit 13.1-K: AmeriHealth Caritas' Enterprise Storage Solutions

Server access to the EMC storage is redundant through multipath switching which provides servers redundant paths to storage disks through multiple storage switches. VPLEX, another component of the EMC-based storage architecture, enables recovery points for data migration between the primary and secondary data centers, enabling us to roll back or forward across four weeks of data, if needed, during an event.

How data are stored at an offsite location

All AmeriHealth Caritas computer systems and data are backed up and safely stored for timely access and restoration in the event of loss of data and/or an unplanned disaster. The data backups address the full range of resources, including HP UNIX systems, Linux, database systems, Windows/Intel, local area network (LAN), wide area network (WAN) and voice communications (PBX and adjuncts).

AmeriHealth Caritas management has recognized the potential financial and operational losses associated with loss of data, and/or service interruptions and the importance of maintaining viable emergency response and business resumption strategies. AmeriHealth Caritas has contracted to provide off-site storage capabilities for safekeeping and securing of vital records. Storage team maintains daily, weekly and monthly backup cycles.

Backups of all critical production systems are performed in the Data Center. Access to the Data Center is via magnetic card key system. Only authorized personnel have access to the Data Center. Tapes to be sent off-site are prepared and kept in the Data Center until they are ready for pickup by the off-site vendor. All off-site bound backups are transported in secured cases.

Monthly full backups of applications and user data are performed on all UNIX, Linux and Windows servers on the last weekend of the month. Upon completion of the backups, data is replicated to a secondary data domain unit at our Disaster Recovery site for two months and subsequently replicated to encrypted tapes which are then placed in secure containers and sent off-site to the secure facility and kept for 10 years. The production Facets Sybase database dump files are exceptions. They are backed up on the last Wednesday of each month.

Weekly full backups of applications and user data are performed on all UNIX, Linux and Windows servers every weekend and stored on data domain in our primary Data Center and replicated to a secondary data domain unit at our Disaster Recovery site for two months. The production Facets Sybase database dump files are exceptions. The weekly backups for these files are performed every Wednesday.

Daily incremental/full backups of applications and user data are performed on all UNIX, Linux and Windows servers every Monday through Friday and stored on data domain in our primary data center and replicated to a secondary data domain unit at our Disaster Recovery site for two (2) weeks.

All backup tapes are bar-coded for tracking purposes and readable by our backup/recovery solution. Our backup/recovery assigns a tape serial number for inventory purposes and to reconcile tapes coming in and going out.

The storage team logs backups (e.g., LTO) to track tape movement to and from the off-site vault utilizing VRI Extranet. VRI Extranet reports complement the tape library log of activity for that particular backup cycle. All other tapes are logged into VRI Extranet, a tape-tracking product of the off-site vendor.

Upon arrival at the AmeriHealth Caritas Data Center, the off-site vendor delivers tapes in secured containers.

Sample disaster recovery plans

All AmeriHealth Caritas affiliates use a common, best-practice set of disaster recovery guidelines to ensure world-class availability and preparedness. The Attachment 13.1-A: AmeriHealth Caritas Iowa Business Continuity/DR Plan (at the end of this section) is a sample disaster recovery plans for Iowa.

3. Describe how clinical data received will be used to manage providers, assess care being provided to members, identify new services and implement evidence-based practices.

The power of clinical data is key to turning individual encounters into patterns of care that providers can use to change clinical processes, and that AmeriHealth Caritas Iowa can direct into assessing the care provided to its members. To be useful, the raw clinical inputs must be structured into a data architecture that allows consistent results. This requires uniform data entry and accurate attribution of clinical practice to the appropriate provider. Feedback must be timely and actionable. Programs with incentive structures increase the adoption of new processes to further improve outcomes.

Data to drive quality

AmeriHealth Caritas has experience in several states with improving quality of care in multiple clinical conditions simultaneously, as described in Section 10 (Quality Management and Improvement Strategies). By use of the 3M Treo analytic tools, AmeriHealth Caritas has been providing clinical practices with reports measuring more than 50 key quality indicators. Rather than focus on just two or three quality measures, our clinical practices embrace the depth of information provided in these reports. Typically, the physician practices find common process issues among those clinical indicators in which they are below normative standards. This may represent failures of adequate care coordination, late notice of laboratory findings or missed follow-up appointments. Rarely does a practice score poorly in only one area, but because of ineffective processes, multiple clinical conditions are not optimally managed. With the information gleaned from these more comprehensive reports, and with coaching by AmeriHealth Caritas clinical teams, the network practices generally find ways to adjust their practices. For most practices that engage with us in review of the quality data, the net result yields a global improvement in quality indicators rather than focusing in on just one disease entity. As a result, clinical practice quality improves as a whole. For those practices which participate with AmeriHealth Caritas Iowa in its PerformPlus® value-based programs, the incentives to use this data for practice improvement, there is even greater improvement in quality scores. The financial incentives align the practices with the quality goals of AmeriHealth Caritas Iowa.

Portfolio of Products

Exhibit 13.1-L: AmeriHealth Caritas' PerformPlus® Value Based Programs

The programs represented in this portfolio of clinical-data driven programs include:

- A shared savings program with the following current entities:
  - ACO-PA (formerly Jefferson Health System).
  - Pinnacle Health.
  - Einstein Healthcare Network.
  - Crozer-Keystone Health System.
  - Temple University Health System.
  - Christus Health System.
  - With several other programs ready to begin.
- Quality Enhancement program, involving more than 500,000 members over five of our lines of business.
- The Community Partners program, providing clinical data feedback specifically to Federally Qualified Health Centers.
- Women's Health program, focusing on areas of pregnancy management and access to women's general health concerns, including data feedback on rates of:
  - Cervical cancer screenings.
  - Breast cancer screenings.
  - Chlamydia screenings.

- Prenatal care during the first trimester.
- Frequency of prenatal care.
- Postpartum care.
- Dental referrals for pregnant women.
- Immunizations.
- Influenza.
- Tetanus booster.

- Cardiology program is a new program that allows data sharing from electronic medical records.
- Customized programs have been initiated based upon clinical data evidence in gaps in care. Such programs allow for individualization to improve the health of local communities for the medical conditions of greater concern in those communities i.e. tailored programs to meet local needs. AmeriHealth Caritas recognizes that one solution to health care quality cannot be applied universally. AmeriHealth Caritas Iowa will work with Iowa health systems to identify and improve health issues of concern to our Iowa membership. Clinical Data to Assess Gaps in Care

Clinical data to assess gaps in care

Gaps in care arise when the potential for attainment of benchmark standards of clinical quality for any given metric are not realized. These gaps in care may be recognized at the population level, health system level or provider level. The 3M Treo analytic tools allow AmeriHealth Caritas Iowa to assess quality data at these differing levels of measurement. The analysis of clinical data using these tools allows for a strategic focus at the level of the integrated delivery system or accountable care organization (ACO) to drive a population health based solution, such as use of mobile phone outreach campaigns to provide health alerts or care follow-up recommendations. At the practice level, the use of clinical data on gaps in care can be used to assist the physician with Maintenance of Certification requirements, such as changing the way office staff is used for practice-based care coordination. Without such clinical data packaged through the AmeriHealth Caritas analytics, it is more difficult for the practice or the ACO to focus on specific opportunities for quality improvement. Greater details of the PerformPlus programs are provided in Section 10.4 of this response.

Identification of new services

While the clinical data-based information will be helpful to the AmeriHealth Caritas Iowa provider community, it will also help inform us address areas of concern for which new programs or services may need to be developed. In other states, the clinically-based data on caesarian section rates has led to specific programs designed to reach women early in their pregnancies to assist them in regular prenatal care, since such care has been demonstrated to reduce the rate of primary caesarian sections. We anticipate that clinical data may demonstrate that geographic access to laboratories may mean reduced frequency of measurement of HbA1c in diabetic members or prothrombin time testing in patients with atrial fibrillation. The solutions may involve new laboratory access methods, which would require tailoring to the needs of rural communities.

Clinical data impact on evidence-based clinical policies

AmeriHealth Caritas Iowa will be an active participant in the AmeriHealth Caritas Clinical Policy committee. Clinical data demonstrating overutilization or underutilization helps to inform the Clinical Policy committee

on evidence-based policy development. That means our clinical policies are based upon real needs to understand the medical evidence behind requests for high tech services or distinguish between the appropriate and the investigational use of technologies. For example, the clinical data on the rates of laparoscopic power morcellation of uterine fibroids provided the basis for a review of the medical literature and the development of a clinical policy that such technology carried the risks of spread of undiagnosed uterine leiomyosarcoma. As a result there is no coverage by AmeriHealth Caritas of power morcellation or of investigational techniques using radiofrequency ablation to remove uterine fibroids. With the clinical data to provide the rationale for clinical policy development, AmeriHealth Caritas continues to develop policies that have strong bearings on actual clinical situations of our members.

4. Submit a draft Information Systems Plan as described in Section 13.1.5.

AmeriHealth Caritas Iowa will deliver world-class, tailored IT capabilities to Iowa, leveraging both our shared AmeriHealth Caritas infrastructure, as well as deep experience tailoring our systems to meet the specific needs of each of our 16 states.

Below is our approach to each of the specific requirements outlined.

Planning, developing, testing and implementing new operating rules, new or updated versions of electronic transaction standards, and new or updated national standard code sets

AmeriHealth Caritas is a member of WEDI (Workgroup for Electronic Data Interchange). Participation enables us to keep abreast on all federal initiatives including Operating Rules, electronic transaction standards or updated national standard code set (including ICD-10). Electronic data interchange (EDI) staff also attend Coucil for Affordable Quality Healthcare sponsored webinars held regularly to stay abreast on upcoming mandates and industry best practices. AmeriHealth Caritas leverages the standard systems development life cycle (SDLC) for planning, developing and testing (unit and testing partner testing) when enhancing or remediating our application systems to support new federal mandates. For example, during HIPAA 5010 upgrade, our EDI manager contributed to a white paper on HIPAA 5010 testing.

Concurrent use of multiple versions of electronic transaction standards and codes sets

AmeriHealth Caritas leverages best-in-class EDI translation solution (IBM Websphere Extender) to translate all EDI X12 HIPAA transaction standards including current and previous versions. For example, during the HIPAA 5010 transaction upgrade, AmeriHealth Caritas leveraged IBM Websphere Extender to accept both HIPAA 4010 and 5010 version concurrently. This enabled us to support both versions while providers, EDI clearinghouses and vendors were fully in compliance with the HIPAA 5010 format.

Registration and certification of new and existing trading partners

AmeriHealth Caritas leverages Emdeon Business Services (Emdeon) to receive EDI X12 claim transactions electronically. Emdeon provides an Emdeon Enrollment Guide that provides step-by-step instructions on how EDI software vendors and providers interact with Emdeon's implementation team, including how to register as a trading partner, complete payer enrollment form and an overview of testing and certification. Once the contract and non-disclosure agreement have been signed by the provider and Emdeon, implementation can begin. During the implementation process, the customer becomes familiar with Emdeon system processes, edits, reports, resources and enrollment. In addition to a structured implementation process, Emdeon offers access to its services and payers through a variety of communication methods. Existing trading partners introducing a new line of business will work with

Account Management to complete the necessary documentation for a new transaction type. New trading partners are assigned an implementation analyst (IA) once the contract is approved. The IA or account representative is the primary contact throughout the implementation process. In addition, throughout their association with Emdeon, they have access to the following support resources:

- ON 24/7, Emdeon's all-hours, customer-service portal that allows trading partners direct access to their activity tracking application.
- Emdeon Vision, Emdeon's Web-based claim management application.
- Community Portal, a third-party X12N validation and certification site, to allow their organization to verify X12N syntax and HIPAA rules prior to submission.

Creation, maintenance and distribution of transaction companion guides for trading partners

AmeriHealth Caritas leverages the CAQH CORE v5010 Master Companion Guide Template when creating, maintaining and distributing companion guides to all trading partners.

Staffing plan for electronic data interchange (EDI) help desk to monitor data exchange activities, coordinate corrective actions for failed records or transactions, and support trading partners and business associates

AmeriHealth Caritas has a dedicated EDI Coordinator who has oversight of managing, tracking, reconciling and addressing any corrective actions for failed transactions. The Coordinator also monitors our dedicated help desk and emails received from provider community.

Compliance with all aspects of HIPAA Privacy and Security rules

AmeriHealth Caritas is compliant with the Operating Rules established in the Patient Protection and Affordable Care Act for Eligibility and Claim Status (Phase 1) and Electronic Fund Transfers (EFT) and Electronic Remittance Advices (ERA) (Phase 2). Employees and subcontractors that interact with protected health information (PHI) 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 we were in full compliance with all electronic transactions impacted by the most recent Operating Rules. Written attestation of the positive 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.

Strategies for maintaining up-to-date knowledge of HIPAA related mandates with defined or expected future compliance deadlines

Several AmeriHealth Caritas associates are active members of WEDI, a trusted health IT advisor to Health and Human Services (HHS). Associates participate in a number of workgroup sessions and have previously contributed to several white papers on HIPAA 5010 Testing. WEDI enables us to contribute and define the impact of healthcare legislation and regulation and develop best practices that are implemented in our organization. It also better equips us to improve operational efficiencies as new legislation is introduced. Our member associates attend yearly national and regional WEDI conferences to stay abreast of upcoming federal mandates including on topics related to Operating Rules (837 claims, 275 Attachment, 834, etc.), ICD-10, HIX, HPID and health plan certifications.

5. Describe your proposed information systems staffing model

AmeriHealth Caritas Iowa will leverage AmeriHealth Caritas's current information solutions organization and resources to manage its core systems and deliver shared IT services. AmeriHealth Caritas Iowa will supplement this with 13 additional Iowa-focused IT professionals who will deliver services tailored to Iowa.

These resources will be focused on desktop support, production operations, information systems management, encounters, provider data management, EDI, eBusiness, data warehouse and business intelligence, medical management and application support.

AmeriHealth Caritas Iowa's Information Solutions is supported by AmeriHealth Caritas's Enterprise Information Solutions (IS) team, which has a long history of implementing and supporting the information and technology needs of Medicaid programs, including Iowa. IS has extensive experience managing the specific capabilities and capacities required to support state Medicaid requirements.

IS's people, process and technology will continue to provide a sound information system implementation plan for Iowa through:

- People — A technically deep resource team, with an average of 10+ years of Medicaid healthcare industry experience working with healthcare systems and business environments.
  The programmer staff is allocated across three areas of work: Production Support/Maintenance; Regulatory, Compliance and Enhancements; and Strategic Initiatives. Typically the programmer resources are not dedicated or trained for a specific affiliate, but are aligned by application group and areas of expertise. This approach, where appropriate, ensures a more flexible model and provides an opportunity to leverage standard capabilities, ensures required resources are available to meet needs and support processes across affiliates, improves our speed to market, avoids key person dependencies and provides individuals with greater personal development opportunities.
- Process — Consistent and repeatable methodologies and best practices for implementing and supporting state Medicaid programs.
- Technology — Industry-proven applications and infrastructure.

Detail on the incremental resources that will be added to directly support Iowa technology needs: Position/IS Area	FTEs
Desktop Support	1
Production Operations	1
Information Systems Manager	1
Encounters	2
Provider Data Management	1
EDI Analysts	1
Application Support	3
Data Warehouse and BI	1
Medical Management	1

Detail on the incremental resources that will be added to directly support Iowa technology needs: Position/IS Area	FTEs
eBusiness	1
Total FTEs	13

6. Describe your plan for creating, accessing, transmitting, and storing health information data files and records in accordance with the Health Insurance Portability and Accountability Act's mandates.

AmeriHealth Caritas Iowa will leverage the information systems and technology used by AmeriHealth Caritas. Our information system successfully maintains and secures PHI so that 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, blocking unauthorized access) and physical safeguards (facility protections).

Our systems fully comply with the HIPAA Privacy Rule and the HIPAA Security Rule. Our dual-layer DMZ topology provides additional security by separating public Internet connectivity from private business partner connectivity. The Internet-facing DMZ supports secured FTP connections, including SFTP, FTPS, HTTPS/S, SCP2 and FIPS 140-2 validated cryptography.

Safeguarding System Information through Access and Identity Management

AmeriHealth Caritas Iowa 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 run 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 member information, all centered on the minimum necessary rule and reviewed regularly. Access to viewing and modifying information is restricted to those who "need to know" and all modifications 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, 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 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 annually 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 associates on various information security topics each month.

Role-based access profiles are 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 be able to modify the 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 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 continuously monitored 24/7/365. Technical limits on unauthorized access attempts are configured to automatically lock accounts and alert appropriate security personnel.

Authorized Representatives

AmeriHealth Caritas has established defined processes to request and provide access needs, as required, to meet the needs of our customers. Access will be provisioned based on the principle of "least privilege."

Intrusion Detection and Prevention

The AmeriHealth Caritas Information Security team continuously monitors public-facing entry points and devices residing on the 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 Systems (IDS)** monitor and alert on anomalous network and host traffic that require intervention and/or escalation to a dedicated team of Information Security and Risk Management analysts and engineers.
- **Intrusion Prevention Systems (IPS)** monitor and react to anomalous network traffic patterns and events. The systematic reactions can include sending alerts or notices, but also block or drop network packets to proactively protect enterprise computing environments and assets. IPS is based on "inline" technology, protected by a pair of Zero Power High Availability (ZPHA) devices.
- **Websense** enforces Internet access allow/deny lists to reduce exposure to Web threats.
- **LogRhythm** is 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** is 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)** prevents the sending of Protected Health Information (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.

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 also 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.

Making System Information Accessible to DHS, Providers, and Members

AmeriHealth Caritas Iowa understands that effectively sharing member information with covered entities and other review agencies drives improvements in care coordination and quality of care for our members. We will provide DHS, providers, members and other authorized representatives with access to member information in accordance with HIPAA requirements.

Sharing Information for Quality Audits and Other Inspections

AmeriHealth Caritas Iowa will make system information available to DHS-authorized representatives to support quality audits and other inspections. As a nationwide Medicaid contractor, AmeriHealth Caritas regularly participates in state agency reviews to demonstrate contract compliance and successful quality outcomes. In addition to DHS-initiated inspections, AmeriHealth Caritas Iowa will use Inovalon's NCQA-certified HEDIS Advantage™ tool to support regular HEDIS quality reporting and compliance auditing through monthly information exchanges.

Securely Sharing Information with Providers to Support Medical Management

AmeriHealth Caritas Iowa will use several secure mechanisms to share information with in-network or out-of-network providers to support care coordination and case management activities. These will include our Provider Portal, the Iowa Health Information Network (IHIN), secure FTP and secure email. All system information will be shared in compliance with HIPAA standards.

The Contact Center of Excellence provider services helpline will operate Monday through Friday 7:30 am to 6:00 pm 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 are able to leave messages and are also alerted to the process for obtaining emergency prior authorizations.

In addition to transferring information to providers, AmeriHealth Caritas is currently working with provider partners in other states to securely receive electronic health record information from provider systems to further enhance collaborative patient management and care coordination.

Ensuring Members can access information online and telephonically

AmeriHealth Caritas Iowa members will have access to the mobile application, Member Portal, plan website and the CCOE around the clock. Customer service representatives with Iowa-specific knowledge will always be available to answer member inquiries, whether telephonically or through the Internet. This is supported by AmeriHealth Caritas' distributed telephony model, which ensures that members and providers will be able to access service in the event of an outage or emergency event.

Ensuring access to system information through system availability

AmeriHealth Caritas uses redundancy, resiliency and scalability as central design principles in our infrastructure, network topology, databases and application servers to ensure that members, providers and DHS will have access to the information they need. Redundancy ensures everything operates through a secondary path, should the primary path become non-functional, and our high level of resiliency results

in system availability that will meet the standards established in the RFP and the Contract. Designing for scalability ensures that our infrastructure maintains capacity to support increased demand or growth.

AmeriHealth Caritas adheres to comprehensive Service Level Agreement (SLA) policies and procedures that are supported by staff dedicated to each core domain, including applications, infrastructure and security, in order to provide access, availability and reliability through our information and telecommunication systems. These SLAs will be updated as necessary to comply with the average response times and other availability requirements noted in the final Contract. AmeriHealth Caritas will track and maintain critical application performance and availability in accordance with these SLAs.

AmeriHealth Caritas leverages industry-standard technologies and applications to support system uptime and maintain access to business-essential functions outside of scheduled unavailability. Our approach to high-availability infrastructure design provides an integrated, secure and reliable technology environment to support AmeriHealth Caritas plans nationwide. Routine availability is supported through four areas of our technology framework:

- **Fault management** enables the early detection, isolation and correction of any abnormal operation of our networks and their associated environments.
- **Configuration management** controls, configures, identifies and collects data from the various network elements, such as routers and switches, and provides this information to the network management system.
- **Performance management** evaluates and reports on the individual behavior of components within our networks and associated environments network facilities. This includes the ability to map behavior to SLA metrics and to track quality of service metrics.
- **Security management** provides protection and the 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.

The following strategies ensure high availability of core AmeriHealth Caritas systems:

- **Data Centers** — Our primary and secondary Tier 3 certified data centers are built with power, cooling and monitoring redundancies. The architecture continually monitors for potential failures and automatically mitigates their effects. Data and transactions are preserved through near real-time data replication.
- **Storage Architecture** — We leverage EMC technology to provide redundant and fault-tolerant storage to all of our servers. If a storage failure occurs, our technology provides a seamless transition to a redundant, high-performance storage device. It supports storage configuration in a highly tolerant Mirror or Raid level of protection, capable of absorbing physical disk failures. VPLEX, another component of the EMC-based storage architecture, enables recovery points for data migration between the primary and secondary data centers, enabling us to roll back across four weeks of data if necessary.
- **Server Architecture** — AmeriHealth Caritas utilizes a combination of clustered and virtualized servers to provide fault tolerance and high availability. Clustered servers are grouped together so that if any active server goes down, a secondary server takes up operations, minimizing impact to critical applications. Virtualized servers are automatically migrated from one physical machine to another as needed to protect or scale operations.

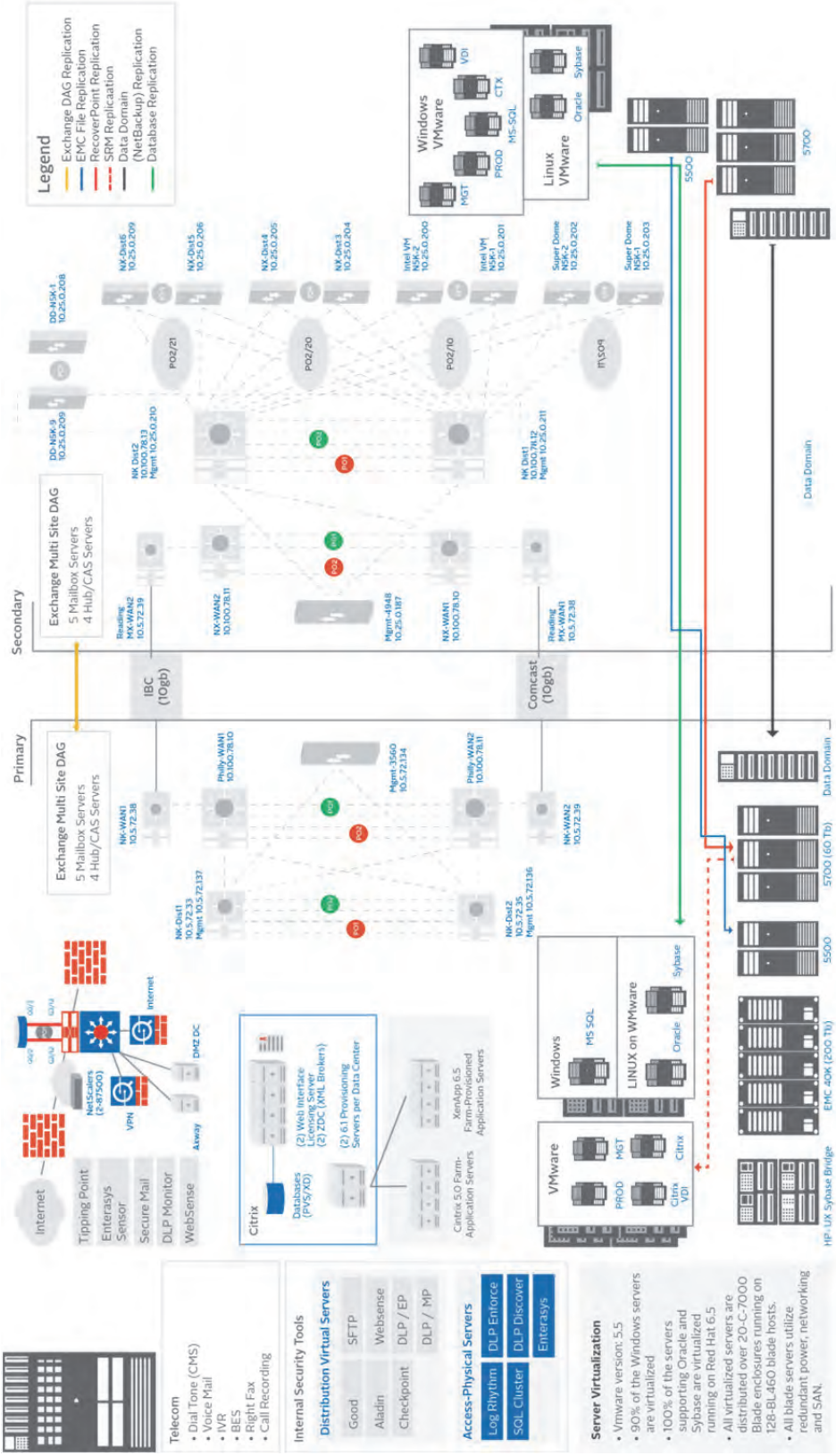


Exhibit 13.1-M: AmeriHealth Caritas System Architecture Availability

Generating and Securely Transmitting HIPAA-Compliant Files

AmeriHealth Caritas securely exchanges inbound and outbound HIPAA-compliant files and other health information data through SFTP or secure VPNs with Medicaid entities in numerous other states. This includes the following ASC X12N transaction and response files:

- Batch transaction types
  - 820 Premium Payment
  - 834 Benefit Enrollment and Maintenance
  - 835 Health Care Claims Payment/Advice
  - 837I Health Care Claims (Institutional)
  - 837P Health Care Claims (Professional)
  - 837D Health Care Claims (Dental)
  - 277CA Health Care Claims Acknowledgement
- Online transaction types
  - 270/271 Health Care Eligibility Benefit Inquiry
  - 276/277 Health Care Claim Status Request and Response
  - 278 Utilization Review Inquiry

AmeriHealth Caritas uses IBM Standards Processing Engine (SPE), including the HIPAA adapter, to validate and compliance check incoming and outgoing EDI ASC X12 transaction sets up to WEDI/SNIP level 6. SPE enables us to:

- Process increasing volumes and regulatory complexity associated with US 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 data from and to ASC X12N formats and flat file/data base file formats.

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, including the plan's Information Systems Manager, will work with DHS representatives during the implementation and readiness phases to incorporate any Iowa-specific code sets into our systems and processes.

Resolving Discrepancies in Member Information to Support Accurate Information Exchange

AmeriHealth Caritas understands that accurate, high-quality member data directly contributes to better coordination of care and reduces duplication of effort across the multiple agencies and organizations that use the data. We take a master data management approach to ensuring our member data is accurate and complete. We also validate member information with every contact.

We will work with DHS to share correct member information in compliance with HIPAA standards. This includes exchanging information about pregnancies, third-party liability changes or other key changes to member statuses that could affect their benefits or eligibility.

Reconciling Information Received via ASC X12N 834 Transaction Files

Our enrollment processes are built around the HIPAA-compliant ASC X12N 834 Benefit Enrollment and Maintenance transactions, which are processed chronologically to add or disenroll members, as well as update existing member eligibility data and contact information. Eligibility and enrollment information transmitted in the 834 files is loaded into TriZetto Facets®, our claims and benefits administration platform, within 24 hours of receipt and compared against our membership records. New entries are loaded, existing entries are updated and error reports are created when discrepancies are identified between the 834 file and the information in our system. These daily error reports are reviewed and reconciled by designated associates in the enrollment department. As these associates collect or verify information (e.g., address changes, telephone numbers, cell phone numbers, email addresses, spelling errors or insurance coverage), it is updated in the member's eligibility record using integrated Agent Desktop, our state-of-the-art contact center desktop.

Mastering Membership Data to Create "Golden Records"

AmeriHealth Caritas employs a master data management (MDM) solution to improve our ability to identify, store and use member information. The amount of data available to health plans is greatly increasing, and AmeriHealth Caritas has implemented industry best practices to ensure we have high-quality data that supports the effectiveness of our customer service, accuracy of our analytics and more efficient care coordination.

Our member MDM solution maintains a "golden record" for each member, which is used as the single source of truth across AmeriHealth Caritas applications. These golden records are the result of enriching member data through defined algorithms and data validation tools, such as GeoCoding and USPS mailing address standardization. The MDM solution also improves traceability, providing a better understanding of data origins, versions and modifications, resulting in high-quality, trusted data across all member interactions. This is the foundation for a holistic view of the member.

In conclusion, AmeriHealth Caritas is in compliance with HIPAA standards for information exchange and uses HIPAA-compliant files and transaction standards. We employ a dedicated team, including many who are active members of WEDI, to ensure we maintain compliance over time. Our Information Security processes and technology ensure adequate system access management and information accessibility. Our processes for cleansing and enhancing member information, including resolving discrepancies between

member eligibility files and our internal membership records, contribute to better coordination of care and reduce duplication of effort across the multiple agencies and organizations that use the data.

7. Describe your proposed electronic case management system and all information which is tracked in such system

AmeriHealth Caritas' care management and quality architecture will be leveraged to support the coordination of care, care management, utilization management, quality management and value-based contracting functions for AmeriHealth Caritas Iowa. ZeOmega Jiva™ serves as the backbone for these services, with support from a number of applications, discussed in detail below.

ZeOmega Jiva™

Jiva is AmeriHealth Caritas' core care-management platform, which provides a 360-degree view of the member by integrating access to medical, pharmacy, lab and behavioral health data. This information will feed AmeriHealth Caritas Iowa's case management, disease management, utilization management (UM) and quality management strategies. Jiva's broad range of capabilities will enable AmeriHealth Caritas Iowa to provide quality healthcare to members while strengthening relationships with members and providers, optimizing operational efficiencies and managing healthcare costs.

Jiva stores evidence-based clinical pathways that will enable AmeriHealth Caritas Iowa care management and Rapid Response staff to help members through efficient and holistic management of their chronic conditions, pregnancies and pediatric preventive care. The application will also enable AmeriHealth Caritas Iowa's care management staff to coordinate and collaborate with providers to improve health outcomes across shared populations, primarily through care gap alerts.

Service Authorization Procedures

Prior authorization information from Jiva, our clinical care management system, is transmitted into the Facets claim processing system daily via interfaces. During the adjudication process, Facets uses the procedure type and location to determine if the service requires authorization. For service/location combinations that require authorization, Facets queries against authorization data to find a match. If the system identifies an authorization for the service, the authorization is attached to the claim, and the claim adjudicates according to the provider agreement and any other applicable edits.

If the system cannot find an authorization, the claim pends to a queue for a Claims Examiner to manually review. The Claims Examiner searches the Utilization Match dataset in Facets to validate that no authorization is on file for the service. If one is found, the Claims Examiner manually attaches the authorization to the claim and adjudicates the claim for payment. If the authorization is not found, the Claims Examiner will access the Jiva system to verify the absence of an authorization on file.

Inovalon

Inovalon, HEDIS Advantage™ (formerly Catalyst Quality Spectrum®) is a Web-enabled, dedicated data repository used for HEDIS reporting, provider profiling and the generation of "care gap" intelligence. AmeriHealth Caritas loads monthly source files into the repository. HEDIS AdvantageTM is NCQA-certified for HEDIS reporting.

NaviNet Provider Portal

NaviNet's Provider Portal is designed to allow providers access to patient information across all participating payers. Claims and clinical data for AmeriHealth Caritas health plan members are pulled from

Facets® and Jiva to support the portal's standard transactions. These include eligibility and benefits verification, referral submission and prior authorization requests. The portal also supports:

- Checking the status of claims, as well as correcting or submitting additional information to submitted claims.
- Access to provider manuals, forms and other administrative documents.
- Pushing care gap alerts, generated from Jiva, to providers to assist in disease or chronic condition management and to encourage preventive health activities.

Member information stored in Facets® and Jiva is accessible through NaviNet's Provider Portal reporting tools. Providers can monitor key metrics, patient data and outcomes related to pay-for-performance programs, and build customized reports through filters and sorting. These reports can be downloaded in Excel CSV or CCD formats, which can then be uploaded into providers' electronic health record systems.

HIPAA 5010 compliant electronic remittance advices are delivered directly to the provider's practice management system through NaviNet for fully electronic posting.

Support Tools for Clinical Care Management

- Our custom REL module collects race, ethnicity and language data on our members in addition to and without overwriting the 834 information sent by the Enrollment Broker. This module is fully integrated with Jiva and Facets® and enhances AmeriHealth Caritas' ability to help our members access the care they need.
- McKesson's CareEnhance® Review Manager Enterprise (CERMe) is a decision support system that leverages InterQual® Criteria. CERMe is integrated into ZeOmega's Jiva application and is used as a guideline for medical necessity determinations.
- HLI codes embedded in Jiva's care management application provide cross-reference look-ups to ICD-9/ICD-10 diagnosis codes.
- IBM SPSS® provides data management and statistical analysis. It is used to analyze survey data, utilization data, cost data, record sampling and control group versus test group outcomes.

Information Tracked in Electronic Case Management System

Data captured in the care management system are used day-to-day by the Case Manager to:

- View any current or past inpatient admissions and monitor the member's progress to discharge and all outpatient services (home care and durable medical equipment, or DME) reviewed and approved/denied.
- Receive automated alerts in the system for all of his or her members when they are admitted to the hospital.
- View all pharmacy activity showing when medications are filled, who prescribed them and any medications not filled on a regular basis.
- View activity completed by different departments in the member's notes and activities tab completed or scheduled by Case Management, Rapid Response, Community Outreach (COS), the Community Care Management Team (CCMT) and Pharmacy Drug Therapy Management (DTM) Team to better coordinate care.
- View all phone calls in the call log and viewable by all Jiva users.

- View all faxes and/or requests for services via the Jiva documents tab for review, which assists the case manager in helping the member know what has been received by medical management and where it is in the review process.
- View provider information and locate appropriate providers (PCPs, specialists, hospitals, DME, home care, nutritionists, diabetic education classes, etc.) as needed.
- View all care gaps on each member's screen to remind the Case Manager what the member needs to complete, such as: scheduling mammograms, PAP smears, flu shots, dental visits, follow-up on taking asthma medicines, blood tests and getting immunizations for their children.
- View links to all members in that member's household so they can touch and educate the entire family on the importance of closing their care gaps.
- View all medical claims for researching what has been completed or paid.

The care manager uses it to:

- Perform assessments and view all other assessments or surveys completed by teams such as Rapid Response, welcome center and utilization management to help assess and evaluate the member's needs, formulate a member-specific care plan and assist the member to achieve better outcomes.
- View all assessments and care plans as part of the Jiva care management system record. These care plans are available to all integrated team members to assist the member in achieving the outcomes. The care manager also has access to the member's medical history summary showing all activity in the last six (6) months on one (1) screen including tests/services, medical conditions, prescriptions, ER visits, inpatient admissions and office visits to assist the case manager in managing the member's care.

8. Indicate if an Electronic Visit Verification (EVV) System is proposed and what methodologies will be utilized to monitor member receipt and utilization of HCB

We will work with providers, members and advocacy groups to develop a process to ensure that home and community-based services are provided based on the plan of care and that services meet the needs of the member. Ideally, the solution will involve technology to track the workers' whereabouts along with a confirmation from the Member that the worker did provide the medically necessary services prescribed in the 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.

9. Describe in detail how clinical records, as described in Section 13.1.13 will be maintained in your information system.

The diagnosis is entered into Jiva and can be entered on a Case Management episode as well. It is part of the medical record that is maintained for such use. The functional assessment scores would be part of the assessment summary in Jiva, included in the overall medical record.

Level of functioning is captured in the care management notes within Jiva as well in the AmeriHealth Caritas set of assessment tools. These data are part of the Jiva medical record.

Services authorized are entered in Jiva, including the specifics of the request, inclusive of diagnosis and procedure codes, dates of service, and treating providers. In addition, the authorization details are transferred to Facets for claims payment. In this case, the data are captured in Jiva and Facets. The criteria to make determinations is defined by InterQual and is captured in Jiva as well.

Services denied are managed in Jiva similarly to approved requests. Denied authorization information also crosses to Facets. The denial reasons and verbiage are part of the Jiva episode and on the denial letters. The denial letter verbiage is stored in the Jiva episode as well as on the client letter. The InterQual clinical review is also captured.

Missed appointments information is stored as notes in the care management episodes in Jiva.

ER follow-up information on discharged members is stored as notes in the care management episodes in Jiva.

Treatment planning: Documentation of joint treatment planning, clinical consultation and other interaction with the member or providers is stored as notes in the care management episodes in Jiva.

Medication management documentation is stored as notes in the care management episodes in Jiva.

Inpatient data: Documentation of assessment and determination of level at admission, continued service and discharge criteria are part of UM episodes. Inpatient data are stored in the episode notes, stay request and assessments. All data are maintained as part of the electronic record.

Joint treatment planning data are part of the care management episode, stored under contacts and in the notes.

Discharge planning data are part of the Jiva UM episode. Data are available in the episode notes and assessments. All data are maintained as part of the electronic record.

At the conclusion of the Contract, all clinical records generated by AmeriHealth Caritas Iowa will be transferred to DHS, upon request, at no additional cost. AmeriHealth Caritas Iowa will keep copies of clinical records to the extent necessary to continue to provide run-out services, including verifying the accuracy of claims submitted.

10. Submit system problem resolution plans and escalation procedures

AmeriHealth Caritas has robust problem resolution and escalation procedures that have been deployed across our 16 states. We will leverage these to support Iowa.

Below are a subset of the plans procedures that are most applicable.

- Attachment 13.1-B: AmeriHealth Caritas Problem Management High Level Process
- Attachment 13.1-C: AmeriHealth Caritas Incident Management Run Book

11. Submit sample release management plans

AmeriHealth Caritas is committed to maintaining high-quality, stable information and technology systems that meet the needs of the state, its members and providers. Over time, those needs change, and AmeriHealth Caritas implements system changes — from design to quality assurance testing — across all technology platforms and environments using information technology infrastructure library (ITIL) principles. Our dedicated team of ITIL practitioners ensures changes are aligned with business goals by providing leadership, management and overall governance of the processes, policies and procedures around the delivery of information systems changes.

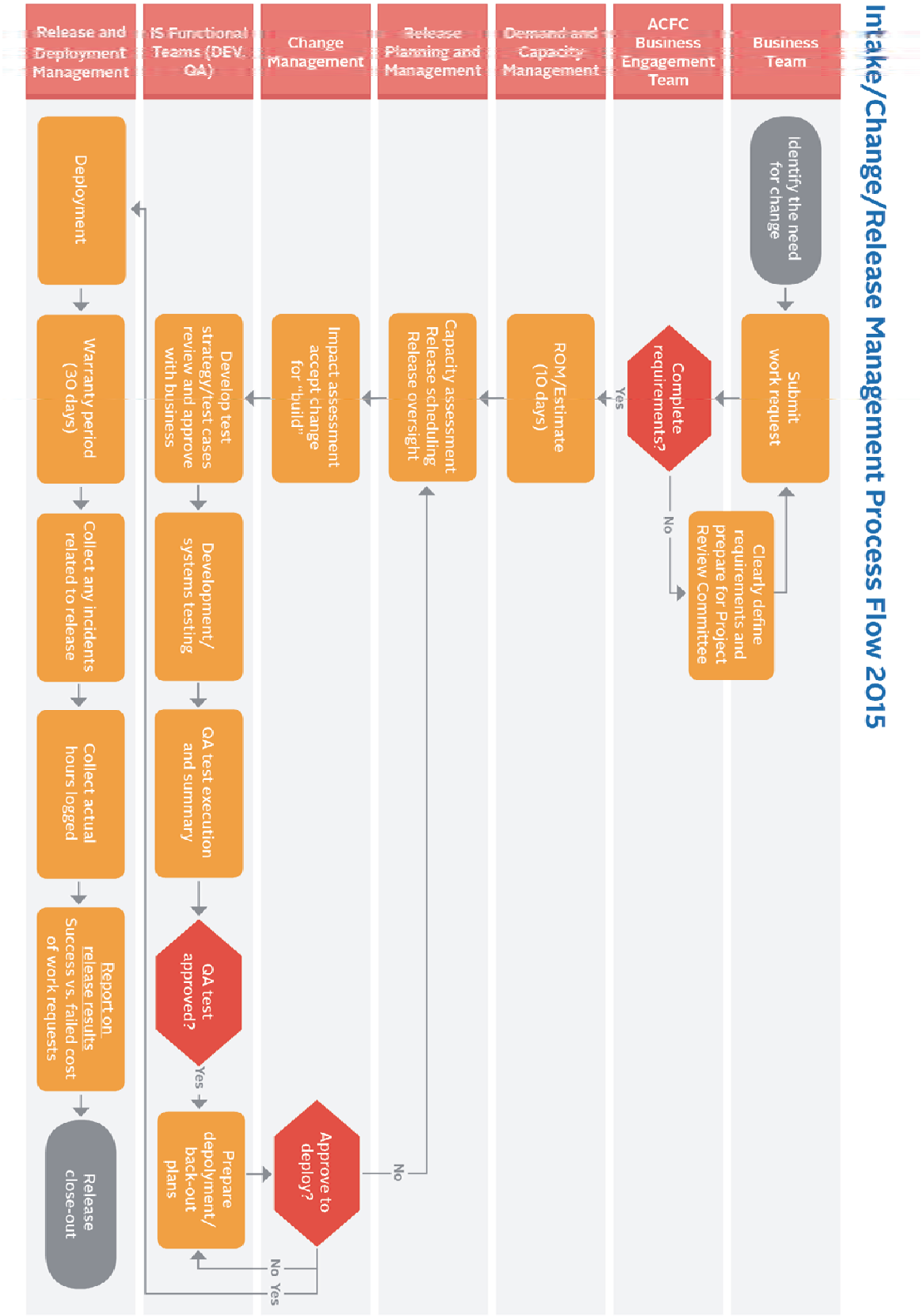


Exhibit 13.1-N: Systems change and release management process flow

System Change Management Process

AmeriHealth Caritas' change management process manages the potential business impacts and risks inherent in system changes. Our IS Change Management Team facilitates the implementation of planned and unplanned changes across the enterprise's production environment using SSAE 16 (formerly SAS 70) compliant practices.

These practices create a stable production environment that adheres to system availability contractual requirements. The change management process utilizes HEAT, an IT service management tool from FrontRange, and provides a complete view of system changes from inception through implementation, as well as metrics for continual service improvement. While the time frames to implement system changes may be accelerated for urgent requests or may be longer for more complex changes, a typical system change requires 12 weeks from identification to implementation.

Identifying System Changes — the AmeriHealth Caritas Iowa Business Team

AmeriHealth Caritas Iowa will work closely with DHS, attending DHS meetings where recommended system changes are identified and discussed. Upon receipt of requirements (e.g., revised system companion guides, file layouts) AmeriHealth Caritas Iowa will initiate the work intake process by completing an IS work request identifying the requirements of the requested changes.

Implementing System Changes — Release and Change Management

Using the estimates provided by the IS functional teams, the release management team schedules the system change into a monthly release based on available resource capacity. A Request for Change (RFC) is then generated within the change, release and deployment process. The change is assessed for impact by the Change Management Advisory Board (CAB) prior to acceptance. The impact assessment is a structured process for considering the implications of a requested change on other business processes, either manual or automated.

The AmeriHealth Caritas IS release and change management processes reduce risk by controlling the frequency of changes introduced into the production environments, bundling changes into related deployments and ensuring all required approvals and artifacts are in place.

Implementing System Changes — IS Functional Teams

AmeriHealth Caritas IS functional teams use systems development life cycle (SDLC) and project life cycle (PLC) best practices to design, develop and configure system changes. Upon completion of systems testing, all changes are migrated from the development environment to the Quality Assurance (QA) environment, entering the QA testing process.

Implementing System Changes — Release and Deployment Management

The AmeriHealth Caritas IS release and deployment management team governs the process from intake through successful project close. After deployment, the release management team monitors the changes for the next 30 days (warranty period) for any disruption to business services. After the warranty period, a post-implementation review is performed, reporting on the overall outcome of the deployment (successful/failed changes, cost of overall release, actuals vs. estimated hours) and the release is officially closed.

13.2 Contingency and Continuity Planning

1. Provide a detailed disaster recovery plan and contingency and continuity planning documents.

Supporting Operational Continuity through Preparedness and Planning

AmeriHealth Caritas Iowa will be continually prepared to invoke a Business Continuity and Disaster Recovery Plan that will enable a quick return to operating capacity in the event of technology failure, facility emergency, fire, natural disaster (including tornados and hurricanes), pandemic or other catastrophic scenario. This plan will be based on the enterprise crisis management, crisis communications, pandemic and business continuity, and disaster recovery plans, which are themselves based on practical experience through lessons learned, and industry best practices. AmeriHealth Caritas employs an "all hazards" approach to preparedness and planning, which has enabled our health plans to quickly and efficiently respond to hurricanes, fires, floods, snowstorms and technology failures.

Our Business Continuity program:

- Prepares associates to respond to a crisis, emergency or natural disaster in a safe manner.
- Enables efficient responses to business or technology interruptions to resume essential business operations and limit the operational downtime and costs.
- Prepares associates to continue to deliver essential business services during outbreaks of influenza, other infectious diseases or other disasters.
- Minimizes delays and improves guidance for decision making during an interruption or disaster.
- Enables essential business functions and engages responsible associates at the time of disaster.
- Helps control risks and exposures to associates, members and providers.

We will ensure that AmeriHealth Caritas Iowa's official draft business continuity and disaster recovery plan will be submitted within 30 days of the Contract signing, and will address the specific scenarios in compliance with Section 13.2 of the RFP scope of work (SOW). It will also address our plans to recover systems, networks, workstations and applications in the event of a disaster (disaster recovery), with plans to restore all operational functions (business recovery). The plan will contain information related to crisis management, pandemics, tropical storms and hurricanes, and disaster recovery.

Crisis Management

The Crisis Management Plan provides steps to be followed by the Crisis Management Team to assess the impact of a disaster and to allow restoration of services within required timeframes. In addition to identifying resources needed to respond to a significant incident or crisis, the plan outlines procedures for swift team mobilization and assembly, incident fact finding, declaration of a disaster, potential relocation of associates, execution of our corporate and local business continuity plans and recovery of our data processing facilities. This enables us to:

- Manage communications during a crisis
- Minimize service disruptions to critical business functions
- Resume critical operations in an accurate and timely manner using predetermined actions

Pandemic

The Pandemic Action Plan uses the Centers for Disease Control and Prevention (CDC) model to monitor changes in demand for services and our capacity to meet that demand. We have identified essential business functions, critical skills and strategies to manage essential business activities up to and during the declaration of a pandemic. Each department has identified modifications they will implement to address increased demand and/or decreased capacity. AmeriHealth Caritas Iowa will have direct access to AmeriHealth Caritas' enterprisewide resources of trained professionals to ensure the ability to respond to increased demand and decreased availability of local staff in the event of a disease outbreak. Key strategic partnerships with select vendors give us the ability to expand capacity quickly to meet the demand. In the event of a disease outbreak, associates at AmeriHealth Caritas' lines of business will be recruited to respond to increased demand and decreased availability of local staff.

Disaster Recovery

AmeriHealth Caritas' Disaster Recovery Plan is designed to support the detailed recovery of critical applications, services and infrastructure that are hosted at the primary data center, within specified service levels. AmeriHealth Caritas Iowa will work with DHS upon award to identify and achieve backup and recovery time requirements in compliance with 13.2.3 of the RFP. AmeriHealth Caritas Iowa's plan will specifically include provisions for the following RFP requirements:

- The central computer installation and resident software are destroyed or damaged
- System interruption or failure resulting from network, operating hardware, software or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage
- System interruption or failure resulting from network, operating hardware, software or operational errors that compromise the integrity of data maintained in a live or archival system
- System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system, but does prevent access to the system, i.e., causes unscheduled system unavailability.

Data and Application Replication through Our Secondary Data Center

Each of the enterprise's office locations is connected to AmeriHealth Caritas' dedicated secondary data center so that operations can be maintained in the event the primary data center is incapacitated. Our Tier 3 certified secondary data center provides a "warm-hot" recovery solution, employing near-real- time data replication for business critical applications and systems. The wide-area connectivity between the primary and secondary sites is redundant and capable of scaling as needed based on monitored usage to support operations throughout the country. Both data centers are protected by a UPS infrastructure, a redundant cooling model as well as backup diesel-powered generators, and are designed to protect data assets in the event of total facility outage, system interruption or component failure.

- **Storage architecture:** As part of our enterprise storage solution, AmeriHealth Caritas' EMC VMAX and VNX technology provides redundant and fault-tolerant storage to support business-critical applications. The internal components of the storage frames are capable of maintaining operation availability in the event of a failure. If storage attached to a server fails for any reason, this technology provides a seamless transition to a redundant, high-performance storage disk.
- **Data and application replication** are addressed through the use of several tools: Oracle Data Guard, Sybase Native Replication, MS SQL Server Log Shipping, EMC VNX Replicator, VMware Site Recovery

Manager (SRM) and EMC RecoverPoint and Data Domain. Oracle Data Guard replicates real-time changes from our primary site to the AmeriHealth Caritas secondary facility. Sybase uses native replication tools to off load processing to maintain a synchronized copy of the databases. Microsoft SQL leverages log shipping to efficiently transfer changes of the primary Database at IP2 to the secondary copy in Reading, Pennsylvania. EMC VNX Replicator replicates all corporate file systems to a like system at the secondary data center. EMC RecoverPoint is used with VMware's SRM to replicate virtualized Windows servers to the secondary data center, synchronizing the storage every 15 minutes or less. VMware SRM is responsible for the orchestration of the recovery plans for the protected business-critical virtualized Windows servers.

- **Backup:** AmeriHealth Caritas uses EMC Data Domain to maintain a synchronized disk-to-disk backup solution between our primary and secondary data centers. Data replication resumes within 10 minutes after completion of backup jobs. Each data domain appliance has the capacity to maintain two (2) months of backups at any point in time. Symantec NetBackup is used to back up AmeriHealth Caritas data and systems. Monthly backups are also copied to tape and stored at a secured off-site facility for 10 years.

Promoting Preparedness through Employee Training and Awareness

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

Testing Exercises

Key AmeriHealth Caritas associates are trained on disaster recovery and business continuity through annual testing activities. These annual tests simulate a data center disaster to verify that our data, core infrastructure, applications, systems and services can be quickly recovered using our secondary data center. Business recovery activities are tested alongside disaster recovery activities to ensure critical systems will be available to meet business defined recovery time objectives.

Successive tests are typically performed by different associates to broaden awareness of recovery procedures. They must rely on their understanding of the recovery plans and procedures and be familiar with what to expect in an actual disaster. Testing also builds organizational acceptance that the business and technology recovery strategies satisfy business requirements.

Building Evacuation (Fire Drills)

Each AmeriHealth Caritas location has an evacuation plan and procedure designed for its unique requirements. All associates receive evacuation training that provides directions on how to evacuate the building and informs them of their responsibilities during an emergency situation.

An evacuation awareness and education training handout will be developed and distributed to AmeriHealth Caritas Iowa associates. The handout will prepare associates for a safe and efficient building evacuation, with defined roles and responsibilities for associates, visitors and vendors. Designated Floor Marshals, Floor Captains and Security team members will be appointed to assist with evacuation. We will also educate associates on how to assist and account for all persons with disabilities, including associates, visitors and vendors.

Identifying Essential Business Functions and Responsible Key Employees

AmeriHealth Caritas conducts an annual Business Impact Analysis (BIA) to gather information and assign criticality, recovery point objectives, recovery time objectives, daily business process steps, accompanying resources, applications, tools, dependencies and manual work-around procedures. The BIA is used to identify the extent and time scale of the impact on different levels of our organization. The BIA assesses current activities and the effect of the disruption on business operations.

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

We use an Employee Impact Analysis (EIA) to evaluate all functions performed by an associate to determine the impact on the organization should they become unavailable for work. Those who perform functions that impact business operations if unavailable are identified as Essential Employees. The chart below identifies the current list of critical business functions that support Medicaid managed care and essential employees. Specific AmeriHealth Caritas Iowa functions and staff will be added to the list if future impact analyses indicate the need to do so.

Essential Business Functions	Key Responsible Staff
Contact Center Services (Member/Provider/Provider Claims Services)	Customer Service Representative staff and directors
Claims Processing and Remittance Advices	Claims examiner staff and directors
Enrollment/Eligibility eligibility	Enrollment specialist staff and directors
Integrated Care Management	Integrated Care Management staff and directors
Payment Integrity (TPL and Subrogation)	Payment Integrity staff and director
Rapid Response and Outreach & EPSDT	Care Connector staff and director
Utilization Management - prior authorization, concurrent and retro review and appeals	Prior authorization/pre-certification coordinators and director
Integrated Document Services and Print Services	Mail services coordinators and manager
Workforce Management	Workforce management capacity analysts and director

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

Contingency Planning for Essential Business Functions

If an emergency event affects staff, physical buildings or other portions of the business, we have contingency plans in place that allow us to continue operations while minimizing downtime. As part of a national organization with facilities in other states, AmeriHealth Caritas Iowa will be able to quickly shift operations as necessary to other AmeriHealth Caritas locations. For instance, if a tornado, fire or other natural disaster were to impact AmeriHealth Caritas Iowa 's facility, we could quickly route incoming calls and local operations to call centers run by an affiliate plan in an unaffected state. Leveraging our

enterprise Information Solutions infrastructure, Member Services, Provider Services and Medical Management associates in other regions can be granted temporary access to Iowa Medicaid members and provider data to make the transition seamless and invisible to Iowa members.

Maintaining Communication with Employees During Emergency Events

A crisis communications plan will be included in the Business Continuity and Disaster Recovery Plan. Representatives from all levels of the organization are involved to provide consistent communication to manage the incident. Designed to support effective and quick communication, the plan leverages a variety of mechanisms to communicate regularly with our associates, instructing staff on the actions they need to take in the event of a disaster.

Dell AlertFind Enterprise Notification

AmeriHealth Caritas uses AlertFind to quickly communicate with its associates in a crisis through emails, two-way SMS (text) messages or voice calls with the goal of reaching anyone, anywhere, at any time and on any device. The notification system quickly and automatically notifies internal crisis management team members, senior management and associates of issues that may affect our operations. These notifications provide instructions, ask questions and/or collect responses. AlertFind can also be used to provide business recovery updates, additional instructions or information to business continuity coordinators and associates. The Enterprise Business Continuity Program Management office routinely uses AlertFind during winter months to guide associates about office delays or closures due to snowstorms or other hazardous conditions that would put associates at risk during travel.

Emergency Hotline

Emergency updates, instructions and other information are also available to associates through the enterprisewide Emergency Hotline. During normal operations, the hotline is also used to disseminate information about the components of our business continuity program.

iNSIGHT Announcements

Announcements related to business continuity and disaster recovery are also posted to iNSIGHT, our intranet website. iNSIGHT is accessible to all associates who have network access. This includes announcements about:

- Business continuity planning (planning and software tools, business recovery and glossary terms)
- Crisis management (emergency notification, evacuation and inclement weather)
- Disaster recovery (disaster recovery test information)
- Pandemic awareness (flu information and interoffice communications)

Content on the iNSIGHT home page is refreshed daily with new or updated information featured prominently at the top of the page.

Communications Announcements (E-mail)

The Business Continuity Program office coordinates with Corporate Communications to disseminate important information about evacuations, inclement weather, emergency notifications and to create general awareness of our business continuity program. For instance, when extreme weather emergencies are predicted, email alerts encourage associates to monitor local radio and television news programs for information on weather events and company communications related to office openings and/or closings.

Ensuring Continuity of Provider and Member Services

Providers and members will continue to receive services throughout disaster events through AmeriHealth Caritas' shared infrastructure, which enables unaffected call centers and affiliated Medicaid managed care plans to seamlessly support essential business functions. This includes Member Services, Provider Services, and Medical Management. Depending on the emergency event, referral and authorization requirements will be adjusted to ensure members can access the providers and services they need in a timely manner.

Supporting Continuity of Care using the Member Clinical Summary

AmeriHealth Caritas provides Member Clinical Summaries through the Member Portal, which captures information about the member's medical history, including chronic conditions, recent prescriptions and fill dates, inpatient admissions, ER and office visits. The Member Clinical Summary also includes the member's demographic information, open authorizations and identified gaps in care. For example, if members evacuate to a neighboring state and must see a provider, the provider can access the Member Clinical Summary through the Provider Portal to review the member's recent health history or reconcile medications.

Communicating with Providers and Members

Effective and timely communications to members and providers before, during and after a natural disaster is critical to ensuring successful continuity of care and services. AmeriHealth Caritas is guided by an emergency preparedness communications plan that outlines the messages, strategies and tactics our health plan must take to support the ongoing provision of high-quality healthcare services to relevant stakeholders during an emergency.

Message Development

To comply with regulatory requirements and approval time frames, AmeriHealth Caritas works with state agencies to develop pre-approved emergency messages for specific natural disasters. These messages are stored, ready for use in the event a disaster occurs. Among other things, the messages describe:

- Temporary relocation and address change procedures
- Referral and prior authorization guideline updates
- Process for obtaining medical records
- Notification of provider office closings
- Transportation coordination
- Availability of temporary medical supplies
- Shelter and other emergency resource listings
- Processes for using out-of-state or out-of-network providers

Message Dissemination

AmeriHealth Caritas uses a number of mechanisms to disseminate the messages at critical, pre-defined trigger points during emergency events. This includes call center scripting, updates to the plan website, Member Portal and Provider Web Portal, and automated telephone messages.

Testing the Business Continuity and Disaster Recovery Plan

AmeriHealth Caritas maintains a detailed testing strategy that includes an annual system test of our disaster recovery capabilities to ensure our data, core infrastructure, applications and services can be fully recovered at our secondary data center. In parallel, business recovery activities are also tested. In addition to testing our recovery capabilities, the tests are used to confirm that the technical recovery procedures, recovery teams' contact information, communications and recovery of all critical vendor information (e.g., names, phone numbers, escalation process) outlined in the Business Continuity and Disaster Recovery Plan are adequate.

Test results are used to enhance AmeriHealth Caritas' ability to perform essential business functions in the event of a disaster by identifying potential improvements in the plans. Any problems, issues or lessons learned during testing are retested during the next test cycle. AmeriHealth Caritas Iowa will prepare and submit a formal written report of the findings to DHS.

Tabletop Walk-through Tests

AmeriHealth Caritas utilizes tabletop walkthrough tests of the Crisis Management Plan and the Business Area Continuity Plan to confirm that team members are aware of their assigned activities, identify potential improvements to the plan and test whether communication among the teams is appropriate. The key activities of both tabletop tests are outlined in the table below.

Plan	Key test activities
Crisis Management Plan	• Establishing a Crisis Command Center to manage the crisis and recovery effort • Testing the notification processes to the Crisis Management Team members and other support staff members as needed. • Testing the notification processes to Executive Management
Business Area Continuity Plan	• Testing the adequacy of defined resources and team tasks (e.g., manual procedures to be used only if the automated support is not available; pre-defined alternate work locations; specific procedures required to recover "work in progress" lost during the disaster). • Testing the notification processes to critical associates and/or outside vendors and services.

AmeriHealth Caritas' proven emergency response continuity of operations and disaster recovery processes and technologies ensure that Iowa Medicaid members and providers will continue to have access to essential services in a crisis.

An initial draft plan is submitted as Attachment 13.1-A (ACI Business Continuity/DR Plan) at the end of this section.

13.3 Data Exchange

1. Describe your process for verifying member eligibility data and reconciling capitation payments for each eligible member.

AmeriHealth Caritas has established member eligibility processes that are currently in place in multiple states. Our enrollment processes are built around the HIPAA-compliant ASC X12N 834 Benefit Enrollment and Maintenance transactions, which are processed chronologically to add or disenroll members, as well as update existing member eligibility data and contact information. Eligibility and enrollment information transmitted in the 834 files is loaded into TriZetto Facets®, our claims and benefits administration platform, within 24 hours of receipt and compared against our membership records. New entries are loaded, existing entries are updated, and error reports are created when discrepancies are identified between the 834 file and the information in our system. These daily error reports are reviewed and reconciled by designated associates in the Enrollment department.

AmeriHealth Caritas' finance department will on a monthly basis complete a reconciliation of the capitation payments from the state with the membership/eligibility information maintained in our Facets system. Our current documented policy and procedures related to membership reconciliation will be updated to incorporate any Iowa-specific requirements. The end to end monthly reconciliation process is fully documented at each step.

Currently, for our affiliate health plans, our Finance department completes a monthly reconciliation of capitation payments received from the state by following the below steps:

- The EDI X12 835 file payment file generated by the state, which contains capitation payments for the current month as well as adjustments, is loaded by our Data Center into the Facets database.
- Several reports are developed from the comparison of the payment data and the eligibility records in Facets – which are based on the daily/monthly eligibility files loaded :
    - HIT report – contains all members who were on the eligibility file and payment was received.
    - MISS report – contains any member who was on the eligibility file and no payment was received.
    - EXCEPTION report – contains any person who was not on the eligibility file and however, a payment was received for the current month plus any payments for prior months.
    - TAKEBACK report - contains recoupments made by the state on a previous payment.
    - ADJUSTMENT report –contains payment adjustments made by the state adjusting a previously paid rate.
    - RATE DISCREPANCY report- contains the variances between the rate that was expected to be paid by the state and the actual amount paid.
- The MISS and EXCEPTIONS reports are reviewed by the Enrollment department to validate the eligibility data against the state's eligibility portal/system.
- Any member appearing on the MISS report who is no longer eligible based on the state's system is disenrolled from the AmeriHealth Caritas Iowa Facets system.
- Any member appearing on the EXCEPTION report who is eligible based on the state's system is added into the AmeriHealth Caritas Iowa Facets system.

- After the review is complete, the Finance department summarizes the results from the report's analysis and prepares a reconciliation report package for AmeriHealth Caritas Iowa's finance plan director. In addition, a lag schedule for the Accounting department is created.
- Once approved, the lag schedule is forwarded to the Accounting department for entry.

13.4 Claims Processing

1. Describe your capability to process and pay provider claims as described in the RFP in compliance with State and Federal regulations.

AmeriHealth Caritas Iowa claims management approach will emphasize accuracy, timeliness and efficiency in processing by employing and training highly skilled associates, deploying a rigorous and continuous quality assurance process and utilizing state-of-the-art technology to comply with all provider claims payment rules and regulations. Additionally, this approach will be designed to align with our encounter process to ensure complete, timely and accurate encounter submission to DHS' Fiscal Agent Supplier as per requirements.

Using TriZetto Facets® as our core claims administration platform , AmeriHealth Caritas processes thirty-one (31) million claims annually. Eighty-nine (89) percent of claims are electronically submitted by providers . All non-electronic claims are scanned and adjudicated within the same time frames and quality standards as those submitted electronically.

To support complete, accurate and timely claims submission, AmeriHealth Caritas encourages providers to submit electronic claims, receive reimbursement through EFT, as well as receive their remittance advices electronically.

End-to-End Claims Process

AmeriHealth Caritas' claims processing is accomplished through Facets, TriZetto's industry-leading health plan administration software. AmeriHealth Caritas has used the application for more than ten (10) years to support the unique requirements for Medicaid plans in Pennsylvania, South Carolina, Louisiana, Florida, Michigan, New Jersey, Indiana, Nebraska, District of Columbia and Kentucky.

An enterprise wide solution with a high degree of automation and data capture, Facets achieves fast, accurate claims processing and high auto-adjudication rates. Medical and hospital claims submitted via paper, online or electronically can be processed in an automated fashion, with full support for highly productive electronic adjudication. Facets' electronic commerce capabilities are designed to accept and transmit eligibility and claim information in HIPAA-compliant transaction set standard formats. In addition, Facets has been further customized for auto-adjudication of certain coordination of benefit claims.

During the various stages of the adjudication process, Facets interacts with membership eligibility, product benefit parameters, provider pricing agreements, medical management requirements and clinical editing information to provide accurate and highly automated adjudication of claim and/or encounter submissions. Claims processing utilizes diagnosis codes and procedure codes to read service-based rules and includes parameters for handling benefit limitations, deductibles, co-pays and COB situations.

Claims Submission and Loading

Our system has the flexibility to be configured to automate nearly all payment scenarios and requirements, including unique requirements of state-sponsored programs, such as state fee schedules,

DRG methodologies and EPSDT claims, among others. Complex benefit structures and pricing schedules of all types can be configured in Facets to comply with all state and/or contracting requirements. It has been customized to support the unique requirements of each Medicaid program that we support.

The system enables us to:

- Deliver provider table driven edits of claims ICD-9 (and ICD-10 as of October 1, 2015); CPT4; category of service; provider type; revenue code; member type; authorization requirements; bill type and place of service.
- Determine appropriate co-payments based on third party liability, COB or other insurance and adjudicate claims accordingly.
- Provide detailed explanations of benefits and remittance advice.
- Track timeliness of claim payments.
- Track claims pended for additional information.
- Provide detailed reporting for current inventory, aging inventory and pended claims.

In addition, AmeriHealth Caritas partners with NaviNet to support a provider portal through which providers can check their claim status and be alerted to members' gaps in care. Other innovative functionality, such as access to real-time medication and comprehensive member visit histories, enhances the coordination of care. NaviNet is the largest multi-payer provider portal vendor reaching over 60 percent of providers in Iowa.

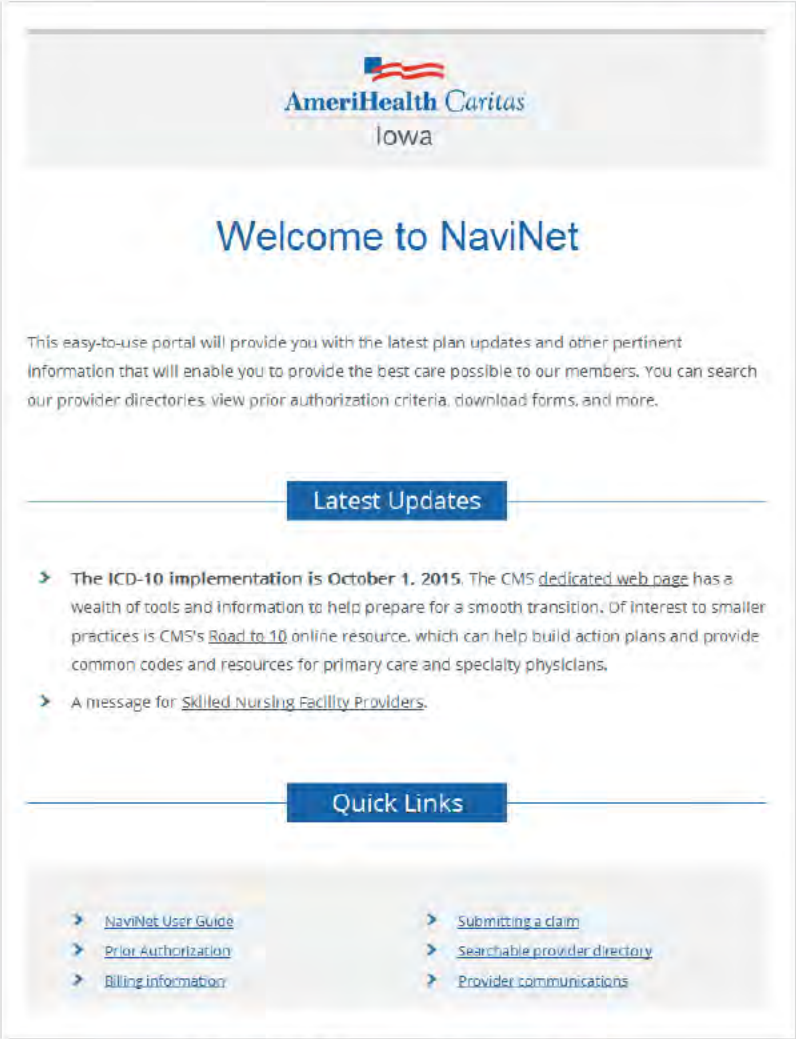


Exhibit 13.4-A: View of NaviNet Portal

Claims Processing Methodology

AmeriHealth Caritas Iowa will leverage AmeriHealth Caritas's robust procedures and systems, including the core claims processing system (Facets) and workflow management system (SunGard EXP Macess) to ensure that all claims are processed according to the requirements in the RFP. The combination of these two applications, coupled with AmeriHealth Caritas's experience, will provide the flexibility to meet the health plan's claim processing requirements. The claims processing components and associated methodology that support the business are described below.

SunGard EXP Macess - Document Management/Workflow Solutions

SunGard EXP Macess is an imaging-based operations management, workflow management, enterprise content management and customer service solution that has been standardized for managed healthcare organizations. The EXP Macess module facilitates scanning and data entry for incoming paper documents (claim forms, member data). Once entered, these documents are sent to the host system (Facets) for adjudication and the associated data and images are stored in the centralized document management system.

EXP Macess tracks and manages the flow of data and documents through our organization. EXP's tools for capturing, centralizing and archiving data and documents help ensure that all of our operations are standardized and integrated. Reporting tools monitor workflow, helping managers identify bottlenecks and increase efficiency. EXP Macess offers solutions for document management and content management that help organizations automate workflow and improve productivity. Some of the documents we capture include:

- Incoming correspondence from members or providers.
- Claims.
- Prior authorization records.
- Letters of medical necessity (electronic and scanned images).
- Outgoing correspondence to members or providers. (e.g., letters to request additional information, notice of action, notice of appeal resolution).
- Electronic documents; e.g., the data associated with the check number created when Facets pays a claim).

EXP's Doc-Flow module enables documents to be processed into work queues for efficient work assignment and management. The Doc-Flow module of EXP Macess enables queue-based work distribution. Graphical design component can be used to create electronic workflow and routing flows to match a predefined workflow process. The system will perform automatic searches for supporting documents to complete tasks in the queue. Time sensitive documents trigger alerts. System flags can be used to indicate the need for dual review. Our core integration framework enables integration of Doc-Flow with other applications, such as Facets, Argus (used to administer pharmacy benefits), TopDown Client Letter (used for automated letter generation), Jiva (our care management system) and the Data Warehouse.

Facets Claims Adjudication

The robust capabilities within the Facets system allow it to access numerous edits and processing routines during the claim adjudication process based on the claim's data elements. These processes and edits allow Facets to take different actions based on eligibility, provider/PCP/network parameters, authorization and referral requirements and pricing agreements. These determinations will be coded to meet AmeriHealth Caritas Iowa's provider contracts and State payment guidelines. These processes are part of the core functionality within Facets and ensure the accuracy of the claims processing and payment. Facets considers the following information during claims adjudication:

- **Eligibility:** During claims adjudication, Facets eligibility logic will check for valid eligibility and the benefits associated with the member.
- **Provider/PCP/network determination:** Facets will determine whether the servicing provider on a claim is the member's PCP and whether the provider participates in AmeriHealth Caritas Iowa's network.
- **Service definition:** Facets will obtain the service definition that is linked to the specific provider agreement and determines the price. The "provider agreements" in Facets are based on the payment schedule in each of the executed provider contracts.
- **Duplicate editing/claims history check:** Rules are used to define what constitutes a definite or possible duplicate claim. Numerous groups of claim parameters are configured and linked to evaluate the member's claims history to determine whether the current claim is a duplicate of a prior submission. Facets performs a duplicate check for each claim line.

- **Managed care edits** are configured and applied based on claims processing guidelines, benefit coverage and limits, clinical authorization requirements and referral requirements for each plan, including edits for valid dates of service that coincide with membership eligibility span.
- **Service authorization procedures:** UM associates enter service authorizations into the Jiva care management application which supports prior authorization functions. Prior authorization information is transmitted into the Facets claim processing system daily via interfaces. During the adjudication process, Facets editing keys on procedure type and location to determine if the service requires an authorization. For service/location combinations that require authorization, Facets searches the authorization data for a match. If the system identifies an authorization for the service, the authorization is attached to the claim and the claim adjudicates according to the provider agreement and any other applicable edits.
- **Clinical editing:** Facets comes with basic clinical edits already configured in the system. Facets also has the capability to create custom edits and to have select services bypass edits. AmeriHealth Caritas also contracts with a vendor, iHealth Technologies (iHT), to enhance the clinical editing capabilities in Facets. During the implementation process, AmeriHealth Caritas Iowa will determine which edits will be applied to claims. At a minimum, AmeriHealth Caritas Iowa will apply standard edits to prevent claim overpayments.
- **Pricing:** Facets uses all of the appropriate codes on the claim (procedure codes, revenue codes, CPT codes, ICD-9/ICD-10 codes and place of service codes) to determine the appropriate reimbursement according to the provider agreement.
- **Service rules** allow Facets to adjudicate payment based on multiple parameters. A service rule establishes the calculation method for the service, the claims processing edits to be applied, penalty types and amounts and service tiers. For example, medical claims are priced based on reasonable and customary (R&C) rates, fee schedules, per diem/per case, DRG or percentage of charges. Facets has the flexibility to handle any pricing methodology.
- **Benefit limit** rules are used to define each benefit limitation if applicable. Each limit rule can be applied to selected benefit types, based on amounts paid or allowed or based on the number of services paid. The rule can also be applied during a plan year or over the member's lifetime. A limit is a dollar amount or number of units that, once reached, will not permit further reimbursement. Limits can be established to apply to all services or only to selected services or related diagnoses. Limits can be at the member level or the family level. Limits can be based on a dollar amount or a number of units.
- **Penalties:** Facets can be configured to establish service penalties for application during claims processing. For example a penalty can be configured to apply when guidelines were not followed or an out-of-network provider was used without authorization. Penalties can be applied as a flat amount or a percentage; can be set to apply to the allowable or paid amount; and can include a maximum dollar limit.
- **Coordination of benefits:** Facets will be configured to meet the specific COB payment guidelines for the State.
- **Accumulator Update:** Accumulators can be set in Facets to perform 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.

Auto-Adjudication

AmeriHealth Caritas has achieved high accuracy levels and auto-adjudication rates through end-to-end integration of health plan data for all of the lines of business that we serve. AmeriHealth Caritas health plans have a year to date monthly average auto-adjudication rate of 83.7 percent. These high rates have been achieved by utilizing standard provider agreements and pricing methodologies. The agreements have been modified over the years based on our experience, working with providers to improve payment accuracy, region-specific preferred payment methodologies and ease of doing business.

Facets auto-adjudicates the claim to pend, deny or pay statuses. Pended claims are claims that require a manual review before adjudication can be finalized, while denied claims are returned to the submitting provider for correction, if applicable. Facets also sends electronic remittance transactions to trading partners in the HIPAA compliant 835 transaction set standard format.

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

Before claims undergo auto-adjudication, Facets checks that the member is eligible and verifies that services are covered. The claim is then auto-adjudicated using medical necessity criteria, prior authorization data and COB/TPL requirements. Claim processing rules use diagnosis codes and procedure codes to read service-based rules and include parameters for handling benefit limitations, deductibles, copays and COB situations. If the claim can be adjudicated automatically, it is processed straight to payment. Claims that cannot be automatically adjudicated are pended for manual review and adjudication. The system indicates the nature of the possible error(s) with the claim, to assist the claim examiner in his or her review.

Manual Claim Processing Rule

AmeriHealth Caritas' detailed claims-processing procedures have been developed to assist claims examiners when they are required to manually process a claim. These procedures are maintained in a searchable HTML-based files associates can access directly from their desktops. For example, if a provider is not participating with us, and has never submitted a claim before, the claim will need to be manually processed. The claim procedures outline the payment rules and detailed steps an examiner must follow to ensure accuracy of provider payments.

Facets' interface functionality will make information from the Facets databases easily available to AmeriHealth Caritas Iowa's provider services representatives, who will respond to provider inquiries and have the ability to adjust a claim, if warranted, for providers in real-time, while they are on the phone. Providers will also be able to easily check the status of their claims by querying through our interactive voice response (IVR) system or accessing our provider portal.

Key Claims Management Standards

AmeriHealth Caritas affiliates typically exceed claims management standards in the states in which we operate, and will build on its experience to meet and exceed the Iowa claims time to pay requirements. We will adhere to all claim payment time to pay requirements. Adherence is achieved through daily monitoring of the claims inventory by the claims management team and reviewing the daily inventory

report that provides an aging of all pended claims. Based on this report, workload is appropriately distributed to ensure claims meet the established metric. Managers also review the weekly claims timeliness report as well as the weekly metric scorecard to ensure all contractual metrics are met. Exhibit 13.4-B presents a claims daily inventory report for an AmeriHealth Caritas affiliate.

Open Workflow Items Aging Report

Document Detail — Claim Regions

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

Exhibit 13.4-B: Claims Daily Inventory Report

2. Describe your plan to monitor claims adjudication accuracy.

AmeriHealth Caritas Iowa will use several approaches to ensure claims and encounters are accurate and timely. Our dedicated quality auditing department will be accountable for reviewing adjudicated claims for financial, procedural and claim accuracy.

Stratified Health Plan Audit Program

Every month, we will complete a stratified health-plan audit, which consists of a random sample of at least 385 electronic and paper claims processed in the previous month. The payment strata will be adjusted depending on claims volume and then divided into three (3) payment stratum, with a fourth stratum used for adjusted claims, and a fifth stratum for zero-paid claims. Parameters will be based on the previous year's historical data.

Claims pulled for stratified audits will consist of manually adjudicated and system adjudicated claims, as well as those handled by HP Quick Test Pro, a claims testing tool that processes routine claims that fall

outside of our auto-adjudication process. The quality scores achieved will serve as the official score, which include financial, procedural and claim accuracy percentages.

Monthly encounter status reports

Monthly status reports pulled from the encounter audit table will validate the integrity of the encounter data and overall system. Analysts will monitor the rejections on each error file received and use cumulative encounter error reports to identify trends.

Manually adjudicated audit program

On a daily basis, the selection for this audit will consist of a random sample of at least three (3) percent of each claim examiner's processed work. Audits will be performed on a pre- or post-disbursement basis. The quality scores achieved for each claim examiner will serve as a performance management analysis for the claims operations management team. If a claims examiner needs further assistance, the claims management team will direct the auditor to pull a higher percentage of the individual's processed claims for an agreed-upon period.

Assisted adjudicated audit program

On a daily basis, a selection for this audit will consist of a random sample of at least one (1) percent of claims process through the HP Quick Test Pro. AmeriHealth Caritas Iowa utilizes an automated tool for batch claims reprocessing. This tool enables us to perform systematic payment updates to multiple claims when necessary, e.g., retro changes to updated fee schedules. This audit reviews processing of claims against specific adjustment criteria and plan-specific processing rules, and is also used to address provider claim payment issues (e.g., retrospective fee schedule adjustments) when multiple claims are impacted. Audit results are also used to identify process improvement opportunities.

Cost containment/Claim Reconciliation Recovery Unit audit program

For this daily audit, we will choose a random sample of at least 10 percent of monthly claims adjusted by the Claim Reconciliation Recovery Unit (CRRU) and at least three (3) percent of monthly claims adjusted by the Cost Containment team. Audits will be performed on a pre- or post-disbursement basis. The quality scores of each examiner will serve as a performance management tool for the Cost Containment and CRRU management teams. Upon request from the CRRU/Cost Containment management teams, a higher percentage of an individual's processed claims can be pulled and audited for an agreed-upon period.

System adjudicated target audit program

The sample criteria for this audit will be based on claims management team requests, which may include previously identified quality auditing errors and recent configuration changes to the claim system (Facets). The sample will be focused on specific claim types and calculated to meet a minimum of a 95 percent confidence level and five percent precision level. Target audits will be performed on a pre- or post-disbursement basis as requested by the claims management team. Errors assessed during the target audit will be sent by the quality audit department to the configuration and claims operations management teams for review.

High-dollar, pre-disbursement audit program

The criteria for this audit will be claims with total billed charges equal to or greater than $50,000. These claims will be reviewed by the quality audit team for procedural, financial and claim accuracy. Any identified discrepancies will be resolved prior to claim adjudication/payment.

New hire quality onboarding audit program

The selection for this audit will consist of a random sample, between five (5) and 30 percent of the claims processed daily for each new associate, to identify performance gaps. The training program will be broken into three (3) modules for new associates to learn to process one (1) type of claim and gain experience before moving on to another type. Modules exist for medical, hospital and COB claims. As each module of the training program concludes, the associate will begin processing that claim type in the production environment and the auditing periods begins. The first module is medical claim processing training. Subsequently, there is an audit period of three (3) weeks, with a two (2) week period following the hospital and COB modules. The quality auditors may review errors with an associate up to two (2) to three (3) times per week, and with the trainer/supervisor at least once per week.

The quality scores achieved for each associate will serve as a performance management tool for the trainer and the claims management team. Upon completion of the "new hire" claims training and audit period, the associate will be monitored through the manually adjudicated audit program.

Claims payment subcontractor audit

AmeriHealth Caritas Iowa will collect "accuracy percentage" from the monthly delegation performance report submission required of all delegates. Additionally, we will ensure the delegate has approved procedures that include a process for reviewing claims for accuracy and acceptability. These policies will be reviewed by AmeriHealth Caritas Iowa during the annual delegation audit.

Local AmeriHealth Caritas Iowa review audit processes

In order to address errors in a timely manner, AmeriHealth Caritas Iowa will utilize a local quality auditor. This auditor will be responsible for the review of the lifecycle of all claims, contracting, configuration updates, fee schedule updates, provider maintenance, member reassignments and the monitoring of statutory reports/performances metrics from the Network Operations department. Audited information will be tracked and any discrepancies or identified claims issues will be reported at weekly meetings between Provider Network Operations (PNO) and the claims team. If updates or corrections are identified, the appropriate steps will be taken to address the issues as soon as possible. Additional staff within the PNO department will also audit the recoveries efforts, clinical editing and billing issues to ensure we are following standard Medicaid guidelines.

Documentation and reporting of audit results

The documentation of the audit results will reside in a dedicated database. The results for the monthly Stratified Plan Audit will be distributed to the claims operations management team on a monthly basis. The results for the manually adjudicated claim audit will be available to the claims operations management team in real-time, as the management team will have the access to pull quality audit results at any time, either by individual examiner or department. For both audits, the QA department will issue a claim summary report with the financial, procedural and claim accuracy scores for the month and a claim detail report to support claim errors identified in the audit.

Once the results are compiled, the claims operations teams will access the results through a self-service reporting application. Reports will be available on a real-time basis and will include the following:

- Claim detail report by individual.
- Health plan summary report.

- Supervisor summary report.

Audit results will be utilized as a tool for the management staff of each claims team to identify trends and to enact procedures to remediate any identified errors. This will include, but not be limited to, individual coaching, targeted training (e.g., authorization, COB training) and progressive performance management. Results and any associated action plans will be reported to AmeriHealth Caritas Iowa's Quality of Service Committee and to the executive management team responsible for the health plan.

Necessary corrective action processes

Claim operations managers and supervisors will be responsible for reviewing the manually adjudicated (performance management) audit reports and determining if the errors are charged appropriately. If there is a discrepancy, the team lead will follow a formal appeals process to review the audit result. In addition, an internal credibility audit will be performed monthly to validate the accuracy of auditing statistics.

If the final monthly financial or procedural accuracy metrics do not meet our goal, the claims manager will develop an action plan, which will include a detailed analysis of the identified errors and a remediation plan. Action plans, which could include targeted refresher training, amended work aids and/or additional pre- and post-adjudication auditing, will be reviewed monthly and remain active until identified errors are resolved. Any claim payment error identified will be immediately corrected and reprocessed for appropriate payment.

3. Describe your provider claims submission process, including provider communications addressing the provider claims process.

Claims Submission

Facets provides functionality to manage the electronic submission and exchange of data. While medical, vision and hospital claims can be submitted via paper, the system supports claims submission either online or electronically. Facets can also send paper and/or electronic remittance transactions to trading partners in the HIPAA compliant 835 transaction set standard format. Providers have the ability to check claim status via the Web or IVR or they may speak directly with a customer service representative.

AmeriHealth Caritas accepts claims through a number of clearinghouses, including Emdeon, Zirmed, NaviNet and HDX. We primarily partner with Emdeon, who not only has a large footprint in provider offices, but also receives "pass-through" claims from virtually every other clearinghouse. As a result, providers who submit electronic claims to almost any payer will find it quick and easy to submit electronic claims to AmeriHealth Caritas Iowa.

AmeriHealth Caritas Iowa's clearinghouse(s) will validate submitted claims to identify missing and invalid required fields. Claims lacking HIPAA compliant data fields will be rejected and returned to the provider. Claim acknowledgements will be returned to providers via the clearinghouse for EDI submitted claims. A control process will acknowledge all claims received.

For our paper clearinghouse, a similar validation is performed to identify any missing or invalid data fields. Paper claims are scanned via optical character recognition (OCR) and the data, both the image and date, is converted into an 837 flat file. If a claim does not pass OCR, the paper claim is manually keyed. Numerous edits alert the claims entry associate to any inconsistencies during entry. These predefined system warning messages result in increased accuracy and productivity. For claims not submitted in the required format, a rejection letter will be generated informing the provider of all the reasons for the rejection(s), and be accompanied by a copy of the claim form submitted. A copy of both the rejection letter and claim will be

sent by AmeriHealth Caritas Iowa via an XML file for storage in the SunGard EXP MACESS tool. EXP MACESS is an imaging-based operations management, workflow management, enterprise content management and customer-service solution that has been standardized for managed healthcare organizations.

Once processed through the clearinghouses, the claims are transmitted in a HIPAA 5010 X12 837 file format and loaded into Facets, which will verify the completeness and accuracy of provider numbers, member ID numbers, diagnosis codes and procedure codes.

Reconciling pended, paid or denied claims to remittance advices

The claims processing system will set the claim to a status of pend, deny or ready for payment. Pended claims require a manual review before adjudication can be finalized, and will be routed to claims examiners via an automated workflow system. The workflow system will track each pended claim until adjudication is finalized. If a claim is denied because the provider did not submit required information or documentation with the claim, then the remittance communication will identify all missing information and documentation. The resubmission of a claim with further information and/or documentation will be processed for payment within the required timeframes. The remittance advice (RA) will include information on all claims paid, denied and adjusted during the claim payment cycle. The associated payment to the provider will consist of the net of all debits and credits.

Support for electronic data interface

AmeriHealth Caritas Iowa will maximize claims submission via EDI, encouraging providers to utilize electronic claims submission, use electronic funds transfer (EFT) for payment and adopt electronic remittance advice. These electronic claims will be submitted through secure, web-based portals, such as Emdeon's Provider WebConnectSM. These portals enable providers to improve practice efficiency and reduce expenses through real-time access to key administrative transactions, such as:

- Claim inquiries.
- Electronic referrals.
- Eligibility inquiry, including benefit verification.

Optical character recognition of paper claims

AmeriHealth Caritas Iowa's paper claims will be converted into electronic data by a vendor that uses optical character recognition (OCR) and performs a character repair function. Claims that do not pass OCR will be keyed through a data-capture application. The vendor and AmeriHealth Caritas Iowa's quality auditors will separately pull a sample of keyed claims monthly to validate quality and accuracy.

Communicating Requirements to Providers

To encourage the submission of timely and accurate claims, AmeriHealth Caritas Iowa will disseminate instructions on how to submit paper and electronic claims, as well as the billing requirements for paper and electronic claims to providers. We provide this information through the provider handbook, AmeriHealth Caritas' claims filing Instructions, provider orientation and ongoing training, as well as AmeriHealth Caritas' provider newsletter. Copies of these materials are available through plan website and paper copies may be requested by contacting provider services.

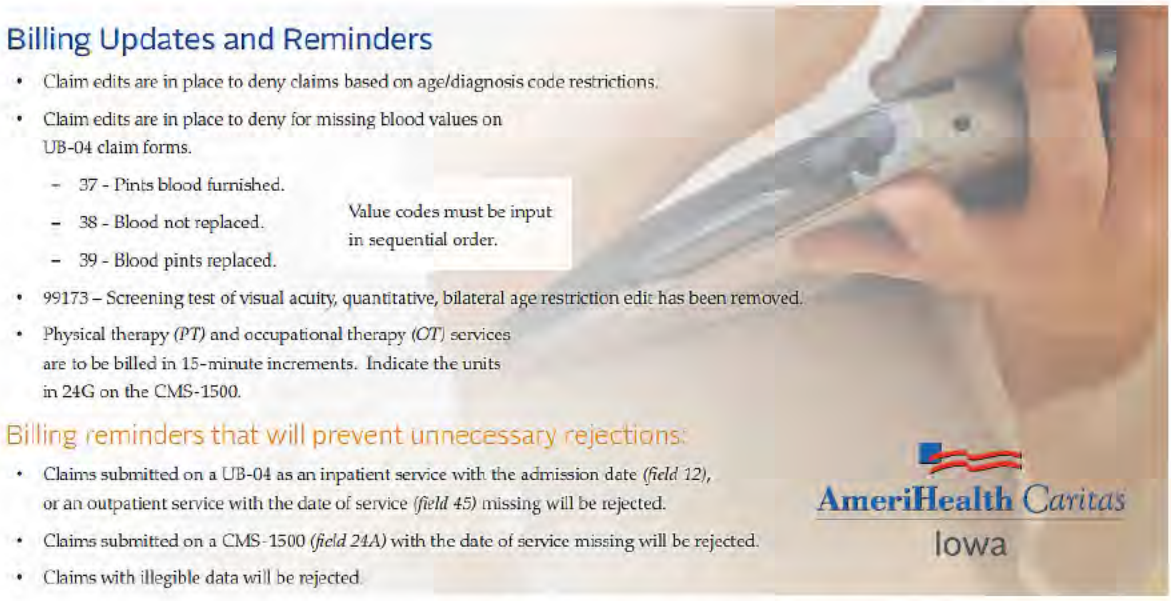


Exhibit 13.4-C: Addressing Claim Requirements through Provider Newsletter

Through these materials, AmeriHealth Caritas Iowa will advise providers about the health plan's claims processes and claims submission requirements. This includes the requirements for accurate and acceptable claim submissions, common causes of rejections and denials identified during AmeriHealth Caritas Iowa review, how to correct and resubmit rejected/denied claims and available options for providers to dispute determinations. Other topics of information addressed in the provider handbook and claims filing instructions include the following:

Provider Handbook	Claims Filing Instructions
Timely filing requirements	Claims submission
Prompt pay requirements	Electronic claims submission (EDI)
Third-party liability instructions	Claim mailing
Dispute resolution (complaints/grievances, appeals)	Claim filing deadlines
Fraud, waste and abuse requirements	Claim form field requirements
Electronic claims submission and monitoring	Electronic billing inquiries
Supplemental claims information for covered services	Supplemental claims information for covered services
Common reasons for claim rejections and denials.	

Exhibit 13.4-D: Topics Included in AmeriHealth Caritas Iowa's Provider Handbook and Claims Filing Instructions

AmeriHealth Caritas Iowa will also have a full-time provider claims educator who provides guidance about our claims submission requirements, coding updates, EDI and EFT capabilities and available plan information to providers. This will be done through routine site visits and provider workshops held by the

provider claims educator within provider communities for their convenience. The provider claims educator will also conduct regional provider trainings across the State to target billing questions and issues. Changes and updates to claims and billing will be included in our regular provider communications.

4. Describe policies and procedures for monitoring and auditing provider claim submissions, including strategies for addressing provider noncompliance; include any internal checks and balances, edits or audits you will conduct to verify and improve the timeliness, accuracy, and completeness of data submitted by providers.

Ensuring completeness of claims data

AmeriHealth Caritas Iowa will implement defined processes to ensure all claims submitted by providers are processed appropriately and that claim acknowledgements are returned to providers. We will use several strategies to ensure accurate claims data submissions. This will include employing a full suite of clinical and administrative rules, maintaining up-to-date system rules and edits and regularly monitoring quality through audit programs. If a clean claim is denied because the provider did not submit required information or documentation, then the remittance communication will identify all missing information and documentation. The resubmission of a claim with further information will be processed within the required timeframes.

Our flexible claims system enables us to confirm accuracy through the following:

- Delivering Provider table driven edits of claims ICD-9/10; CPT4; NCCI edits; category of service; Provider type; Provider specialty; revenue code; Member type; authorization requirements; bill type; and place of service.
- Determining appropriate secondary payment based on TPL COB, or other insurance and adjudicating claims accordingly.
- Providing detailed explanations of benefits and remittance advice.

To improve the accuracy and completeness of claims submitted by providers, AmeriHealth Caritas Iowa will produce monthly trending reports, such as claim denials, by reason code and provider. The results of the analysis will be shared with the Network Account Executive, to use as the basis for additional provider billing education, if required.

In addition, to promote the use of EDI claims submission, on a monthly basis, a report is produced of the top providers who submit paper claims. Outreach will be conducted to the providers to provide additional information on the benefits of EDI claims submission and how to sign up with our EDI clearinghouse.

Claims Accuracy

AmeriHealth Caritas has partnered with an external operation management-consulting firm to provide claims accuracy assessment services to our affiliate plans. AmeriHealth Caritas has the capability to evaluate the accuracy of nearly 100 percent of claims adjudication against all provider type contracts, government regulations, and industry standards. This process enables us to identify any potential claim payment issue and operational improvement opportunities within our organization.

5. Describe your claims dispute procedures.

Providing a forum for provider inquiries

AmeriHealth Caritas Iowa prioritizes our relationship with providers by ensuring that we have trained staff available to address provider inquiries and concerns. There will be no wrong door for providers to seek help, because we will make help available through multiple channels.

Providing a forum for provider dispute

AmeriHealth Caritas Iowa's objective is to ensure smooth transactions and interactions with our provider network community. We will address any verbal or written complaint from a provider and resolve complaints without delay. Providers are encouraged to try to resolve their concerns by calling the CCOE's Provider Services representatives, who can assist with resolving provider complaints such as:

- Dissatisfaction with policy.
- Dissatisfaction with an associate interaction.
- Claims payment issues, for which we have a specially trained unit.

Often, the issue can be resolved during the call. There are some common reasons for the rejection or denial of a claim and our provider services representatives attempt to resolve the issue through documented steps, alleviating the need to initiate a formal claims dispute.

Examples of easily resolvable concerns may include:

- Service issues, including failure to return a provider's calls, frequency of site visits by network account executives and provider network education.
- Credentialing concerns, such as timeliness or an allegation of a discriminatory practice or policy.
- Claims disputes, including claim denials or payments made in error that can easily be handled by phone.
- Administrative denials, such as a failure to request prior authorization when required.
- Issues with AmeriHealth Caritas Iowa's processes, including dissatisfaction with the prior authorization process, the referral process, or the formal provider complaint process.
- Contracting issues, including dissatisfaction with reimbursements, incorrect capitation payments or incorrect information regarding the network provider in the AmeriHealth Caritas Iowa's database.
- Issues with non-covered services.

Within the CCOE, we have a team that receives extensive claims training and will have expertise in our Iowa provider contracts and associated reimbursement rules. They will be able to walk the provider through an explanation of a claim payment, and why it paid or denied a certain amount. If the claim needs to be adjusted, it can be completed in real time while on the phone with the provider.

In addition, provider inquiries — whether through the contact center, plan website or correspondence — are logged and tracked through our workflow management solution. As providers may interact with different employees, the centralized documentation repository provides for a seamless resolution of a provider's concern.

If a provider continues to be dissatisfied after attempts to resolve an issue, a formal complaint process is available at any time. The dispute process will be outlined in our Provider Handbook, which will be

distributed to all network providers and will be available electronically through the plan website. The information will include specific instructions regarding how to contact CCOE Provider Services, how to file a provider complaint, and details about the complaint review process. A summary of the policy and link to our plan website will also be included with the remittance advice for claims processed to out-of-network providers. AmeriHealth Caritas Iowa will initially submit our dispute policies and procedures to DHS for review and approval, and prior to revising thereafter.

Providing escalating levels of appeals

The provider dispute process has two levels, affording providers the opportunity to escalate an issue if the initial resolution process is unsatisfactory. Guidance on the dispute process will be available to providers in the Provider Handbook, in our online provider resources, and through our CCOE's Provider Services staff or their assigned network account executive.

First-level dispute resolution process

Initial provider disputes, including claim and administrative denials, must be in writing and filed within 90 days of the original denial or proposed resolution to a complaint. For accurate and timely resolution of issues, providers should include the following information:

- Provider name.
- Provider number.
- Tax ID number.
- Number of claims involved.
- Claim numbers, as well as a sample of the claim(s).
- A detailed description of the denial issue.

Providers may request an on-site meeting with a network account executive, either at the provider's office or at AmeriHealth Caritas Iowa's office to discuss the dispute. The provider or network account executive must request the on-site meeting within seven (7) calendar days of the filing of the dispute with AmeriHealth Caritas Iowa. The network account executive assigned to the provider will be responsible for scheduling the on-site meeting at a mutually convenient date and time.

Second-level dispute resolution process

If the provider continues to be dissatisfied with the proposed resolution of their complaint or claims dispute, the provider has the option to file a written second-level dispute, which should include any additional information. The second-level dispute must be filed within 30 calendar days of the first-level dispute denial.

Second-level claims disputes will be referred to an internal dispute committee. All previously submitted documentation, along with any additional materials submitted by the provider will be forwarded to our committee for review. Second-level disputes about claims policy and procedures, such as National Correct Coding Initiative (NCCI) or other edits, will also be forwarded to the committee.

Second-level formal disputes unrelated to claims, such as a credentialing policy, will be reviewed and decided upon by a Dispute Committee of at least three (3) individuals. The Committee comprises the following members:

- Manager of Provider Network Management or his or her designee.

- Manager of Operations or his or her designee.
- Manager of Appeals or his or her designee.
- An independent review organization (if applicable).

The second-level dispute resolution will be decided within 30 days of receipt of the dispute. The decision on behalf of AmeriHealth Caritas Iowa will be final and will not be reconsidered.

Adhering to time frames provides efficiency for our valued providers

AmeriHealth Caritas Iowa will investigate an issue, conduct an on-site meeting with the provider upon request, and issue the resolution of the dispute within 30 calendar days of our receipt of the dispute from the provider. All disputes and associated deadlines are tracked within our workflow management tool until resolution, ensuring that providers will receive decisions in a timely manner.

Tracking provider complaints to improve provider relations

The director of AmeriHealth Caritas Iowa's Provider Network Operations will regularly compile a Dispute Complaints Report, which is a summary of complaints received by both the CCOE and the local Provider Network Management team. The complaints will be tracked and addressed in our System of Care platform by the appropriate people or departments at enterprise and plan levels.

The information will be used to set goals, address specific issues and make changes in departmental operations to maintain provider satisfaction. The resulting Dispute Complaints Report will identify the complaints by broad and specific sub-categories for use by various departments, such as Provider Services, Claims Research and Analysis, and Utilization Management. Results of the report will lead to an identification of opportunities for improvement and interventions, to optimize services and enhance provider satisfaction. For example, in one of our affiliate health plans, analysis of Dispute Complaints Reports led to the following activities:

- Hiring a provider educational consultant to provide onsite trainings at provider offices with network account executives for large groups.
- Cross training local Network Operations teams to assist with provider issues.
- Additional training on the functionality of the Provider Portal, including obtaining claims status.
- Providing updates to targeted audiences, utilizing the provider newsletters and fax blasts.

6. Describe proposed processes for collaborating with other program contracts to simplify claims submission and ease administrative burdens for providers.

AmeriHealth Caritas Iowa will work with providers during orientation and subsequent educational meetings to help providers and their office staff understand the claims submission process.

Electronic solutions will be made available. For instance, AmeriHealth Caritas accepts claims through a number of clearinghouses, including Emdeon, Zirmed, NaviNet and HDX. We primarily partner with Emdeon, who not only has a large footprint in provider offices, but also receives “pass-through” claims from virtually every other clearinghouse. As a result, providers who submit electronic claims to almost any payer will find it quick and easy to submit electronic claims to AmeriHealth Caritas Iowa.

Emdeon Provider WebConnect offers real-time transactions, improved efficiency and reduced expenses through a personalized, payer-branded portal. Providers access our secured portal through the Web for direct claims entry submission, real-time eligibility and benefit verification, and claim status inquiries.

Provider WebConnect is Web-based, with no requirements for specialized software or management systems, intermediary vendor relationships or transaction fees. This helps promote electronic claim submission, especially among small practices with low claim volumes, including physical therapists, DME and home health providers. Providers simply complete a self-service registration and setup process. Online training is offered to assist with the initial setup process and to address any product support inquiries.

AmeriHealth Caritas Iowa will perform quarterly joint operating committee meetings with the major provider systems to help understand issues and develop processes that will help reduce the administrative burden for the providers. These meeting will include claims submissions data and trends, review of any issues and status of remediation, if required.

7. Propose ideas for handling Medicare crossover claims which reduce the administrative burden on providers.

AmeriHealth Caritas has processed Medicare crossover claims received directly from the State for two (2) health plans, including a State with a sizable dual eligible population whose secondary insurance is provided through the Medicaid managed care program. For these members, the majority of claims require appropriate coordination of benefits when processing the claim. AmeriHealth Caritas is able to accept crossover claims either directly from the provider via electronic or paper claim submission, or is able to load a State/vendor crossover claim file.

Our claims processing system will track non-covered and exhausted benefits to minimize the administrative burden to providers. Non-covered and exhausted benefits are services that have been deemed as not payable by the primary insurance carrier based on the member's plan. After a third-party resource has been sufficiently documented as exhausted or non-covered, the provider is not required to submit an EOB along with the claim, which is then processed as primary.

A suggestion for improving the Medicare crossover process is to allow managed care plans to engage with the Medicare intermediary directly and exchange data. Reducing the handoffs of data among the State, Medicare and the managed care plans will improve accuracy. The improved accuracy of the data will decrease processing time and administrative burden for all parties.

Our claims platform, Facets, will be configured to meet the specific COB payment guidelines for the State. In any given month, we currently process approximately 175,000 COB claims through our claims platform.

8. Describe processes for notifying providers of a member's financial participation or cost sharing requirements.

AmeriHealth Caritas Iowa will offer providers resources to understand when a copay or cost sharing is required. We will make sure the general member benefit and copayment schedule is available to providers through:

- The provider manual as a part of the appendix.
- Our plan website in the billing section.
- Training during provider orientations.
- A "leave-behind" pamphlet in provider 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 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 Web Portal or through the Provider Services Helpline, to verify the member's cost-sharing requirement for a given service in real time.

9. Describe processes for providing monthly prospective reimbursement to providers of IDPH funded services.

AmeriHealth Caritas Iowa recognizes the need to incorporate additional reimbursement methodologies based on the financial needs of some providers. The AmeriHealth Caritas claims payment system is nimble and able to apply alternate payment methodologies such as monthly prospective reimbursement and capitation to providers of IDPH funded services. AmeriHealth Caritas has experience targeting specific provider groups and will be effectively able to provide prospective reimbursement each month to contracted IDPH-funded, substance-use-disorder network providers and/or other providers as indicated by DHS.

Medicaid fee-for-service payment will be used to set the baseline for the Prospective Payment Systems (PPS). The baseline revenue will be used to set an annualized budget as well as minimum delivery standards with the provider. The provider will receive one-twelfth (1/12th) of the budget total each month. The budget and payment structure will be evaluated routinely and adjusted as appropriate to match productivity and will be increased or reduced as needed and mutually agreed upon with the provider. Record reviews will be done on a regular basis to review for under- or over-utilization of services.

Similarly, a capitation or case rate system may be considered. In such a scenario, we will again use previous cost and payment information to develop a case rate and minimum delivery standards will be set to reduce any risk of under-delivery. Once a case rate is developed, a payment will be made for a given episode of care. This type of structure works best for intermittent, brief episodes but it may also be configured to a situation where a member may receive a full array of services and be paid as a per-member, per-month payment. In either situation, accurate person level encounter information is critical so precise data will be required and used to routinely evaluate the payment structure.

13.5 Encounter Claims Submission

1. Describe your policies and procedures for supporting the encounter data reporting process, including:

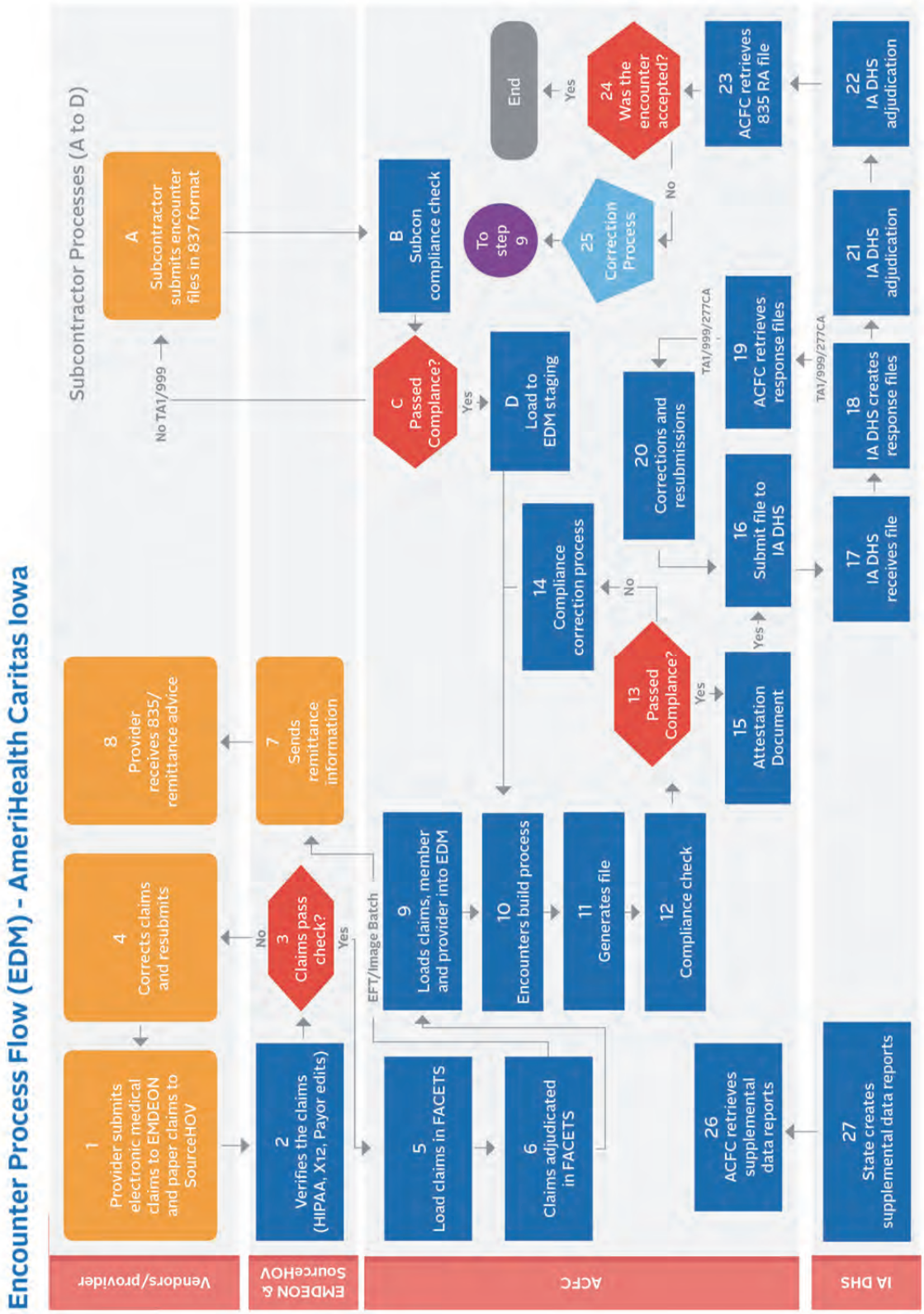
a. A workflow of your encounter data submission process proposed, beginning with the delivery of services by the provider to the submission of encounter data to the State. If you will subcontract with multiple vendors or provider organizations for claims processing management, workflows should incorporate all such vendors, including vendor's names and the approximate volume of claims per vendor identified.

b. Your operational plan to transmit encounter data to the State, indicating any internal checks and balances, edits or audits you will use to verify and improve the timeliness, completeness and accuracy of encounter data submitted to the State.

Per our encounters operating policy, AmeriHealth Caritas' Information Solutions (IS) department will submit encounter data to the State Medicaid agency in the standard format, according to the submission time schedule set by the Medicaid agency. Within State-specified timeframes, AmeriHealth Caritas will also review, research and correct encounter data that the Medicaid agency rejects or returns as an error.

Encounter processes and procedures

Below is a diagram that depicts the collection, submission and reconciliation of encounter data. The swim lanes represent responsible parties and key parties in the process. The steps are outlined in sequence. All descriptions for each step are provided in the following section.


Encounter Process Flow (EDM) - AmeriHealth Caritas Iowa
Vendors/provider
EMDEON & SourceHOV
ACFC
IA DHS
Subcontractor Processes (A to D)
1 Provider submits electronic medical claims to EMDEON and paper claims to SourceHOV
2 Verifies the claims (HIPAA, X12, Payor edits)
3 Claims pass check?
No
Yes
4 Corrects claims and resubmits
5 Load claims in FACETS
6 Claims adjudicated in FACETS
7 Sends remittance information
8 Provider receives 835/ remittance advice
9 Loads claims, member and provider into EDM
EFT/Image Batch
10 Encounters build process
11 Generates file
12 Compliance check
13 Passed Compliance?
14 Compliance correction process
15 Attestation Document
16 Submit file to IA DHS
17 IA DHS receives file
18 IA DHS creates response files
19 ACFC retrieves response files
20 Corrections and resubmissions
TA1/999/277CA
21 IA DHS adjudication
22 IA DHS adjudication
23 ACFC retrieves 835 RA file
24 Was the encounter accepted?
25 Correction Process
26 ACFC retrieves supplemental data reports
27 State creates supplemental data reports
A Subcontractor submits encounter files in 837 format
No TA1/999
B Subcon compliance check
C Passed Compliance?
D Load to EDM staging
To step 9
End

Process Item	Process Description
1. Provider submits digital medical claims to Emdeon and paper medical claims to SourceHOV.	The provider submits electronic medical claims to Emdeon and paper claims to SourceHOV, which contain member, diagnosis code, procedure and provider information for verification.
2. Verifies Claims (HIPAA, X12, payer edits).	The submitted medical claims are verified by Emdeon for the required compliance standards, pre-edits, EDI standards, HIPAA and X12.
3. Claims pass check.	Claims that pass pre-processing and verification by Emdeon are sent to AmeriHealth Caritas.
4. Correct claims and resubmit.	Claims that do not meet the Emdeon compliance check and pre-processing requirements are sent back to the provider for correction and resubmission.
5. Load claims into Facets.	The claim data are loaded into the Facets application for further processing.
6. Claims adjudicated in Facets.	The data are processed in Facets.
7. Sends remittance information.	The remittance information containing details on payment, adjustment and uncovered charges are generated and sent to the provider.
8. Provider receives 835/remittance advice.	The provider receives the 835 healthcare claim payment/advice containing the payment details for the claim.
9. Loads claims and member and provider data into EDM.	The claims, member and provider details are loaded into the EDM database from Facets for the encounter build process. Subcontractor claims are loaded into EDM staging tables after compliance checks are performed (Step 12). Files with 999 errors are returned to subcontractor for correction.
	Subcontractor Processes
A. Subcontractor submits files in 837 format.	Subcontractor claims are received via SFTP from each vendor (e.g. dental, vision, transportation).
B. Compliance check.	Subcontractor 837 files are validated by the SPE/WTX compliance process.
C. Passed compliance?	The IS encounter business analyst reviews the compliance 999 file to determine if any non-compliant claims should be returned to subcontractor. No 999 errors – Continue to load subcontractor encounter data into EDM staging tables. 999 Errors – File is returned to subcontractor for resolution and resubmission.
D. Load into EDM staging.	Subcontractor encounter data are parsed and loaded into EDM staging tables for processing.

Exhibit 13.5-A: Encounter Processes and Procedures Descriptions and Content further details the steps in the Encounter Processes

Encounter system overview

Our encounter system utilizes subject matter experts from both the Information Technology and Operations departments, which define processes, controls and technology support to ensure accurate, complete and timely encounter processing that will be consistent with the requirements of the RFP. A cross-functional Enterprise Encounter team is dedicated to managing the entirety of AmeriHealth Caritas Iowa's encounter process, which includes building the files, submitting the files, managing error resolution and payment reconciliation. By leveraging expertise across the enterprise, the team maintains a high level of integrity, validity and completeness in AmeriHealth Caritas Iowa's encounter data.

Building and transmitting encounter transactions

AmeriHealth Caritas Iowa recognizes that providing contract compliant encounters is critical for meeting program requirements. Our integrated encounter solution will produce and submit HIPAA 5010 ANSI X12 837 provider-to-payer-to-payer COB transactions in professional, institutional and NCPDP formats. In addition, our systems are configured to produce proprietary files in support of the federal and state drug rebate process. Encounter files will be built in accordance with Iowa's billing manuals and payment rules. AmeriHealth Caritas' encounter and claims system components are regularly updated with updated editions of CPT, HCPCS, ICD-9, ICD-10, HCPCS Level II and Category II CPT codes, as well as any new state or federal requirements.

Encounter files will be built with settled claims, adjustments, denials and voids from the most recent month and weekly for drug encounter data. Fully adjudicated, AmeriHealth Caritas Iowa and subcontractor claims will be loaded into the Trizetto's EDM application, along with the most recent member eligibility and provider data files received from DHS. EDM will then build HIPAA 5010 ANSI X12 837 encounter files that include all paid, adjusted and denied claims, including zero-dollar claims from capitated providers. The files will be formatted in the 837-I (institutional) and 837-P (professional). Pharmacy encounter from our Pharmacy Benefit Manager (PBM) will be prepared as HIPAA NCPDP transactions and include all paid, adjusted, denied or voided claims, including those showing a zero-dollar amount.

All encounter files will be checked for completeness and accuracy, which will include verifying claim counts, as well as HIPAA compliance validation, to identify potential TA1 or 999 errors. Any encounter that results in an error will be reviewed to identify root causes for the error and identify adjustments that need to be made in order for the encounter to process correctly. The review process will be repeated until a compliant file is created. Compliant encounter files will be submitted via SFTP in accordance with contracted time frame requirements and any file size limitations, along with a certification attesting to the accuracy, completeness and truthfulness of the information.

When the State response file is received, encounter analysts will review each rejected encounter and coordinate its remediation within the required time frames. The Enterprise Encounter team actively manages and tracks error resolution through completion. Corrected encounter with repairable errors will be included in the next encounter build processes and resubmitted to the fiscal agent (FA) supplier.

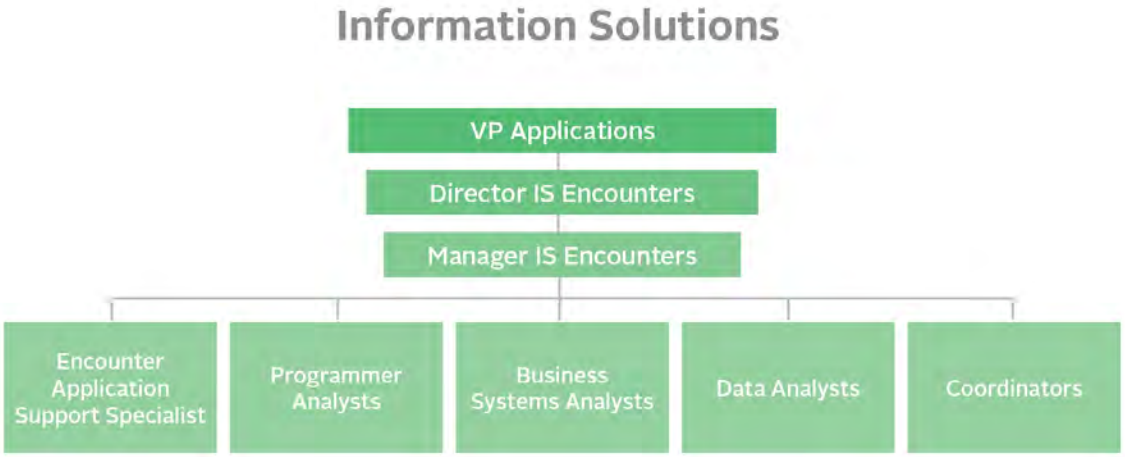
Please see the encounter policy and procedures provided for step-by-step details on encounter system processing. It should be noted that the EDM system is quickly configurable to meet Iowa's unique requirements.

To ensure timely, accurate and complete encounter submissions, AmeriHealth Caritas Iowa will utilize AmeriHealth Caritas' leading practice approach to reconcile encounters data to provider payments. We will use a standard methodology to reconcile claims, encounters and cash on a monthly basis. Our dedicated team examines our encounter reconciliation report, comparing total claims processed to

submitted encounters. This process is accomplished via a detailed CDJ comparison of claims adjudicated to reconcile claims through to encounters by financial and volume metrics.

Dedicated Enterprise Encounter Team

The Enterprise Encounter Team, illustrated in the organization chart below, is comprised of IS and operations stakeholders. This team works to provide complete, timely and accurate encounter submissions, as well as analysis and remediation of all rejected encounters. AmeriHealth Caritas maintains formalized policies and desk procedures for building and exchanging encounter data, ensuring thorough and consistent understanding across the dedicated encounter team. Daily meetings are held to review acceptance rates, inventory management and error resolution. The Enterprise Encounter team will participate in DHS meetings to remain current with changes and outcomes. Weekly reports are provided to corporate, regional and local leadership to foster accountability and achieve results. This centralized, dedicated oversight identifies and resolves encounter processing issues before Contract compliance is negatively impacted. In addition, an information solutions manager and team will be assigned to oversee the Iowa encounter process on a day-to-day basis. The organization charts below depict the Enterprise Encounter team and roles.



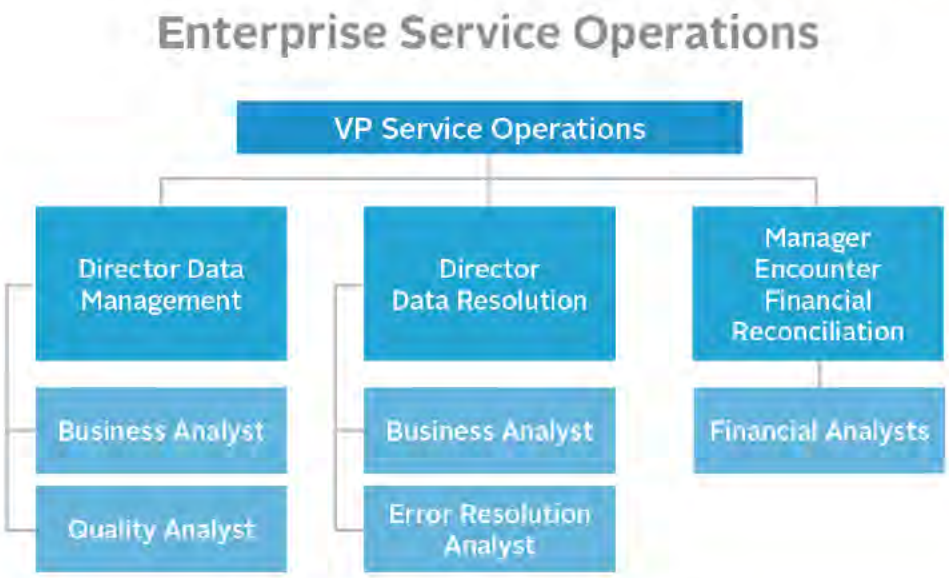


Exhibit 13.5-B: Enterprise Encounter team

Controls to ensure accurate encounter submission

Using edits defined in the systems companion guide, encounters that would fail the encounter process are not included in the generated file. These encounters are "scrubbed" to a report to be reviewed and worked by the Enterprise Encounter team. These scrubbed encounters go through a complete review to identify adjustments that need to be made to the claim/encounter for submission acceptance. Claims errors are flagged, enabling associates to research and correct the data in the source system.

The Enterprise Encounter team maintains formalized policies and procedures for ensuring accurate error resolution to meet the required acceptance threshold. The team utilizes an error tracking database to categorize error types for timely and accurate resolution. Additionally, the team identifies root causes for remediation.

For example, a rejection for an NDC invalid unit of measure prompted us to confirm configuration against plan and State rules. After review, we updated the logic in our system to properly process claims, resulting in accurate encounter acceptance.

Total claims submitted are confirmed weekly through an encounter reconciliation report that compares paid claims to submitted encounters.

To support accurate subcontractor encounter data reporting, delegation oversight meets with the subcontractors monthly to identify, discuss and resolve claims or encounter issues resulting from FA response files. Performance is regularly monitored against documented and agreed-upon standards.

AmeriHealth Caritas proactively communicates changes to state or federal requirements, industry-standard code sets, procedure codes, diagnosis codes and provider data reference files to subcontractors. Delegation oversight associates collaborate with subcontractors to ensure changes are implemented in the subcontractor's systems, processes and policies.

AmeriHealth Caritas Iowa will delegate the performance of some health plan functions to subcontractors, but will remain fully accountable for the performance of those functions. AmeriHealth Caritas Iowa's quality of service committee will be responsible for reviewing, approving and monitoring subcontractor activities associated with service standards, access and availability.

The annual delegate review is a core component of delegation oversight. Such reviews will be performed according to AmeriHealth Caritas Iowa's delegation oversight policies. The purpose of the predelegation review was to ensure the vendor's compliance with AmeriHealth Caritas Iowa and state standards.

Controls to ensure timely encounter submissions

Our automated encounter application also processes response files received from the state. The state's dispositions are loaded into EDM, and our automated encounter application categorizes encounters as accepted or rejected. Rejected encounters are reviewed and analyzed for correction and resubmission to the FA. All 999 and 835 response files received from the state are reconciled in EDM and the state's dispositions (accepted, rejected or translation error) are used to update the status of the encounter in the system. Analysts on the Enterprise Encounter team review each rejected encounter and coordinate its remediation within the required time frames. The team actively manages and tracks error resolution through completion. Corrected encounters with repairable errors are included in the next encounter build processes and resubmitted.

The Enterprise Encounter team tracks all encounter submissions through file tracking and acknowledgement response files from the FA. Analysts address identified issues by correcting and resubmitting files that were not successfully transmitted. This may be accomplished internally or through collaboration with the DHS, as necessary.

Controls to ensure complete encounter submissions

Financial reconciliation between paid claims and submitted encounters is another critical responsibility of the Enterprise Encounter team. Our dedicated team members will examine our weekly encounter reconciliation report, comparing total claims processed to the number of submitted encounters. This process is accomplished through a reconciliation of encounters submitted and accepted to the CDJ related to claims adjudicated, by both dollars and volumes metrics.

At specific milestones throughout the encounter submission process, plan and subcontractor encounter status data will be reconciled to the CDJ to confirm that all claims processed during the period have been submitted to the FA.

Service level monitoring and standard reporting

To monitor service level performance per requirements, AmeriHealth Caritas has developed a suite of standard encounter reports which are produced automatically on a weekly or monthly schedule. The reports can also be produced upon request. A list of the report names is shown below along with a brief description of the purpose of each report.

Report Name	Description
Error Rejection Summary	Claim/encounter counts for each DHS error identified.
Error Rejection Detail	Claim/encounter detail to the error summary report.
File Tracking Detail	Reconciliation results of each file submitted.

Report Name	Description
Financial Summary	Reconciliation results to financial information.
RA Summary	File disposition results for each file submitted.

Exhibit 13.5-C: Encounter Reporting Overview

2. Describe your experience and outcomes in submitting encounter data in other states.

AmeriHealth Caritas recognizes that submitting accurate, timely and complete encounter data is important for conducting data and rate analysis, HEDIS evaluations, and meeting many other DHS program requirements, including the state's submission of encounter data to CMS. As such, AmeriHealth Caritas has developed a robust encounter data oversight program for managing file submissions, analyzing and correcting any errors that may occur in the submission process, tracking and reporting of encounter acceptance rates, and reconciling encounter submissions to cash distributions. We are proud of our success submitting encounters in nine other states and the District of Columbia. Through our robust encounter data program and data management system, we process and track approximately 60 million encounter lines annually.

The table below shows a summary of our historical experience with medical encounter acceptance:

Affiliate Health Plans	2014 Average Monthly Encounter Acceptance Rate
Keystone First/AmeriHealth Caritas (Pennsylvania)	95%
Select Health of South Carolina	99%
AmeriHealth Caritas Louisiana (Based on rolling 12 month period)	97%
Arbor Health Plan (Nebraska)	96%
AmeriHealth District of Columbia	95%

While each state has different encounter criteria and submission rules, AmeriHealth Caritas, through our dedicated Encounters Oversight department, has successfully met encounter requirement and is consistently improving our submission process to ensure that we continue to achieve these results.

AmeriHealth Caritas has implemented a CDJ reconciliation process for all of its health plans and will do so for our Iowa plan, as well. Our CDJ reconciliation is completed on a monthly basis, comparing the dollar value of accepted encounter records to the amounts paid to providers. According to the Mathematica Policy Research Institute, actuaries report that one of the most important validation checks for encounter data is the comparison of amounts paid to providers as shown on encounter records to the expenditures for provider payment reported in the financial reports.

Generating and securely transmitting HIPAA-compliant files

AmeriHealth Caritas securely exchanges inbound and outbound HIPAA-compliant files and other health information data through SFTP or VPNs with Medicaid entities in numerous other states. This includes claim/encounter ASC X12N transaction and response files, including:

- Batch transaction types:
  - 820 Premium Payment.
  - 834 Benefit Enrollment and Maintenance.
  - 835 Health Care Claims Payment/Advice
  - 837I Health Care Claims (institutional).
  - 837P Health Care Claims (professional).
  - 837D Health Care Claims (dental).
  - 277CA Health Care Claims Acknowledgement.
- Online transaction types:
  - 270/271 Health Care Eligibility Benefit Inquiry.
  - 276/277 Health Care Claim Status Request and Response.
  - 278 Utilization Review Inquiry.

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 data from and to ASC X12N formats and flat file/database file formats using WTX.

CISCO Tidal Enterprise Scheduler

CISCO's Tidal Enterprise Scheduler is used to manage and automate encounter file exchanges, including 837, NCPDP, TA1, 999 and 835 files, in accordance with submission guidelines. This automated submission process reduces manual operations, improves reliability and facilitates monitoring activities. The predetermined schedules allow alerts to be signaled if a file is not received or sent when expected, if a file transfer is not successful, or if any of the processing steps fail. These alerts are continually monitored so the problem can be resolved immediately.

13.6 TPL Processing

1. Describe your plans for coordinating benefits in order to maximize cost avoidance through the utilization of third-party coverage.

AmeriHealth Caritas's dedicated Payment Integrity TPL unit identifies and obtains third-party payer information, including Medicare, commercial insurance and/or accident-related coverage. The TPL unit expertly administers the collection and adjudication of TPL information.

Once TPL data are loaded into Facets, it is available immediately to all system users including claim examiners, member and provider service representatives, enrollment associates, medical management associates and cost containment associates.

Facets serves as the primary source for the plan's claims, referral, prior authorization, provider network and pricing agreements, and member eligibility data, including third-party liability and coordination of benefits (COB) information. This integration enables edits that check claims data against the other data stored in the system, including third-party coverage. These edits allow for greater claims processing accuracy and efficiency during the COB process. The integrated information stored in the Facets databases is easily available to confirm eligibility and enrollment and TPL during the adjudication process.

Coordination of Benefits

Our claims processing system coordinates benefits for claims containing explanation of benefits (EOBs) from other insurance carriers. If the claim pends for manual review, it is routed to a claim examiner for further examination and processing. The COB module in Facets captures and displays line-level data of AmeriHealth Caritas' and the alternate insurer's allowed amounts.

This information supports specific reporting requirements and enables the Claim Department to process COB claims appropriately by using "flags" established with the Facets system. The flags assure that TPL information is considered prior to finalizing claim adjudication.

In the event the TPL information on the EOB does not match the TPL information documented in the system, the claim is routed via an automated workflow process to the Payment Integrity TPL Unit. The Payment Integrity TPL Unit verifies TPL data from the carrier, updates the member's information in the system and returns the claim to the Claim Examiner for COB.

2. Describe your process for identifying, collecting, and reporting third-party liability coverage.

AmeriHealth Caritas' TPL Unit obtains other insurance coverage of members from four main sources. They are state Medicaid Agencies (via proprietary file or 834 transactions), members or providers (self disclosed), TPL identification vendors (usually charge per new piece of TPL identified) and other internal departments (e.g., medical management).

Identifying and Collecting

State Medicaid agencies: Most of our client states utilize a proprietary file to provide member TPL information. The files come in via a secured site and are then run through extensive inbound logic to ensure data integrity. Disposition reports are generated after each file load, confirming the disposition of every record on the file. These reports are analyzed and select records are audited by the TPL staff.

Member/provider self disclosed: The Enrollment department is required to ask members at the time of enrollment if they have other insurance coverage. Providers ask members at the point of service if they have other insurance as well. This information is passed to the TPL department where it is validated by contacting the other insurance company.

TPL identification vendors: AmeriHealth Caritas contracts with a TPL Identification vendor to supplement TPL data. Member eligibility data are submitted securely via file feed to the vendor. The vendor performs data matches and submits an electronic file that is run through the same inbound logic and process the state proprietary files are put through.

Other internal departments, through the normal course of business, may find out about members who have other insurance. Through our EXP workflow system, these associates can forward TPL information to the TPL Unit for investigation and updating into the claims processing system.

Reporting

State notification: In the event that a member's TPL information is updated or added via any of the sources mentioned above, a file of this newly updated information would be submitted to the state on a scheduled basis via an electronic file.

Cost avoidance and savings reporting: Claims savings and cost avoidance reports are available for each client state. Retrospective recovery reports are available on a monthly basis.

3. Describe your process to identify members with third party coverage who may be appropriate for enrollment in the Health Insurance Premium Payment (HIPP) program.

AmeriHealth Caritas will share TPL information with DHS on an agreed upon frequency via secure automated file transmissions. The TPL file will contain information, including the SID number, for members having other health insurance. This information will assist the DHS HIPP Unit to identify potential HIPP members.

13.7 Health Information Technology

1. Describe your proposed healthcare information technology (HIT) and data sharing initiatives.

AmeriHealth Caritas understands the value of leveraging electronic health records (EHR) and is actively working with health information exchanges (HIE) partners in six states to increase sharing of EHR information to improve the quality of services for our members, enhance the effectiveness of providers and reduce the cost of healthcare services. AmeriHealth Caritas recognizes the key role that HIEs play in enabling effective transitions in care, improvements in health outcomes and reductions in cost of care. We believe and have demonstrated through our leadership elsewhere that health plans play a critical role in advocating for HIEs, supporting the exchange of information in a meaningful way and playing our part in ensuring privacy and security requirements are met.

AmeriHealth Caritas Iowa will work closely with providers to demonstrate the value of sharing EHR through its active participation in the Iowa Health Information Network (IHIN). Given our experience with EHR and HIE programs and the caliber of our key staff who have contributed to the national dialogue, we are well positioned to help Iowa providers recognize and leverage EHRs to improve patient outcomes,

develop targeted programs to affect improvements in population health and reduce costs for unnecessary or preventable hospital and ER admissions.

AmeriHealth Caritas Iowa will support IHIN and its growth in a manner that is similar to what we have done in other states, through incentives, financial support and advocacy to encourage providers to participate in the Iowa network. Through our involvement and support, we can create the stimulus to engage providers and with our track record we can demonstrate how the exchange of information is a win-win for both provider and plan. AmeriHealth Caritas Iowa will participate in IHIN as both a supplier and consumer of member information and will encourage use by Iowa providers as we continue to build our provider network in Iowa. We will also educate providers on the federal funding sources available to help them develop their programs and become active members of IHIN.

AmeriHealth Caritas has been a leader in HIE initiatives in states where we operate and an advocate for HIE initiatives across the country. As leaders, we are committed in shaping the future of Medicaid through our people, processes and technology. AmeriHealth Caritas Iowa, by receiving alerts for admissions, discharges and transfers (ADT), will be more effective in coordinating and managing member care and identifying opportunities such as reductions in avoidable ER visits. Making the health plan aware of member behaviors in near real-time creates an opportunity for pro-active intervention for member engagement and education.

In 2011, AmeriHealth Caritas developed one of the first health plan CCDs (C32) as part of a pilot program with the Kentucky Healthcare Information Exchange. The CCD and process has been enhanced over the years to include new data and recipients including member's medications pulled in real-time from our Pharmacy Benefits Manager, encounters (inpatient, emergency department and office visits), labs and radiology procedures, gaps in care, problem lists and diagnoses. PCPs, specialists and even home-health providers depend on this comprehensive summary of member care to ensure appropriate and timely care. This tool will be enhanced as required to meet and exceed all of the IHIN requirements.

2. Describe how you propose to interface with the Iowa Health Information Exchange.

AmeriHealth Caritas will utilize its multi-state HIE Gateway to support the various use cases and connectivity patterns for IHIN. The multi-state HIE Gateway is a flexible asset capable of connecting to the HIEs in our various plans (see below) to consume ADT information, receive Consolidated Clinical Document Architectures (C-CDA) from providers, as well as provide health plan C-CDAs back to providers. These capabilities will be enhanced as required to support IHIN. AmeriHealth Caritas will utilize at least two methods (Direct Secure Messaging (DSM) and Cross-enterprise Document Sharing (XDS)) for integrating with IHIN. All additional exchange requirements will be addressed as needed.

AmeriHealth Caritas has worked with several HIEs utilizing DSM to "push" or receive documents and transactions targeting DSM addresses. DSM is being used in the District of Columbia to share ADT information from local hospitals in real-time. DSM is also expected to be used in Michigan (MIHIN), Nebraska (NeHII) and Pennsylvania (HealthShare) to implement use cases in those regions. AmeriHealth Caritas is also evaluating the use of DSM for the secure exchange of other information to support administrative processes with healthcare providers where PHI is involved.

XDS is also utilized in a number of states where AmeriHealth Caritas has health plans including South Carolina (SCHIEx), Nebraska (NeHII), Michigan and in the near future with Pennsylvania (HealthShare). The applicable use cases vary but typically include pulling a consolidated C-CDA from the repository to support coordination of care for members who are transitioning from one care setting to another. Additionally, a health plan C-CDA, generated from information available to the plan such as claims, medications, labs, and gaps in care, is delivered to providers to offer them a comprehensive view of the member's encounters. The

HIE Gateway will be capable of addressing these use cases as well as others that IHIN and its partners may require.

While the flexibility and adaptability of AmeriHealth Caritas' multi-state HIE Gateway is its hallmark, what the platform does with the information in real-time once it is received is where the true value is delivered to our clients. Beyond the sophisticated processes for receiving, normalizing and storing the information, the platform is optimized to dissect, analyze and deliver actionable information in real-time to key members of the care team including PCPs, specialists and care managers.

AmeriHealth Caritas understands the volume of information available to providers and plans continues to grow as HIE adoption improves, however, not all information is actionable. Our HIE platform identifies important content, compares that content to the current member health profile from the clinical data repository (CDR) and routes the information to the most appropriate care team member to act on it.

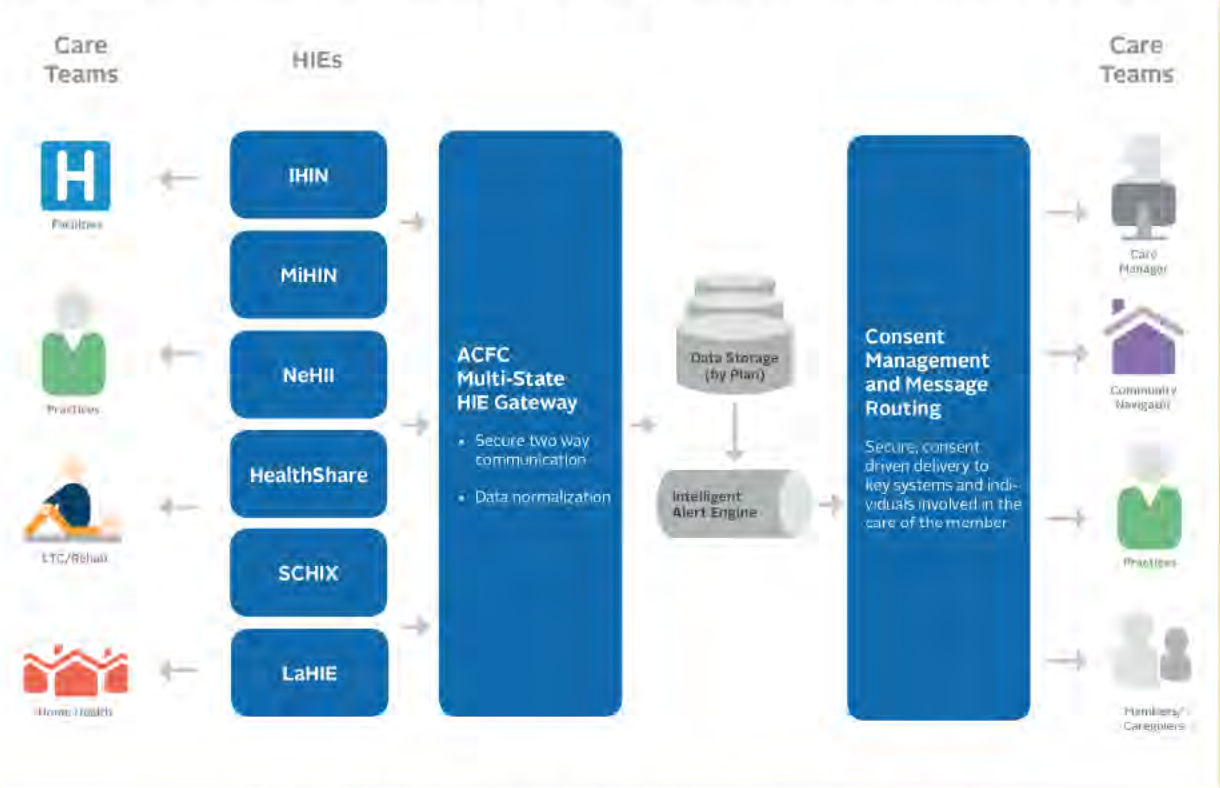


Exhibit 13.7-A: AmeriHealth Caritas HIE Gateway Overview

3. Describe HIT initiatives you have implemented in other states.

AmeriHealth Caritas has demonstrated extensive leadership with HIEs through the involvement of its clinical and Information Solutions leaders as listed below.

AmeriHealth Caritas' corporate Chief Medical Officer served since 2012 on the Board of Directors of HealthShare, the HIE covering the Philadelphia area and suburbs. She also speaks frequently on HIE and related topics, most recently at the American Medical Informatics Association. She is an incorporator of eHealthCt, served on the eHealthCt executive committee and as project committee chairman.

AmeriHealth Caritas' Medical Director for its First Choice by Select Health of South Carolina plan serves on the Board of Directors of SCHIX, the South Carolina HIE. He brings his clinical expertise around pediatrics to support the work of the HIE.

AmeriHealth Caritas' Director of Information Solutions Strategy and Innovation leads AmeriHealth Caritas' work with HIE's which includes foundational work with HealthShare, collaboration with HIE's in MI, LA, NE, and DC, and HIE development for AmeriHealth Caritas. He has spoken at numerous conferences on our HIE efforts including HIMSS, WEDI and Medicaid Innovations. He is an author of the book Implementing the Electronic Record: Case Studies and Strategies for Success, and was Annual Conference Chair at HIMSS15.

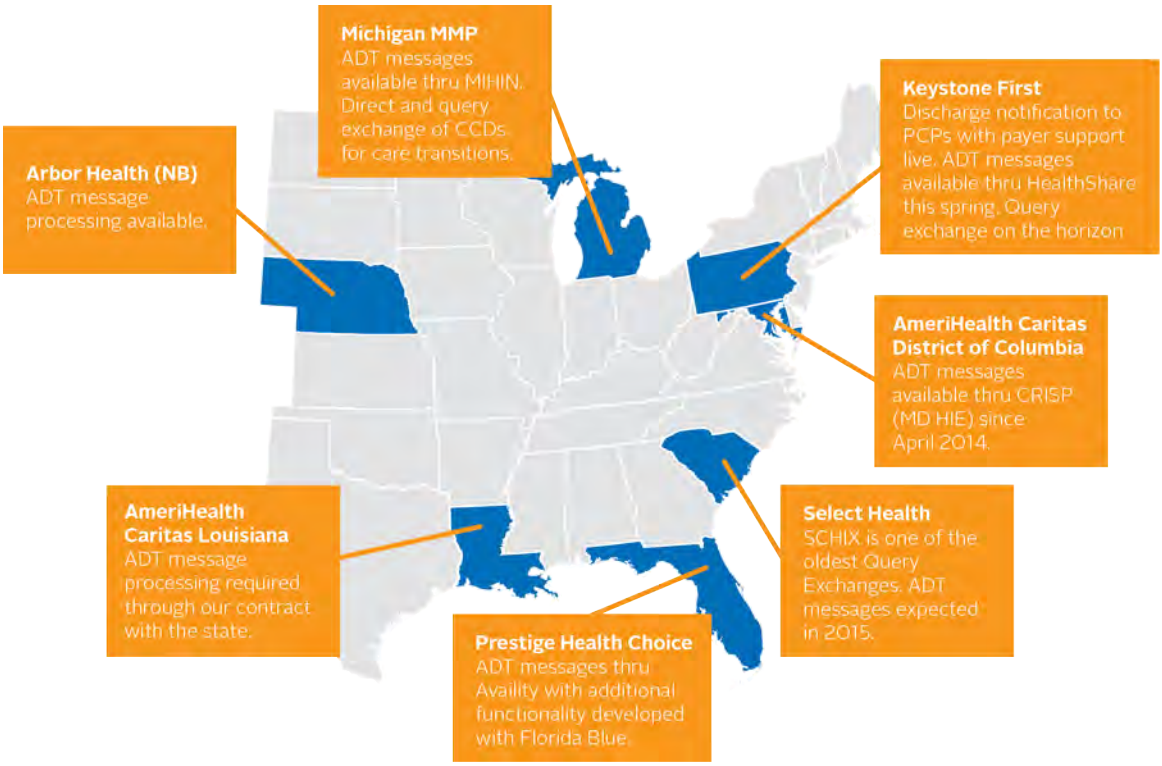


Exhibit 13.7-B: AmeriHealth Caritas HIE Collaboration

District of Columbia: One of AmeriHealth Caritas affiliates, AmeriHealth District of Columbia (AmeriHealth D.C.), is currently participating in the District of Columbia Health Information Exchange (DC HIE), which utilizes Maryland's Chesapeake Regional Information System for our Patients (CRISP). Six of the eight acute care hospitals in Washington D.C., as well as all 46 of the acute care hospitals in Maryland, are participating in the CRISP exchange. AmeriHealth D.C. has been receiving secure Health Level Seven (HL7) Admission, Discharge, and Transfer (ADT) messages from hospitals as part of CRISP's Encounter Notification System for over a year. These HL7 ADT messages communicate in near real-time a member's admission status for an inpatient admission or emergency room visit. The ADT messages are used by care managers to follow up with members after Inpatient or ER visits to support transitions in care. The system analyzes the messages against our plan member data to determine which encounter require immediate attention by a care manager. We are a financially contributing member of the exchange.

Southeastern Pennsylvania: HealthShare is the HIE covering Philadelphia and its adjacent suburbs. Home to five medical schools and over 40 acute care facilities, the greater Philadelphia area is estimated to be the fifth largest healthcare marketplace in the US. HealthShare was founded in 2012 by AmeriHealth

Caritas along with two other health plans and the major healthcare integrated delivery networks including; University of Pennsylvania Health System, Thomas Jefferson University Health System, Health Network, the City of Philadelphia and numerous other organizations. Since inception, AmeriHealth Caritas has played a pivotal role developing the founding use cases, supporting CMS Medicaid grant opportunities and participation on the Board and standing committees. HealthShare introduced DSM in 2014, will implement ADT alerts in 2015 and will begin a query exchange pilot by the end of the year. AmeriHealth Caritas is participating in all use cases and providing leadership around CCD structure and content which it has previously implemented elsewhere.

Michigan Health Information Exchange (MiHIN): MiHIN is one of the most established HIEs in the U.S. AmeriHealth Caritas has two health plans engaged with MiHIN, a Medicaid plan and a new Medicare and Medicaid Plan (MMP). The MMP is working with MiHIN and the state to establish a standard for exchanging information with behavioral health providers utilizing the C-CDA. AmeriHealth Caritas expects DSM communications, ADT alerts and other features to be implemented by the end of 2015.

Nebraska Health Information Exchange (NeHII): AmeriHealth Caritas' Arbor Health Plan is a member of NeHII and plans to receive ADT alerts and CCDs for its members. This, as with all AmeriHealth Caritas implementations will utilize our multi-state HIE Gateway.

Louisiana Health Information Exchange (LaHIE): AmeriHealth Caritas is working with LaHIE to plan for the implementation of ADT alerts in 2015.

AmeriHealth Caritas has a demonstrated commitment to the adoption of electronic health records and information exchange. We will encourage other healthcare constituents in Iowa to adopt these technologies to help drive improvements in the quality and cost of healthcare services.

Attachment 13.1-A: AmeriHealth Caritas Iowa Business Continuity/DR Plan

AmeriHealth Caritas Iowa

Business Continuity/DR Plan

Prepared by:
Corporate Business Continuity & Emergency Management Office
Original Document Release Date:
00/00/2015
Recent Document Release Date:
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Doc. Version:
Final 1.0 – Month Day, Year

Proprietary and Strictly Confidential:

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Sample Plan

AmeriHealth Caritas Iowa

Business Continuity/DR Plan

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AmeriHealth Caritas Iowa

Business Continuity/DR Plan

Approvals

Name	Title	Signature	Date	Version
	Market President			
	VP, Risk Management			
	Business Continuity			

Sample Plan

AmeriHealth Caritas Iowa

Business Continuity/DR Plan

1. Introduction

This Plan is to provide an understanding of the actions AmeriHealth Caritas Iowa (ACIA) will fulfill for services provided in the event there is an incident/disaster impacting the ACIA office to maintain a continuity of services. This Business Continuity Plan (the "Plan") provides the ACIA Leadership and Business Continuity Teams information for determining the extent of damage, the status of employees, and the ability to restore services in the required timeframes. It also outlines the procedures for the declaration of a disaster, relocation to an alternate site, and the restoration of the primary data processing facility.

1.1 Use of this Document

This is a living document updated to reflect the current environment and needs of the business. Please be sure you are referring to the most recent version of the Plan as defined under *Recent Document Release Date* and *Doc. Version* on the cover and footer. The Plan is reviewed at least annually by ACFC Corporate Business Continuity & Emergency Management Office and the ACIA Business Continuity Team to incorporate any necessary changes and actions needed to ensure continuation of services in the event there of an incident/disaster impacting the ACIA office.

1.2 Purpose of this Plan

The purpose of this Plan is to provide guidelines and instructions for each associate within ACIA business units in the event there is an incident/disaster impacting the ACIA office.

This Plan is intended to:

- Provide an effective method of communication during a crisis situation.
- Eliminate, or at least minimize the risk of service disruptions to critical business functions caused by natural, technological or human error problems.
- Maintain the ability to expeditiously resume critical operations in the event of an emergency through the use of predetermined checklists that assure rapid and accurate recovery.

1.3 Definition of a Disaster

ACFC defines "***Disaster***" as a crisis situation causing wide spread impact which exceeds ACFC's or Line of Business' ability to recover under normal circumstance or processes.

1.4 Services Performed

1.4.1 Services Performed in the Other Offices

This Plan applies to the ACIA offices for the services performed at *[location address here]*.

- Business function name here
- Business function name here
- Business function name here
- Business function name here
- Business function name here
- Business function name here

1.4.2 ACIA Services Performed in Philadelphia and/or Jacksonville

This Plan does not apply to services performed outside of the ACIA Office. Philadelphia and Jacksonville have business continuity plans to recovery the services below.

Jacksonville

- Business function name here

Philadelphia

- Business function name here
- Business function name here
- Business function name here
- Business function name here
- Business function name here
- Business function name here

1.5 Plan Testing

This Plan is typically tested as needed (and at a minimum annually) in a tabletop walkthrough format with the Regional President, ACIA Market President, Corporate Business Continuity and employees. Once a tabletop walkthrough test is executed, test results are properly documented to include the lessons learned, findings and observations. The Plan is then updated with the learnings and distributed to the employees.

1.6 Supporting Plans

This Plan may be implemented in conjunction with our Enterprise Crisis Management/Communication Plan, Pandemic, Business Area Continuity and Disaster Recovery Plans.

1.7 Roles and Responsibilities

ACIA Management Team Roles and Responsibilities:

- Provide strategic direction and oversight to ensure an effective response is undertaken
- Establish and maintain clear communication channels / provide briefings to the media and the public
- Manage potential damage to the reputation of ACIA
- Authorize business continuity plan activation
- Authorize expenditures needed to recover from a disaster
- Keep partners and key stakeholders and the Crisis Management Team/Crisis Management Team informed
- Receive and consider situation reports
- As appropriate, requesting assistance from local authorities/agencies/parties

ACIA Business Continuity Team Roles and Responsibilities:

- Execute the business continuity plan
- Participate in the plan execution and co-ordinate the recovery phase of the incident
- Maintain an accurate log of decisions made and actions taken during the incident to facilitate feedback and lessons learned
- Manage ACIA's operational response to the incident, providing a single point of contact for decisions likely to affect the ACIA office
- Co-ordinate AmeriHealth Caritas' operational response in liaison with Business Units and/or Line of Business offices
- Ensure prioritization of critical business services
- Provide appropriate information on tactical issues to the Crisis Management Team/Operating Committee informed
- Provide ongoing and consistent communication and information to the staff

AmeriHealth Caritas Iowa

Business Continuity/DR Plan

1.8 Notification/Communication Tools

AlertFind (AmeriHealth Caritas Emergency Notification System)

AlertFind is the recommended tool to quickly notify and convene the ACIA Business Continuity Team, associates, or the Crisis Management Team. AlertFind may also be used to communicate updates, additional instructions or information to the associates. AlertFind can facilitate sending of emails; SMS (text) messages, and voice calls to anyone, anywhere, at any time and on any device. A recipient may receive a notification in one of six ways:

1. Incoming call on Blackberry
2. Incoming call on Work Phone
3. Incoming e-mail to Outlook
4. Text message to Blackberry
5. Incoming call on Cell Phone
6. Incoming call on Home Phone (After Hours and on Weekends Only)

E-mail (Outlook)

- During a disaster response, Outlook distribution lists will be used to communicate with the various teams. If necessary, additional members may be added by the owner of the Distribution List.

AmeriHealth Caritas Enterprise Emergency Hotline

- The emergency hotline will be used to provide updates, additional instructions or information for associates
- The Market President and Voice Network Services (Philadelphia) will be responsible for updates to the hotline messages as needed. Procedures have been provided to the responsible parties.
- **Emergency Hotline Number:** 1-800-521-5565

Conference Bridge Lines

- During a disaster response and activation, the bridge lines will be activated and utilized throughout the response.

ACFC Crisis Management Bridge Line	Business Recovery Bridge Line	Disaster (IT) Recovery Bridge Line
Toll Free: 1-719-867-1571	**Toll Free:** 1-877-860-3058	**Toll Free:** 1-719-325-2630
# of Participates Permitted: 125	**# of Participates Permitted:** 125	**# of Participates Permitted:** 125

Service Desk Assistance

- Contact the Service Desk if you are experiencing an technology issues when working from home at **1-855-547-HELP (4357)**

Sample plan

2. First Response, Damage Assessment and Notification Procedures

2.1 Evacuation

ACIA has an Evacuation Plan with assigned emergency coordinators, fire wardens and floor captains, floor marshals and assembly captains. Emergency coordinators, fire wardens and/or floor captains are responsible for directing associates to the nearest exit in the event of an emergency, provide support to evacuate personnel in a safe an orderly manner to their assigned assembly area and assist the Floor Marshals with head count. Emergency coordinators, floor marshals and/or assembly captains are responsible for directing and monitoring evacuated associates while at the assembly area, assisting department managers and fire wardens and floor captains with personnel head count at the designated assembly areas.

2.2 Notification of Damage Assessment Team

Depending on the nature and extent of the incident, the Damage Assessment Team will be notified to visibly inspect damaged and destroyed structures and other facilities. Their first responsibility will be to assess damages and declare the level or severity of the incident and thereby the level of response needed to survive and recover.

ACIA Damage Assessment Team	
Name	Role
	Executive Management
	Facilities
	Data and Technical Services

2.3 Preliminary Damage Assessment

Report details will be provided by the damage assessment team. Reports and updates will be distributed to the ACIA Business Continuity Team based on the nature and severity of the situation.

Sample Plan

3. Plan Activation and Notification Procedures

3.1 Plan Activation

Only authorized ACIA Leadership may direct the activation/deactivation of the Plan. These include:

- Regional President
- Market President
- Corporate Business Continuity & Emergency Management

The Plan (or a component) will be activated when one or more of the following criteria is/are met:

- The incident cannot be managed through normal operational procedures.
- An issue is likely to cause widespread disruption to the majority of services.
- An AmeriHealth Caritas site accommodating multiple services is rendered unavailable
- The incident is a direct result of failures of other external resource or third party suppliers which directly impact ACIA's ability to deliver services.

3.2 Notification of ACIA Business Continuity Team

AlertFind is the recommended tool to quickly notify and convene the ACIA Business Continuity team. The following broadcast group in AlertFind, "**ACIA Business Continuity Team**", shall be used.

Business Continuity Team	
Name	**Role**
	Incident Commander
	Corporate Business Continuity & Emergency Management
	Title/Business Function Name
	Title/Business Function Name
	Title/Business Function Name
	Title/Business Function Name
	Title/Business Function Name
	Title/Business Function Name
	Title/Business Function Name

3.3 Emergency Operations Center (EOC)

Based on the results of the damage assessment inspection and the duration of the incident/event, an Emergency Operations Center (EOC) location will be selected to manage the event. The primary EOC may be on-site. The alternate EOC should be located off-site. If neither is available, team members will utilize a conference bridge number.

In the event of a disaster or emergency, the ACIA Business Continuity Team, a Crisis Management Team or an Emergency Management Team will convene at a physical location known as the Emergency Operations Center (EOC). From this location the Teams will manage the disaster or emergency and recovery process.

3.4 Declaring a Disaster

Based on the results of the damage assessment inspection, the duration of the incident/event, the impact to the business and its operations, the Crisis Management Team (at Corporate) will determine if a declaration of disaster is necessary.

Sample Plan

AmeriHealth Caritas Iowa

Business Continuity/DR Plan

4. Plan Administration

4.1 Business Continuity Strategy

4.1.1 Overall Business Continuity Strategy

In the event a business or technology disruption or disaster affects the staff and or the ACIA office, business contingency plans exist that allow us to continue operations while minimizing down time. We are able to rapidly shift operations as necessary to our Philadelphia or Jacksonville location. Our IS infrastructure is shared throughout the organization, member services, provider services, and medical management employees in other regions can be quickly granted permission to access appropriate data, making the transition seamless to the caller.

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

Each business area has a specific Business Area Continuity Plan for their respective critical business functions and processes. Business (Area) Continuity plans for business units are maintained and are exercised annually.

4.1.2 Business Function MTODs

Maximum Tolerable of Duration is the maximum allowable time that ACIA's essential business services is made unavailable or cannot be delivered before its impact is deemed as unacceptable.

Business Function Name	Maximum Tolerable Outage Duration (MTOD)
Business Function Name	24 Hours
Business Function Name	
Business Function Name	
Business Function Name	48 Hours (2 Days)
Business Function Name	
Business Function Name	
Business Function Name	
Business Function Name	72 Hours (3 Days)
Business Function Name	
Business Function Name	
Business Function Name	96 Hours (4 Days)
Business Function Name	
Business Function Name	
Business Function Name	120 Hours (1 Week & Beyond)
Business Function Name	
Business Function Name	

45.1.3 Workforce Recovery

ACIA's business continuity and emergency response capabilities are currently in place and are continually updated to meet the needs of the business and members. In the event of a loss of staff or building, ACIA has contingency workforce recovery plans in place to ensure continuance of operations with minimal disruption. Business Continuity capabilities include:

- Locations in multiple states that allow ACIA to rapidly shift critical operations (member calls) to Philadelphia or Jacksonville in the event of a loss of operations, staff or buildings.
- ACIA employees performing administrative functions will continue performing their functions from home.
- ACIA's Business Continuity plan is also part of the AmeriHealth Caritas Enterprise Pandemic Plan component.

4.1.4 Crisis Management/Crisis Communication

At the onset of a crisis, news is likely to spread quickly. ACFC's Enterprise Crisis Communications Plan ensures that all necessary notifications are reliably completed. The Enterprise Crisis Communications Plan establishes procedures related to communications with internal and external audiences (i.e., associates, members, providers, media, local, state and federal government, community, etc.).

The Crisis Management Team has primary responsibility to effectively managing any crisis that might affect ACIA and for that matter, any ACFC location.

During crises, ACIA has processes that address the needs of emergency response operations and recovery management. To address such emergencies, ACIA has established emergency response procedures that provide guidelines for the management of the immediate actions and operations required to respond to an emergency or disaster.

The overall objective is to respond to an emergency condition or disaster and manage the process of restoring normal business operations.

4.1.5 Disaster (IT) Recovery

Corporate Data Center Infrastructure Capabilities

ACFC's primary production data center has controls and capabilities in place to minimize the impact of any adverse event that would impact our ability to maintain critical systems. These include:

- Dedicated UPS (battery) and generator as a double backup. Contracts exist with fuel vendors to ensure that we can continue to operate our generator for an extended period of time
- Multiple power feeds to the data center
- Appropriate physical security, HVAC and power appropriate for a dedicated data center such as ours exists
- Continual real time monitoring of the data center operations exists to identify and address any issues that could impact the facility, so that immediate action can be taken
- The data center is elevated (2nd floor) to avoid any flood related issues

Disaster Recovery Capabilities

AmeriHealth Caritas' disaster recovery location is a dedicated facility which provides a "hot-cold" recovery solution. The solution employs a disk to disk (Data Domain) recovery for Tiers 0 and 1 applications with staged servers providing technology recovery due to a loss of the corporate data center located in Philadelphia. The DR solution consists of redundant wide area connectivity to a recovery data center located outside of a 50 mile radius of the current corporate data center.

- Scalable computer network that links the corporate data center with the recovery data center in Reading, Pennsylvania with built-in redundancy
- Staged server solutions to support recovery due to loss of the primary facility
- Disk to disk recovery for all tier 1 applications
- Full control over enhancements and testing of the technical environment
- Full control of the disaster recovery environment
- Routine maintenance consistency with the corporate data center and the recovery data center

AmeriHealth Caritas Iowa

Business Continuity/DR Plan

AmeriHealth Caritas can recover critical applications from a disaster within the all specified service levels detailed within the service agreement.

The AmeriHealth Caritas Disaster (IT) Recovery Plan is designed to support the detailed recovery of AmeriHealth Caritas business critical applications and infrastructure hosted at the AmeriHealth Caritas Data Center.

Disaster Recovery Plan Testing
Our disaster recovery capabilities (IT) are also tested annually to ensure that our technology capabilities can be quickly recovered to ensure continuity of business processes.

Voice Communications
ACFC relies on its Voice Network Services team to support the Avaya phone infrastructure. The ACFC telephony backbone is the Avaya™ Communication Manager (r5.2) System. This is configured with the Critical Reliability architecture to ensure optimum performance and uptime of all telephony systems and services needed to support our 24/7/365 call center.

ACFC also utilizes the Avaya Single Image Switch architecture; a fully distributed IP-based phone system. This system provides feature transparency across ACFC and also extends contact center and other telephony applications throughout the enterprise. This architecture allows for seamless routing of call routing capabilities to any of our sites. In the event of an outage or service impacting issue at the main Philadelphia call center campus, calls can easily and seamlessly be redirected to any other location within the enterprise.

The main Avaya Communication Manager server resides at 200 Stevens Drive and supports all ACFC locations including our data center and all Lines of Business offices. The secondary standby server is located at 100 Stevens Drive. Since ACFC has migrated to the Avaya single image switch platform, all Lines of Business offices are fully capable of providing contact center call handling for any type of situation.

This architectural design also takes into account survivability in the event of wide area network failures. If any ACFC site were to lose connectivity to the main Avaya server, the local Avaya gateway(s) at the Line of Business office would then register to the local Avaya Communication Manager standby server. In essence this site would function as a standalone PBX and would be fully capable of servicing calls.

In the event of a shutdown of any Line of Business office, full phone system functionality can be achieved by the Philadelphia corporate site, or any other Line of Business offices. Calls would be redirected by our phone providers to such location so to provide seamless transition of call handling during any impactful event.

Ultimately, the goal is to provide real-time component and full data center redundancy that will provide our customers, members and providers with virtually no down time in the event of a technology failure or data center disaster.

4.2 Continuity of Services

The essential business services below, performed in Iowa, have identified contingency strategies to maintain business services in the event of an environmental or weather related event.

4.2.1 Contingency Plan Strategies for [business function name]

Supports LOB:

- [Enter LOB]

Contacts:

- Name, Title (Office: xxx-xxx-xxxx, Mobile: xxx-xxx-xxxx)

- Name, Title (Office: xxx-xxx-xxxx, Mobile: xxx-xxx-xxxx)

Impending Weather Readiness:

[Contingency Plan Strategies will be identified by the essential business function at time of Plan development]

Office Remains Open under Liberal Leave:

[Contingency Plan Strategies will be identified by the essential business function at time of Plan development]

Office Building is Closed and Contingency Plans are in affect:

[Contingency Plan Strategies will be identified by the essential business function at time of Plan development]

Power Outage and Office Building is Closed:

[Contingency Plan Strategies will be identified by the essential business function at time of Plan development]

4.2.2 Contingency Plan Strategies for [business function name]

Supports LOB:

- [Enter LOB]

Contacts:

- Name, Title (Office: xxx-xxx-xxxx, Mobile: xxx-xxx-xxxx)
- Name, Title (Office: xxx-xxx-xxxx, Mobile: xxx-xxx-xxxx)

Impending Weather Readiness:

[Contingency Plan Strategies will be identified by the essential business function at time of Plan development]

Office Remains Open under Liberal Leave:

[Contingency Plan Strategies will be identified by the essential business function at time of Plan development]

Office Building is Closed and Contingency Plans are in affect:

[Contingency Plan Strategies will be identified by the essential business function at time of Plan development]

Power Outage and Office Building is Closed:

[Contingency Plan Strategies will be identified by the essential business function at time of Plan development]

4.2.3 Contingency Plan Strategies for [business function name]

Supports LOB:

- [Enter LOB]

Contacts:

- Name, Title (Office: xxx-xxx-xxxx, Mobile: xxx-xxx-xxxx)
- Name, Title (Office: xxx-xxx-xxxx, Mobile: xxx-xxx-xxxx)

Impending Weather Readiness:

[Contingency Plan Strategies will be identified by the essential business function at time of Plan development]

Office Remains Open under Liberal Leave:

[Contingency Plan Strategies will be identified by the essential business function at time of Plan development]

Office Building is Closed and Contingency Plans are in affect:

Sample Plan

[Contingency Plan Strategies will be identified by the essential business function at time of Plan development]

Power Outage and Office Building is Closed:
[Contingency Plan Strategies will be identified by the essential business function at time of Plan development]

4.3 Provisions for Managing a Pandemic

We have a Pandemic Response Plan which is an all perils plan addressing the concern of a pandemic, which is a significant and prolonged reduction of staffing resources.

In a pandemic, ACIA will continue to provide staffing resources by:

- Providing associate remote access via VPN encryption
- Invoke social distancing practices (tele/video conferencing, limiting travel, etc.)
- Reduction or suspension of non-critical functions allowing cross trained associates to fill in critical functions
- Scheduling alternate or extended working hours

Sample Plan

5. Restoration of Normal Operations

5.1 Preliminary Home Site Test

ACIA's Facilities Management and Corporate Facilities Management will work with the landlord representatives and maintenance personnel to test facility prior to moving back.

5.2 Facility Verification

After facility is deemed to be safely accessible, the Building Landlord, ACIA's Facilities Management, ACFC Corporate Facility Management and IS leadership will perform a facility walk-through for evaluation purposes.

5.3 Restoration of Home Site

After the permanent site is ready for relocation, Business Unit Leaders will verify that the home site has all necessary resources, connectivity, and functionality to continue business operations. The Business Unit Leaders will report any problems found to the BCP Task Force for resolution.

Once this verification is complete, the Business Unit Leaders will decide whether to move the Business Units all at once or in stages (so as to maintain continuity of operations). The Business Unit Manager will also contact the Business Unit's vendors and customers to inform them as to when Business Units permanent location and contact information will take effect.

5.4 Resume Normal Operations

The BCP Task Force will de-activate the Disaster Declaration and Recovery Site. Contingency team will gather reports, logs and information to assimilate and provide a report to executive and senior management.

Sample Plan

6. Demobilization

Following a crisis, it will be necessary to demobilize and coordinate a smooth transition from emergency response activities to standard (or modified standard) daily operating procedures and evaluate the response.

6.1 Deactivation

Business Continuity Management will assess the impact of the crisis on operations, personnel, clients, partners, and vendors. Recovery from the pandemic can begin when it is determined that adequate personnel, supplies, resources, and systems exist to manage all or the majority of standard daily operating activities. The ACIA Leadership Team and the Crisis Management Team must approve deactivation and the transition plan.

6.2 Evaluation

It is essential following an emergency or incident for a formal structured debrief to be held. The aim of the debrief is to ensure that positive and areas for development experienced by the responders are discussed and recorded, from this the lessons identified can be used to amend plans as appropriate. A complete report will be generated and used to update existing Enterprise Plans, Emergency Management Plans and Business Continuity/DR Plans to prepare for future events.

The Corporate Business Continuity and Emergency Office will normally co-ordinate attendances at an internal debrief.

Sample Plan

Attachment 13.1-B: AmeriHealth Caritas Problem Management High Level Process

AMERIHEALTH CARITAS FAMILY OF COMPANIES

(PLAN NAME)

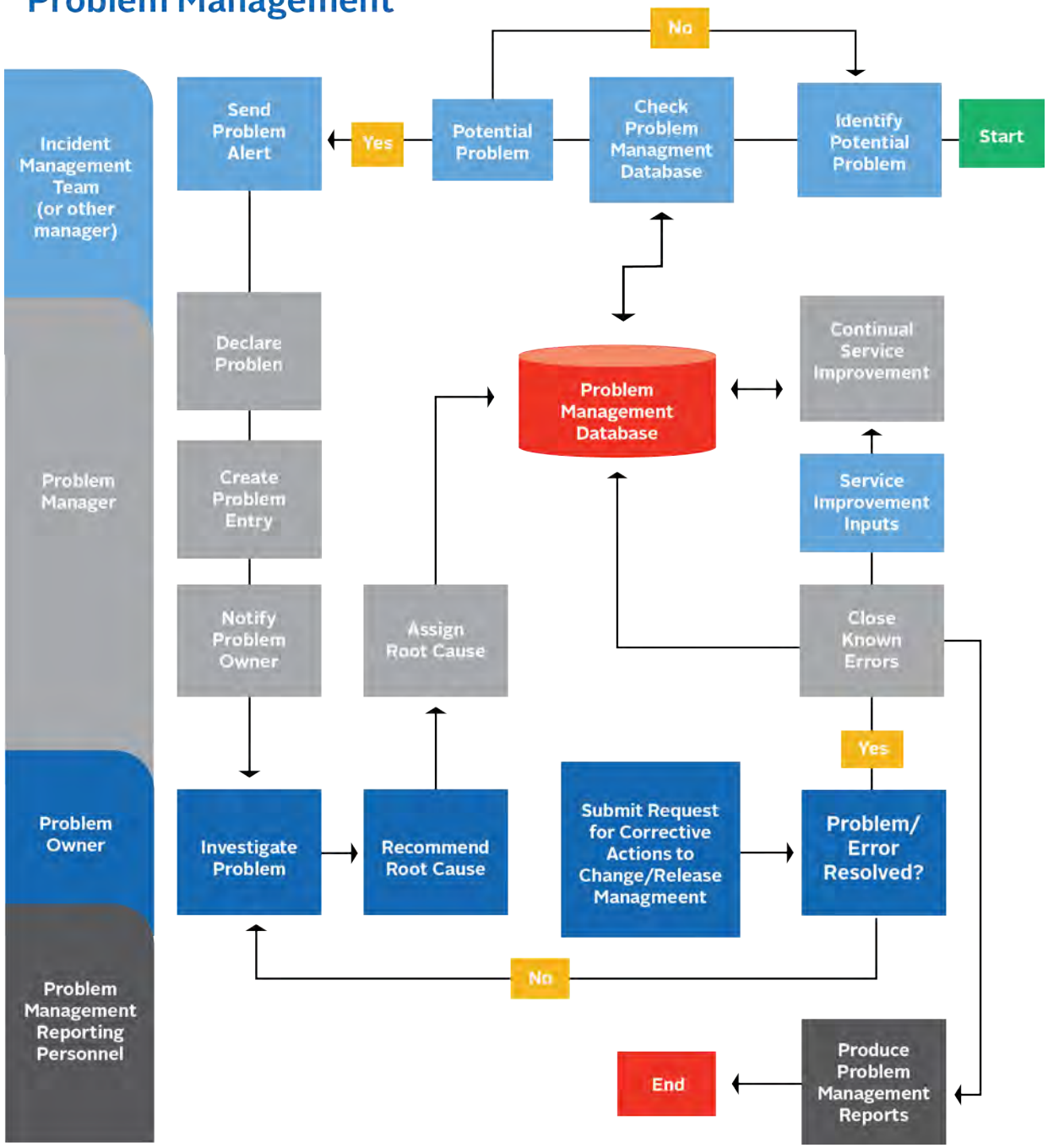
POLICY AND PROCEDURE

Supersedes:		**Policy No:**	**459-002**
		Page:	**1 of 3**
Subject:	**Problem Management High Level Process**		
Department:			
		Current Effective Date:	**2014-04-03**
		Last Review Date:	
		Original Effective Date:	**2014-04-03**
		Next Review Date:	
Unit:	Information Systems		
Stakeholder(s):	Information Systems		
Applicable Party(s):	All Information Systems Departments		
Line(s) of Business:	All		

Purpose: The purpose of the Problem Management process is to minimize disruption to the business by proactive identification and analysis of the causes of incidents and potential incidents by managing problems to closure. The Problem Management process is designed to investigate the underlying causes of incidents and proactively prevent the recurrence or replication of incidents or known errors.

Process:

Problem Management



Definitions:

Term	Definition
Problem	Any incident or set of incidents meeting the criteria, which the root cause and a method of resolution has not been identified.
Known Error	Any incident or set of incidents meeting the criteria, which the root cause and method of resolution have been identified, even if the resolution has not yet occurred.
Incident	Any event which is not part of the standard operation of the service and which causes, or may cause, an interruption or a reduction of the quality of the service.
Critical Incidents	Incident Management provides a ticket or report which identifies a single incident which has met the criteria for a Priority 1 incident.
Systemic Incidents	Incident Management identifies multiple incidents with similar root causes that are not part of an open problem, indicating a new systemic trend of incidents.

Related Policies and Procedures:

- **Problem Management Policy** 459-001
- **Problem Management Declaration Criteria – Priority** 459-003
- **Problem Management Root Cause Classification** 459-004

Superseded Policies and Procedures: None

Source Documents and References: None

Attachments: None

Prepared By: AmeriHealth Caritas associate

Date Prepared: 2014-04-03

Signatures of Approval of the Problem Management Policy and Procedures

The approval signatures below agree that Process Number 459-002 for Problem Management is accurate and states the AmeriHealth Caritas Family of Companies policy and procedures for the stated policy to the best of their knowledge.

Director of Client Experience and Production Operation

Signature Date

VP Infrastructure

Signature Date

Attachment 13.1-C: AmeriHealth Caritas Incident Management Run Book

1.1 - Document Purpose

The purpose of this document is to identify and define a set of procedures and policies guiding the identification, investigation and management of AmeriHealth related technology Incidents (Incidents) by the AmeriHealth Incident Management Team.

1.2 - Document Scope

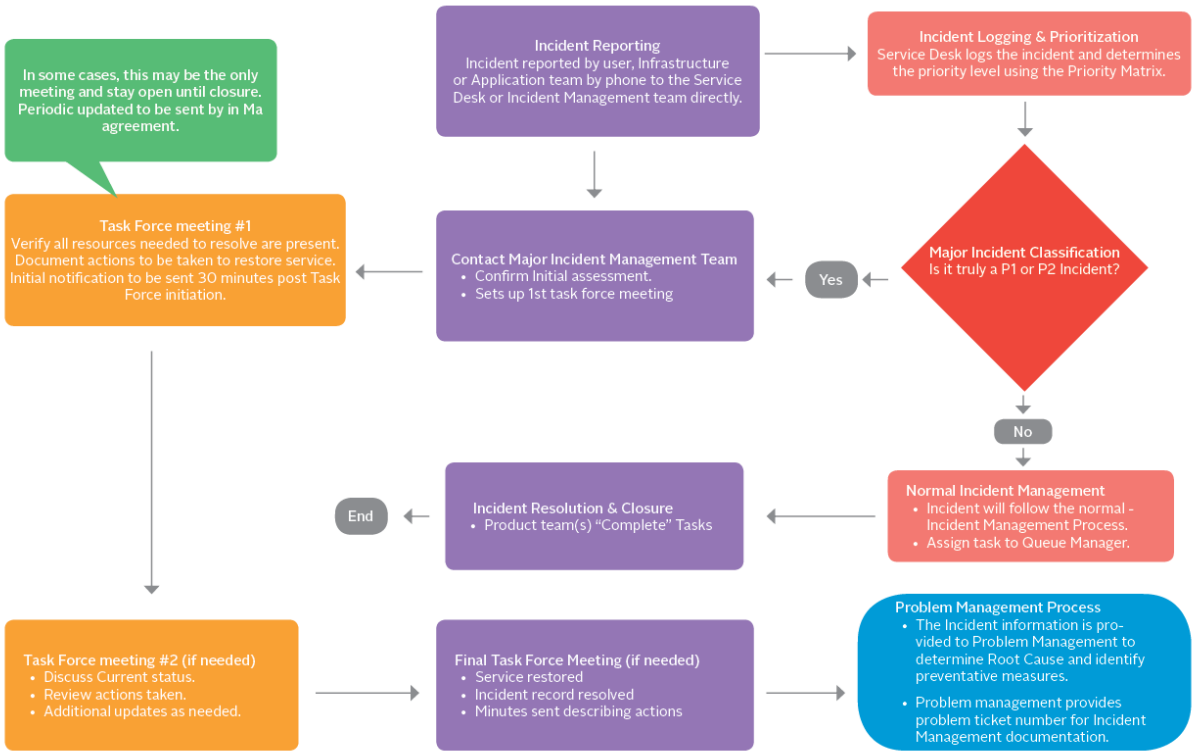
This document applies to all Incidents that impact the business of AmeriHealth and/or its partner organizations and/or its clients.

1.3 - Major Incident Management Process

Definition

The Process responsible for managing the Lifecycle of all Incidents. The primary Objective of Incident Management is to return the IT Service to Users as quickly as possible.

Major Incident Process Flow



Major Incident logistics can differ in the support needed. In some cases, the Task Force Meeting will continue throughout the lifecycle (Service Restored). During those events, periodic updates (every 1 or 2 hours as needed) will be performed using the pre-defined template; see page 18. Other Incidents may

require a separate management meeting to discuss status. The needs will be determined by the Incident Manager along with Senior Management.

1.4 - Priority Matrix – Initial Priority

Purpose

The purpose of this matrix is to provide guidance on establishing the relative initial priority of each Incident; considering what is known/suspected of the Impact to the business, and the Urgency of resolving the Incident, at the time of identification; a judgment.

Impact	Urgency	High (1)	Med (2)	Low (3)
		Needs Immediate Attention	Important to address in a timely fashion	Can be planned/scheduled
High (1)	-Critical deadlines missed -Unable to perform a mission critical function resulting in an area's ability to meet customers requirements -High Visibility with partners, customers or marketplace. Reputational Impact	1	2	3
Med (2)	-Measureable impact due to loss in funcitonality, productivity or revenue -Critical deadlines may be missed -Application unavailable -Entire group/department affected -Affects more than 5 users, Make this high urgency -Call Center lost connectivity or voice services impacted -Critical infrastructure component fails, but a workaround exists- make this a high urgency	2	3	4
Low (3)	-Affects less than 5 users- make this a High urgency -Failure causes client to be unable to perform a small portion of their jobs but are till able to complete other tasks and/or requests -SIngle user (workstoppage) Make this a High Urgency -No Impact- workaround exists for a non critical service. Make this a low Urgency.	3	4	5

1.5 - Priority Matrix – Actual Impact

Purpose

The purpose of this matrix is to provide guidance on establishing the actual priority of an Incident; considering what is known/suspected Impact to the business, at one or more points during the Incident's resolution phase, or immediately following its resolution for up to 1 week; a judgment.

Priority Matrix — Actual Impact

Priority	Descriptions	Additional Factors & Examples for Consideration
Critical (1)	• Critical deadlines missed. • Unable to perform a mission critical function resulting in an area's ability to meet customers requirements. • High visibility with partners, customers or marketplace. Reputational impact. • Tier 1 application down across multiple LOB's for an extended period of time. • Data Center down. • Significant Financial Impact.	• Incidents can evolve to a P1 status depending on the time an application is down/slow, site down. • Data Center down. • Multiple Center down. • Multiple Call Centers down or 1 for an extended period of time. • Jiva, Facets unavailable.
High (2)	• Measurable impact due to loss in functionality, productivity, customer experience, or revenue. • Entire group/department affected the performs a mission critical function. • Single Call Center lost connectivity or voice services impacted. • Tier 1 down across multiple LOB's.	• P2 incidents can become a P1 incident if the outage is long enough in duration. An example would be a Call Center being down for 30 mins. vs. 1 or several days would be a factor if the it's a P1 incident. The deciding factor would be the actual Impact (e.g. High visibility to customer, reputation impact, etc.). • Call Center • Connectivity internally or externally. Internet and Intranet as well as a remote office locations.
Med (3)	• Affects multiple users. • Single user (work stop page). • Non-Tier 1 Application slow/degraded. • Critical infrastructure component fails, but a work-around exists.	N/A
Low (4)	• No impact - workaround exists for non critical service. • Single user (small portion of their job duties). • Failure causes client to be unable to perform a small portion of their jobs but are still able to complete other tasks and/or requests.	N/A

1.6 - Service Desk Escalation

Purpose

The purpose of this procedure is to provide guidance on the actions of the Service Desk Team whenever an Incident has the potential to be, or is categorized as a "P1" or "P2"; a judgment.

Service Desk Escalation

Escalation Scope

All real or potential Priority 1 & 2 incident based on Priority Matrix definitions.

Escalation Process

In the event you become aware of an issue that you deem as being of real potential significant impact as outlined above:

1. The Incident Management team **must** be contacted **as soon as possible** by phone.
2. **Do not use email** as a vehicle for escalating.
3. Incident Management On-Call Blackberry: 1-215-983-3987 (Off-hours); if no answer, other Incident Management Team off-hours contact numbers are listed below.
4. Continued calling until someone on the Incident Management Team is reached in the following order:

First Name	Last Name	Desk #	Mobile #
-	-	X-XXX-XXX-XXXX	X-XXX-XXX-XXXX
-	-	X-XXX-XXX-XXXX	X-XXX-XXX-XXXX
-	-	X-XXX-XXX-XXXX	X-XXX-XXX-XXXX
-	-	X-XXX-XXX-XXXX	X-XXX-XXX-XXXX

1.7 - Incident Management - Golden Rules

- When unclear on initial assessment/Impact of an incident, escalate to next level of management within the Incident Management Team.
- Use the standard templates provided for notification & escalation.
- Notifications MUST be executed at regular intervals and according to the communicated next update.

- Consider need for splitting taskforces as needed.
- Consider contingency plans in parallel to primary resolution plans.

1.8 - Major Incident Process – Discovery thru Post Restoration

Major Incident – Definition

A Major Incident is defined as an event that has significant impact or urgency for the business/organization, and which demands a response beyond the routine Incident Management Process. A Major Incident will be an Incident that is either defined in the Priority Matrix as a P1 or P2 and or which:

Notification & Assessment: Once the Incident Management team is notified of a Potential Major Incident, the team performs an initial assessment of the issue (the goal is to complete the initial impact assessment within 15 minutes – the ITSM task is completed.). Answers to key questions below are used to judge impact:

- Application(s) impacted.
- Amount of users affected
- Associated error messages

Task Force Initiation: (15 minutes. post incident assessment) A determination is made if a Task Force is required to resolve the issue. In most cases, a Task Force is established. Notifications to the support teams needed to participate in the Task Force are sent by the Incident Management Team **Email to Text**. A **Meeting Invite** is also issued by the Incident Management Team to all Task Force participants for a conference call. This invitation "initiates" the Task Force. Factors to consider when initiating a Task Force:

- **Application(s) Affected:** Incidents limited to a single application or several applications that are dependent on each other would normally require the application representatives on the call, as well as the supporting Infrastructure teams.
- **Loss of Connectivity:** would indicate a Network issue and not involve Application support.
- **Infrastructure Reported Issues:** in many cases, a Task Force would be called only as appropriate.
- Service Desk, Security, Business Continuity Planning, and Disaster Recovery teams are invited to all Task Force meetings for Major Incidents.

Notifications: (30 minutes post Task Force Initiation) Notifications to the business, Sr. Infrastructure Leadership is the vehicle used to inform stakeholders of Issues. See Appendix for Communication Process

- Notifications come in a variety of forms and recipients including:
  - Text Messages to Sr. Infrastructure Management on progress
  - Level 0 Communication: IS Senior Management
  - Level 1 Communication IS Assessment Team
  - Level 2 Communication :DL-ACFC: Daily Turnover to notify morning callers and the business engagement side
  - Level 3 Communication 'AmeriHealth Caritas Enterprise' (Enterprise notification)

Notifications can vary based upon State, and or TPA requirements and performed based on contractual requirements –See Passport Health Plan Escalation Requirements 1.9 Page 9.

Post Incident: (48 hrs. to complete) Once the Incident is resolved, there are a number of steps needing to be performed until the Incident Management Team has completed their involvement:

- Problem & Lead ticket creation.
- Verifying all tickets are linked to the Lead ticket
- Outage section of Lead ticket is updated
- Major Incident spreadsheet updated
- Actual Impact assessment is completed based on matrix. This may require further analysis and discussion with business, application, and WFM to determine.
- Passport SLA documentation is retained for audit & reporting purposes.

1.9 - Passport Health Plan Escalation Requirements

Scope

These represent specific Service Level Agreement requirements for all Incidents related to Third Party Affiliate; Passport Health Plan. Failure to perform to these levels on a monthly basis will result in a contractual failure with specific, defined financial consequences to AmeriHealth.

Priority	Actions	SLA
P1	• Within 15 business minutes post "validation" by Incident Management Team: ○ initiate "Task Force" – send "invitation" to team • Within 1 business hour post "validation" by Incident Management Team: ○ Send initial notification to Passport DL • Every 2 business hours after initial notification: ○ Send update notification to Passport DL • Work does not cease until issue resolved	98%
P2	• Within 15 business minutes post "validation" by Incident Management Team: ○ initiate "Task Force" • Within 1 business hour post "validation" by Incident Management Team: ○ Send initial notification to Passport DL • Every 3 business hours after initial notification: ○ Send update notification to Passport DL • Work does not cease until issue resolved	98%

Priority	Actions	SLA
P3	• Within 1 business day post "validation" by Incident Management Team: ○ Support Team(s) begin addressing issue • ITSM record updated as resolution progresses • Updates to Passport as requested	98%
P4/5	• Within 5 business days post "validation" by Incident Management Team: ○ Support Team(s) begin addressing issue • ITSM record updated as resolution progresses	98%

Appendix

Assessing an Incident

Incident Assessment - Initial

The following guiding questions are for use in the initial assessment and judgment of Incident priority. See also "Incident Priority Assessment – Supplemental Question Set

Assessing an Incident

When assessing the Priority of an issue, one has to consider several factors. The following should be considered in order to make a proper determination:

- Number of users impacted.
- Damage caused by the incident has the potential to increase rapidly.
- Application affected.
- Business hrs. (Monday - Friday 6 a.m. - 7p.m.) or non-business of incident - If an issue occurs during the business day, the impact of the issue is typically than off hours. At the same time, impact is easier to determine during the business day since the volume of users calling will be significantly higher. However, an issue that occurs of hours, could be an indicator of a larger issue, which would be more difficult to determine at that of hour time due to the low volume of users impacted.
- Business function affected.

Questions to ask when assessing an issue:

- Is the application inaccessible.
- If the application is slow, what is the response time? If yes, when was slowness first noticed - is slowness limited to this one application?
- What business function is being impacted?
- If after hours for the end user, can this wait until the next business day morning?
- How many users are impacted?
- Is an entire office, site or floor down?
- Is the work affected time sensitive?
- Are any external partners or customers affected?
- Are the users internal or external?
- What level of impact is this having on your work?

Incident Priority Assessment – Supplemental Question Set

The following guiding questions are for use in managing Incident priority during the initial and post-initial phases of resolution.

1. **What application is affected?**
2. **Is the application down or slow?**
3. **What time did the issue start?**
4. **What is the ITSM#?**
5. **How many (potential or real) people are being affected?**
6. **What Line of Business?**
7. **Is the issue impacting users? (What aren't they able to do because of the issue?)**

If yes, how are they impacted?

Include in provider manual as appendix

Do we have a workaround?

8. Are there any real/potential financial or reputational impact?

   Did we miss any deadlines?

   Are external clients impacted?

9. How long (duration) did it take to resolve the issue?
10. What actions were taken to resolve the issue?

Off-Hours Infrastructure Support

The following guidelines apply to contacting Level 2 Development and Quality Assurance teams for assessment after normal business hours

Off Hour Infrastructure Support for Development and QA Support

Supported (must meet all 3 requirements)	**Not Supported**
Multiple user impacting issue.	Single user.
No workaround exists.	QA/Dev Application down but not impacting users.
The issue prevents users from performing a key task or function of their job.	

*Application owner should be the first point of contact for any application issue (e.g., slowness).

Incident Notifications

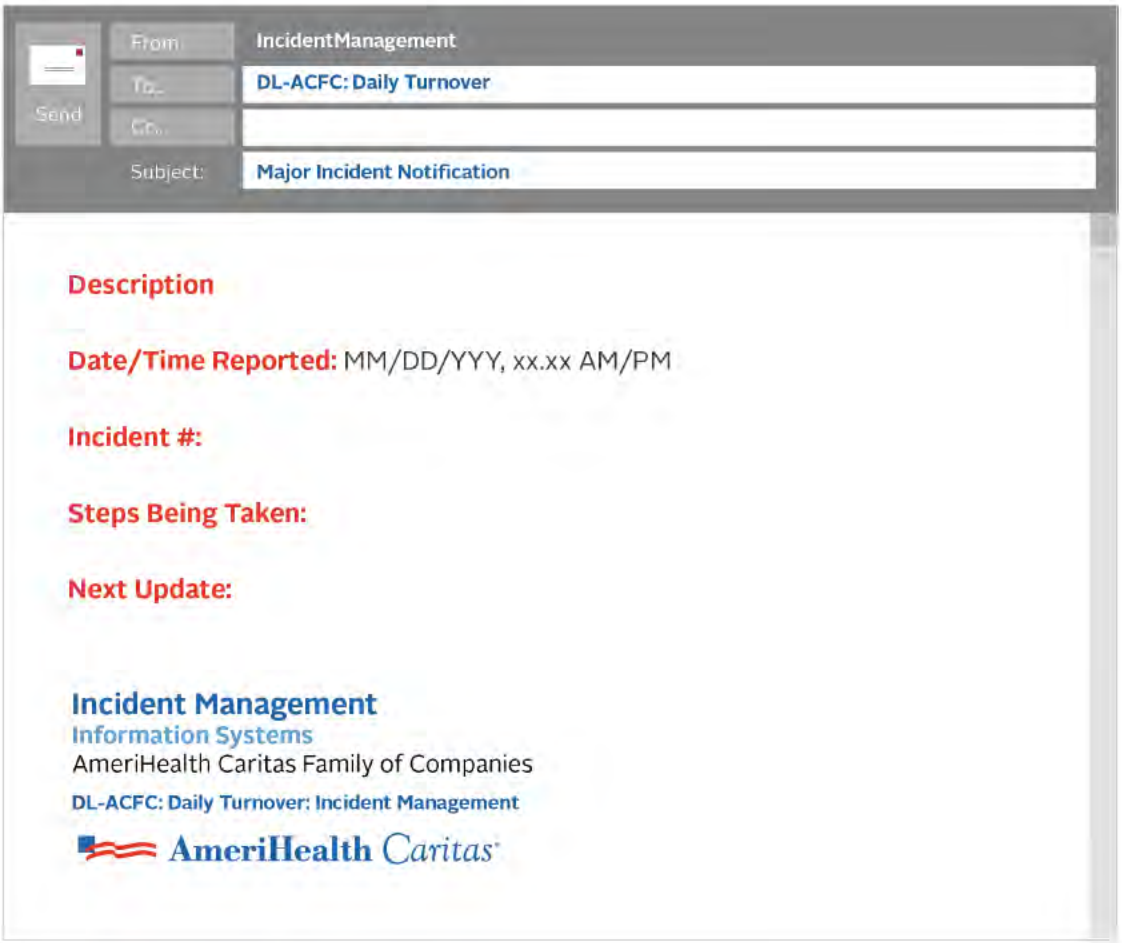
Incident Management Level Notifications

Target Audience/Recipients	Use Scenarios
Level 0	
Vice President of Infrastructure and all direct reports - The list provides the names of Managers and Directors that report to the Vice President of Infrastructure: • Dir. Server Architect, Infrastructure • Dir. IS, Infrastructure Management • Mgr. Database Administrator • Mgr. Information Services, Windows Server • Mgr. LAN/WAN • Mgr. Voice Network, IS Voice Services • Mgr. IS Information/Client Services • Mgr. Production and Change Control	This communication level would be used as informational when a Major Incident has occurred in the environment.
Level 1	
I.S. Assessment Team – The list provides a Primary and Alternate contact from the following IS Teams: • LAN/WAN • Windows Server • Unix / Linux Server • Sybase DBA • Oracle DBA • Voice Network • Service Desk • Facets Production Support • Production Control • Information Security • Desktop Engineering	This communication level would be used when a Major Incident has occurred in the environment. The notification would be sent to any and all of the teams identify to be part of the trouble-shooting efforts in order to restore service. We would initially start with the I.S. Assessment Team and expand to Additional I.S. Teams as necessary. Notifications are sent in the form of an e-mail and SMS text message to mobile phone contacts identified.

Target Audience/Recipients	Use Scenarios
Level 2	
DL-ACFC: Daily Turnover - The DL is made up of everyone in Level 1 in addition to contacts from the following departments: • Architecture & Data Management • Technical Writers • Corporate Sourcing • Accounts Payable • Medical Economics • Strategy & Shared Services • Contact Center • Service Operations • IT Integration • Pharmacy Operations • Account Services • Identity Management • Workforce Management • Financial Services • Enrollment • Payment Integrity Reporting • Vendor Management	This communication level would be used when a Major Incident has occurred and the business impact has been determined. The notification would be sent by the Incident Management Team to the DL-ACFC: Daily Turnover as soon as the business impact has been determined.
Level 3	
Enterprise Communication – An enterprise e-mail notification would be sent to all (or some) of the DLs listed below: • DL-ADC: All Associates (AmeriHealth DC) • DL-AHP: All Associates (Arbor Health Plan) • DL-ACFC: FTH-Associates-All (Florida True Health) • DL-MHA: All Users (MDWise Hoosier Alliance) • DL-LC: All Associates (LaCare) • DL-SHSC: All Select Health Employees (Select Health of SC) • DL-ACPA: All Users (AmeriHealth Caritas PA) • DL-PC: Employees (PerformCare) • DL-ACFC: ABC Users (Airport Business Center - Philadelphia Campus)	This communication level would be used when a Major Incident has occurred that is affecting the majority of users or a business critical application and/or function is unavailable. The notification would be sent by the Incident Management Team to any and/or all of the DLs identified, depending on the issue and whether it's affecting that business. Notification to Third Party Affiliates is performed by the Business Engagement Services team.

Standard Format of Incident Notifications

The format below is used by the Incident Management Team for Notification Updates and the Final Notifications (Resolved).



Miscellaneous Incident Management

Incident Management Meeting Minutes

Date	Time	Location	Incident #	Level of Communication
(Pick the Date)		Conference Line 719-457-1414 x2859695#		
Meeting Called By				
Current Issue				
Facilitator				
Invited Attendees				
Actual Attendees				
Description of Action Taken				

Incident Handling Scorecard

Use the following SLAs when rating the management of Major Incidents in the environment:

SLA/Score	1	2	3	4
Meeting scheduled with appropriate I.S. Teams within 15 minutes of incident awareness.	15 minutes or less.	15 – 30 minutes.	30 – 45 minutes.	45 minutes or more.
E-mail notification sent to appropriate business contacts within 15 minutes of incident awareness.	15 minutes or less.	15 – 30 minutes.	30 – 45 minutes.	45 minutes or more.
Update e-mail notification to appropriate business contacts is sent on-time as stated on previous e-mail(s).	On or before time due.	< 5 minutes after time due.	5 – 15 minutes after time due.	> 15 minutes after time due.
Final Update/Resolution e-mail notification sent to appropriate business contacts within 15 minutes of confirmed service restoration.	15 minutes or less.	15 – 30 minutes.	30 – 45 minutes.	45 minutes or more.

Date and Time	Incident Description	Source of Awareness	Awareness Method	Meeting Scheduled	E-mail Notification	Update e-mail notification	Final Update/ Resolution e-mail	Comment
		❑ Service Desk ❑ Infrastructure ❑ Application ❑ WFM ❑ Other	❑ Phone ❑ E-mail ❑ Other					

Front end ACD Message Administration (CAI Agent Only)

Purpose: To provide information to add and remove the AmeriHealth front end ACD message to help curb high volume due to a system outage, emergency, or other unusual situation.

Applicability: These instructions are applicable to the message administration through AmeriHealth's Service Desk services provider (CAI) only. These instructions cannot be executed outside of the CAI system, nor by any AmeriHealth associate.

The Incident Management Team determines and establishes the message, then the service desk supplier (CAI or other), or AmeriHealth Voice Team is engaged to execute the following procedure:

Criteria for putting up a front end message:

A message will only be posted if:

1. Call volume dictates that it should be posted
2. 1st level and 2nd level already have enough information on the outage that we do not need to continue troubleshooting the issue
3. AmeriHealth or CAI Service Desk management has been notified, and approves adding the front end message.

Procedure to Create a Front End Message:

1. Ensure criteria and approval defined above has been met.
2. Dial 5351 or (302)444-5351
3. At prompt "enter access code" type: 8615
4. At prompt "enter command" type: 7 (to record)
5. At prompt "enter message number"
   - Type 12 (the AmeriHealth message number)
   - Record message (see message examples below)

     Please Note:

     - It is important to speak loudly and clearly, and to turn the sound on your phone up before recording a front-end message.
     - Once you press 7, recording starts immediately so be ready with your message/text

     Samples below:
   - When complete press *
6. At prompt "enter command" type: 8 (to listen)
7. At prompt "enter message number" type 12 (the same number recorded above)
8. Press 0 and hang up

Examples:

Please PRECEDE all messages with: "Thank You for calling the AmeriHealth Caritas Service Desk."

Problems logging into Application X

"Thank you for calling the AmeriHealth Caritas Service Desk. This is a service announcement for

"Day," "Date," at "Time" AM or PM.

"Callers are currently having an issue logging into the X application. The application support team is aware of the situation and is currently addressing this issue. If you are calling for any other issue, please hold for the Service Desk."

Slow Response from Application X

"Thank you for calling the AmeriHealth Caritas Service Desk. This is a service announcement for

"Day," "Date," at "Time" AM or PM.

Callers are currently experiencing slow response times in the X application. The application support team is aware of the situation and is currently addressing this issue.

If you are calling for any other issue, please hold for the Service Desk."

Application X is "Down"

"Thank you for calling the AmeriHealth Caritas Service Desk. This is a service announcement for

"Day," "Date," at "Time" AM or PM.

Application X is currently not available. The application support team is aware of the situation and is currently addressing this issue.

If you are calling for any other issue, please hold for the Service Desk."

System Upgrade/System Release

"Thank you for calling the AmeriHealth Caritas Service Desk. This is a service announcement for

"Day," "Date," at "Time" AM or PM.

The Service Desk is experiencing higher than usual call volume because of the release (or upgrade) of Application X. If your call is not urgent, you may want to hang up and call back later,. Otherwise, please hold for the Service Desk."

Procedure to Remove a Front End Message:

1. Dial 5351 or (302)444-5351
2. At prompt "enter access code" type: 8615
3. At prompt "enter command" type: 7 (to record)
4. At prompt "enter message number"
    - Type 12 (the AmeriHealth message number)
    - Press *
    - You will hear "no message recorded"
5. At prompt "enter command" type: 0
6. Hang up

Incident Management - Taskforce Meetings

- 1st Taskforce Meeting:
  - Take attendance.
  - Ask participant with disturbing noise to go on mute.
  - Ask people who are not needed on the call to leave the conference.
  - Expand group as needed.
  - Next meeting (set date, time, venue, conference call number and pin).
  - Keep updates consistent and in accordance with 'Next Update' on template.
- 2nd and Subsequent Taskforce Meeting(s):
  - Check attendance
  - Obtain status
  - Set up Next Call if service is not yet restored.
  - Send out minutes (See appendix item "Incident Meeting Minutes", page 20)
  - If Service is restored, send out meeting minutes and final update notification.
  - Complete scorecard after meeting is over and service is confirmed as "restored". (See appendix item "Incident Handling Scorecard", page 16)

Document Update Log

This log contains the date this document was created, the date it was last updated and by whom, and a brief description of the changes made.

Date Updated	Description of Changes made:	Version	Name
9/30/2013	• IS Contact information	2	Incident Management
10/23/2013	• Additional communication if needed • Incident Management conference number • Distribution Lists • IS Assessment Team contact list • Table of contents	3	Incident Management
11/5/2013	• IS Assessment Team contact list • Email to text notification • Facility Contact information • Distribution Lists	4	Incident Management

Date Updated	Description of Changes made:	Version	Name
11/18/2013	• CAI Contacts for escalations • Front end ACD message administration • Enterprise Wide Area Network 2013, 2014	5	Incident Management
11/21/2013	• Account Managers and IS Engagement Consultants	6	Incident Management
1/10/2014	• Enterprise Wide Area Network • AlertFind Training and Documentation • Oracle On-Call Schedule • Updated Facility Contact Information • Updated IS Assessment Team Contact List • Added Operations Shift Times and Location	7	Incident Management
2/4/2014	• Added New Incident Notifications Templates • Added Operations Manager Information	7.1	Incident Management
2/11/2014	• Updated LAN/WAN Contact Information • Updated Facility Contact Information	7.2	Incident Management
3/4/2014	• VIP has been removed from the Priority Matrix	7.3	Incident Management
4/9/2014	• Added Questions on Reported Issues • Added Meeting Invite Sample • Added Incident Management Communications (Recipients) • Added Meeting Minutes Sample • Added Scorecard Sample • Updated Incident Notification Samples • Added Select Health After Hours Call Tree • Updated Section1.2 - Incident Management - Initiation to Restoration of Service • Updated Section 1.3 - Communication Process • Updated Section 1.4 - Incident Management - Taskforce Meetings	7.4	Incident Management
4/18/2014	• Updated the Incident Handling Scorecard	7.5	Incident Management
5/6/2014	• Added Alternate Conference Number & Passcodes	7.6	Incident Management

Date Updated	Description of Changes made:	Version	Name
2/26/2015	• Added updated IT Escalation Contact List • Added revised priority matrix	7.6.1	Incident Management

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14. Performance Targets and Reporting Requirements

Please explain how you propose to execute Section 14 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) operates in 16 States and the District of Columbia through its managed risk plans and ancillary businesses. In all of our markets, we have met or exceeded State performance targets and all State reporting requirements. Our 30 years of experience in managing Medicaid populations and partnering with States to address their goals have allowed us the opportunity to build the infrastructure and expertise to measure, report and improve performance. AmeriHealth Caritas has robust performance monitoring systems by which we access and use accurate and up-to-date information to drive better outcomes at greater efficiency.

- With 30 years of experience, AmeriHealth Caritas has the infrastructure and expertise to partner with Iowa in its reporting and performance goals.
- AmeriHealth Caritas' robust data and reporting measures will provide the timely and actionable information to best monitor and improve programs continuously.

1. Describe your plan to provide the reports described in the RFP, in the format required, and using templates that may be specified in the Reporting Manual and updated from time to time.

AmeriHealth Caritas Iowa will be able to provide all the reports in the RFP in the format required. As we have done in other new markets, all of our reporting capabilities will be extensively tested during implementation and communicated to the State for user acceptance testing prior to deployment to ensure accuracy and completion. The AmeriHealth Caritas Regulatory Reporting Unit, situated within our Finance department, will be responsible for submitting most reports. Our Regulatory Reporting Unit uses an internally developed database, the Reports Monitoring System, to track all reporting requirements. The Reports Monitoring System contains detailed data relating to each reporting requirement, enabling the Regulatory Reporting Unit to generate management reports and to ensure compliance with final submission due dates.

Our success in compiling accurate reports is due largely to the front-end work of our Regulatory Reporting Unit and the quality assurance mechanisms it has established. The Regulatory Reporting Unit reviews all RFPs, State Contracts, reporting manuals, operational memoranda and other correspondence that notifies of new or modified reporting requirements to compile all reporting requirements. These lists are used as working documents to coordinate internal discussions and establish data collection processes. The Regulatory Reporting Unit also identifies other internal departments and external subcontractors who may be affected by these requirements and creates work groups to identify relevant issues and questions. Requests for clarification are coordinated with our Compliance department to ensure full compliance with reporting requirements.

Our Regulatory Reporting Unit works across internal departments to develop report specifications that identify supporting systems, data requirements, reporting periods and the appropriate coding documentation to meet all reporting requirements. Based on the outcome of that research, a technical solution is developed to extract the required information from the most appropriate data source for the particular report. Reports are prepared according to requirements and, where possible, verified through benchmarking and/or trend analysis. The Regulatory Reporting Unit audits each report for accuracy and to ensure the report is in the correct format.

Before submission to the State, all reports are subject to review and approval by Regulatory Reporting and Finance management and the appropriate internal business owner(s). They undergo extensive testing by the Regulatory Reporting Unit. This documentation ensures consistency and continuity between reporting periods and supports the cross-training of staff. Hard copies of all report submissions and supporting documentation are maintained in central files, and electronic files are stored in discrete directories on a network drive that is backed up each evening.

Because of the time we dedicate to detailed reviews, development of report specifications, and report monitoring and quality assurance mechanisms, we are confident that we are able to provide Iowa with timely, accurate reports if awarded a contract.

2. Describe additional data/reports you are capable of providing that can help the State evaluate the success of the program.

AmeriHealth Caritas Iowa applauds the State for the comprehensive list of industry-standard performance metrics it has chosen. We believe that solid, actionable data drives good decision-making. This philosophy is the backbone of all of our quality programs across AmeriHealth Caritas plans. Our data systems allow us to monitor and measure a wide variety of performance metrics and use the results to refine our programs, ultimately improving the health outcomes of our members.

The Department of Human Services (DHS) has chosen a strong and comprehensive set of reports to help evaluate the success of the program. Given our experience in similar programs in other States, we believe there are two additional reports that might add value and help DHS continuously manage and improve the program:

- **Pharmacy utilization reporting**: With the growth of high-cost specialty medication utilization, we have found it increasingly important to closely monitor the appropriate use of these drugs. AmeriHealth Caritas Iowa will have detailed reports available to help evaluate and address any pharmacy utilization goals the State sets.
- **Care management reporting**: AmeriHealth Caritas Iowa can also supply detailed reporting to support its care management selection and engagement rates.

AmeriHealth Caritas Iowa is ready to provide the metrics and reports required in the scope of work (SOW) and also supply any additional requested reports to help the State evaluate contractor performance.

We have robust data management and reporting capabilities to not only assess performance, but also to provide actionable information to improve results. Below, we further detail the additional data and reporting we will use to improve performance and drive meaningful program changes.

Data Sources

AmeriHealth Caritas Iowa's robust data infrastructure allows us to collect, analyze and incorporate data from a variety of sources into our program evaluation and refinement cycles. Data sources include, but are not limited to:

- **Healthcare Effectiveness Data and Information Set/Children's Health Insurance Program Reauthorization Act (HEDIS®/CHIPRA) results:** AmeriHealth Caritas uses Inovalon's Quality Spectrum Insight, a National Committee for Quality Assurance (NCQA) HEDIS-certified product to create a HEDIS/CHIPRA reporting repository. This solution allows us to run monthly reports on progress toward HEDIS goals, identify low performing measures, and drill down to the member and provider level. The dataset serves as the backbone for our care gap infrastructure, allowing us to alert and report on overdue and missing recommended services to providers, and to AmeriHealth Caritas Iowa staff working with members. Provider-level data from this system also feed our provider performance programs. Note: AmeriHealth Iowa will also have NCQA-certified HEDIS auditors who review all results submitted to NCQA.
- **CAHPS results (adult and child versions):** We partner with NCQA-certified vendors to collect and analyze data and report on member satisfaction using the CAHPS survey tools. We analyze results at the individual question and composite score levels. Annually, we add approved questions to the survey to collect data on focus areas. This applies to all lines of business. In addition, our software can modify an existing HEDIS measure or create a new measure specific to Iowa.
- **Provider satisfaction survey results:** We use an outside vendor to objectively collect and analyze data on provider satisfaction with our utilization management, care management, quality, credentialing and provider service programs. The data collection tool is refined each year to collect data on areas of importance to the provider network.
- **Medical and pharmacy claim data:** Data from medical and pharmacy claim transactions in Iowa will be fed from our TriZetto Facets® (Facets) claim/eligibility system to AmeriHealth Caritas Iowa's data warehouse. We will use data from AmeriHealth Caritas Iowa claim transactions, as well as historical claim data provided by DHS as a starting point in our analyses of utilization rates, chronic care, maternity incidence and outcomes, clinical guideline performance and gaps and health outcome measurement.
- **Care management assessment data:** Data collected through the care management process are stored in our ZeOmega Jiva® care management system. Specific elements, including new member assessment responses, comprehensive and condition-focused assessments and barrier identification, are used to identify non-claim-related areas of focus and member response to interventions.
- **Eligibility and demographic data:** Eligibility feeds and updated demographic information collected by the Member Services team are entered into our Facets® claim/eligibility system. Member race, ethnicity, language and ZIP code/census block data are used to identify important subpopulations and geographic pockets with specific needs. Medicaid category and length of enrollment with AmeriHealth Caritas Iowa will be used to augment clinical risk score analysis.
- **Member and Provider Contact data:** The Contact Center of Excellence tracks reasons for and frequency of contacts to identify opportunities for program enhancement including improving and augmenting our administrative processes to enrich the customer experience as well as expanding communication, outreach and education related to contact trends.
- **Member disenrollment surveys:** The reason for disenrollment, along with responses from members who dis-enroll voluntarily, is collected by the Contact Center of Excellence. Information from member

disenrollment surveys is used to identify potential areas of dissatisfaction and/or gaps in health plan services.

- **Utilization data:** Utilization data are collected through our clinical care management system Jiva® and through analysis of claim information. Data on requested and incurred services are used for analysis of health outcomes, clinical guideline adherence and utilization management processes, such as prior authorization.
- **Claims, member eligibility, provider and third-party liability (TPL) data:** This data is utilized to identify additional TPL information for our Medicaid members, to identify potential overpayments from professional, outpatient, facility and DME claims as well as to identify potential incidents of suspected fraud and abuse.
- **Provider access and availability data:** We use GeoAccess reporting tools and data collected from provider assessments to evaluate network adequacy and provider adherence to appointment and availability standards.
- **Internal service data:** AmeriHealth Caritas Iowa's systems and processes will enable collection of performance data for all key service areas. Data related to AmeriHealth Caritas Iowa service levels, including call center service level performance (speed of answer, abandonment rate and hold time); transaction time (authorization and claim timeliness); and performance quality (claim accuracy, encounter acceptance and denial processing) will be used to identify areas of weakness and opportunities to improve performance.
- **Delegate subcontractor reports:** Monthly subcontractor report data are reviewed by staff overseeing delegate performance and aggregated to identify trends and potential areas of service improvement. Focus areas, as appropriate to the subcontractor's scope of service, include phone performance (speed of answer, abandonment rate and hold time); transaction time (authorization and claim timeliness); and performance quality (claim accuracy, encounter acceptance, denial processing and trip timeliness).
- **Clinical Risk Groups:** AmeriHealth Caritas Iowa licenses Clinical Risk Groups (CRGs) algorithms from 3M. CRGs are a risk-adjustment tool and clinically based classification system to measure a population's burden of illness through longitudinal analysis of medical and pharmacy claims data. Each individual is assigned to a single, mutually exclusive risk group. CRGs use the historical, clinical and demographic characteristics of the member to predict the amount and type of healthcare resources the member will use in the future.
- **Preventable Events:** AmeriHealth Caritas Iowa also licenses algorithms and software to identify and measure Potentially Preventable Events (PPEs) from 3M. PPE analysis will allow AmeriHealth Caritas Iowa to target interventions to members whose utilization patterns are most likely to improve through better access to and coordination of healthcare services. Conversely, a reduction in the level and number of PPEs indicates more appropriate use of healthcare services and a member's ability to better manage his or her condition.
- **Member medical records:** AmeriHealth Caritas Iowa will collect data directly from member medical records to support analysis of health outcomes. Lab data such as body mass index (BMI) and A1C values will be obtained from member medical records.

Within these data sources, AmeriHealth Caritas Iowa will identify key measures and results for ongoing monitoring. Performance goals and benchmarks, where available, will be defined for each measure based on performance targets, industry trends, State experience and quality committee recommendations.

Using SAS and other analytical tools, the AmeriHealth Caritas Iowa medical economics team will perform a more detailed drill-down analysis to understand the drivers of different results.

We will incorporate internal performance targets, standards and external benchmarks into our internal key indicator monitoring and reporting as we work with the State and provider partners to identify areas for additional analysis and, as necessary, implement quality improvement activities and corrective actions.

Using data to drive meaningful program changes

AmeriHealth Caritas has a strong track record of data-driven program improvements. The examples in the following section outline the data, reports and outputs used and actions taken in focus areas for the Medicaid beneficiaries across the States we serve.

Predictive modeling and stratification help us identify member needs

Clinical Risk Grouping identifies needs based on past claims

A key component of our approach focuses on identifying members whose clinical diagnoses and utilization demonstrate patterns that suggest the members are unable to manage their conditions on their own. To identify this population, we use the 3M risk adjustment and patient classification methodology to help us identify a target population. Our target population goes beyond the sickest members, including those who have serious chronic conditions that could lead to progressive health deterioration, making them future high utilizers of healthcare services. In our experience, this population benefits significantly from care management programs.

To complete this analysis, we use the 3M CRG, a risk-adjustment tool and clinically based classification system to measure a population's burden of illness. 3M CRG uses AmeriHealth Caritas's standard medical and pharmacy claims collected longitudinally to assign each individual to a single, mutually exclusive risk group. The underlying categorical clinical model for 3M CRG is applicable to all types of episodes, creating a uniform and stable clinical language. Across all potential configurations of episodes, such as window lengths, and included resources, the episode clinical model remains unchanged. CRGs relate the historical clinical and demographic characteristics of the individual to the amount and type of healthcare resources that the individual will consume in the future.

Since the CRGs are clinically based, rather than using a regression risk-adjustment model, they create a language that links the clinical and financial aspects of care. This language is easily understood by clinicians and therefore actionable. CRGs provide a comprehensive and clinically specific classification for a full range of populations.

Exhibit 14.0-A: CRG Assignment Phases

Our strategy in using CRG methodology is to focus on members with a dominant chronic condition, moderate chronic condition of asthma, or pregnancy. Dominant chronic conditions are serious lifelong conditions that if untreated often result in progressive deterioration of an individual's health, including heart failure, diabetes and chronic obstructive pulmonary disease.

Identifying Potentially Preventable Events to guide our care management

In addition to focusing on members who have chronic conditions, we also concentrate on members who have the highest potentially preventable utilization.

PPEs include avoidable hospital admissions and readmissions, unnecessary emergency room (ER) visits and ancillary services, and hospital-acquired complications. AmeriHealth Caritas currently monitors the following types of PPEs:

- Potentially Preventable Initial Admissions (PPAs) are avoidable hospitalizations based on conditions determined to be ambulatory care sensitive. Adequate patient monitoring and follow-up can often avoid the need for admission.
- Potentially Preventable ER Visits (PPVs) may result from a lack of adequate access to care or ambulatory care coordination.
- Potentially Preventable Ancillary Services (PPSs) include high-cost imaging, minor cardiac and vascular tests, and certain lab tests that may not provide useful information for diagnosis and treatment.
- Potentially Preventable Readmissions (PPRs) are return hospitalizations that are clinically related to a previous hospital admission and happen within a 30-day readmission time interval.

Using data to form additional claim analysis to guide our care management

Additional data sets that factor into our stratification methodology include Logical Observation Identifiers Names and Codes (LOINC®), drug therapy management (DTM) algorithms and care gap algorithms. Commonly found in laboratory billing data, LOINC data facilitates the exchange of clinical results, such as maternal risk conditions. Reports based on maternity-related LOINC identify pregnant women who may have a change in their pregnancy risk status, which will trigger a care management re-assessment by the Bright Start® (maternity management) team. DTM algorithms identify members receiving multiple medications where there may be an opportunity to streamline the medication regimen and improve adherence. Care gap algorithms identify members who are not receiving recommended care related to prevention and chronic condition management guidelines.

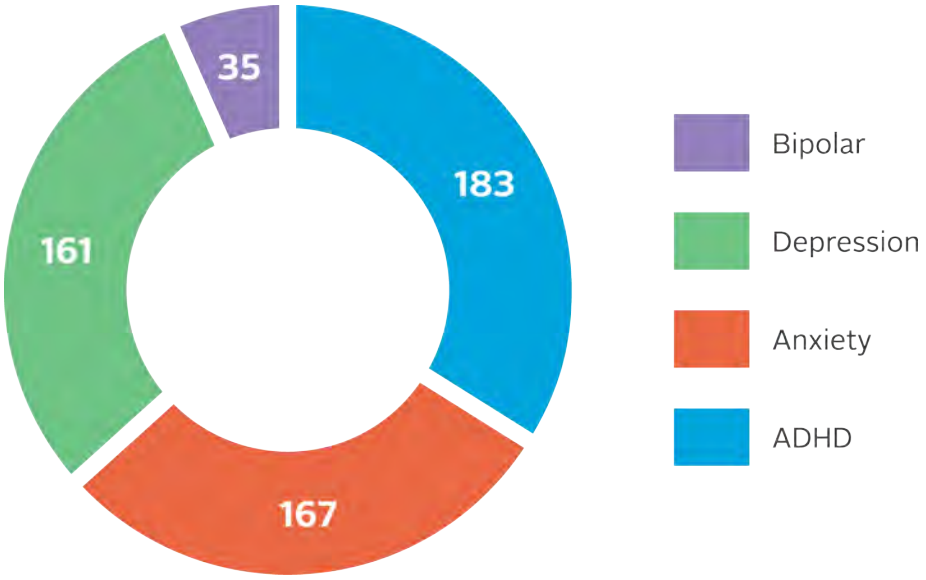

Exhibit 14.0-B: Example analysis — identification and grouping by condition

The children were placed into groups by the number of and similarity across their comorbidities. The members were further triaged into four groups to identify those most in need of intervention:

- Significant identified care gaps.
- Immediate referral/Care Management.
- Behavioral or physical health diagnoses with untreated behavioral health problems.
- Stable but had behavioral or physical health diagnoses.

In this example, the analysis identified 338 children with an unexpectedly high number of comorbidities. These children are being assessed by AmeriHealth Caritas Louisiana care managers for ongoing coordination and management. To ensure this situation is not repeated, the methodology is now a routine part of our population analysis and triggers a care management assessment if one is needed.

Perinatal care and birth outcomes

Improving birth outcomes through better use of data is a key focus for many of our health plans. Data sources used to monitor performance and identify areas for improvement include medical and pharmacy claims, member eligibility and demographic profiles, HEDIS results, and member medical records.

Preterm delivery rates

Using a combination of State benchmark data and health plan data, AmeriHealth Caritas Iowa's South Carolina affiliate, Select Health, identified underutilization of 17-hydroxyprogesterone (17-P) as a potential driver of high pre-term birth rates.

In 2011, 14.1 percent of live births in South Carolina were pre-term, an increase of more than 1 percent between 2001 and 2011. From 2009 to 2011, the highest average pre-term rates were found in blacks (18.9 percent), followed by Native Americans (14.7 percent), whites (12.1 percent), Hispanics (12.0 percent) and Asians (11.8 percent). In 2011, 9.9 percent of live births in South Carolina produced low-birth-weight babies (< 2500 grams) — an increase of more than 3 percent between 2001 and 2011 — and 1.8 percent were very low-birth-weight babies (< 1500 grams). Select Health's rate for preterm deliveries was 12.2 percent in 2012, with 7.7 percent in the low birth-weight category. Even though the health plan's

rates for preterm births were better than the available State data, the rates were not at the goal of 9.4 percent recommended by the March of Dimes.[1]

Further analysis by the South Carolina team, including consultation with a national obstetrical medicine specialist, identified that pregnant members with a history of preterm birth, a risk factor for a subsequent preterm delivery, were not receiving 17-P treatment in accordance with recommended guidelines.

In addition to an ongoing focus on identification, education and barrier management for pregnant members, Select Health implemented a 17-P program to encourage the use of 17-P for women with a prior history of preterm birth. Educational materials, including clinical guidelines on appropriate use and safety, were developed with input from network obstetricians. The plan leveraged its strong partnership with the March of Dimes to increase awareness of the issues. It held educational sessions with the high volume providers and arranged processes for medication delivery and administration. A contracted home care vendor was also utilized to provide members with home monitoring and 17-P injection administration.

The Bright Start Care Connectors team also monitored and provided prescribed treatments for gestational diabetes, high blood pressure, nausea and vomiting. Members were also eligible for a gift card program for prenatal and postpartum visit completion. As a result of this program, low birthrates decreased by 3.19 percent (from 7.70 percent in 2012 to 5.51 percent in 2013).

While these results and activities are specific to the Select Health Plan, AmeriHealth Caritas Iowa intends to undertake a similar analysis and develop activities that target the needs of its pregnant members. Some additional activities, which target preterm birth, include partnership with the Progesterone Outreach Program (POP) for 17-P, utilization of the Nurse Family Partnership program for in-home member services and continued partnership with the March of Dimes.

Postpartum visit rates

Through analysis of medical claim data, member medical records and demographic data, AmeriHealth Caritas Iowa's affiliate in Pennsylvania identified three geographical areas within the market, with high volumes of pregnant women who did not complete their postpartum visits. As a result of this analysis, the plan's Bright Start (maternity program) staff has collaborated with high volume hospitals and pediatrician offices in each area to track births and encourage new moms to have a postpartum visit. Interim HEDIS report tracking indicates that rates are up year over year approximately 10 percent because of this data-driven targeted intervention.

Planned early deliveries

AmeriHealth Caritas Iowa plans to analyze data on gestational delivery dates, focusing on elective deliveries (induction or C-section) that occur prior to 39 weeks. C-section deliveries tend to be a major driver of the late preterm birth.

AmeriHealth Caritas focuses on interventions to eliminate elective deliveries prior to 39 weeks unless there is a clinical reason for the procedure. AmeriHealth Caritas Iowa's affiliate in Louisiana, in addition to creating member education campaigns, is partnering with Louisiana Department of Health & Hospitals to require providers to submit information through vital records that supports the medical necessity for any

[1] National Center for Health Statistics, final natality data. From March of Dimes: Peristats, 2014. https://www.marchofdimes.com/peristats/Peristats.aspx; accessed on March 5, 2014.

delivery performed before 39 weeks. Provider education on this initiative and the resultant medical necessity review is incorporated into AmeriHealth Caritas Louisiana's Bright Start maternity program.

Reducing childhood obesity

AmeriHealth Caritas also has a strong track record of implementing childhood obesity initiatives. For example, using a combination of benchmark data, plan demographics and HEDIS results, AmeriHealth Caritas has identified pediatric obesity as an area of need across our plans and implemented a program to improve provider attentiveness to the health outcomes in this population. Currently, approximately 17 percent (or 12.5 million) of children and adolescents 2 – 19 years of age are obese, with Iowan children having a similar obesity rate, though it has recently dropped to ~15 percent. Across the United States, childhood obesity remains an epidemic. Since 1980, obesity prevalence among children and adolescents has almost tripled. One (1) in three (3) children is obese or overweight before his or her fifth birthday.[2] Obese children are more likely to have high blood pressure, high cholesterol and type 2 diabetes, which are risk factors for cardiovascular disease.

Additionally, the BMI tracking that occurs from early childhood to adulthood shows that early adiposity rebound in young children is associated with increased risk of obesity in young adulthood.[2] Studies have shown that obese adolescents have a 70 percent chance of becoming overweight or obese adults. If current trends continue, one out of three children born in 2000 will develop type 2 diabetes, primarily due to a poor diet and lack of physical activity.

Addressing the childhood obesity epidemic remains a priority for AmeriHealth Caritas, as all of our health plans have a high volume of pediatric membership, analogous to the Medicaid population in Iowa.

The AmeriHealth Caritas results for the three components of the HEDIS 2013 Weight Assessment and Counseling for Nutritional and Physical Activity for Children/Adolescents (WCC) measure were below the NCQA 10th percentile. Analysis of the data revealed opportunities to improve the documentation by primary care providers (PCPs) of BMI percentile and nutritional and activity counseling. All AmeriHealth Caritas health plans implemented a pediatric obesity care plan for members identified for complex care management. The care plan outlines member and parent education steps and coaching interventions designed to assist small, meaningful changes and includes access to a library of educational and referral resources for the care manager, parents and provider network.

Reduction of inappropriate utilization of emergency services

Use of hospital ERs for non-emergent conditions is a drain on national healthcare resources, resulting in medically and financially ineffective patient care, unnecessary testing and treatment and missed opportunities for PCP-patient interactions. Each year, more than 25 million children under the age of 15 years — including almost 10 million under the age of 4 — seek medical care in EDs across the United States. A federal study focusing on 9,240 Head Start families found ER visits dropped by 58 percent when parents opted to treat their children's non-emergent conditions at home, after the appropriate training from a licensed professional. Parent and caregiver self-confidence had markedly improved post-training, suggesting an improved understanding and comfort level in dealing with common childhood illnesses.

[2] Centers for Disease Control and Prevention, www.CDC.gov, 2011.

Pediatric non-urgent ER use

Like many Medicaid Managed Care Organizations (MCOs), AmeriHealth Caritas's Medicaid health plans have a high percentage of pediatric membership, and a high volume of pediatric members receiving care for common childhood illnesses at ERs. Based in the urban market of Philadelphia, Pennsylvania, AmeriHealth Caritas Iowa's affiliate Keystone First identified infants (< 1 year old) as the most frequent utilizers of ER services, accounting for over 90 per 1,000 total member visits, and acute upper respiratory infections were by far the most frequent diagnoses in the ER for Keystone First members. Four other common childhood conditions were identified in addition to upper respiratory infection as the main drivers: common cold and flu, earache, fever, and asthma exacerbation.

In a matched control evaluation of the program (geography, race, ethnicity, language and risk score), Keystone First showed a statistically significant drop in ER visits for non-urgent conditions for members whose parent or guardian attended the 4 Your Kid's Care class (a program offered to AmeriHealth Caritas health plan members). To assess knowledge gained from the program, the study group completed a six-point (6-point) questionnaire before and after attending the educational sessions. Results showed statistically significant improvements in all six questions asked. Beyond this, AmeriHealth Caritas' Medical Economics team also reviews office visit distributions based on the severity of the medical codes, primary diagnostics and member distribution of ER visits per plan to monitor and provide communication back to the plan for proactive impact to reduce overall costs.

Heart failure and diabetes high utilizers

AmeriHealth Caritas uses an analysis of claim and medical record data for members with diabetes and heart failure to identify members with potentially preventable ER visits and inpatient admissions. Many of these ER and inpatient events could be prevented if the symptoms were identified and treated before an ER trip. To better meet the needs of these members, the AmeriHealth Caritas Iowa affiliate in South Carolina, Select Health, partnered with a vendor for in-home monitoring services. Enrolled members receive a combination of daily monitoring, provider coordination and clinical assessment. Objective measures obtained included blood pressure, glucose and daily weight monitoring. Select Health care managers refer members to this program as one of the interventions within the health plan's chronic care/disease management programs. Network providers were then educated on the benefit for members, including how to make referrals for the in-home monitoring service through the Select Health care manager.

This program has been in place in AmeriHealth Caritas Iowa's affiliate in South Carolina for over four years. Recent outcome reports assessing members who had received service from January 2013 through May 2014 demonstrated significant decreases in inpatient utilization, ER utilization and total cost for those members stratified as high risk.[3]

Children with special needs

Foster care children

In Louisiana, through review of pharmacy data and member eligibility files, AmeriHealth Caritas Iowa's Louisiana affiliate identified that many children in the foster care population were prescribed behavioral

[3] National Hospital Ambulatory Medical Care Survey: 2010 Emergency Department Summary Tables. Available at: <http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2010_ed_web_tables.pdf> Last accessed February 20, 2014. Niska R, Bhuiya F, Xu J. National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary. National Health Statistics Reports; No. 26. Hyattsville, MD: National Center for Health Statistics; 2010.

health medications. A significant portion of those members were at risk for uncoordinated care. In some cases, the physician currently treating the member is not the physician who originally prescribed the medication and may not be skilled at managing a child on a behavioral health drug.

As a result of this analysis, AmeriHealth Caritas Louisiana launched a DTM program that targets foster care children with at least one of the following conditions: (1) a unique drug count of four or more in the previous 90 days, or (2) a behavioral health medication (including medication for ADHD) filled in the previous 90 days. AmeriHealth Caritas Louisiana care managers work collaboratively with the pharmacist, prescribing practitioner and member/guardian to address any concerns impacting positive outcomes for these members. As appropriate, these members will be screened and referred to the Statewide Management Organization for additional care coordination.

Children with behavioral health comorbidities

AmeriHealth Caritas Louisiana also analyzed pediatric members with behavioral and physical health comorbidities. Through this analysis, AmeriHealth Caritas Louisiana identified a small cohort of children with ADHD who would benefit from collaborative care.

ADHD drug therapy management

In 2011 the U.S. Centers for Disease Control and Prevention (CDC) published a study that found nearly one in 10 children in the U.S. has been diagnosed with ADHD. Within Louisiana, an analysis of AmeriHealth Caritas Louisiana pharmacy and medical claims identified high volumes of members prescribed attention deficit disorder (ADD) or ADHD medication with low rates of follow-up for children started on the medication. Through additional analysis, AmeriHealth Caritas Louisiana identified a large number of children under age 6 who were receiving ADD/ADHD medication that was not approved by the Food and Drug Administration (FDA) for their age group.

To address these issues, AmeriHealth Caritas Louisiana implemented clinical guidelines for ADD/ADHD medication and is exploring the implementation of an outreach program to address follow-up care for children prescribed ADHD medication, mirrored after the outreach program implemented in our affiliate, Select Health of South Carolina. The outreach program is designed for our members between the ages of 6 and 12 years who have been newly prescribed an ADHD medication.

Appropriate follow-up

Our AmeriHealth Caritas Iowa affiliate in South Carolina reported high rates of ADHD diagnosis at greater than 13.1 percent compared to national lows of < 7.0 percent. In South Carolina, claims paid in 2010 with a primary diagnosis of ADHD for Medicaid recipients accounted for 5.13 percent of the State's Medicaid expenditures at $264,749,623. South Carolina is also at a national high for prescription of medications for the treatment of ADHD at > 9.1 percent (low < 3.0 percent). The affiliate in South Carolina's recognized that 80 percent of their members were less than 18 years of age, which led to the implementation of a program to increase follow-up care for children prescribed an ADHD medication. The program includes physician education and direct outreach for members started on a Central Nervous System stimulant or related medication to treat ADHD.

AmeriHealth Caritas Louisiana's data analysis and reporting also identified low rates of follow-up for children newly prescribed medication to treat ADHD. To address this opportunity, AmeriHealth Caritas Louisiana's Quality and Rapid Response departments, in partnership with PerformRx (AmeriHealth Caritas's pharmacy benefits manager), developed a summary ADHD clinical practice guideline that is currently being reviewed by the AmeriHealth Caritas Louisiana Quality committees for approval and

distribution to providers. Outreach, through the Rapid Response team, will be provided to the members with new ADHD prescriptions to facilitate the required follow-up visits with their prescribers. Members identified with special health needs will be referred to complex Case Management for further evaluation and care coordination.

A drug evaluation tool will be used to educate and assess prescribers on the appropriate diagnosis, non-pharmacological interventions and drug use when needed. Follow-up activities for prescribers will be based on their individual audit scores.

Disease management

Asthma is a leading chronic illness in the pediatric population, and a significant driver of healthcare service utilization for organizations managing Medicaid beneficiaries. AmeriHealth Caritas Iowa and its affiliate plans will continually look for ways to improve health outcomes for this population

Medication adherence

Using a combination of medical and pharmacy claim analysis, AmeriHealth Caritas's enterprise project team identified adherence to asthma controller medications as an opportunity for improvement. The proportion of days covered (PDC) metric was used to assess adherence. PDC calculates the percent of days in the period for which the member has a medication in the targeted drug class.

Through focused outreach and specifically designed education materials, we have improved medication adherence for asthma controller medications across our health plans (e.g., in Louisiana, from 2012 to 2013 we improved adherence by 6.2 percent).

Health® Tablet computer system

AmeriHealth Caritas Iowa's affiliate in Louisiana is piloting a program in partnership with our corporate pharmacy affiliate, PerformRx, to create an asthma medication management program to increase adherence and reduce overall costs. The program uses a Wi-Fi/cellular-enabled tablet given to the member that provides two-way communication between members and the AmeriHealth Caritas Louisiana care team. The tablet will incorporate several tools to measure adherence, monitor symptoms, and deliver asthma-specific and general health education topics. To assist members who have poor literacy skills, the tablet provides both audio and visual delivery of educational material. AmeriHealth Caritas Louisiana is the first AmeriHealth Caritas affiliate to pilot this program. Results will be evaluated to determine whether this would be an effective program to launch in Iowa.

Diabetes care

Using benchmark data, AmeriHealth Caritas Louisiana strengthened its diabetic management program by adding the Diabetes Boot Camp program.

In 2012, 12.3 percent of the Louisiana adult population, aged 18 years and older, was told by a doctor that they had diabetes.[4] From 2009 – 2010, only 71.1 percent and 68.5 percent of Louisiana adults diagnosed with diabetes had at least one (1) prior-year foot examination and dilated eye examination, respectively;

[4] America's Health Rankings. United Health Foundation. http://www.americashealthrankings.org; accessed on 3/3/2014.

only 56.8 percent had ever attended a class in diabetes self-management; only 66.6 percent perform daily self-monitoring of blood glucose; and only 71.3 percent had at least two HgbA1c tests in the past year.[5]

Case study

In 2006, the total cost of diabetes to Louisiana was approximately $2.431 billion, including $1.625 billion in direct medical costs and $806.2 billion in lost productivity. In 2010, the total cost of hospital discharges for people with diabetes in Louisiana was approximately $231 million. Based on an analysis of Louisiana Medicaid SFY13 data, diabetes of all types affected approximately 32,541 managed care recipients, roughly 4 percent of the Louisiana Medicaid managed care population. Over 4,700 AmeriHealth Caritas Louisiana members have been identified as having diabetes. Of these, slightly more than 64 percent have poor blood sugar control (HgbA1C > 9 percent) and only 37 percent received the recommended eye examination to assess for retinopathy. To improve self-management skills in the diabetic population, AmeriHealth Caritas Louisiana evaluated its current program offerings and went a step further, holding the Diabetes Boot Camp program in collaboration with the AmeriHealth Caritas Partnership. Using a curriculum approved by the American Diabetes Association, the program educated members on how to win the fight against the disease.

Anchored by a team of diabetes educators, attendees were rotated through four (4) 50-minute health workshops. Topics included healthy eating, being active, monitoring and taking medication, reducing risks,, and health and healthy coping. Members received a free A1C screening and healthy snacks. Members were also treated to live cooking demonstrations.

Recipes were shared to enable members to duplicate the meals at home. Everyone left with information on how to better take care of themselves, feeling empowered. Through the leadership and the dedicated associates of the Community Health Education team, the event offered fertile ground to plant seeds of awareness. Two post-event surveys indicated members were still on track to healthier living, are interested in healthier lifestyles and are continuing to grow.

Hospital readmissions and avoidable hospitalizations

Preventable hospital readmissions are a significant avoidable cost in the healthcare system. Readmission rates have been proposed as an important indicator of quality of care, because the readmissions may result from actions taken or omitted during the initial hospital stay. Readmissions are often driven by poor discharge procedures, poor coordination of services, incomplete discharge care and inadequate follow-up care. Readmissions are important, not only because of quality of care concerns, but because they have the potential to drive up healthcare costs.

Analysis of claim data, incorporating the classifications used in the 3M CRG algorithms, identified a subset of members with dominant chronic conditions and asthma who had the highest 30-day all-cause readmission rates (18 – 47 per 1,000 members across AmeriHealth Caritas health plans). In response, all AmeriHealth Caritas health plans implemented initiatives to decrease readmissions for these chronically ill members. Program changes supporting these efforts include:

- Contact with high-risk members during the hospitalization to confirm discharge plans, availability of support systems, post-discharge appointments and contact information.

[5] Age-adjusted; Centers for Disease Control and Prevention: National Diabetes Surveillance System.

- Use of the Community Education and Outreach Team to visit high-risk members after discharge to check that services are in place, verify that the member received needed medication and confirm arrangements for follow-up provider appointments.
- Enhancement of system tools and implementation of an Outpatient Management Checklist to track discharge plans and trigger follow-up activities.
- Implementation of systems to alert the PCP of the hospital admission and discharge (initiated based on results from a focused survey of PCP offices to ask their preferences on notification).
- Creation of focused materials to educate members on questions to ask during the discharge planning process.
- Implementation of shared-savings arrangements with hospital systems that reward the facility for lower potentially preventable readmission rates, among other parameters.

Through August 2014, readmission rates for members with a dominant chronic condition or asthma in all AmeriHealth Caritas plans have decreased by 11.5 percent, with the AmeriHealth Caritas Louisiana rate decreasing by 7 percent.

Additional data-driven programs

Other examples of data-driven medical management programs are summarized in the below table:

Data source and findings	Action taken	Health plan
Pharmacy claims data: low medication adherence rates (proportion of days covered) for oral hypoglycemic, anti-hypertensive and cholesterol-lowering (statin) medication	Implemented a 90-day refill program, allowing member to receive a 90-day supply of the targeted medication classes. Members incurred a single copay (where a copay applied) and pharmacies were paid two (2) dispensing fees as an incentive. The health plan saved by reimbursing two (2) dispensing fees versus what would have been three (3) 30-day supply fees.	AmeriHealth Caritas Louisiana AmeriHealth Caritas Pennsylvania Select Health of South Carolina Florida True Health Keystone First
Inpatient utilization data and member medical records: length of stay in the neonatal intensive care unit (NICU) was extended for members in need of ongoing apnea monitoring, network DME providers not willing to provide the equipment	Identified new network provider for home apnea monitoring services; changed payment policy to provide enhanced reimbursement for the service. Engaged services of NICU consultant to participate in case discussions with health plan staff and education treating providers, as needed.	AmeriHealth Caritas Louisiana
Utilization data and claim data: sharp increase in claims for speech therapy services after removal of prior authorization requirement	Reviewed records associated with submitted claims and re-instituted requirement for prior authorization for speech therapy services.	Select Health of South Carolina

Data source and findings	Action taken	Health plan
Utilization data: frequent requests for out-of-network service agreements for medically necessary skilled nursing facility services and cochlear implants	Added to health plan network through change in payment policy to provide enhanced reimbursement for the service to qualified providers.	AmeriHealth Caritas Louisiana
Interim HEDIS results for health outcome measures: significant volume of members missing or overdue for recommended services	Implemented provider bonus campaign to incent providers to arrange for members in need of recommended services to receive the clinically recommended care.	AmeriHealth Caritas Louisiana AmeriHealth Caritas Pennsylvania AmeriHealth District of Columbia Keystone First

Operational Data Analysis and Performance Improvement

Member and Provider Contact Data and post-call surveys

AmeriHealth Caritas uses a third-party vendor to track and assess the "voice of the customer" and quantify the level of member/provider satisfaction, based on post-call surveys. Specifically, a sampling of members and providers who call into the Contact Center receives a live call back to assess their satisfaction with the call. Metrics include first call resolution performance and overall satisfaction with the health plan and services provided. Additionally, data is collected within the Contact Center relative to the reasons for and frequency of contacts. These data are trended to identify opportunities for performance improvement within the contact center as well as to identify opportunities for overall program enhancements such as additional education and outreach for both members and providers.

Internal Service Data

Detailed operational reports are created from internal service data and reflect standard performance metrics including but not limited to: customer service quality, first call resolution and service levels (speed to answer and abandonment rates); complaints, grievance 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. Reports are reviewed regularly to identify performance trends and areas in which process and program improvements may be applicable.

3. Describe your internal operational structure that will support the compilation of the performance data and reporting processes of the programs, including:

a. The qualifications and experience of the staff responsible for the production and delivery of performance data to the State.

The AmeriHealth Caritas team responsible for supporting the analysis, reporting and programmatic innovations is an interdisciplinary unit. We have industry-leading expertise and, across our expert teams, work in an interdisciplinary fashion to process, understand and deliver performance data and insights both within our organization and externally, such as to DHS and the public.

Overviews of key teams within our data analytics and reporting organization

Advanced Analytics team

Our Advanced Analytics (AA) team is a group of Master- and Ph.D.-level statisticians and statistical programmer/analysts who use a wide range of innovative statistical and data-mining techniques to evaluate outcomes for AmeriHealth Caritas member intervention programs. Our team has extensive combined experience in healthcare and partners with each program or pilot to develop rigorous program evaluation methodologies that are timely, dynamic and actionable. Utilizing a proactive, analytic learning model approach, the AA team provides systematic quantitative feedback in program monitoring, statistical evaluation and predictive modeling.

This learning model effectively allows for anything from minor course corrections to complete overhauls while a program is in process; there is no need to wait until program completion to quantitatively evaluate program performance.

Additionally, the AA team supports all analytics used in external publications, including journal articles, conference presentations and posters, and press releases.

HEDIS team

The AmeriHealth Caritas HEDIS team is composed of experienced quality analysts and clinicians. Each individual on the team has years of experience in HEDIS/CAHPS. The team provides aggregated results and actionable member-level detail for quality improvement activities. The HEDIS team submits all annual reports to NCQA and State agencies, and also creates monthly reports monitoring quality programs and clinical gaps in care. The team uses NCQA-certified HEDIS software, which can also build State-specific quality measures based on Iowa State requirements.

The HEDIS team works closely with State agencies, provider groups, hospitals, lab vendors and others to collect data that supplements claims for helping members get appropriate care.

Healthcare Analytics team

The Healthcare Analytics team is a group of Bachelor- and Master-level programmer/analysts who utilize a range of data and analytical techniques to evaluate performance and quality outcomes throughout the organization. Using a proactive approach, the Healthcare Analytics team provides actionable and timely reporting to support:

- HEDIS reporting.
- Quantitative analysis.
- Preventable and risk-adjusted reporting.
- Internal and external dashboarding.
- Quality incentive programs and reports.
- Member identification for outreach/intervention.

b. The process for internal review and validation of data prior to submission to the State.

Any data submissions undergo multiple levels of review prior to submission to the State. The primary analyst will notify a peer analyst to review documentation. Upon notification, the primary analyst will share the following components: data architecture/programming logic, results/formats and the report

narrative for the entire lifecycle of the project to be reviewed. The peer analyst will validate and provide commentary. Upon acceptance of validation through recreating the code logic and reviewing results/narration, the quality check has been passed and the documentation can be submitted to the departmental director for final review. Upon certification, the information is submitted to the State.

4. Please provide any available Medicaid HEDIS scores in states in which you operate.

AmeriHealth Caritas submits HEDIS measures across its plans. Available HEDIS scores across plans have been made available in Tab 6 of this submission.

5. Provide a copy of your most recent external quality review report for the Medicaid contract that had the largest number of enrollees as of the RFP release date.

We are pleased to submit results from Select Health of South Carolina, a wholly owned subsidiary of AmeriHealth Caritas. Select Health had the largest number of members in any of our plans as of January 1, 2014, managing the delivery of healthcare to more than 345,000 enrollees statewide through the First Choice health plan. As the State's first and largest Medicaid MCO, Select Health of South Carolina continues to score as the top-ranked Medicaid health plan in the State, according to rankings released from the NCQA. In fact, Select Health scores better than all of its competitors and receives the majority of quality financial incentives available to all managed care entities in South Carolina.

External quality review report

The most recent full external quality review (EQR) report for Select Health of South Carolina is provided within Tab 6 of this submission. The report provides a detailed evaluation of Select Health's performance in 2013 and was completed and finalized by the South Carolina Department of Human Services' External Quality Review Organization, the Carolinas Center for Medical Excellence (CCME), in 2014.

Immediately following receipt of the 2013 EQR findings, a task force was created at Select Health to determine root cause analysis for all findings and develop individual corrective action plans. In response to the findings, a Policy and Procedure committee was put in place to ensure policies and procedures were well documented and there was a streamlined process for doing so. All issues identified from the EQR have been corrected, and Select Health has received approval from the South Carolina auditing body to confirm corrective actions were sufficient.

Select Health's Quality Program continues to lead all competitors in South Carolina. In 2013, Select Health earned $[redacted] in state quality withhold funds. Select Health received this amount for meeting the State's quality improvement goals for selected quality measures. Additionally, Select Health achieved a score above the 75th percentile on 12 measures, resulting in an additional quality bonus in the amount of $[redacted]. This bonus takes into account the relative size of the health plan and the number of measures, which scored above the 75th percentile during the 2013 calendar year. In South Carolina, the bonus pool is composed of left over withhold funds that other plans failed to earn during the year due to not meeting the State's quality improvement goals, and Select Health is on track to continue to lead all other plans in the market.

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15. Termination

Please explain how you propose to execute Section 15 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 delivering the highest levels of care and service to the State of Iowa and its Medicaid members. However, in the event of Contract expiration, our promise and commitment to serve will not end; we have processes in place to minimize disruption of services to members and providers. We commit to meeting — if not exceeding — all requirements outlined by the State, and will work with the State and our members to ensure the best possible transition.

Over the past 30 years, AmeriHealth Caritas Family of Companies (AmeriHealth Caritas) has always been committed to serving our States and members. We have never had an event in which our Contract was terminated.

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

15.1 Contractor's Termination Duties

1. Describe your plan to complete the duties outlined in Section 15 in the event of contract termination or expiration.

AmeriHealth Caritas Iowa will ensure a smooth turnover upon the termination or end of the Contract by implementing an end-of-contract transition plan outlining the hand-off process to the State or replacement Contractor. The transition plan will include time frames for critical milestones for the changeover from the current to the new Contract. We will ensure the transition is seamless, with no material adverse effect on services to members or the State. As part of its transition plan, AmeriHealth Caritas Iowa will continue to meet all Contract duties outlined in the scope of work (SOW) and obligations incurred prior to the actual termination of the Contract.

AmeriHealth Caritas Iowa commits to the following:

- Maintaining the level of resources dedicated to fulfill program operations through Contract termination.
- Complying with all duties and obligations incurred prior to the actual end-of-contract date.
- Cooperating in good faith during the transition.
- Taking necessary actions to ensure a smooth transition of members from coverage under the Contract to coverage under any new arrangement developed by the Iowa Department of Human Services (DHS).

2. Provide a general end-of-contract transition plan which addresses the key components outlined in Section 15.

AmeriHealth Caritas Iowa will be ready and able to cooperate with DHS during the planning and transition of Contract responsibilities to the replacement Contractor or to DHS. We will develop a transition plan that will specify actions needed to be taken to meet the State's needs and ensure a smooth and timely transition.

The end-of-Contract transition plan will ensure normal operations and service are not interrupted or delayed during the remainder of the Contract, and this will be communicated to all involved parties.

During the transition, AmeriHealth Caritas Iowa will:

- Participate in a final-year external-quality review as required by 42 CFR 438, Subpart E.
- Arrange for provision of services to members for up to 45 calendar days from Contract end or until members can be transferred to another program Contractor, whichever is longer.
- Provide all records related to Contractor's activities pursuant to the Contract within 30 days of the request, including:
    - Information on all Iowa Health and Wellness Plan members' completion of Healthy Behaviors Program requirements.
    - Performance data including, but not limited to, Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Healthcare Effectiveness Data and Information Set (HEDIS).
    - Encounter data for all claims incurred before the Contract expiration date according to the established timelines and procedures, and for at least 15 months after termination or expiration of Contract.
    - Any capitation or other overpayments made by the State to the Contractor within 30 calendar days of discovery.
- Cooperate with State investigations regarding possible overpayments and return capitation or other overpayments within 14 calendar days of reporting the overpayment, including those discovered after Contract termination.
- Maintain financial requirements and payment obligations as described in the end of Contract termination notice until in receipt of written notification that all continuing obligations of the Contract have been fulfilled.
- Maintain financial responsibility for:
    - All claims with dates of service through the end of Contract, including those submitted within the established time limits after the day of termination or expiration of Contract.
    - Services rendered through day of termination or expiration of Contract for which payment is denied by Contractor and subsequently approved upon appeal or state fair hearing.
    - Inpatient services for patients hospitalized on or before the day of Contract termination or expiration through the date of discharge, including diagnosis related group (DRG) payment and any outlier payments.
- Collaborate with DHS/Contractor to:
    - Supply program information to ensure smooth transition.

- Arrange for the orderly transfer of patient care and patient records to those providers who will assume the care of the member.
- Ensure any patient transfers are not harmful to the member and continue to provide services until the treatment is concluded or appropriate transfer of care can be arranged.
- Coordinate the continuation of care for members who are undergoing treatment for an acute condition.

- Provide notifications on the process by which:
  - Members will continue to receive medical care.
  - Iowa Health and Wellness Plan members, hawk-i members and Medicaid for Employed People with Disabilities (MEPD) members will continue to make premium payments and receive medical care.
- Resolve member grievance and appeals with respect to dates of service prior to end of Contract, including those filed after end of Contract but for dates of service within the Contract period.
- Maintain claims processing functions as necessary for a minimum of 12 months in order to adjudicate claims for services delivered prior to end of Contract.

The attached example end-of-Contract transition plan (Attachment 15-A) complies with the needs of the SOW in the event of Contract termination or expiration.

Attachment 15-A: Example End-of-Contract Transition Plan

Task Name
1. De-Implementation
1.1. Administrative
1.1.1. Identify liaison for post transition.
1.1.2 Set meeting schedule with DHS to coordinate transition.
1.1.3 Begin weekly de-implementation reports.
1.1.4 Communicate to internal staff about termination of Contract.
1.1.5 Submit transition plan to DHS for approval.
2. Transfer All Records Related To Contract Activities
3. Transfer Iowa Health and Wellness Plan Member Information On Completion Of Healthy Behavioral Program Requirements
4. Provide Performance Data
5. Participate in External Quality Review for the final year of the Contract
6. Maintain Financial Requirements

Task Name
7. Member Grievances and Appeals
7.1. Develop a plan for managing the transition of grievances and appeals. a. At midnight on the transition date, the Replacement Contractor (RC) will assume responsibility for all new requests for grievances and appeals. b. Contractor will complete all determinations for existing grievances and/or appeals received prior to midnight of the transition day. c. On a date to be determined by DHS, the Contractor and the RC, the Contractor will transfer all existing data and documents regarding grievances and appeals to the RC or DHS.
7.2. Identify pending appeals.
7.3. Determine workflow for appeals received after Contract end date.
8. Claims Processing
8.1 Complete adjudications of all claims for services prior to Contract end date.
8.2 Assume financial responsibility for all claims with service date through the day of end of Contract and subsequent approval upon appeal or State fair hearing.
8.3 Assume financial responsibility for inpatient services for patients hospitalized on or before the day of Contract termination or expiration through the date of discharge, including diagnosis related group (DRG) payment and any outlier payments.
8.4 Submit encounter data to DHS for all claims incurred before the Contract expiration date according to the established timelines and procedures.
9. Patient Transfer Develop a plan to ensure orderly transfer of patient care and records.
10. Communications
10.1. Determine disposition of member communications materials.
10.2. Determine disposition of provider communications materials.
11. Customer Service
11.1. Determine staffing needs for run-out period. Location of run-out staff will be in an existing consolidated call center. The number of staff is contingent upon agreed-upon workflows.
11.2. Develop Q&A script for reps on phones; contingent upon agreed upon workflows, as well as timeline for any mailing to members and providers regarding change of vendors for this Contract.
11.3. Refer callers to new 1-800#
11.4. Terminate Member Line phone number.

Task Name
11.5. Obtain new vendor address, as well as fax number, for providers to submit the orderly transfer of records (OTR). This information will also be included in the frequently asked questions (FAQ) document given to customer service representatives for provider education.
11.6. Request the State to include pertinent new vendor information on its website to assist with increased call volume prior to transition.
11.7. Any communication to internal staff relating to the Contract, ramp down, etc., should be handled by HR.
12. Facilities
12.1. Order supplies as needed (e.g., boxes and tape) for packing/relocating.
12.2. Negotiate arrangements for existing lease; review sublease provisions; review real estate lease for availability of assignment; sublease and early-termination options.
12.3. Review fixed asset list for disposition of furniture and equipment; negotiate the transfer or sale of certain fixed assets to replacement Contractor.
12.4. Terminate our vending agreements.
13. Finance
13.1. Establish account for de-implementation expenses. Report any capitation or other overpayments made by the State or Contractor.
13.2. Determine disposition of performance bond, risk reserves, etc.
13.3. Plan for closing ledgers.
14. Human Resources
14.1. Develop termination plan for identified employees.
14.2. Determine staff end-dates.
14.3. Investigate possible placement opportunities for terminated staff.
14.4. Determine last-day activities.
14.4.1. Notify staff of process.
14.4.2. Complete HR forms.
14.4.3. Collect all company equipment.

Task Name
15. Information Management – Full Data Export, Database Information File Transfer
15.1 Supply DHS with a full data export from the MIS Application. a) Phases: • One initial full data export. • One additional full data export, if needed. • One final full data export. b) Delivery of final full data export will be within 48 hours of the Contract end date.
15.2 Send HIPAA-compliant data transmissions. a) SAFE FTP transmission protocol.
15.3. Data transmissions will be in de-normalized file layout — description of data elements on file. a) Reference: Ramp-down proposal sample data set.
15.4 Provide DHS with appropriate IT staffing to supply information specific to the data extract fields based on a de-normalized model.

3.2.5 Bidder's Background

The bidder shall provide the information set forth in this section regarding its experience and background.

3.2.5.1.1 Level of technical experience providing the types of services sought by the RFP

Overview

AmeriHealth Caritas Family of Companies (AmeriHealth Caritas) is an industry-leading Medicaid managed care organization in the United States, touching the lives of over 6 million people in 16 states and the District of Columbia through a philosophy of care that is comprehensive, compassionate and outcomes-driven. We deliver care that honors the uniqueness of each member, while removing barriers to healthcare for the less advantaged. Wherever our members live, we reach them in meaningful ways they understand and that matter most to them, enhancing their quality of life. From start to finish and then beyond, we are where our members are.

AmeriHealth Caritas has a long and successful history of partnering with states to address their unique and diverse needs and challenges. We have begun meeting with key Iowa stakeholders to develop a plan of action to tackle 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.

The AmeriHealth Caritas offers a range of products targeting the less advantaged, special needs and at-risk populations, including:

- **Full-risk Medicaid managed care** services with a variety of programs and capabilities to meet the special medical and social needs of less advantaged populations (Temporary Assistance for Needy Families [TANF], Aged, Blind and Disabled [ABD], foster care and Children's Health Insurance Program [CHIP]).

- 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 less advantaged 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 provides 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 healthcare, measurable improvements in outcomes and increased cost-effectiveness makes AmeriHealth Caritas the right partner for the Iowa Medicaid modernization.

- **Dual eligible services** with prescription drug coverage and a specialized Medicare Advantage special needs plans (D-SNP) and Medicare Medicaid Plans (MMP) designed for members enrolled in both Medicare and Medicaid.
- **Behavioral health services** leveraging our wholly owned subsidiary PerformCare®, a full-service behavioral health managed care company that supports members through specialized behavioral health and human services programs in the public and private sectors.
- **Pharmacy services** through our wholly owned subsidiaries PerformRx℠ and PerformSpecialty℠. PerformRx provides innovative, cost-effective pharmacy benefits management services for Medicaid, Medicare and commercial health plans, while PerformSpecialty provides specialty pharmacy solutions to members with complex pharmacy needs. Through a distinctive, high-touch approach, PerformRx and PerformSpecialty partner with health plans to improve member outcomes and financial performance. PerformRx and PerformSpecialty base their success on a clinical focus that is driven by cutting-edge, proprietary technology and a strong Medication Therapy Management program.
- **Insourced dental services** utilizing an internal team to create and manage the programs. This allows for the development of value-added integrated programs that add to improved quality outcomes for dental and physical health.
- **Third-Party management and administrative services (TPA)** provided to Medicaid managed care clients in four markets across the country, including Indiana, Michigan, Kentucky and New Jersey.
- Program for members who need long-term services and supports (LTSS). Designed as an integrated solution across physical health, behavioral health, pharmacy, institutional care, home-based care and social support, that is applied across all our markets, including in our MMPs in South Carolina and Michigan.

AmeriHealth Caritas currently provides Medicaid managed care solutions to Iowa's bordering state of Nebraska, giving us the ability to leverage relationships and networks. Our Nebraska affiliate, Arbor Health Plan, has been working with Iowa providers to service the unique needs of Nebraskan Medicaid recipients since 2012.

AmeriHealth Caritas brings a mission-driven approach to its work in improving the healthcare of the communities we serve. Our success in these communities reflects in our ability to understand and build programs that address those needs, such as:

- **Member-centered approach to care.** Care is individual and our members' needs are unique, from prenatal care to LTSS. AmeriHealth Caritas provides "care in context," offering our members care according to their needs and what they value most. Understanding our members and their life circumstances is paramount. Our care managers work closely with our members to adapt care and support to an individual by providing person-centered care plans with active coaching models to support healthy outcomes.
- **Collaborative partnerships with the state, providers and community organizations.** AmeriHealth Caritas is a community partner, driven by creating stakeholder value versus shareholder profits. We work collaboratively with state, advocates, providers, caregivers, members and community partners to address the challenges of rising costs of care, remove barriers to accessibility and manage administrative complexities.
- **Holistic approach to care.** As a company whose sole focus is on serving less advantaged populations, AmeriHealth Caritas delivers person-centered, holistic population health management not only through traditional avenues, but as embedded partners in the communities we serve. Our approach to

care management addresses disabilities and chronic medical concerns by connecting our members to the right care at the right time. Using proven, data-driven identification techniques and engaging members where they live, work and learn, we are able to reduce emergency room (ER) utilization, increase home-based community services, reduce care gaps, decrease admissions, increase preventive services and get members the help they need.

- **Access to care when and where it is needed.** Access to care is fundamental in improving health outcomes. It is also one of the biggest challenges that the Medicaid population faces in receiving timely and quality healthcare. By putting people at the center of healthcare, understanding their needs and meeting them wherever they are, AmeriHealth Caritas enables and empowers access to care when and where it is needed. This includes tackling barriers to care access on multiple fronts. For example, we have been making efforts to touch every provider in Iowa, especially those providers in the northern and western part of the state.
- **Data-driven results and evidence-based outcomes.** At AmeriHealth Caritas, we measure success through the health of our members. Our goal is to improve the daily lives of moms, dads, kids and caregivers with quality, cost-effective managed care. As stewards of the less advantaged, we are committed to helping those who are in need and at risk by creating responsible solutions that prevent and address their most pressing healthcare needs.

Our proposed approach includes partnering with the Department of Human Services (DHS), developing strategic partnerships with institutional providers and community-based organizations, and building an accessible, flexible health system that meets the current and future needs of the Iowa Medicaid population. Our system of care is designed to provide the highest quality of care at maximum value for Iowa and the state's Medicaid members and providers.

AmeriHealth Caritas Iowa understands that at-risk populations have special needs that cannot be effectively addressed through traditional healthcare services. Our approach extends well beyond healthcare delivery and includes programs that have positive impacts on the overall well-being of each member. From work-skills training to job placement, we are forever inspired to help people realize better futures. AmeriHealth Caritas Iowa will continue this tradition and bring holistic, person-centered care to the state of Iowa.

AmeriHealth Caritas is genuinely excited and expertly suited to partner with DHS to execute the Iowa Medicaid modernization. Just as we have proven through our partnerships with other states, we are ready and equipped to engage and address the financial, socioeconomic and technical challenges that Iowa faces daily. By establishing footprints, putting feet on the street, coordinating with advocates and knocking on doors, we have earned a rich heritage of performance that is national in scope and local in feel.

Information Solutions overview

The AmeriHealth Caritas Information Solutions (IS) team has a long history of implementing and supporting the information and technology needs of Medicaid programs. IS has extensive experience managing the specific capabilities and capacities needed to support state Medicaid requirements.

IS' people, processes and technologies will provide a sound information systems implementation for Iowa Medicaid through:

- **People —** The IS team is a technically deep resource team with most members having over 10 years of experience working with Medicaid healthcare systems in its unique business environments. AmeriHealth Caritas employs 370 full-time IS associates and leverages existing strategic partnerships with vendors who provide additional technology support and expertise, as needed. These strategic

relationships allow AmeriHealth Caritas to scale based on business needs. IS staff is allocated across Production Support/Maintenance, Regulatory/Compliance, Enhancements and Strategic Initiatives departments. Typically, IS resources are not dedicated or trained for a specific affiliate, but are aligned by application group and areas of expertise. With a more flexible model and the opportunity to leverage standard capabilities, this ensures required resources are available to meet needs and processes across affiliates, where appropriate, improve our speed to market, avoid key person dependencies and provide individuals with greater personal development opportunities. Every health plan is assigned an IS business relationship manager, encounters associates and other aligned IS roles to ensure that system processes, driven by state-specific business rules, are quickly addressed by associates who know the market variables.

- **Process** — AmeriHealth Caritas is committed to maintaining high-quality, stable information and technology systems that meet the needs of the state, its members and its providers. Over time, those needs change, and AmeriHealth Caritas implements system changes (e.g., design and quality assurance testing) across all technology platforms and environments using Information Technology Infrastructure Library (ITIL) principles. Our dedicated team of ITIL practitioners ensures changes are aligned with business goals by leading and governing the processes, policies and procedures around the delivery of IS changes and enhancements.
- **Technology** — AmeriHealth Caritas leverages an industry-proven suite of best-in-class enterprise applications for the care management, core administration (e.g., claims and benefits), provider management and contact center domains. Assigned domain managers work with key stakeholders to ensure our platforms address near-term business needs, state requirements and compliance changes, as well as future strategic directions. All applications and infrastructure components are supported in accordance with software releases and hardware lifecycle schedules. Our Management Information System (MIS) is kept current and scalable through collaboration with state and federal agencies, evaluating vendor software, participating in user groups, performance monitoring and trend analyses.

3.2.5.1.4 Letters of reference from three (3) of the bidder's previous clients

Copies of three letters of reference are attached from:

- Pennsylvania Department of Human Services.
- Louisiana Department of Health and Hospitals.
- Michigan Department of Health and Human Services.

To further clarify and support our proposal, we have included additional references in Tab 5 of our response. These references and perspectives are from a variety of clients and partners, including provider organizations, a provider-sponsored health plan partner, advocacy groups and a state agency. The insight contained in these letters confirms we are the right partner for Iowa DHS and the Medicaid managed care program.

April 1, 2015

Ms. Carrie Lindgren
Iowa Issuing Officer
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114

Dear Ms. Lindgren:

RE: Letter of Reference for Iowa High Quality Health Care Initiative RFP

It is my pleasure to offer this letter of reference in support of AmeriHealth Caritas' proposal to serve as a Medicaid Managed Organization for Iowa's managed care program. AmeriHealth Caritas operates Medicaid Managed Care health plans in four regions of Pennsylvania – Southeast Zone (Keystone First), Lehigh/Capital and New West Zones (AmeriHealth Caritas Pennsylvania) and the New East Zone (AmeriHealth Northeast) – encompassing over 512,000 TANF and SSI/ABD members in urban and rural Pennsylvania counties.

I have had 25 years of experience working AmeriHealth Caritas and have found that the company has been a wonderful partner to members, the provider community, and my team. The team is dedicated to improving the health status of entire communities, whether it is value-added services for the entire population or intensive care coordination for high-risk members. In particular, AmeriHealth Caritas contracts with some of the largest health systems in Philadelphia, Harrisburg, and Allentown offering its members a comprehensive provider network and access to care. AmeriHealth Caritas also received the best scores overall among health plans, including top scores for access to care and for member satisfaction based on 2014 data.

As Pennsylvania considers the path forward for Medicaid expansion, AmeriHealth Caritas has been an invaluable partner as we define our program. I believe their 30 years of experience, expertise and insight would be invaluable to the state of Iowa as you navigate the transition to a managed care system to achieve the goals of the High Quality Care Initiative.

Bureau of Managed Care Operations
P.O. Box 2675 Harrisburg, Pennsylvania 17105 | T: 717.772.6300 | F: 717.772.6328 | www.dhs.state.pa.us

Ms. Carrie Lindgren (2)

Should you have any further questions on AmeriHealth Caritas' operations in Pennsylvania, please do not hesitate to reach out to me.

Sincerely,

Allen W. Fisher
Division Director
Financial Analysis Division

Bureau of Managed Care Operations
P.O. Box 2675 Harrisburg, Pennsylvania 17105 | T: 717.772.6300 | F: 717.772.6328 | www.dhs.state.pa.us

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

April 8, 2015

Carrie Lindgren
Iowa Issuing Officer
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114
Phone: 515-281-7556
Bidders4MED16009@dhs.state.ia.us

RE: Letter of Reference for Iowa High Quality Health Care Initiative RFP

On behalf of the Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF) (Louisiana's single state Medicaid agency), I am pleased to offer this letter of reference in support of AmeriHealth Caritas' proposal to serve as a Medicaid Managed Organization for Iowa's managed care program. AmeriHealth Caritas Louisiana (ACLA) has been one of the statewide, risk-bearing Medicaid Managed Care organizations in Louisiana's Bayou Health program since the delivery model was launched on February 1, 2012. ACLA was recently selected as a successful bidder in the reprocurement of the managed care contracts in October 2014 and just began their fourth year of operation in Louisiana, currently serving over 150,000 TANF and ABD members.

In the areas of access, cost, and quality, ACLA's performance has been key in helping the Bayou Health program demonstrate early success. They have developed or tailored their programs to our members' needs, which vary significantly by geographic region within the state. For example, ACLA's Care Management team currently has a pilot program in the Baton Rouge market focusing on direct contact with high-risk members in their home and community settings to ensure the best possible outcomes. ACLA also has a Community Education team spread across the state who have helped to connect members with appropriate care (i.e. missed preventative care & redirection of high ER utilization).

ACLA has effectively implemented targeted programs to address quality and cost of care. In 2014, they demonstrated a reduction of 30-day hospital readmissions by 17 percent for members with asthma or other chronic health problems by proactively engaging members, providers and pharmacists. Through investments in their BrightStart care management program targeting pregnant women and babies, they have also experienced a reduction in NICU days by over 8 percent in 2014.

Bienville Building • 628 North 4th Street • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone #: 225/342-9240 • Fax #: 225/342-9598 • *www.MakingMedicaidBetter.com*
"An Equal Opportunity Employer"

Lindgren, Carrie
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Though Behavioral Health services are currently carved-out of the managed care contracts in Louisiana, these services will be carved-in beginning December 1, 2015 and ACLA will have the opportunity to leverage the in-house expertise of PerformCare to develop a fully integrated solution for ACLA members.

ACLA's parent company, AmeriHealth Caritas, has extensive experience in providing health care solutions for Medicaid populations with differing demographics in both urban and rural areas and in diverse states and the District of Columbia. As a relative "late comer" to the managed care delivery model, Louisiana Medicaid has benefited from their lessons learned and the best practices in other states.

I believe their mission orientation and extensive expertise would be highly beneficial to the state of Iowa as it transitions to a managed health delivery system. We recommend AmeriHealth Caritas as a managed care partner. Similar to Iowa, their work in Louisiana aligned with the state's entry into managed care, and ACLA proved to be a valued partner to us in this transition.

Should you have any further questions on AmeriHealth Caritas' operations in Louisiana, please do not hesitate to contact me. I can be reached by phone at 225-342-3032 or via e-mail at ruth.kennedy@la.gov.

Sincerely,

J. Ruth Kennedy
Medicaid Director

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

April 20, 2015

Carrie Lindgren
Iowa Issuing Officer
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114
Phone: 515-281-7556
Bidders4MED16009@dhs.state.ia.us

RE: Letter of Reference for Iowa High Quality Health Care Initiative RFP

Dear Ms. Lindgren:

On behalf of the Michigan Department of Health and Human Services (MDHHS) it is my pleasure to offer this letter of reference in support of AmeriHealth Caritas' proposal to serve as a Medicaid Managed Organization for Iowa's managed care program. Blue Cross Complete (BCC), a division of Blue Care Network HMO, has been partners with the MDHHS in serving the Medicaid managed care program in their service areas for the past seven years and the Healthy Michigan Plan (HMP) since April 1, 2014. During this time, BCC has successfully demonstrated a positive working relationship with MDHHS as well as achieving compliance with program requirements and regulations for the Medicaid managed care program. They provide medical services to over 83,000 Medicaid beneficiaries in groups such as the Aged, Blind and Disabled (ABD), Temporary Assistance to Needy Families (TANF) and children with special health care needs, residing in Livingston, Washtenaw and Wayne counties.

In 2013, Blue Cross Complete launched a new operating plan with AmeriHealth Caritas and successfully implemented Healthy Michigan Plan, the state's expansion program in 2014. In addition to providing TPA services and other operation support to Blue Cross Complete, AmeriHealth Caritas provides PBM to the plan through its PerformRx product.

Apart from supporting the Medicaid population in the state through its collaboration with Blue Cross Complete, AmeriHealth Caritas was one of the successful bidders selected by the state to administer the Duals Demonstration programs in Wayne and Macomb service areas anticipated to launch this year. They have been very cooperative as the state works through the details of the Demonstration and have collaborated closely with MDHHS to meet our citizens' needs to ensure a robust launch and enrollment.

AmeriHealth Caritas has extensive experience and knowledge of the Medicaid market assisting members across various categories of aid. They have been a great asset to Blue Cross Complete and I believe they would be a great partner to the state of Iowa as it transitions to a Medicaid managed care system.

I look forward to answering any questions you or your team may have about AmeriHealth Caritas in the State of Michigan.

Sincerely,

Kathy Stiffler, Director
Bureau of Medicaid Care Management and Quality Assurance
Medical Services Administration
Michigan Department of Health and Human Services
Phone: 517-241-8055
stifflerk@michigan.gov

CAPITOL COMMONS CENTER • 400 SOUTH PINE • LANSING, MICHIGAN 48913
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3.2.5.1.5 Description of experience managing subcontractors

AmeriHealth Caritas Iowa understands that accountability for the completion of a function or responsibility, even when performed by a subcontractor, remains with AmeriHealth Caritas Iowa. Our subcontractor oversight program is 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 Iowa. Below, we have outlined our experience managing subcontractors.

Management administrative services

AmeriHealth Caritas Iowa will subcontract certain services with its affiliate AmeriHealth Caritas Services LLC to meet the needs of our members in Iowa. Key work will be delegated from the Call Center, Claims Services, Corporate Services (e.g., Compliance, Finance, Human Resources, Legal, Information Solutions and Marketing), Operations and Corporate Medical Management.

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 weekly and monthly. 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; and encounter data acceptance and completeness. In addition to standard performance metrics, those requirements unique to the Iowa High Quality Healthcare Initiative 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 health 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 to discuss performance metrics and trends to ensure compliance with contractual requirements, internal service level requirements and performance improvement outcomes.

Any performance issues 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 ensure an accounting of all issues and their resolution outcomes.

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 necessarily AmeriHealth Caritas Services' performance) against the requirements of our Contract with DHS. The auditing and monitoring of AmeriHealth Caritas Services will thus be a matter of measuring Contract compliance. We have successfully deployed this model 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) 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 that meets weekly to review all operating reports. If nonperformance 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 quickly due to AmeriHealth Caritas' robust performance oversight.

Pharmacy benefits management

As sister companies within AmeriHealth Caritas, both AmeriHealth Caritas Iowa and PerformRx will be wholly owned by the same 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 plans, 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 (D-SNP and dual demonstration plans) and to 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 our 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.

AmeriHealth Caritas Iowa is committed to complying with all relevant laws, regulations and contractual requirements, and ensuring that our subcontractors, including PerformRx, are compliant. AmeriHealth Caritas Iowa will implement our strong corporate subcontractor oversight program and will monitor and evaluate PerformRx's performance. 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 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 meet both members' and Iowa's needs. 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 monthly. In addition, Delegation Oversight will complete an annual audit of PerformRx on behalf of all AmeriHealth Caritas health plans, for compliance, Contract and regulatory items.
- Regional pharmacy directors 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 identified that need resolution. The pharmacy directors work with PerformRx in reference to

state audits, onsite visits and/or onsite audits via desktop 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 health plan-specific initiatives.
- AmeriHealth Caritas Iowa will complete a quarterly drug utilization review (DUR) to evaluate trends and spend.
- AmeriHealth Caritas Iowa's Compliance staff will hold monthly compliance meetings to address regulatory, state and Contract items. We will also have clinical meetings to review 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 for and work with AmeriHealth Caritas Iowa directly for resolutions, data anomalies and pharmacy issues as they pertain to state reporting.

AmeriHealth Caritas Iowa holds performance guarantees with PerformRx to ensure a 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 nonperformance. Any penalties are paid quarterly.

Performance guarantees include, but are not limited to:

- Claims processing timeliness.
- Systems availability.
- Eligibility accuracy load based on data provided by the plan.
- Network access requirements.
- State reporting requirements.
- Prior authorization turnaround time.
- Call Center average speed of answer.

Clinical subcontractors

AmeriHealth Caritas Iowa has extensive experience managing clinical subcontractors to whom we delegate administrative services. These services typically include provider contracting, credentialing, claims processing and other related financial services, and utilization management. The subcontractors we manage include:

- Vision (routine/eyewear only, and comprehensive eye medical/surgical).
- Dental.
- 24/7 Nurse Call Line.
- Non-emergent medical transportation.

We use subcontractors who are commonly used by our affiliates to increase our leverage and ability to hold the subcontractor to performance standards. As part of the contract finalization process, we conduct an onsite audit of the subcontractor's records using comprehensive assessment tools that combine National Committee for Quality Assurance (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 include a review of credentialing files, policies and procedures, relevant workflows, and claims payment and encounter processing, as applicable. The results of the audit are compiled and presented to management and the relevant quality committees. 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 partnerships are supported by a written contract that includes a detailed delegation agreement reflecting NCQA requirements. Our contracts include language that allows us to place subcontractors on a corrective action plan, and if performance does not improve, the contract allows us to terminate the subcontractor.

Our oversight activities are guided and supported by a corporate delegation oversight policy maintained by our corporate Quality department.

We have staff dedicated to subcontractor oversight, including a full-time specialist, who will monitor subcontractors' performance against documented performance standards each month. These standards include timely claims payment, encounters processing and call center performance. At a minimum, we require performance consistent with industry standards. Below are examples of typical performance standards.

Activity	Standards
Claims processing	
Claims financial accuracy.	≥ 98%
Claims processing accuracy.	≥ 98%
Clean claims processed within 20 business days.	≥ 90%
Clean claims processed within 60 calendar days.	≥ 99%
Process 100% of all other claims within 90 days of date of receipt.	100%
Report of summary data, including claims payment activity and reasons for claims denials.	Monthly
Call Center management	
Service level calculated with this equation: ((T-(A+B)/T)*100) where T = all calls that enter queue, A = calls that are answered after 30 seconds, B = calls that are abandoned after 30 seconds.	≤ 80%
Average speed of answer.	85% ≤ 20 seconds
Blocked call rate.	≤1%
Average hold time.	≤2 minutes
Call resolution (same-day response).	98%
Provider complaint acknowledgment within two (2) business days.	98%

Activity	Standards
Provider complaint resolution within 30 calendar days.	98%
Average response to email inquiries from the health plan within two (2) business days.	98%
Account administration	
Electronic eligibility online within two (2) business days.	98%
Provider Web Portal availability.	98%
Credentialing.	
Complete provider credentialing within 30 calendar days of receipt of complete application.	90%
Complete provider credentialing within 45 calendar days of receipt of complete application.	100%
Compliance with 36-month recredentialing cycle.	95%
Utilization Management	
Regular prior authorizations processed within seven (7) calendar days of the request for service.	100%
Expedited prior authorization requests processed within three (3) business days of the request for service.	100%

Most subcontractor performance metrics are tracked monthly (the remainder are tracked quarterly) and are compiled into a report presented to the Quality committee(s). We review month-over-month results to identify performance trends and quickly address any deficiencies. When a subcontractor has a significant or persistent failure to meet agreed-on performance standards, we seek out the root cause and implement a corrective action plan. We require a subcontractor to meet the performance standard for three (3) 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.

Annually, we audit all subcontractors to ensure that their credentialing, utilization management, and other business processes and procedures are continuing to meet AmeriHealth Caritas and state requirements. The results of these audits are compiled and submitted to the appropriate Quality committee(s), along with any recommendations.

Payment integrity

All prospective payment integrity subcontractors go through a formal RFP process with guidance from AmeriHealth Caritas' Sourcing department.

This process includes the following steps:

- RFPs are sent out to potential subcontractors and include any RFP statement-of-work goals and objectives.

- Potential subcontractors are required to submit references from other clients as part of their RFP response.
- Each potential subcontractor is also required to do an onsite presentation.
- A scorecard based on key functions is prepared and weighted for all potential subcontractors who submitted an RFP to aid in the final selection process.

Once a subcontractor is hired, AmeriHealth Caritas performs a full health plan implementation process and supplies each subcontractor with all internal and state required reports to track and monitor provided services.

Subcontractor implementation

- Weekly and ad-hoc meetings are held to review project plan of implementation and discuss any current or potential concerns.

Edit approval/health plan savings and recoveries

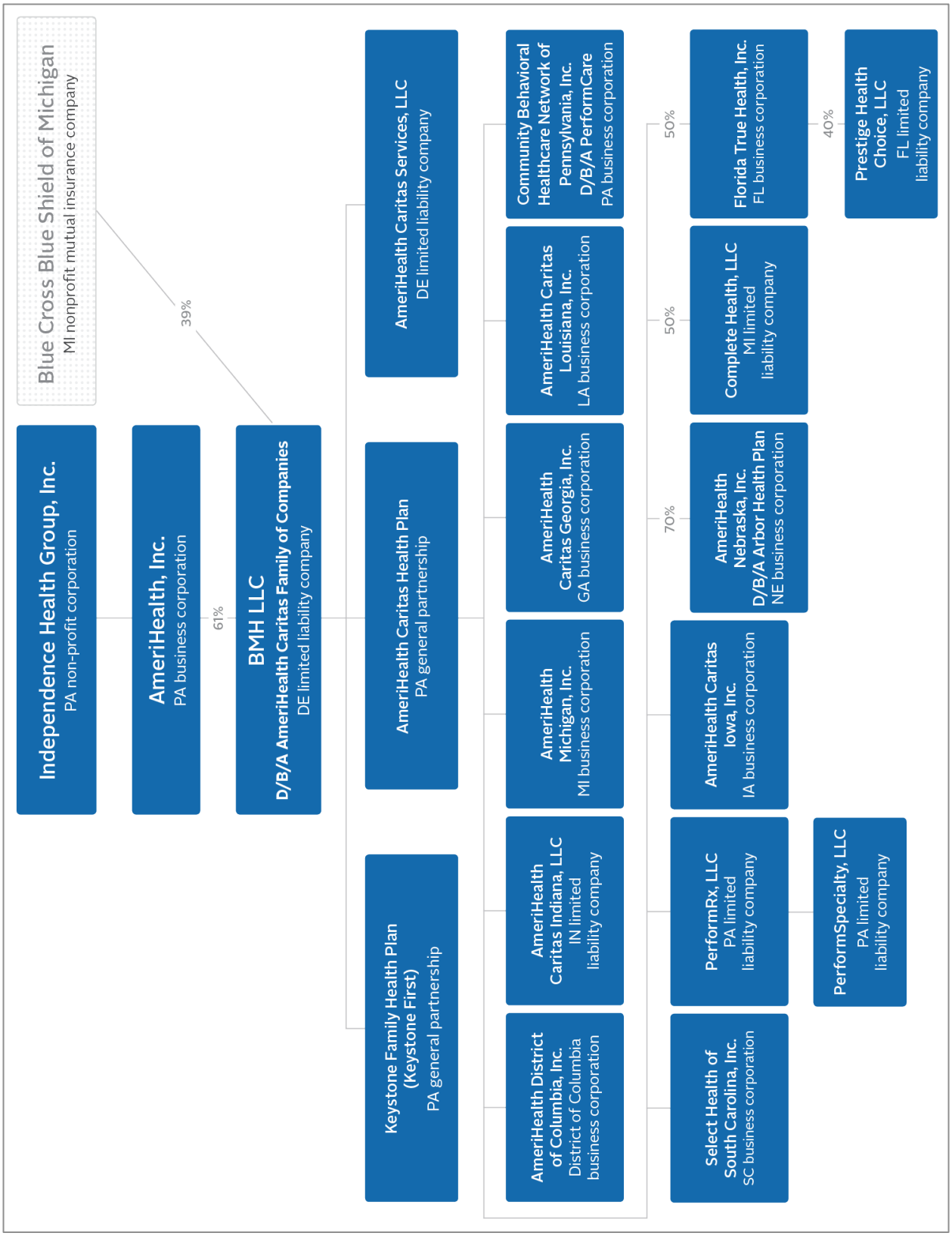
- Edit review and approval with health plan.
  - All plans approve edits prior to going live with a subcontractor.
- Tracking of all projects and outcomes is completed through weekly reports sent to both the health plan and the subcontractor.

Performance tracking

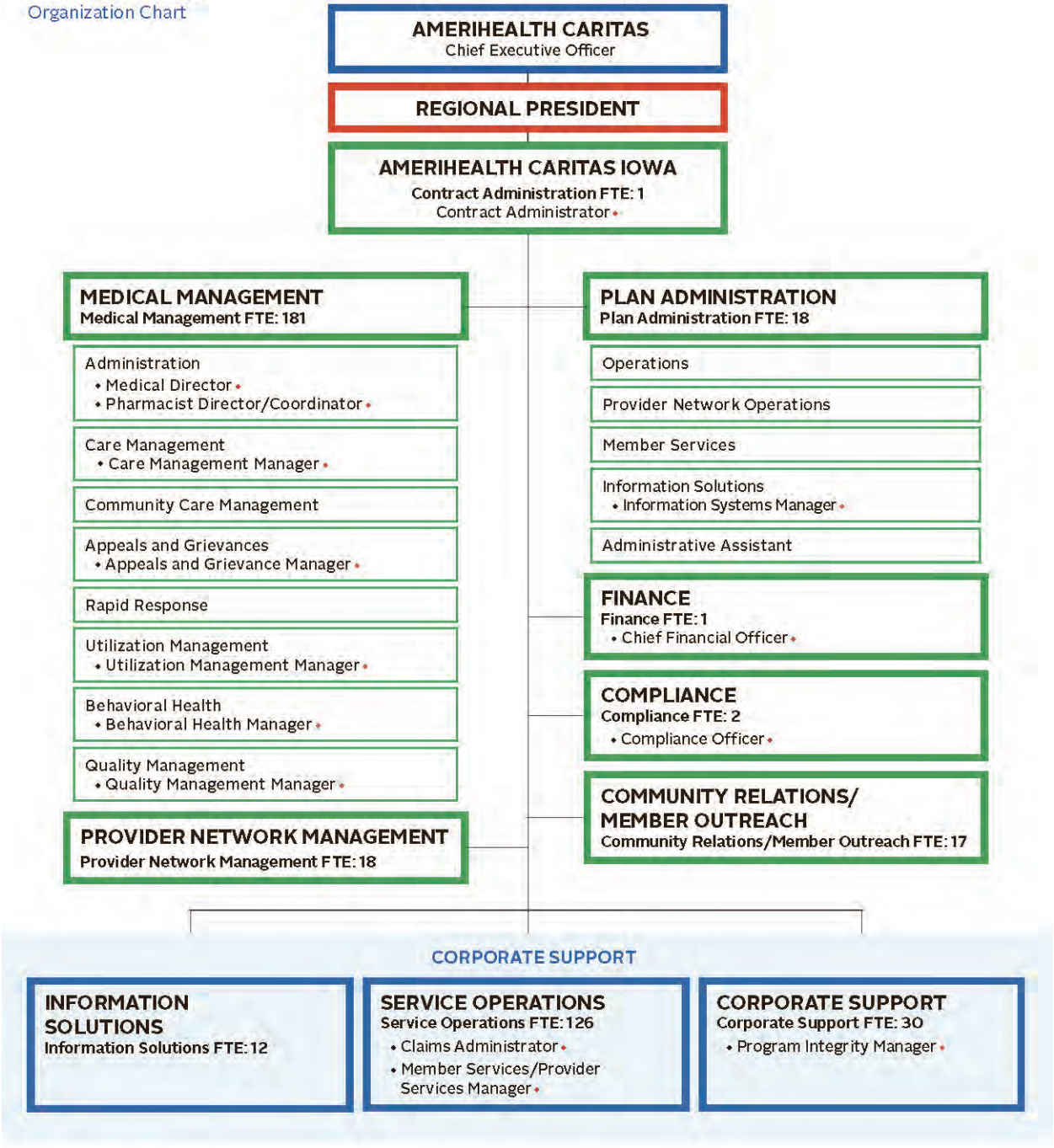
- Subcontractor performance is monitored through weekly and/or monthly meetings and quarterly reviews to discuss and review all payment integrity issues, projects, edit developments and potential service expansion.

3.2.5.2.1 Tables of organization

The following tables depict our overall ownership structure and post-implementation organization for AmeriHealth Caritas Iowa.


Independence Health Group, Inc.
PA non-profit corporation
Blue Cross Blue Shield of Michigan
MI nonprofit mutual insurance company
39%
AmeriHealth, Inc.
PA business corporation
61%
BMH LLC
D/B/A AmeriHealth Caritas Family of Companies
DE limited liability company
AmeriHealth Caritas Services, LLC
DE limited liability company
AmeriHealth Caritas Health Plan
PA general partnership
Keystone Family Health Plan (Keystone First)
PA general partnership
Community Behavioral Healthcare Network of Pennsylvania, Inc.
D/B/A PerformCare
PA business corporation
AmeriHealth Caritas Louisiana, Inc.
LA business corporation
AmeriHealth Caritas Georgia, Inc.
GA business corporation
AmeriHealth Michigan, Inc.
MI business corporation
AmeriHealth Caritas Indiana, LLC
IN limited liability company
AmeriHealth District of Columbia, Inc.
District of Columbia business corporation
50%
Florida True Health, Inc.
FL business corporation
50%
Complete Health, LLC
MI limited liability company
70%
AmeriHealth Nebraska, Inc.
D/B/A Arbor Health Plan
NE business corporation
AmeriHealth Caritas Iowa, Inc.
IA business corporation
PerformRx, LLC
PA limited liability company
Select Health of South Carolina, Inc.
SC business corporation
40%
Prestige Health Choice, LLC
FL limited liability company
PerformSpecialty, LLC
PA limited liability company

Post-Implementation Organization Chart



• Indicates required role

The specific staff that will provide services under the RFP is detailed in Section 2.9 of our response and is also provided below. Titles 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	Supervisors, Community Relations/Outreach (Field)	2	Local
Community Outreach	Community relations representatives	10	Local
Community Outreach	Marketing coordinators	3	Local
Subtotal Community Relations and Member Outreach		17	
Plan Administration			
Operations	Director, Plan Operations and Administration	1	Local
Operations	Facilities	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 analysts	5	Local
Provider Network Operations	Coordinators, Provider Operations	2	Local
Member Services	Director, Member Engagement	1	Local
Information Solutions	**Information systems manager**	1	Local
Information Solutions	Tech analyst	1	Local
Administrative Assistants	Administrative assistants	4	Local
Subtotal Plan Administration		18	
Medical Management			
Administration	**Medical Director**	1	Local

Department/function	Title	Head-count	Staff location
Pharmacy	**Pharmacist director/coordinator**	1	Local
Care Management	Director, Integrated Care Management	1	Local
Care Management	Care managers	26	Local
Care Management	Care connectors	12	Local
Care Management	**Care management managers**	2	Local
Care Management	Supervisors, Care Management	3	Local
Care Management (maternity)	Care managers	7	Local
Long-Term Care	**Long-Term Care manager**	1	Local
Community Care Management	Community program manager	1	Local
Community Care Management	Clinical educators	2	Local
Community Care Management (registered nurse)	Community Care Management care managers	2	Local
Community Care Management (Master of Social Work)	Community Care Management care managers	2	Local
Community Care Management	Community Care Management care connectors	6	Local
Community Care Management	Community Care Management coordinators	2	Local
Appeals and Grievances	**Appeals and Grievances manager**	1	Local
Appeals and Grievances (registered nurse)	Clinical care reviewers	2	Local
Appeals and Grievances	Appeals coordinators	5	Local
Rapid Response	Manager, Rapid Response	1	Local
Rapid Response	Supervisors, Rapid Response	2	Local
Rapid Response	Care connectors	10	Local
Rapid Response	Care managers	3	Local
Rapid Response, EPSDT	Care connectors	4	Local
Utilization Management	Medical directors, Utilization Management	2	Local
Utilization Management	Clinical care reviewers, Utilization Management	20	Local

Department/function	Title	Head-count	Staff location
Utilization Management	Utilization Management techs	6	Local
Utilization Management	Durable medical equipment (DME) specialists	6	Local
Utilization Management	**Utilization Management managers**	2	Local
Utilization Management	Supervisors, Utilization Management	4	Local
Behavioral Health	**Behavioral Health manager**	1	Local
Behavioral Health	Medical director	1	Local
Behavioral Health	Psychiatrist/psychologist advisor	1	Local
Behavioral Health	Utilization Management supervisors	2	Local
Behavioral Health	Utilization Management Clinical care reviewers	7	Local
Behavioral Health, After-Hours Clinical	Clinical care managers	3	Local
Behavioral Health	Care managers	6	Local
Behavioral Health	Care connectors	3	Local
Quality Management	**Quality Management manager**	1	Local
Quality Management	Quality Performance Management specialists, nonclinical	3	Local
Quality Management	Cultural linguistic appropriate services (CLAS) coordinator	1	Local
Quality Management	Community outreach solutions specialists	8	Local
Quality Management	Quality Management registered nurses (quality performance specialists-clinical)	2	Local
Quality Management	Clinical auditors	3	Local
Quality Management	Clinical trainers	2	Local
Subtotal Medical Management		181	
Provider Network			
Provider Network	Director, Provider Network Management	1	Local
Provider Network	Provider network account executives	8	Local

Department/function	Title	Head-count	Staff location
Provider Network	Provider communications specialist	1	Local
Provider Network	Managers, Provider Network Management	2	Local
Provider Network	Credentialing coordinators	6	Local
Subtotal Provider Network/Provider Network Operations		18	
Service Operations			
Service Operations (IS/operations)	Encounters analysts	2	Corporate
Service Operations (configuration and testing)	Analysts	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 managers**	2	Corporate
Service Operations (member-provider services)	Customer service representatives	35	Corporate
Service Operations (provider claims services)	Customer service representatives	10	Corporate
Service Operations (provider maintenance)	Provider maintenance technicians	5	Corporate
Service Operations (enrollment and welcome calls)	Enrollment specialists/Customer service representatives	6	Corporate
Service Operations (cost containment)	Cost containment analyst	1	Corporate
Service Operations (other operations)	Invalid Provider Queue(IPQ) representatives and Quality Auditors	15	Corporate
Subtotal Service Operations		126	
Information Solutions			

Department/function	Title	Head-count	Staff location
Information Solutions	Apps, EDI, production control, desktop support, and business engagement specialists	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 specialists	5	Corporate
Payment Integrity	**Program integrity manager**	1	Corporate
Payment Integrity	Investigator/recovery analysts/research and reporting analysts	6	Corporate
Medical Economics	Medical Economics analysts	4	Corporate
Marketing and Communications	Web designers/plan communications managers	2	Corporate
Integrated Document System	Coordinators, Mail Services	4	Corporate
Human Resources	Human Resources business partner	1	Local
Other Corporate		7	Corporate
Subtotal Corporate support staff		30	
Grand total		**406**	

3.2.5.2.2 Name and Credentials of Key Corporate Personnel

AmeriHealth Caritas Iowa is a wholly owned subsidiary of AmeriHealth Caritas Health Plan and a member of the AmeriHealth Caritas Family of Companies. All ownership within the family of companies (including ownership of AmeriHealth Caritas Iowa) is by a business entity. No individual holds an ownership interest in any portion of the AmeriHealth Caritas Family of Companies.

AmeriHealth Caritas Iowa is ultimately owned (through subsidiaries) by Independence Health Group Inc. (an affiliate of Independence Blue Cross) and Blue Cross Blue Shield of Michigan. See the above company organization chart for the identification of all entities with an ownership interest in AmeriHealth Caritas Iowa.

AmeriHealth Caritas Iowa's board of directors	AmeriHealth Caritas Iowa's executive officers
Russell Gianforcaro J. Michael Jernigan Steven H. Bohner	Russell Gianforcaro, President Steven H. Bohner, Treasurer Robert H. Gilman, Secretary

The resumes for Russell Gianforcaro, J. Michael Jernigan, Steven H. Bohner and Robert H. Gilman are available below.

RUSSELL R. GIANFORCARO

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EDUCATION

- Villanova University, Villanova, Pennsylvania

  Bachelor of Science in Accountancy
- University of Pennsylvania, Wharton School

  Executive Program
- Certified Public Accountant (Pennsylvania)

PROFESSIONAL EXPERIENCE

- **AMERIHEALTH CARITAS — Philadelphia, Pennsylvania**
  Regional President — 2014 to Present
  Responsible for the growth and operations of health plans in southeastern Pennsylvania, northeastern Pennsylvania, central/western Pennsylvania, the District of Columbia and New Jersey.

- **AMERIHEALTH CARITAS — Philadelphia, Pennsylvania**
  Market President — 2012 to 2014
  Responsible for the oversight and strategic direction of Keystone First health plan.

- **AMERIHEALTH CARITAS — Philadelphia, Pennsylvania**
  Chief Accounting Officer — 2009 to 2012
  Responsible for enterprise-wide financial and accounting oversight of AmeriHealth Caritas.

- **AMERIHEALTH CARITAS — Philadelphia, Pennsylvania**
  Chief Financial Officer, Pennsylvania — 2006 to 2009
  Responsible for managing the financial operations of health plans in Pennsylvania.

- **HEALTH PARTNERS PLANS, INC. — Philadelphia, Pennsylvania**
  Corporate Controller — 1995 to 2006
  Responsible for the accounting and financial oversight of the company.

- **TENET HEALTH SYSTEM, CITY AVENUE AND PARKVIEW HOSPITALS — Philadelphia, Pennsylvania**
  Director of Finance/Controller — 1994 to 1995
  Responsible for the overall financial reporting of the hospitals.

- **DELOITTE, Philadelphia, Pennsylvania**
  Senior Auditor, Audit Manager — 1989 to 1994
  Progressive, diversified accounting, auditing, consulting and financial reporting experience with predominantly healthcare and insurance clients.

PROFESSIONAL AND PERSONAL ACTIVITIES

- Member of the PICPA and AICPA
- Member of the Board of Directors of the Eastern Delaware County YMCA

J. Michael Jernigan

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Regional President

Responsible for growth and operations of AmeriHealth Caritas Family of Companies business covering multiple states. Strategic growth and successful implementation of new business is a critical focus of this new responsibility.

Summary

Visionary healthcare executive with strong people skills, seeking opportunity to provide strategic direction to a mission focused health insurer. The right opportunity will allow me to utilize team building skills to focus on expanding health insurance coverage in growth market in collaboration with business customers, providers and consumers.

Personally committed to community service, I have participated with many community organizations with missions consistent with helping people get care, stay well and build healthy communities.

Lead a health plan executive team for past 15 years focused on customer service, quality improvement and strategic growth through collaboration with providers.

- **2010-Present AmeriHealth Caritas Family of Companies**

  Regional President

  Responsible for growth and operations of AmeriHealth Caritas Family of Companies business covering multiple states. Strategic growth and successful implementation of new business is a critical focus of this new responsibility.

- **1995-2010 Select Health of South Carolina, Inc., Wholly-owned subsidiary of AmeriHealth Mercy**

  President and Chief Executive Officer

  Founded Select Health in September of 1995 and received a license from the South Carolina Department of Insurance to operate as a domestic HMO in February of 1996. Contracted with the South Carolina Department of Health and Human Services on August 1, 1996, the company began enrolling members effective December of 1996.

  Lead a successful transition when Select Health was acquired by AmeriHealth Caritas in September of 1999. As a member of the AmeriHealth Caritas Family of Companies, Select Health has grown to 215,000 members, while maintaining its commitment to enrollees and providers. Recognized as one of the best places to work in South Carolina for 2008, 2009, and again in 2010 by the SC Chamber of Commerce, Select Health has established a reputation for commitment to excellence.

  Our recent independent satisfaction survey for adult enrollees places Select Health in the 90th percentile or above, for all categories of measured results.

- **1993-1995 Ultramedix Health Care Systems, Inc.**

  Treasurer and Senior VP of Development

Founded Ultramedix with two physicians and a business colleague in 1993. At the time, Ultramedix was a prepaid health plan serving 15,000 Medicaid members in the north Florida market. Evaluated expansion opportunities into other states for Ultramedix and determined that South Carolina offered the best opportunity. When Ultramedix indicated that they were unwilling to pursue the SC opportunity, I resigned and moved to South Carolina to start Select Health.

- **1989-1993 Centurion Hospital of Carrollwood**

  Associate Administrator and CFO

  Responsible for all aspects of financial operations, including networking, contracting, physician recruiting, purchasing, TQM and operations. Worked with various managed care programs, including prepaid health plans providing services to Medicaid recipients.

- **1985-1988 Forum Health Investors**

  Vice President of Finance

  Started a hospital management company with former Operations Director of Southern Health Services and grew company to eight hospitals, owned or managed.

- **1983-1985 Sunbelt Healthcare**

  Corporate Controller

  Joined the former CFO of Southern Health Services in management and operation of two community hospitals.

- **1981-1983 Health Group**

  Regional Controller

  Provided financial operations support for hospitals owned and operated by the company, which was the successor to Southern Health Services.

- **1979-1981 Arthur Young and Company**

  Senior Auditor

  Involved with the financial audits of hospitals and nursing homes, including Beverly Enterprises and Southern Health Services.

- **1977-1979 Peat, Marwick, Mitchell and Co.**

  Senior Auditor

  Involved with the audits of various public companies and hospitals in South Carolina.

Education

- **1976 Clemson University, Bachelor of Science**

  Recipient of Scholarship from Society of CPA

  Various Executive leadership training programs including Harvard and the Kellogg School of Business

Steven Bohner

STEVEN H. BOHNER, CPA

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[redacted]

EDUCATION:
December 1989

Davis and Elkins College, Magna Cum Laude — Elkins, WV
BS: Accounting and Finance — Minor: Political Science
Overall GPA: 3.87/4.00

CERTIFICATION:

Successfully completed the Certified Public Accountant examination and is licensed in the state of Pennsylvania. Member of PICPA and AICPA.

COMPUTER SKILLS:

Proficient in the use of Microsoft Office and PeopleSoft.

PROFESSIONAL EXPERIENCE:
September 1992 to Present

THE AMERIHEALTH CARITAS FAMILY OF COMPANIES:

Senior Vice President, Finance and Chief Financial Officer	09/2009 to Present
Interim Chief Financial Officer and Chief Accounting Officer	03/2009 to 09/2009
Vice President, Finance	2001 to 03/2009
Director, Accounting	1998 to 2001
Accounting Manager	1994 to 1998
Senior Accountant	1992 to 1994

Since joining the Finance Department in 1992, I have taken on increasingly responsible roles and am currently the Senior Vice President, Finance and Chief Financial Officer of this national managed care company. During my tenure, the Company has grown from one product line and 50,000 members in one state, to five product lines and almost 7 million members in 16 states and the District of Columbia. Additionally, revenue has grown from $275 million to over $6.0 billion.

Senior Vice President, Finance and Chief Financial Officer

- Responsible for leading the finance department including oversight of finance units in South Carolina, Indiana, Pennsylvania, Florida, Louisiana and Nebraska.
- Provided strategic financial oversight to the most recent three-year strategic plan process.
- Led efforts to secure additional lines of credit with financial institutions.
- Oversees financial evaluation of potential business expansion.
- Communicate and consult with senior leadership on the overall financial performance of the organization.
- Serve as key financial liaison to Partner CFO's.
- Provides support in managing the Audit Committee and participate as a member of the Investment Committee, Pension Committee and 401(K) Committee.
- Enhanced communication of actuarial reports to local office leaders that led to a better understanding of financial results.
- Led financial due diligence on recent acquisition of AmeriHealth Mercy Family of Companies.

Vice President, Finance

- Led completion of annual corporate budget of over $3 billion, that includes multiple corporate entities operating in 13 states with over 2,500 employees
- Played integral role in development of strategic and annual operating goals for the company.
- Managed team responsible for financial review of new business opportunities and led development of financial model for corporate decision-making.
- Played an integral role in the due diligence of the acquisition of our Behavior Health product.
- Oversaw the corporate treasury function and coordinated daily monitoring of cash flow.
- Oversaw monthly financial statement close and presented financial results to senior management.
- Reduced the financial close process by two business days to meet partner requirements.
- Participated in the following Partnership Board Committees: Audit Committee, Investment Committee, Pension Committee, and 401(K) Committee.
- Served as lead with external auditors with respect to annual and statutory audits.
- Responsible for oversight in implementing the following financial software packages: budget, cost accounting, and financial reporting.

Director, Accounting

- Coordinated monthly financial statement close and presented statements to senior finance management.
- Oversaw cost accounting department, which developed pricing for contractual work, identified trends in unit costs, and evaluated financial impact of new products.
- Directed timely billing and collection of consulting and management agreements.
- Supervised successful general ledger conversion to PeopleSoft.
- Interpreted complex financial issues and condensed information into concise, easy to understand summaries.
- Oversaw timely filing of monthly, quarterly, and annual DOI financial reports.
- Served as liaison with external auditors with respect to annual and statutory audits.
- Supervised, trained and evaluated professional accounting staff of eight.

January 1990
To September 1992

RIMMER & COMPANY
(A local public accounting firm.)
Senior Accountant

- Performed audits, reviews, and compilations for corporations and partnerships.
- Prepared corporation, partnership, trust and individual tax returns.
- Developed financial statements from client's records utilizing spreadsheets and various financial reporting computer packages.

Robert H. Gilman

Home: Confidential & Not for Public Disclosure [redacted]

Work: 200 Stevens Drive
Philadelphia, PA 19113
(215) 937-8560 Phone
(215) 937-5353 Fax
rgilman@amerihealthcaritas.com

Experience:

1993-Present **AmeriHealth Caritas Family of Companies** Philadelphia, PA

Senior Vice President, Legal Affairs and General Counsel

General Counsel of national managed healthcare organization specializing in providing accessible healthcare coverage and services through government-sponsored programs to low-income and disabled populations.

1984-1993 **Reed Smith LLP** Philadelphia, PA

Associate Counsel

Associate in the healthcare and business departments of national law firm. Provided legal advice and representation in healthcare, insurance and commercial matters.

1980-1981 **Hospital University of Pennsylvania** Philadelphia, PA

Hospital Management

Reporting to Chief Operating Officer, supported hospital operational departments in developing and analyzing methods for improved quality and efficiency.

1974-1978 **Institute of the Pennsylvania Hospital** Philadelphia, PA

Program Development

Assisted in the development and operation of start-up partial hospitalization program for young adults. Worked in a variety of therapeutic milieus in support of behavioral health programs.

Education:

Juris Doctor **1984**

University of Pennsylvania School of Law

Masters Business Administration 1981

Wharton School at University of Pennsylvania

Bachelor of Arts **1974**

University of Pennsylvania

Affiliations: Admitted to the Pennsylvania Bar

3.2.5.2.3 Information about Key Project Personnel

AmeriHealth Caritas Iowa will not be submitting key personnel names to Iowa at this present time. Based upon the criteria within the RFP SOW, names and information for key staff persons will be provided to the state in the timeframe designated.

3.2.5.4 Termination, Litigation and Investigation

List any contract for services that the bidder has had that was terminated for convenience, non-performance, non-allocation of funds, or any other reason for which termination occurred before completion of all obligations under the contract provisions.

As stated, AmeriHealth Caritas Iowa is a subsidiary of AmeriHealth Caritas Health Plan and a member of the AmeriHealth Caritas Family of Companies. The family of companies is organized under the parent organization BMH LLC (which operates as the AmeriHealth Caritas Family of Companies). BMH LLC is in turn owned through subsidiaries by Independence Health Group, Inc. Independence Health Group is a holding company system whose subsidiaries include insurers and other managed care entities that offer a variety of commercial insurance products.

There are 11 operating divisions within AmeriHealth Caritas that provide services under Medicaid managed care programs, including eight that operate as managed care organizations. While neither AmeriHealth Caritas Iowa nor its immediate owner (AmeriHealth Caritas Health Plan) has had a contract terminated for convenience, non-performance, non-allocation of funds or any other reason where termination occurred before completion of all contract obligations, PerformRx (a sister company of AmeriHealth Caritas Iowa) has had contracts terminated before the expiration of the term of the contract. PerformRx is AmeriHealth Caritas' pharmacy benefits management (PBM) company, which has been furnishing PBM services in the Medicaid managed care environment since 1999.

Independence Health Group (including its subsidiaries) does business in a highly regulated industry and issues commercial administrative service agreements and group benefit contracts to thousands of group-insured and group self-funded customers, and to hundreds of thousands of non-group members. During the normal course of business and as is customary in the industry, some group customers and some non-group members have not renewed their agreements/contracts at the end of their term, and/or have terminated their agreements/contracts during the term (off-anniversary) for various business reasons (e.g., premiums/fees, benefit coverage and cease business operations).

The following chart details the circumstances of PerformRx terminated contracts:

Contract Party (Client)	Reason for Nonrenewal or Termination	Termination Date
Humana AdvantageCare Plan, Inc. f/k/a Metcare Health Plans, Inc.	Humana acquired Metcare, a Medicare Part D plan for which PerformRx provided PBM services. PerformRx agreed to permit an early termination of the PBM agreement in order to permit Humana to consolidate the lives covered under the Medicare Part D plan with another of Humana's Part D products.	12/31/08
Optimum Healthcare	Client terminated PBM agreement in order to in-source pharmacy benefit administration.	12/31/08
Touchstone Health HMO, Inc.	Client exercised contractual no-cause termination right.	12/31/08
Carolina Crescent Health Plan, Inc.	No reason given by client.	6/30/09
Virginia Premier Health Plan, Inc.	No reason cited.	6/30/09
MDwise, Inc.	PBM contract terminated as a result of the state of Indiana carving out pharmacy from the Medicaid managed care program.	12/31/09
APS Healthcare	PBM agreement terminated as a result of the plan Sponsor's termination of all plan membership following state (Hawaii) determination to resume responsibility for management of behavioral health pharmacy benefit.	10/31/10
Vantage Health Plan	No cause specified.	12/31/14

List any occurrences where the bidder has either been subject to default or has received notice of default or failure to perform on a contract. Provide full details related to the default or notice of default including the other party's name, address, and telephone number.

Except for the single instance described below for PerformRx, AmeriHealth Caritas Iowa's sister company, no other member of AmeriHealth Caritas has either been subject to default or received a notice of default or failure to perform on a contract. AmeriHealth Caritas Iowa's parent company, Independence Health Group (including its subsidiaries other than AmeriHealth Caritas) has also not been subject to default, received a notice of default or failure to perform on a contract.

- In June 2014, PerformRx received a notice of contract breach from MDwise, Inc., in connection with PBM services that PerformRx had been delivering since January 2014 for MDwise's new healthcare exchange product. Limited deficiencies in PerformRx's implementation of this new product resulted in the following claim processing errors: preferred generic drugs and diabetic products were subject to deductibles in error; generic drugs were paying as brand drugs; co-insurance being erroneously charged to members; and issues linking member and case ID number (linking an individual member to family). Corrections of these issues had been occurring since shortly after plan implementation in

January, and had been substantially completed by the end of March. MDwise imposed contract-based financial penalties, and MDwise and PerformRx developed a corrective action plan for claims re-processing in September 2014, which was completed in December 2014. PerformRx continues to provide PBM services to MDwise under this contract.

Contact

Chris Callahan, Pharm.D.
Director of Pharmacy
MDwise, Inc.
1200 Madison Ave., Suite 400
Indianapolis, IN 46225
(317) 822-7427

List any damages, penalties, disincentives assessed, or payments withheld, or anything of value traded or given up by the bidder under any of its existing or past contracts as it relates to services performed that are similar to the services contemplated by this RFP. Include the estimated cost of that incident to the bidder with the details of the occurrence.

AmeriHealth Caritas Iowa is a new company and it has not performed services similar to those contemplated by this RFP. AmeriHealth Caritas Iowa's immediate parent (AmeriHealth Caritas Health Plan) and certain other members of the AmeriHealth Caritas Family of Companies (AmeriHealth Caritas), as well as certain subsidiaries of AmeriHealth Caritas Iowa's parent company Independence Health Group, have had contract damages, penalties or disincentives assessed against them under contracts for services similar to those contemplated by this RFP. The following describes instances where certain members of AmeriHealth Caritas and certain subsidiaries of Independence Health Group have had damages, penalties or disincentives assessed against them under contracts for services under the federal healthcare programs.

Medicare

1. **QCC Insurance Company, Keystone Health Plan East, Inc. and AmeriHealth HMO, Inc.** In 2014, QCC Insurance Company, Keystone Health Plan East and AmeriHealth HMO paid to the Centers for Medicare and Medicaid Services ("CMS") a combined civil monetary penalty of $50,000, imposed on QCC Insurance Company, Keystone Health Plan East and AmeriHealth HMO as a result of incorrectly processed enrollments and disenrollments in accordance with CMS requirements.
2. **Keystone Health Plan East.** In October 2013, Keystone Health Plan East paid to CMS a civil monetary penalty of $47,945 as a result of listing the incorrect Part D prescription drug deductible on a 2013 Annual Notice of Change sent to certain Medicare Advantage members.

Medicaid/CHIP

*Organization Trade Name: AmeriHealth Caritas Pennsylvania/AmeriHealth Northeast/Keystone First**

* AmeriHealth Caritas operates its Pennsylvania Medicaid plans (AmeriHealth Caritas Health Plan, AmeriHealth Northeast and Keystone First) pursuant to the contract between the Pennsylvania Department of Human Services (PADHS) and Vista Health Plan, Inc. (Vista). Vista is an indirect subsidiary of Independence Health Group, Inc., which is AmeriHealth Caritas' parent company. Vista is also subject to regulatory oversight by the Pennsylvania Department of Health for the Pennsylvania Medicaid plans.

Regulatory Agency: Pennsylvania Department of Human Services/Pennsylvania Department of Health, Medicaid Sanctions

1. For the months of May to November 2010, AmeriHealth Caritas Pennsylvania and Keystone First were each sanctioned a total of $9,000 by the PADHS for noncompliance with the timeframe for mailing provider claim checks after the checks were printed. The operational issues leading to this sanction have been corrected by both AmeriHealth Caritas Pennsylvania and Keystone First. The sanction did not result in an administrative proceeding or litigation.
2. For the month of December 2012, AmeriHealth Caritas Pennsylvania incurred sanctions from the Pennsylvania Department of Human Services totaling $13,333, and Keystone First incurred sanctions totaling $8,000 for failure to comply the HealthChoices contract requirement pertaining to provider claims adjudication timeliness standards. The sanction did not result in an administrative proceeding or litigation.
3. For the month of December 2013, AmeriHealth Caritas Pennsylvania incurred sanctions from the Pennsylvania Department of Human Services totaling $10,000, AmeriHealth Caritas Northeast incurred sanctions totaling $6,000, and Keystone First incurred sanctions totaling $8,000 for failure to comply with the HealthChoices contract requirements pertaining to provider claims adjudication timeliness standards. The sanction did not result in an administrative proceeding or litigation.
4. For the month of August 2014, AmeriHealth Caritas Northeast and Keystone First were each sanctioned $1,000 for failure to comply with the HealthChoices contract requirements pertaining to provider claims adjudication timeliness standards. For the month of September 2014, AmeriHealth Caritas Pennsylvania incurred sanctions from the Pennsylvania Department of Human Services totaling $1,333. The sanction did not result in an administrative proceeding or litigation.

Organization: Florida True Health

Regulatory Agency: Florida Agency for Health Care Administration, Medicaid.

Sanctions

1. In January 2014, liquidated damages in the amount of $500 were imposed on Florida True Health by Florida Agency for Health Care Administration for failure to timely file an unaudited Child Health Check-Up program (CHCUP) report with the Florida Agency for Health Care Administration (AHCA). It was later determined that the CHCUP was in fact filed on time, but the report file was incorrectly named. The sanction did not result in an administrative proceeding or litigation.
2. In February 2014, liquidated damages in the amount of $25,000 were imposed on Florida True Health by AHCA for failure to comply with the federal 80 percent participation rate requirement. Florida True Health submitted a CAP addressing the participation ratio, which AHCA accepted on February 20, 2014. The sanction did not result in an administrative proceeding or litigation.

Organization: AmeriHealth Caritas of Louisiana

Regulatory Agency: Louisiana Department of Health and Hospitals, Medicaid.

Sanctions

1. In May 2013, monetary penalties were assessed against AmeriHealth Caritas of Louisiana by the Louisiana Department of Health and Hospitals for non-compliance with contract requirements. $170,000 was assessed for failure to meet pharmacy encounter claims submission requirements. $240,000 was assessed for failure to meet encounter data submission requirements. The sanction did not result in an administrative proceeding or litigation.

Behavioral Health Managed Care

Organization: PerformCare for Pennsylvania

Regulatory Agency: Pennsylvania Department of Human Services, Medicaid Behavioral Health.

Withholds

1. In March 2015, monetary withhold in the amount of $300,000 was assessed against PerformCare for Pennsylvania by the Tuscarora Managed Care Alliance, a Pennsylvania county-based oversight organization, for non-compliance with contract requirements. The withhold did not result in an administrative proceeding or litigation.

Pharmacy Benefit Management

Organization: PerformRx

Sanctions

1. In 2010, monetary penalties were assessed against PerformRx by Virginia Premier Health Plan, totaling $40,645, for pricing guarantees reconciliation.
2. In 2010, monetary penalties were assessed against PerformRx by Carolina Crescent Health Plan, totaling $2,284, for missed performance guarantees.
3. In 2013, monetary penalties were assessed against PerformRx by Essence Health Plan, totaling $191,594, for pricing guarantees reconciliation.
4. In 2014, monetary penalties were assessed against PerformRx by South Country Health Plan, totaling $6,000, for missed performance guarantees.
5. In 2014, monetary penalties were assessed against PerformRx by San Francisco Health Plan, totaling $38,500, for missed performance guarantees.
6. In 2014, monetary penalties were assessed against PerformRx by Contra Costa Health Plan, totaling $3,871, for missed performance guarantees.
7. In 2014, monetary penalties were assessed against PerformRx by MDwise Health Plan, totaling $7,000, for missed performance guarantees.
8. In 2014, monetary penalties were assessed against PerformRx by Blue Cross Complete Health Plan, totaling $8,000, for missed performance guarantees.

List and summarize any current pending or threatened litigation, administrative or regulatory proceedings, or similar matters related to the subject matter of the services sought in this RFP. Bidders may limit disclosure of these matters to a material threshold established by GAAP requirements.

In the course of ordinary business, AmeriHealth Caritas Iowa and its parent Independence Health Group are involved in and subject to claims, contractual disputes and other uncertainties. As reflected in our respective financial statements, neither AmeriHealth Caritas nor its parent Independence Health Group has current pending or threatened litigation, administrative or regulatory proceedings or similar matters that exceed the GAAP materiality threshold.

List any irregularities that have been discovered in any of the accounts maintained by the bidder on behalf of others. Describe the circumstances of irregularities or variances and detail how the issues were resolved.

AmeriHealth Caritas Iowa itself has never maintained accounts on behalf of others; accordingly, no irregularities could have occurred. No irregularities have been discovered by any other member of the AmeriHealth Caritas Family of Companies, or by Independence Health Group and its subsidiaries, in accounts maintained by any of them on behalf of others. Notwithstanding this, Independence Health Group as a service provider does business in a highly regulated industry; and in the ordinary course of business is subject to routine audits by auditors of self-funded (non-governmental) customers regarding the payment of claims for covered services under the terms of their administrative service agreements. Generally, it is Independence Health Group's policy to adjust/reprocess claims, in the normal course of business, for covered services appropriately identified by the auditors in claims audit reports for self-funded customers.

List any details of whether the bidder or any owners, officers, primary partners, staff providing services or any owners, officers, primary partners, or staff providing services of any subcontractor who may be involved with providing the services sought in this RFP, have ever had a founded child or dependent adult abuse report, or been convicted of a felony. Staff providing services shall include anyone having contact with members or member data.

AmeriHealth Caritas Iowa has never had a founded child or dependent adult abuse report, nor has it ever been convicted of a felony. The same is true for the owners and subcontractors of AmeriHealth Caritas Iowa, all of which are business entities. To the best of AmeriHealth Caritas Iowa's knowledge, information and belief, none of the officers, primary partners or staff providing services of AmeriHealth Caritas Iowa, its owners and its subcontractors have ever had a founded child or dependent adult abuse report or been convicted of a felony. Based on our commitment to having a safe, healthy and productive environment for all staff, AmeriHealth Caritas Iowa requires every candidate to undergo a pre-employment screening in accordance with the Pre- and Post-Employment Screening Policy (Policy No. 115.139), which encompasses an all-inclusive background check. Unfavorable results will result in withdrawal of any employment offer or termination of employment if already employed.

Attachments

Any attachments that the Bidder deems necessary to further clarify or support its proposal may be placed behind this Tab.

Letters of reference and support

To further clarify and support our proposal, we are providing additional references and perspectives from a variety of clients and partners, including provider organizations, a provider-sponsored health plan, advocacy groups and a state agency. The insight contained in these letters confirms we are the right partner for Iowa DHS and the future of the Medicaid managed care program.

Additional references found below are provided by:

- IowaHealth+.
- Passport Health Plan.
- Children's Hospital of Philadelphia (CHOP).
- Geisinger Health System.
- District of Columbia Primary Care Association (DCPCA).
- Area Agencies on Aging Association of Michigan (AAAAM).
- George Washington University.
- South Carolina Department of Health and Human Services.

April 17, 2015

Ms. Carrie Lindgren
Hoover State Office Building, 1st Floor
1305 East Walnut Street
Des Moines, IA 50319-0114

Dear Ms. Lindgren:

IowaHealth+ is pleased to submit this letter supporting AmeriHealth Caritas Iowa's (AmeriHealth) proposal to the Iowa Department of Human Services for their Iowa High Quality Healthcare Initiative. IowaHealth+ greatly appreciates AmeriHealth's vision for working in partnership with Iowa's providers to improve the quality of care delivered to the Medicaid populations and values your support of the patient-centered health home model and need to invest in the primary care delivery system. We also want to recognize AmeriHealth's understanding and willingness to work to streamline processes and protocols in order to assist providers in Iowa in efficiently and effectively delivering care to patients (i.e. prior authorization processes, data, reporting, and analytic platforms, etc.).

The goals of IowaHealth+ are to focus resources intended to improve the health outcomes and reduce the health care costs of the populations it serves through the use of patient-centered care. IowaHealth+ was formed to be the vehicle for Iowa FQHCs to participate as a primary care provider led Accountable Care Organization (ACO) for the Iowa Health and Wellness Plan population, which has helped organize and position the FQHCs to participate in a very unique way in the Iowa High Quality Healthcare Initiative. Iowa FQHCs have a long history and commitment to serving vulnerable populations in the state inclusive of Medicaid populations. The Medicaid population constitutes just over 40% of the patients served by the FQHCs in IowaHealth+. The FQHCs have had a long-standing and healthy relationship with Iowa Medicaid Enterprise and look forward to developing meaningfully relationships with the Managed Care Organizations (MCOs) selected to serve our state.

If AmeriHealth is selected as one of the MCOs that will be serving Iowa's Medicaid populations, IowaHealth+ and its members are interested in continuing to explore potential collaborations and partnerships that result in high quality, accessible, and effective services to these populations. We share their commitment to team-based and highly coordinated care and the need to continue to expand innovative delivery and payment models in Iowa. And, we are supportive of working with them to better understand the impact that social determinants of health have on the Medicaid population as well as devising strategies to address these significant issues.

Specifically, we would like to further develop the following possible areas for collaboration depending on the priorities of the state and AmeriHealth:

- Primary care provider-centric payment models designed to support patient centered health home development and quality measures
- Resources to support IowaHealth+ in assisting patients in completing initial health screenings and health risk assessments

iowahealth+

- Support for embedded care coordination resources within the IowaHealth+ FQHCs
- Shared savings and other value-based payment models that support infrastructure investments at the provider level
- Initiatives designed to better integrate behavioral health and primary care inclusive of same day billing for behavioral health and medical services and support for behavioral health consultant and tele health delivery models
- Delegation of credentialing responsibilities to IowaHealth+
- Partnering to provide practice transformation support to providers to encourage health home (in the broad sense) development

Thank you for your consideration of this letter and feel free to contact us should you have any questions.

Sincerely,

Theodore J. Boesen, Jr.
CEO
IowaHealth+

Siouxland Community Health Center
Mari Kaptain-Dahlen
Chief Executive Officer

PEOPLES Community Health Clinic
Jennifer Lightbody
Chief Executive Officer

Crescent Community Health Center
Julie Woodyard
Executive Director

CHC Community Health Centers
Ronald W. Kemp
Chief Executive Officer

Community Health Centers of Southern Iowa
Samantha Cannon
Chief Executive Officer

RIVERHILLS Community Health Center
Richard W. Johnson
Chief Executive Officer

AllCare Health Center
Cecelia Creighton
Executive Director

PROMISE Community Health Center
Nancy Dykstra
Executive Director

Primary HealthCare
Kelly Huntsman
Chief Executive Officer

5100 COMMERCE CROSSINGS DRIVE
LOUISVILLE, KY 40229
502-585-7900 / 800-578-0603
WWW.PASSPORTHEALTHPLAN.COM

April 15, 2015

Carrie Lindgren
Iowa Issuing Officer
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114
Phone: 515-281-7556
Bidders4MED16009@dhs.state.ia.us

Dear Ms. Lingren:

On behalf of Passport Health Plan, it is my pleasure to offer this letter of reference in support of AmeriHealth Caritas' proposal to serve as a Medicaid Managed Organization for Iowa's managed care program. Passport Health Plan, Kentucky's only nonprofit community-based, provider-sponsored health plan, has been administering Medicaid benefits in the state since 1997. In my role as Chief Executive Officer, I have had over four years of experience working with AmeriHealth Caritas and have found that the company has been a great partner in supporting our mission to provide Medicaid managed care services to over 250,000 ABD, TANF, CHIP, and Foster Care members in urban and rural Kentucky counties.

AmeriHealth Caritas has been our partner in supporting the operations of our program since the very beginning when Kentucky began transitioning to Medicaid managed care in November 1997. Their dedicated and knowledgeable team assisted with the implementation activities and collaborated with our owners to support our vision of providing superior health care. Similar to Iowa, Kentucky was new at establishing a managed care delivery model for all categories of aid and Passport Health Plan benefited from having AmeriHealth Caritas as a partner during this transition. Additionally, when Kentucky transitioned to a competitive bid for the Medicaid managed care program in 2011, AmeriHealth Caritas provided support services to position Passport Health Plan for a win against publicly-traded competitors who were more focused on the needs of their shareholders vs. the needs of the Medicaid members and the providers who served them.

Over the past 18 years, AmeriHealth Caritas has been a valued partner to Passport Health Plan in serving Kentucky's Medicaid population. I believe that their knowledge and expertise of providing health care solutions to Medicaid populations across various categories of aid and demographics in urban and rural settings would be invaluable to the state of Iowa as you navigate the transition to a managed care system.

Should you have any further questions on AmeriHealth Caritas' operations in Kentucky, please do not hesitate to contact me.

Sincerely,

Mark B. Carter
Chief Executive Officer
Passport Health Plan
5100 Commerce Crossings Drive
Louisville, KY 40229
(502) 585-8316
mark.carter@passporthealthplan.com

The Children's Hospital *of* Philadelphia

34th Street & Civic Center
Boulevard
Philadelphia, PA 19104-4399
215-590-1000

Thomas J. Todorow
Executive Vice President and
Chief Financial Officer
267-426-6908
Fax 267-426-6990
todorow@email.chop.edu

April 14, 2015

Carrie Lindgren
Iowa Issuing Officer
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114
Phone: 515-281-7556
Bidders4MED16009@dhs.state.ia.us

RE: Letter of Reference for Iowa High Quality Health Care Initiative RFP

I am writing this letter of reference in support of AmeriHealth Caritas' proposal to serve as a Medicaid Managed Care Organization for Iowa's Managed Care Program. AmeriHealth Caritas operates Medicaid Managed Care health plans in four regions of Pennsylvania – Southeast Zone (Keystone First), Lehigh/Capital and New West Zones (AmeriHealth Caritas Pennsylvania) and the New East Zone (AmeriHealth Northeast) – encompassing over 512,000 TANF and SSI/ABD members in urban and rural Pennsylvania counties.

I have been the Chief Financial Officer at The Children's Hospital of Philadelphia (CHOP) for the past 14 years. CHOP has been through a number of contracting cycles during that period with AmeriHealth. Although negotiations with providers and managed care organizations sometimes get contentious, CHOP has found AmeriHealth 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.

As of today, AmeriHealth Caritas has over 50,000 members assigned to our physician groups. The 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.

Should you have any further questions on AmeriHealth Caritas' operations in Pennsylvania, please do not hesitate to reach out to me.

Sincerely,

Thomas J. Todorow

Thomas J. Todorow
Executive Vice President and Chief Financial Officer
The Children's Hospital of Philadelphia

Third Party Contracting
M.C. 49-74
100 North Academy Avenue
Danville, PA 17822
570 214 8792 Tel
570 271 5842 Fax

David J. Friel
Vice President

GEISINGER
HEALTH SYSTEM

April 21, 2015

AmeriHealth Caritas
8040 Carlson Road
Suite 500
Harrisburg, PA 17112

To Whom It May Concern:

Re: Letter of Recommendation

It is my pleasure to recommend the Medicaid Managed Care expertise of AmeriHealth Caritas. AmeriHealth Caritas possesses the resources to successfully implement and sustain hospitals and integrated health systems.

Geisinger's health system and health plan are nationally recognized for integration, quality and service. Our physician-led system is comprised of more than 21,000 employees, including a 1,100-member multi-specialty group practice, eight hospital campuses, two research centers and a 467,000-member health plan -- making Geisinger a major contributor to the economic as well as medical health of the region.

Geisinger Health System is an integrated health services organization widely recognized for innovative delivery of health care, including the use of the electronic health record and the development of advanced care models such as ProvenHealth Navigator® and ProvenCare®. As one of the nation's largest rural health services organizations, Geisinger serves more than 2.6 million residents throughout 44 counties in central and northeast Pennsylvania.

Geisinger Health System has had a relationship with AmeriHealth Caritas for 2 years treating AmeriHealth Medicaid members.
AmeriHealth Caritas's goal is to develop strategic partnerships and build accessible, flexible health systems across the nation. Moving forward - as health care evolves - they will continue 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. This is accomplished through:

Personal support: AmeriHealth Caritas is an industry expert in provider network relations and management, giving providers the tools they need to deliver high quality, patient-centered care. Thirty years of experience drive their ongoing commitment to improving health care delivery and management. AmeriHealth Caritas values partnership and collaboration, and they are committed to supporting facilities and practices. With the resources provided by AmeriHealth, providers can focus on what's most important—our patients.

Claims processing: Geisinger's claims are processed in a timely and efficient manner. AmeriHealth Caritas accepts claims via electronic data interchange (EDI), and can pay through electronic funds transfer (EFT). A provider only needs secure Web access to file claims and receive payment electronically.

WWW.GEISINGER.ORG

Practice management: AmeriHealth Caritas understands that a successful managed care program depends on a true collaboration with all providers of care. Providers can count on AmeriHealth Caritas to:

- Ensure access for members through robust provider networks and telemedicine strategies for rural populations.
- Collaborate closely with hospitals, primary care physicians (PCPs), specialists and other providers.
- Deliver value by conveying the information needed to improve patient care.
- Offer shared-savings incentives that promote better outcomes and accountable care.

Quality of care: AmeriHealth Caritas's goal is to streamline processes and help patients better manage their symptoms, stay well, and out of costly emergency rooms.
Every day, AmeriHealth Caritas puts care at the heart of their work. They truly live up to their mission: To help people get care, stay well, and build healthy communities, all while maintaining their special concern for those who are poor. AmeriHealth Caritas is an industry leader with whom we are proud to partner.

Sincerely

David J. Friel

David J. Friel

April 21, 2015

Carrie Lindgren
Iowa Issuing Officer
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114
Phone: 515-281-7556
Bidders4MED16009@dhs.state.ia.us

RE: Letter of Reference for Iowa High Quality Health Care Initiative RFP

Dear Ms. Lingren,

It is my pleasure to offer this letter of reference in support of AmeriHealth Caritas' proposal to serve as a Medicaid Managed Organization for Iowa's managed care program. AmeriHealth District of Columbia operates a plan in the District of Columbia serving more than 105,000 residents.

I have had nearly two years of experience working with AmeriHealth District of Columbia and have found that the company has been a wonderful partner to members, the provider community, and my organization. In particular, AmeriHealth District of Columbia has invested in the community by establishing a member wellness center, brought innovative member 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. A notable accomplishment is the reduction of 30-day hospital readmissions by 14.8 percent in 2014 for members with asthma or other chronic health problems. Lastly, they effectively partner with community-based organization to focus on upstream interventions and prevention.

As the District implements its strategies to improve population health and create sustained progress in areas of the city with health disparities, we look forward to work with AmeriHealth District of Columbia as an able partner. Should you have any further questions on AmeriHealth District of Columbia, please do not hesitate to reach out to me.

Sincerely,

Jacqueline D. Bowens

Jacqueline D. Bowens
Chief Executive Officer

TAKING ACTION FOR A **HEALTHIER COMMUNITY**

1411 K STREET, NW, SUITE 300, WASHINGTON, DC 20005 ★ www.DCPCA.org

AREA AGENCIES ON AGING ASSOCIATION OF MICHIGAN
6105 W. ST. JOSEPH, SUITE 204, LANSING, MICHIGAN 48917

Ms. Carrie Lindgren
Iowa Issuing Officer
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114

Ms. Lindgren:

I am writing to share the experience of the Area Agencies on Aging Association of Michigan (AAAAM) in collaborating with AmeriHealth Caritas. Specifically, we are partnering on a demonstration program in Michigan providing integrated care for people on both Medicare and Medicaid, known as MI Health Link.

As background, Area Agencies on Aging in Michigan are key players in the provision of Medicaid-funded home and community-based services through a 1915(c) waiver. That waiver served 14,000 adults in Michigan in FY 2014, most of whom were dually eligible for Medicare and Medicaid. AAAs serve as "waiver agents," holding contracts with state to administer the waiver program in their regions. This includes providing care management services to participants, using nurses and social workers, and creating a broad pool of credentialed service providers who deliver 20 different services to adults 18 and older who meet a nursing home level-of-care.

Shortly after Michigan indicated its intention to pursue this innovation, AAAAM was contacted by AmeriHealth Caritas. We were delighted to learn that not only did AmeriHealth Caritas understand the resources and capabilities of the aging network, they were interested exploring a working relationship to provide the highest quality integrated health plan to older adults and people with disabilities.

Since that time, 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.

We look forward to working with AmeriHealth Caritas in the years ahead to make MI Health Link a successful initiative!

Sincerely,

Mary Ablan, MA, MSW
Executive Director

(517) 886-1029, fax (517) 886-1305, www.mi-seniors.net

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Department of Health Policy and Management

April 22, 2015

Carrie Lindgren
Iowa Issuing Officer
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114
Phone: 515-281-7556
Bidders4MED16009@dhs.state.ia.us

RE: Letter of Reference for Iowa High Quality Health Care Initiative RFP

Dear Ms. Lingren:

It is my pleasure to offer this letter of reference in support of AmeriHealth Caritas' proposal to serve as a Medicaid Managed Organization for Iowa's managed care program. AmeriHealth District of Columbia operates a plan in the District of Columbia serving more than 105,000 residents. The Plan has partnered with George Washington University on the project "AmeriHealth Asthma Tablets, An Evaluation of a Pilot to Reduce ER Visits and Hospitalizations for Medicaid Members."

The District of Columbia has a high asthma prevalence compared to communities of similar size across the country and AmeriHealth DC is committed to providing the best, evidenced based care for our asthmatic patients. The Asthma Tablet Program provides a valuable opportunity to pilot and evaluate a collaborative and community-based and accessible health benefit for our asthma patients.

AmeriHealth DC has also worked with the Breathe Easy Asthma Home Visiting Program, which is conducted by Breathe DC, a program that I manage for them. Our work with this program has helped more than 100 asthmatic children and their families mitigate environmental triggers such as smoking, and learn asthma control strategies to reduce and better manage attacks. I value the partnership with Amerihealth DC, and have been impressed with the commitment the organization has shown to providing what families need to maintain their wellness and to improve their health. Our partnership on the Asthma Tablet program the potential to close the gap in health outcomes that asthmatic patients experience as measured in their emergency room use and hospitalizations when compared with patients without asthma.

AmeriHealth DC is an able partner to focus on population health and address social determinants of health in order to achieve health equity. Should you have any further questions on AmeriHealth DC, please do not hesitate to reach out to me.

Sincerely,

Janet A. Phoenix, MD, MPH
Assistant Research Professor

Milken Institute School of Public Health
2175 K Street, NW | Suite 500 | Washington, DC 20037
t 202-994-4100

SOUTH CAROLINA Healthy Connections MEDICAID

Nikki R. Haley GOVERNOR
Christian L. Soura DIRECTOR
P.O. Box 8206 Columbia, SC 29202
www.scdhhs.gov

May 7, 2015

Carrie Lindgren
Iowa Issuing Officer
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114
Phone: 515-281-7556
Bidders4MED16009@dhs.state.ia.us

RE: Letter of Reference for Iowa High Quality Health Care Initiative RFP

Dear Ms. Lindgren:

On behalf of the South Carolina Department of Health and Human Services, I offer this letter of reference on behalf of AmeriHealth Caritas' proposal to serve as a Medicaid Managed Organization in your managed care program. Select Health of South Carolina ("Select Health") has been operating in the state since 1996 and serves over 340,000 ABD and TANF members throughout South Carolina.

Select Health and its parent company, AmeriHealth Caritas, is in good standing with the State of South Carolina and has proven itself capable of operating in a Medicaid managed care environment.

Sincerely,

Christian L. Soura
Director

South Carolina Department of Health and Human Services *Better care. Better value. Better health.*

3.2.7.1 RFP Forms

Release of Information Form

MED-16-009
Iowa High Quality Healthcare Initiative

Exhibit A: Release of Information
(Return this completed form behind Tab 6 of the Bid Proposal.)

AmeriHealth Caritas Iowa, Inc. hereby authorizes any person or entity, public or private, having any information concerning the bidder's background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Agency.

The bidder acknowledges that it may not agree with the information and opinions given by such person or entity in response to a reference request. The bidder acknowledges that the information and opinions given by such person or entity may hurt its chances to receive contract awards from the Agency or may otherwise hurt its reputation or operations. The bidder is willing to take that risk. The bidder agrees to release all persons, entities, the Agency, and the State of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

AmeriHealth Caritas Iowa, Inc.
Printed Name of Bidder Organization

Signature of Authorized Representative

may 12, 2015
Date

Robert H. Gilman
Printed Name

Exhibit B: Primary Bidder Detail Form & Certification

(Return this completed form behind Tab 6 of the Proposal. If a section does not apply, label it "not applicable".)

Primary Contact Information (individual who can address issues re: this Bid Proposal)	
Name:	Mary Pat Sherry
Address:	AmeriHealth Caritas, 200 Stevens Dr., Philadelphia, PA 19113
Tel:	(215) 937-8756
Fax:	(215) 937-5344
E-mail:	msherry@amerihealthcaritas.com

Primary Bidder Detail		
Business Legal Name ("Bidder"):	AmeriHealth Caritas Iowa, Inc.	
"Doing Business As" names, assumed names, or other operating names:	N/A	
NAIC Number:	Pending (HMO license application pending before Iowa Insurance Division)	
Parent Corporation, if any:	AmeriHealth Caritas Health Plan (direct parent)	
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	Corporation	
State of Incorporation/organization:	Iowa	
Primary Address:	200 Stevens Dr. Philadelphia, PA 19113	
Tel:	(215) 937-8000	
Fax:	N/A	
Local Address (if any):	N/A	
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	AmeriHealth Caritas (corporate) 200 Stevens Dr. Philadelphia, PA 19113	AmeriHealth Caritas (service operations) Cambridge West 8171 Baymeadows Way West Jacksonville, FL 32256

Primary Bidder Detail	
Number of Employees:	0
Number of Years in Business:	Less than 1
Primary Focus of Business:	Managed health care
Federal Tax ID:	47-3923267
Bidder's Accounting Firm:	KPMG
If Bidder is currently registered to do business in Iowa, provide the Date of Registration:	May 5, 2015
Do you plan on using subcontractors if awarded this Contract? {If "YES," submit a Subcontractor Disclosure Form for each proposed subcontractor.}	Yes

Request for Confidential Treatment (See Section 3.1)		
Location in Bid (Tab/Page)	**Statutory Basis for Confidentiality**	**Description/Explanation**
AmeriHealth Caritas Iowa makes the general assertion that the information specified in this table is exempt from public disclosure by application of Iowa Code §22.7 and IAC Ch. 9 (describing DHS' Public Records and Fair Information Practices). AmeriHealth Caritas Iowa further considers certain of the information to be protected by the Iowa Uniform Trade Secrets At codified at Iowa Code Ch. 500, in that we: (1) derive economic value from its not being generally known to, and not being readily ascertainable by proper means by a person able to obtain economic value from its disclosure or use; and (2) take reasonable efforts to maintain the secrecy of the information.		
Tab 3 **Pages 68**	Iowa Uniform Trade Secrets Act	Specific financial performance indicators have been redacted. AmeriHealth Caritas Iowa and its owners and affiliates are privately-held companies; line items from its financial statements are not subject to public disclosure.
Tab 3 **Page 923**	Iowa Uniform Trade Secrets Act	Specific payment amounts to AmeriHealth Caritas Iowa's affiliate have been redacted. AmeriHealth Caritas Iowa and its owners and affiliates are privately-held companies, and Select Health's compensation from the State of South Carolina is confidential.
Tab 4 **Pages 954, 956, 958, 960**	Iowa Code §22.7	AmeriHealth Caritas Iowa has redacted the home addresses and phone numbers of its directors and officers.
Tab 6 **Page 987-1088**	Iowa Uniform Trade Secrets Act Iowa Code §22.7	Certain identifying information of individual owners and managing employees of AmeriHealth Caritas Iowa and its subcontractors has been redacted from ownership disclosure forms. These are private data of a sensitive nature that could potentially cause great harm to the subject individuals if publicly disclosed.
Financial Statements Binder	Iowa Uniform Trade Secrets Act Iowa Code §22.7	The financial statements of BMH LLC and Subsidiaries have been redacted. All of these companies are privately-held companies whose audited financial statements are not publicly reported. The companies would be competitively disadvantaged by their disclosure, and they take reasonable measures to prevent their public disclosure in the normal course of business.

Request for Confidential Treatment (See Section 3.1)

Intentionally Left Blank

Request for Confidential Treatment (See Section 3.1)

Intentionally Left Blank

Request for Confidential Treatment (See Section 3.1)

Intentionally Left Blank

BID PROPOSAL CERTIFICATION

By signing below, Bidder certifies that:

1. Reserved;
2. Bidder accepts all capitation rates established by the Agency via the Agency's actuary.
3. Bidder has reviewed the Additional Certifications, which are incorporated herein by reference, and by signing below represents that Bidder agrees to be bound by the obligations included therein.
4. Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;
5. Reserved;
6. Bidder has received any amendments to this RFP issued by the Agency;
7. Bidder either is currently registered to do business in Iowa or agrees to register if Bidder is awarded a Contract pursuant to this RFP;
8. The person signing this Bid Proposal certifies that he/she is the person in the Bidder's organization responsible for, or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive agreements outlined above;
9. Bidder specifically stipulates that the Bid Proposal is predicated upon the acceptance of all terms and conditions stated in the RFP and the Sample Contract without change.
10. Bidder certifies that the Bidder organization has sufficient personnel resources available to provide all services proposed by the Bid Proposal, and such resources will be available on the date the RFP states services are to begin. Bidder guarantees personnel proposed to provide services will be the personnel providing the services unless prior approval is received from the Agency to substitute staff;
11. Bidder certifies that if the Bidder is awarded the contract and plans to utilize subcontractors at any point to perform any obligations under the contract, the Bidder will (1) notify the Agency in writing prior to use of the subcontractor, and (2) apply all restrictions, obligations, and responsibilities of the resulting contract between the Agency and contractor to the subcontractors through a subcontract. The contractor will remain responsible for all Deliverables provided under this contract.
12. Bidder guarantees the availability of the services offered and that all Bid Proposal terms, including price, will remain firm until a contract has been executed for the services contemplated by this RFP or one year from the issuance of this RFP, whichever is earlier; and,
13. Bidder certifies it is either a) registered or will become registered with the Iowa Department of Revenue to collect and remit Iowa sales and use taxes as required by Iowa Code chapter 423; or b) not a "retailer" of a "retailer maintaining a place of business in this state" as those terms are defined in Iowa Code subsections 423.1(42) & (43). The Bidder also acknowledges that the Agency may declare the bid void if the above certification is false. Bidders may register with the Department of Revenue online at: http://www.state.ia.us/tax/business/business.html.

By signing below, I certify that I have the authority to bind the Bidder to the specific terms, conditions and technical specifications required in the Agency's Request for Proposals (RFP) and offered in the Bidder's Proposal. I understand that by submitting this Bid Proposal, the Bidder agrees to provide services described herein which meet or exceed the specifications of the Agency's RFP unless noted in the Bid Proposal and at the prices quoted by the Bidder. I certify that the contents of the Bid Proposal are true and accurate and that the Bidder has not made any knowingly false statements in the Bid Proposal.

Signature:	
Printed Name/Title:	Steven H. Bohner, Vice President & Treasurer
Date:	5/11/15

Subcontractor Disclosure Form (one for each proposed subcontractor)

The following subcontractors' disclosure forms are attached:

- Access2Care, LLC.
- AmeriHealth Caritas Iowa, LLC
- Avesis Third party Administrators, Inc.
- Discovery Health Partners.
- Health Management Systems, Inc. (HMS).
- Medical Transportation Management, Inc. (MTM).
- PerformRx
- SironaHealth, Inc.

Ownership Disclosure Forms

For the sake of uniformity and consistency, and to ensure that the information called for under 42 CFR 455.104 is disclosed, AmeriHealth Caritas Iowa had its subcontractors complete the Department's "Iowa Medicaid Ownership and Disclosure Form" (form 470-5186 Rev. 3/15). These are included along with each subcontractor's "Subcontractor Disclosure Form" within Tab 6.

The ownership disclosure forms are substantially complete, but in certain instances our identified subcontractors have either redacted or withheld certain sensitive personally identifiable information such as dates of birth and social security numbers of their managing employees. We have determined this is primarily due to a lack of understanding of the safeguards available to protect such information. AmeriHealth Caritas Iowa understands the requirement to furnish complete subcontractor information; and we will work with each of our subcontractors in order to provide complete and updated information on or before Contract execution, in accordance with the SOW.

Exhibit C: Subcontractor Disclosure Form

*(Return this completed form behind Tab 3 of the Bid Proposal. Fully complete a form for **each** proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)*

Primary Bidder ("Primary Bidder"):	AmeriHealth Caritas Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Enid Krasner
Address:	6200 South Syracuse Way, Suite 200, Greenwood Village, CO
Tel:	303-495-1214
Fax:	303-495-1295
E-mail:	Enid.Krasner@amr.net

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	Access2Care, LLC
"Doing Business As" names, assumed names, or other operating names:	Previously known as TMS Management Group Inc.
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	LLC
State of Incorporation/organization:	Missouri
Primary Address:	6200 South Syracuse Way, Suite 200, Greenwood Village, CO
Tel:	303-495-1214
Fax:	303-495-1295
Local Address (if any):	Des Moines Airport, 5800 Fleur Drive, Suite 231, Des Moines, IA 50321
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	16331 Bay Vista Drive, Clearwater, FL 33760 Abbot Place, St. Louis, MO 63143
Number of Employees:	297 employees, 20 in Iowa
Number of Years in Business:	11 (date of organization: January 31, 2006)
Primary Focus of Business:	Non-emergency medical transportation and related technologies
Federal Tax ID:	01-0876348
Subcontractor's Accounting Firm:	Ernst & Young LLP, Independent registered public accounting firm
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	TMS Management Group Inc. was registered in Iowa on 6/11/13.
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	<5%
General Scope of Work to be performed by this Subcontractor	
Non-emergency medical transportation and related technologies	
Detail the Subcontractor's qualifications for performing this scope of work	
Access2Care is the only transportation management program operating in Iowa. We serve Medicaid recipients in all 99 Iowa counties, every day, since 2010. We currently maintain a 99.9% COMPLAINT-FREE transportation program. We have the only EXISTING, CREDENTIALED and PROVEN transportation network in Iowa, covering the entire State with an extensive and satisfied provider network. We have knowledge of the rural landscape and proven strategy for effective statewide transportation coverate. Access2Care optimizes all area resources, including public transportation and mileage reimbursement to ensure that the most appropriate and cost efficient mode of transportation is used for every trip. Our Iowa-based staff is experienced and knowledgable in Iowa's regulatory requirements and our Iowa toll-free number are already well known and available in medical centers and facilities across Iowa. We have established relationships with Iowa healthcare facilities and providers.	

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	
Printed Name/Title:	**Steven G. Murphy, President**
Date:	**May 8, 2015**

Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name	Federal Tax ID or SSN
Access2Care, LLC	FEIN# 01-0876348

Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. *See* Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: ☐ Yes or ☒ No

Group of Individual Practitioners ☐ Yes or ☒ No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all ***individuals*** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of your organization if you are organized as a corporation; or
f) is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
N/A					

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of you if organized as a corporation; or
f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
Mission Care Services, LLC	42-1644377	100%	221 Bolivar Jefferson City, MO 65101	221 Bolivar Jefferson City, MO 65101	221 Bolivar Jefferson City, MO 65101

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
N/A					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? ☐ Yes or ☐ No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

☐ Yes or ☐ No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
b) Any Medicare intermediary or carrier; and
c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
Mission Care Services, LLC	Mission Care of Missouri, LLC; Mission Care of Illinois, LLC

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

CONFIDENTIAL

Table 7:

Name	Title	Address	DOB	SSN
Matt McCormick	Vice President	Confidential & Not for Public Disclosure		
Enid Krasner	Director Business Development			
Chris Morris	Director Network Management			
George White	Director Business Integration			
Jade Warren	Director Public Transit Operations			

Please copy this page if additional space is needed. This list continues on the following page 5a.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

CONFIDENTIAL

Table 7:

Name	Title	Address	DOB	SSN
Scott Anderson	Director Operations	Confidential & Not for Public Disclosure		
Tom Bowen	Director Customer Service			
Dan Cyr	Director Operations			
Rich Eberle	Director Operations			

Please copy this page if additional space is needed. This list is a continuation from page 5.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? ☐ Yes or ☒ No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

   ☒ None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

   ☒ None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

   ☒ None

Name:

Please copy this page if additional space is needed.

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4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

   ☒ None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

   ☒ None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory Steven G. Murphy, President	
Signature of Authorized Signatory	Date May 8, 2015

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Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name	Federal Tax ID or SSN
AmeriHealth Caritas Iowa, Inc.	45-3923267

Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. *See* Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: ☐ Yes or ☑ No

Group of Individual Practitioners ☐ Yes or ■ No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all ***individuals*** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of your organization if you are organized as a corporation; or
f) is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Russell Gianforcaro	Director; President	0%	Confidential & Not for Public Disclosure		
James Michael Jernigan	Director	0%			
Steven H. Bohner	Director;VP & Treasurer	0%			
Robert H. Gilman	VP & Secretary	0%			

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of you if organized as a corporation; or
f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
AmeriHealth Caritas Health Plan	23-2859523	100% (direct)	200 Stevens Dr., Philadelphia, PA 19113	8040 Carlton Rd., Newtown, PA 17112	
BMH Subco I LLC	38-36946080	50% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		
BMH Subco II LLC	80-0768643	50% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		
BMH LLC	30-0703311	100% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
N/A					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? ☐ Yes or ☐ No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

☐ Yes or ☐ No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
b) Any Medicare intermediary or carrier; and
c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
Mission Care Services, LLC	Mission Care of Missouri, LLC; Mission Care of Illinois, LLC

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

CONFIDENTIAL

Table 7:

Name	Title	Address	DOB	SSN
Matt McCormick	Vice President	Confidential & Not for Public Disclosure		
Enid Krasner	Director Business Development			
Chris Morris	Director Network Management			
George White	Director Business Integration			
Jade Warren	Director Public Transit Operations			

Please copy this page if additional space is needed. This list continues on the following page 5a.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

CONFIDENTIAL

Table 7:

Name	Title	Address	DOB	SSN
Scott Anderson	Director Operations	Confidential & Not for Public Disclosure		
Tom Bowen	Director Customer Service			
Dan Cyr	Director Operations			
Rich Eberle	Director Operations			

Please copy this page if additional space is needed. This list is a continuation from page 5.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? ☐ Yes or ☒ No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

   ☒ None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

   ☒ None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

   ☒ None

Name:

Please copy this page if additional space is needed.

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4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

   ☒ None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

   ☒ None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory Steven G. Murphy, President	
Signature of Authorized Signatory	Date May 8, 2015

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Exhibit C: Subcontractor Disclosure Form

*(Return this completed form behind Tab 3 of the Bid Proposal. Fully complete a form for **each** proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)*

Primary Bidder ("Primary Bidder"):	AmeriHealth Caritas Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Mary Pat Sherry
Address:	AmeriHealth Caritas, 200 Stevens Dr., Philadelphia, PA, 19113
Tel:	(215) 937-8756
Fax:	(215) 937-5344
E-mail:	msherry@amerihealthcaritas.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	AmeriHealth Caritas Services, LLC
"Doing Business As" names, assumed names, or other operating names:	N/A
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Limited liability company
State of Incorporation/organization:	DE
Primary Address:	200 Stevens Dr. Philadelphia, PA 19113
Tel:	(215) 937-8000
Fax:	N/A
Local Address (if any):	N/A
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	200 Stevens Dr. Philadelphia, PA 19113
Number of Employees:	4,500
Number of Years in Business:	AmeriHealth Caritas Services has been in existence since 2012. It is part of a family of companies that has been in business since 1996.
Primary Focus of Business:	Managed care management & administrative services
Federal Tax ID:	45-5415725
Subcontractor's Accounting Firm:	KPMG
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	N/A – business registration is in process.
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	Based upon the State capitation rates released on April 23, 2015, AmeriHealth Caritas Services' compensation for services furnished under its subcontract with AmeriHealth Caritas Iowa is estimated to be approximately 4.5% of AmeriHealth Caritas Iowa's anticipated capitation payment from DHS.

General Scope of Work to be performed by this Subcontractor
AmeriHealth Caritas Services (ACS) will provide comprehensive management and administrative services to AmeriHealth Caritas Iowa in the operation of its managed care plan.
Detail the Subcontractor's qualifications for performing this scope of work
AmeriHealth Caritas Services (ACS) was formed in 2012 in order to provide staffing and management & administrative services to companies within the AmeriHealth Caritas Family of Companies ("AmeriHealth Caritas"). AmeriHealth Caritas is an enterprise of managed care and related organizations that has been providing services under the Medicaid and Medicare programs since its inception in 1983. Over the years, AmeriHealth Caritas has developed significant experience in providing Medicaid managed care services, and has developed the systems and infrastructure necessary to support the Iowa High Quality Healthcare Initiative. From our roots as a small managed care organization serving low-income residents of West Philadelphia, AmeriHealth Caritas has grown to become an industry leader with over 4,500 employees. Providing health care coverage and services to more than 6 million members nationwide, our partnerships and commitment to excellence ensure that our members have the best possible health outcomes through an integrated, cost-effective approach that coordinates physical health, behavioral health and pharmacy benefits. For decades, AmeriHealth Caritas has provided managed care to Medicaid recipients and other low-income populations throughout the country. This longstanding experience includes managing health care service delivery for TANF, dual eligible, and ABD populations, under programs that include Medicaid risk and non-risk, Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs), Medicare Part D, Medicaid risk and non-risk Behavioral Health Organizations (BHOs), Medicaid/Medicare Dual Eligible demonstrations, and State Children's Health Insurance Programs (SCHIP). ACS is currently in the process of registering to conduct business in Iowa, including securing its TPA certification as required under Iowa Code Chapter 510.

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	Robert H. Gilman
Printed Name/Title:	Robert H. Gilman, Vice President & Secretary
Date:	May 11, 2015

Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name	Federal Tax ID or SSN
AmeriHealth Caritas Iowa, Inc.	45-3923267

Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. *See* Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: ☐ Yes or ☑ No

Group of Individual Practitioners ☐ Yes or ■ No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all ***individuals*** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of your organization if you are organized as a corporation; or
f) is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Russell Gianforcaro	Director; President	0%	Confidential & Not for Public Disclosure		
James Michael Jernigan	Director	0%			
Steven H. Bohner	Director;VP & Treasurer	0%			
Robert H. Gilman	VP & Secretary	0%			

Non-Individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of you if organized as a corporation; or
f) is a partner in you if organized as a partnership.

Table 2: Non-Individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
AmeriHealth Caritas Health Plan	23-2859523	100% (direct)	200 Stevens Dr., Philadelphia, PA 19113	8040 Carlson Rd., Harrisburg, PA 17112	
BMH Subco I LLC	38-36946080	50% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		
BMH Subco II LLC	80-0768643	50% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		
BMH LLC	30-0703311	100% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of you if organized as a corporation; or
f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
Blue Cross Blue Shield of Michigan	38-2069753	38.7% (indirect)	600 E. Lafayette Blvd., Detroit, MI 48226		
IBC MH LLC	45-3672640	61.3% (indirect)	1901 Market St., Philadelphia, PA 19103		
AmeriHealth, Inc.	23-2425461	58.2% (indirect)	1901 Market St., Philadelphia, PA 19103		
Independence Health Group, Inc.	47-1233198	61.3% (indirect)	1901 Market St., Philadelphia, PA 19103		

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
None					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? ☐ Yes or ■ No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth
N/A			

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

☐ Yes or ☐ No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth
N/A			

Please copy this page if additional space is needed.

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Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
b) Any Medicare intermediary or carrier; and
c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
See Attached	

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

AmeriHealth Caritas Iowa, Inc.
Iowa Medicaid Ownership and Disclosure

Table 6 (Other Disclosing Entities)

Name of Owner	Name of Other Disclosing Entity
AmeriHealth Caritas Health Plan	AmeriHealth Caritas Louisiana, Inc.
	Florida True Health, Inc.
	AmeriHealth Nebraska, Inc.
	AmeriHealth Michigan, Inc.
	Select Health of South Carolina, Inc.
	AmeriHealth District of Columbia, Inc.
	Prestige Health Choice, L.L.C.
	PerformSpecialty, LLC
Blue Cross Blue Shield of Michigan	Blue Care Network of Michigan
	Blue Cross Complete of Michigan
IBC MH LLC	Vista Health Plan, Inc. (including CMS contract H4227)
AmeriHealth, Inc.	AmeriHealth HMO, Inc.
	Keystone Health Plan East, Inc.

Table 7:

Name	Title	Address	DOB	SSN
See Table 1				
(No other managing employees at this time)				

Please copy this page if additional space is needed.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? ☐ Yes or ■ No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

   ☐ None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

   ☐ None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

   ☐ None

Name:

Please copy this page if additional space is needed.

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4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

   ■ None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

   ■ None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory	
Robert H. Gilman	
Signature of Authorized Signatory Robert H. Gilman	Date 5/8/15

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Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 3 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder ("Primary Bidder"):	Avesis Third Party Administrators, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Joshua Cohn
Address:	10324 S Dolfield Rd, Owings Mills MD 21117
Tel:	(800) 643-1132, ext. 12410
Fax:	(410) 654-1145
E-mail:	jcohn@avesis.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	Avesis Third Party Administrators, Inc.
"Doing Business As" names, assumed names, or other operating names:	NA
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	corporation
State of Incorporation/organization:	Arizona
Primary Address:	10324 S Dolfield Rd, Owings Mills MD 21117
Tel:	(800)643-1132 ext. 12410
Fax:	(410)654-1145
Local Address (if any):	NA
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	Please see attached.
Number of Employees:	Avesis Incorporated: 384
Number of Years in Business:	15
Primary Focus of Business:	eye care, dental and hearing programs
Federal Tax ID:	86-0986927
Subcontractor's Accounting Firm:	KPMG
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	3/1/2002
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	100%
General Scope of Work to be performed by this Subcontractor	
Please see attached.	
Detail the Subcontractor's qualifications for performing this scope of work	
Please see attached.	

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	
Printed Name/Title:	Joel H. Alperstein, President
Date:	3/27/2015

AVESIS THIRD PARTY ADMINISTRATORS, INC.
Additional Information to Exhibit C: Subcontractor Disclosure Form

OFFICE ADDRESSES

In addition to the primary office location in Owings Mills, Maryland, services are provided at the facilities noted below:

CLAIMS DEPARTMENT

3030 North Central Avenue, Suite 300
Phoenix, Arizona 85012

CALL CENTER

4451 East Oak Street
Phoenix, Arizona 85008

UTILIZATION REVIEW/UTILIZATION MANAGEMENT

2300 Lake Park Drive SE
Smyrna, Georgia 30080

NUMBER OF EMPLOYEES

Avesis Third Party Administrators, Inc. is a wholly owned subsidiary of Avesis Incorporated. Avesis Incorporated, in business since 1978, employs 100% of the personnel involved with all aspects of our program administration services.

SCOPE OF WORK TO BE PERFORMED

As the third party administrator for AmeriHealth for the Iowa Medicaid eye care program, Avesis Third Party Administrators, Inc. will provide comprehensive eye care program administration services including but not limited to: claims processing, adjudication and payment; customer service for members, providers, and the health plan; network development and management; provider contracting; credentialing; utilization review/utilization management; provider appeals; quality assurance; encounter submissions; and reporting.

QUALIFICATIONS FOR PERFORMING THE SCOPE OF WORK

Avesis Third Party Administrators, Inc. has been providing administration services for managed eye care, dental and hearing care programs since 2000. Today, our programs cover nearly 8.5 million members. We have extensive experience working with government-sponsored programs throughout the country. Furthermore, we have been working with AmeriHealth in several other markets. This experience makes us uniquely qualified as we understand and have addressed the various special requirements that AmeriHealth may have for their programs and appreciate the importance of doing everything possible to ensure that the members are 100% satisfied with the services that are provided.

Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name	Federal Tax ID or SSN
Avesis Third Party Administrators, Inc.	86-0986927

Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. *See* Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: ☐ Yes or ☒ No

Group of Individual Practitioners ☐ Yes or ☒ No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all ***individuals*** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of your organization if you are organized as a corporation; or
f) is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Joel H. Alperstein	Pres/Treas	NA	Confidential & Not for Public Disclosure		
Michael P. Reamer	Secretary	NA			

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of you if organized as a corporation; or
f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
Avesis Incorporated	86-0349350	100%	10324 S Dolfield Road Owings Mills, MD 21117	3030 N Central Avenue Phoenix, AZ 85012	

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
None					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? ☐ Yes or ☒ No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth
None			

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

☐ Yes or ☐ No Not applicable.

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth
Not applicable			

Please copy this page if additional space is needed.

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Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
b) Any Medicare intermediary or carrier; and
c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
None.	

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

Table 7:

Name	Title	Address	DOB	SSN
Joel H. Alperstein	President	Confidential & Not for Public Disclosure		
Mark Babbitt	Senior VP			

Please copy this page if additional space is needed.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? ☐ Yes or ☒ No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

   [X] None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

   [X] None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

   [X] None

Name:

Please copy this page if additional space is needed.

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4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

   [X] None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

   [X] None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory Joel H. Alperstein	
Signature of Authorized Signatory Joel H. Alperstein	Date 4/14/2015

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MED-16-009
Iowa High Quality Healthcare Initiative

Exhibit C: Subcontractor Disclosure Form

*(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for **each** proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)*

Primary Bidder ("Primary Bidder"):	AMERIHEALTH CARITAS
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Laura Cohen
Address:	2 Pierce Place, ste 1900, Itasca, Il. 60143
Tel:	224-366-0373
Fax:	224-220-5035
E-mail:	lcohen@discoveryhealthpartners.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	LaunchPoint Ventures, LLC
"Doing Business As" names, assumed names, or other operating names:	Discovery Health Partners
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	LLC
State of Incorporation/organization:	Delaware
Primary Address:	2 Pierce Place, Ste 1900, Itasca, IL 60143
Tel:	224-265-0015
Fax:	224-265-0016
Local Address (if any):	
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	
Number of Employees:	125
Number of Years in Business:	7
Primary Focus of Business:	Payment Integrity, Subrogation & COB
Federal Tax ID:	26-3000153
Subcontractor's Accounting Firm:	Grant Thorton
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	N/A
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	

General Scope of Work to be performed by this Subcontractor

Subrogation and reimbursement services

Detail the Subcontractor's qualifications for performing this scope of work

Our team of highly skilled paralegals, legal assistants and attorneys provide subrogation services to medicaid, medicare and commercial plans throughout the country, including one of the largest National health plans.

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By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	Elizabeth A Longo
Printed Name/Title:	Elizabeth A. Longo / General Counsel
Date:	4/30/2015

Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name	Federal Tax ID or SSN
LAUNCHPOINT VENTURES, LLC	26-3000153

Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. *See* Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: ☐ Yes or ☒ No

Group of Individual Practitioners ☐ Yes or ☒ No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all ***individuals*** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of your organization if you are organized as a corporation; or
f) is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
TERRENCE RYAN	CEO	23.92%	Confidential & Not for Public Disclosure		
JOHN BAIR	CTO	5.41%			
PAUL VOSTERS	PRESIDENT, COO	9.72%			

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of you if organized as a corporation; or
f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
N/A					

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
N/A.					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? ☐ Yes or ☒ No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?
☐ Yes or ☒ No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth

Please copy this page if additional space is needed.

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Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
b) Any Medicare intermediary or carrier; and
c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
N/A.	

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

Table 7:

Name	Title	Address	DOB	SSN
Laura Cohen	VP, OPERATIONS	Confidential & Not for Public Disclosure		
Jeremy Arthur	DIRECTOR, OPERATIONS			
Paul Vosters	PRESIDENT, COO			

Please copy this page if additional space is needed.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? ☐ Yes or ☒ No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

☒ None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

☒ None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

☒ None

Name:

Please copy this page if additional space is needed.

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4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

☒ None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

☒ None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory	
Elizabeth A. Longo	
Signature of Authorized Signatory	Date
Elizabeth A. Longo	5/3/2015

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Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable. If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder ("Primary Bidder"):	AmeriHealth
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Robert Dickerson
Address:	360 Park Ave South NY, NY 10010
Tel:	212 857-5270
Fax:	212 857-5010
E-mail:	rdickerson@hms.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	Health Management Systems, Inc.
"Doing Business As" names, assumed names, or other operating names:	N.A .
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Corporation
State of Incorporation organization:	New York
Primary Address:	360 Park Ave South NY, NY 10010
Tel:	214 453-3000
Fax:	214 453-3023
Local Address (if any):	N.A.
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	5615 Highpoint Drive Irving, TX 75038
Number of Employees:	2,700
Number of Years in Business:	41
Primary Focus of Business:	Cost Containment and Data Analytics
Federal Tax ID:	132770433
Subcontractor's Accounting Firm:	KPMG
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	August 21, 2014
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	50%
General Scope of Work to be performed by this Subcontractor	
Payment Integrity	
Detail the Subcontractor's qualifications for performing this scope of work	
HMS has over 40 years of experience. As a result of the company's services, clients recover billions of dollars every year and save billions more through the prevention of erroneous payments.	

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By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	
Printed Name/Title:	Rohitd Singh - EVP Commercial Mkts
Date:	5/5/2015.

Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name HMS	Federal Tax ID or SSN 132770433

Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. *See* Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: ☐ Yes or ☒ **No**

Group of Individual Practitioners ☐ Yes or ☒ **No**

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all ***individuals*** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of your organization if you are organized as a corporation; or
f) is a partner in your organization if organized as a partnership.

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Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
N.A.					

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of you if organized as a corporation; or
f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
HMS Holdings	1327704333	100%	5615 Highpoint Drive Irving, TX 75038		

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
N.A.					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? ☐ Yes or ☐ No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth
N.A.			

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

☐ Yes or ☐ No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth
N.A.			

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
b) Any Medicare intermediary or carrier; and
c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
N.A.	

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

Table 7:

Name	Title	Address	DOB	SSN
Bill Lucia	CEO	5615 Highpoint Drive Irving, TX 75038		
Jeffrey Sherman	CFO	5615 Highpoint Drive Irving, TX 75038		
Cynthia Nustad	CIO	5615 Highpoint Drive Irving, TX 75038		
Gene DeFelice	General Counsel	5615 Highpoint Drive Irving, TX 75038		
Doug Williams	Division President	5615 Highpoint Drive Irving, TX 75038		

Please copy this page if additional space is needed.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.

- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? ☐ Yes or ☒ No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action
N.A.		

Please copy this page if additional space is needed

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

   ☒ None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

   ☒ None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

   ☒ None

Name:

Please copy this page if additional space is needed.

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4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

   ☒ None

Name

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

   ☒ None

Name

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory	
RONALD SINGH	
Signature of Authorized Signatory	Date
	4/20/2015

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Exhibit C: Subcontractor Disclosure Form

*(Return this completed form behind Tab 3 of the Bid Proposal. Fully complete a form for **each** proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)*

Primary Bidder ("Primary Bidder"):	AmeriHealth Caritas
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Duane Williams, Director, Account Managerment
Address:	16 Hawk Ridge Drive, Lake St. Louis, MO
Tel:	636-695-5706
Fax:	636-561-2962
E-mail:	dwilliams@mtm-inc.net

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	Medical Transportation Management, Inc. (MTM)
"Doing Business As" names, assumed names, or other operating names:	Not applicable
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	S-Corporation
State of Incorporation/organization:	Missouri
Primary Address:	16 Hawk Ridge Drive, Lake St. Louis, MO 63367
Tel:	636-561-5686
Fax:	636-561-2962
Local Address (if any):	Not applicable
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	16 Hawk Ridge Drive, Lake St. Louis, MO 63367
Number of Employees:	928
Number of Years in Business:	20
Primary Focus of Business:	Non-emergency transportation (NEMT) services
Federal Tax ID:	43-1719762
Subcontractor's Accounting Firm:	Internal (MTM)
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	December 9, 2005
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	4%
General Scope of Work to be performed by this Subcontractor	
Non-emergency medical transportation (NEMT)	
Detail the Subcontractor's qualifications for performing this scope of work	
20 years experience providing NEMT. Currently operating in 24 states and the District of Columbia, including providing ten million trips, managing eight million calls, and serving over six million members annually.	

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	Alaina Maciá
Printed Name/Title:	Alaina Maciá, President and CEO
Date:	3/27/15

Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name	Federal Tax ID or SSN
Medical Transportation Management, Inc.	43-1719762

Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. *See* Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: ☐ Yes or ☒ No

Group of Individual Practitioners ☐ Yes or ☒ No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all ***individuals*** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of your organization if you are organized as a corporation; or
f) is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Peg Griswold	Chairwoman of the Board	51%	Confidential & Not for Public Disclosure		
JB Bowers	Director	13%			
Alaina Macia	President & CEO Director	9%			
Lynn Griswold	Exec. VP, Director	5%			

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of you if organized as a corporation; or
f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
N/A					

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
N/A					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? [x] Yes or [ ] No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth
Confidential & Not for Public Disclosure [redacted]	Peg Griswold	Spouse of Lynn Griswold; Step-Mother of Alaina	Confidential & Not for Public Disclosure [redacted]
	Lynn Griswold	Spouse of Peg Griswold; Father of Alaina Macia	
	Alaina Macia	Step-Daughter of Peg Griswold; Daughter of Lynn Griswold	

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

N/A [ ] Yes or [ ] No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth
N/A			

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
b) Any Medicare intermediary or carrier; and
c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
N/A	

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

Table 7:

Name	Title	Address	DOB	SSN
See Attachment				

Please copy this page if additional space is needed.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? ☐ Yes or ☒ No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action
N/A		

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

   ☒ None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

   ☒ None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

   ☒ None

Name:

Please copy this page if additional space is needed.

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4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

   ☒ None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

   ☒ None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory William Bennett, Staff Counsel	
Signature of Authorized Signatory	Date 4/13/15

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Section 5: Managing Employees: Table 7

Peggy A. Griswold
Chairwoman of the Board
Confidential & Not for Public Disclosure
[redacted]

Lynn C. Griswold
Executive Vice President
Confidential & Not for Public Disclosure
[redacted]

J B Bowers
Director
Confidential & Not for Public Disclosure
[redacted]

Alaina Macia
CEO
Confidential & Not for Public Disclosure
[redacted]

Heather Pekar
Vice President, RSD Technologies
Confidential & Not for Public Disclosure
[redacted]

Donald C. Tiemeyer
Executive Vice President, General Counsel
Confidential & Not for Public Disclosure
[redacted]

Natasha Boekholt
Vice President, Operations
Confidential & Not for Public Disclosure
[redacted]

Patrick McNiff
Vice President, Paratransit Operations
Confidential & Not for Public Disclosure
[redacted]

Aaron Crowell
Vice President, Business Development & Sales
Confidential & Not for Public Disclosure
[redacted]

Michele Lucas
Vice President, Marketing
Confidential & Not for Public Disclosure
[redacted]

Kimberly Clark
Regional Vice President, MidAtlantic Operations
Confidential & Not for Public Disclosure
[redacted]

Kerri Schewe
Vice President, Administration
Confidential & Not for Public Disclosure
[redacted]

Philip G. Stalboerger
Vice President, Public Affairs
Confidential & Not for Public Disclosure
[redacted]

Stephanie Klaas
Vice President, Finance
Confidential & Not for Public Disclosure
[redacted]

Carrie Seeler
Vice President, Network
Confidential & Not for Public Disclosure
[redacted]

Valorie Williams
Regional Vice President
Confidential & Not for Public Disclosure
[redacted]

Exhibit C: Subcontractor Disclosure Form

*(Return this completed form behind Tab 3 of the Bid Proposal. Fully complete a form for **each** proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)*

Primary Bidder ("Primary Bidder"):	AmeriHealth Caritas Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Michael Draine
Address:	Vice President, Sales Marketing & Proposals PerformRx 200 Stevens Dr. Philadelphia, PA 19113
Tel:	(215) 863-5829
Fax:	(215) 863-5100
E-mail:	mdraine@performrx.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	PerformRx, LLC
"Doing Business As" names, assumed names, or other operating names:	N/A
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Limited liability company
State of Incorporation/organization:	PA
Primary Address:	200 Stevens Dr. Philadelphia, PA 19113
Tel:	1-866-533-5492
Fax:	1-215-937-8776
Local Address (if any):	N/A
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	200 Stevens Dr. Philadelphia, PA 19113
Number of Employees:	276 (as of March 31, 2015)
Number of Years in Business:	16
Primary Focus of Business:	Pharmacy benefits management
Federal Tax ID:	27-0863878
Subcontractor's Accounting Firm:	KPMG
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	While company registrations are in process, PerformRx is not yet registered to do business in Iowa; PerformRx will be registered as a foreign limited liability company.
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	Based upon the State capitation rates released on April 23, 2015, PerformRx's compensation for services furnished under its subcontract with AmeriHealth Caritas Iowa is estimated to be less than 5% of AmeriHealth Caritas Iowa's anticipated capitation payment from DHS.

General Scope of Work to be performed by this Subcontractor
PerformRx will administer the pharmacy benefit of AmeriHealth Caritas Iowa members, providing full service pharmacy benefit management (PBM) services that includes pharmacy contracting, clinical programs, claims administration and rebate administration (where permitted).
Detail the Subcontractor's qualifications for performing this scope of work
PerformRx has more than fifteen (15) years of experience in furnishing PBM services to support Medicaid managed care plans. PerformRx began as an operating division of AmeriHealth Caritas Health Plan (then known as AmeriHealth Mercy Health Plan) in 1999, providing PBM services to AmeriHealth Caritas Health Plan and its sister company Keystone Family Health Plan (then known as Keystone Mercy Health Plan). PerformRx's client base began expanding to include government-sponsored health plans in South Carolina, Rhode Island and California; and in 2006, PerformRx began providing PBM services to plan sponsors under the Medicare Part D program. Most recently, PerformRx launched its specialty pharmacy (PerformSpecialty), with operations located in Orlando, Florida. Today PerformRx serves more than 4.5 million lives across 14 states and the District of Columbia, providing PBM services for Medicare, Medicaid, Medi-Cal and other state-funded plans, and commercial and exchange clients. PerformRx is currently in the process of registering to conduct business in Iowa, including securing its TPA certification as required under Iowa Code Chapter 510B.

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	
Printed Name/Title:	Mesfin Tegenu, President
Date:	4-29-2015

Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name PerformRx, LLC	Federal Tax ID or SSN 27-0863878

Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. *See* Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: ☐ Yes or ☑ No

Group of Individual Practitioners ☐ Yes or ■ No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all ***individuals*** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of your organization if you are organized as a corporation; or
f) is a partner in your organization if organized as a partnership.

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Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Paul A. Tufano	Chairman	0%	Confidential & Not for Public Disclosure		
Mesfin Tegenu	President	0%			
Steven H. Bohner	Director:VP & Treasurer	0%			
Robert H. Gilman	VP & Secretary	0%			

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of you if organized as a corporation; or
f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
AmeriHealth Caritas Health Plan	23-2859523	100% (direct)	200 Stevens Dr., Philadelphia, PA 19113	8040 Carlson Rd., Harrisburg, PA 17112	
BMH Subco I LLC	38-36946080	50% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		
BMH Subco II LLC	80-0768643	50% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		
BMH LLC	30-0703311	100% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Robert E. Tootle	Assistant Secretary	0%	Confidential & Not for Public Disclosure		
Marie A. Savard	Chief Medical Officer	0%			

Non-Individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of you if organized as a corporation; or
f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
Blue Cross Blue Shield of Michigan	38-2069753	38.7% (indirect)	600 E. Lafayette Blvd., Detroit, MI 48226		
IBC MH LLC	45-3672640	61.3% (indirect)	1901 Market St. Philadelphia, PA 19103		
AmeriHealth, Inc.	23-2425461	58.2% (indirect)	1901 Market St. Philadelphia, PA 19103		
Independence Health Group, Inc	47-1233198	61.3% (indirect)	1901 Market St. Philadelphia, PA 19103		

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
None					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? ☐ Yes or ■ No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth
N/A			

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

☐ Yes or ☐ No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth
N/A			

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
b) Any Medicare intermediary or carrier; and
c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
See Attached	

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

PerformRx, LLC
Iowa Medicaid Ownership and Disclosure

Table 6 (Other Disclosing Entities)

Name of Owner	Name of Other Disclosing Entity
AmeriHealth Caritas Health Plan	AmeriHealth Caritas Louisiana, Inc.
	Florida True Health, Inc.
	AmeriHealth Nebraska, Inc.
	AmeriHealth Michigan, Inc.
	Select Health of South Carolina, Inc.
	AmeriHealth District of Columbia, Inc.
	Prestige Health Choice, L.L.C.
	PerformSpecialty, LLC
Blue Cross Blue Shield of Michigan	Blue Care Network of Michigan
	Blue Cross Complete of Michigan
IBC MH LLC	Vista Health Plan, Inc. (including CMS contract H4227)
AmeriHealth, Inc.	AmeriHealth HMO, Inc.
	Keystone Health Plan East, Inc.

Table 7:

Name	Title	Address	DOB	SSN
Michael W. Reilley	Vice President & CFO	Confidential & Not for Public Disclosure		
Andrew F. Maiorini	Vice President, Clinical Programs			
Patrick M. Gallagher	Vice President, Operations			

Please copy this page if additional space is needed.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? ☐ Yes or ■ No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

   ☐ None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

   ☐ None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

   ☐ None

Name:

Please copy this page if additional space is needed.

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4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

   ■ None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

   ■ None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory	
Mesfin Tegenu	
Signature of Authorized Signatory	Date
	4/20/15

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Exhibit C: Subcontractor Disclosure Form

*(Return this completed form behind Tab 3 of the Bid Proposal. Fully complete a form for **each** proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)*

Primary Bidder ("Primary Bidder"):	AmeriHealth Caritas
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Richard Walker
Address:	500 Southborough Dr, South Portland, Maine 04106
Tel:	207-822-3001
Fax:	207-773-1857
E-mail:	rwalker@sironahealth.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	SironaHealth, Inc.
"Doing Business As" names, assumed names, or other operating names:	NA
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	S corporation
State of Incorporation/organization:	Delaware
Primary Address:	500 Southborough Dr, South Portland, Maine 04106
Tel:	207-775-2600
Fax:	207-773-1857
Local Address (if any):	NA
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	NA
Number of Employees:	170
Number of Years in Business:	7
Primary Focus of Business:	Medical Contact Center
Federal Tax ID:	26-3734240
Subcontractor's Accounting Firm:	Baker, Newman, Noyes
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	No
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	1%
General Scope of Work to be performed by this Subcontractor	
See attached A	
Detail the Subcontractor's qualifications for performing this scope of work	
See attached B	

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	Jeff Forbes
Printed Name/Title:	Jeff Forbes, President SironaHealth
Date:	3/31/2015

Attachment A: General Scope of Work to be performed by this Subcontractor

SIRONAHEALTH'S NURSE TRIAGE SERVICE

SironaHealth's Nurse Triage service provides client members with access to a Registered Nurse (RN) over the telephone at any time, night or day. Our purpose is to ensure patient safety and satisfaction by facilitating the next level of appropriate care with compassion and speed.

During a Nurse Triage call, a SironaHealth RN answers general health questions and evaluates any current symptoms the caller (or a member of their family) is experiencing. Based on the caller's reported symptoms, the RN then provides guidance on the next appropriate course of action.

In addition to the RN's expertise, physician-authored clinical guidelines—created by Dr. Barton Schmitt (Pediatric) and Dr. David Thompson (Adult)—enable RNs to provide consistent health information during every call. SironaHealth RN's also have access to the Healthwise medical content database, providing them with information on over 5,500 topics relating to health conditions, medical tests, procedures, medications, and everyday health and wellness issues.

Attachment B: Detail the Subcontractor's qualifications for performing this scope of work

SironaHealth has been providing nurse triage services for over a decade to healthcare providers and payers. SironaHealth is a URAC accredited center, maintains PCI certification, and is an NCQA delegate. In 2015, SironaHealth is applying for an NCQA certificate as a health information center.

URAC accreditation, with its extensive audit every three years, ensures SironaHealth has the management, privacy, and quality controls needed to perform its duties. Additionally, URAC audits guarantee SironaHealth has annual quality improvement plans in place that produce results.

SironaHealth's quality infrastructure, QCare is the means by which we achieve our stated mission, which is to guarantee patient safety and satisfaction through compassionate and competent care and a relentless focus on quality improvement.

Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name	Federal Tax ID or SSN
SironaHealth, Inc	26-37374240

Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. *See* Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: ☐ Yes or ☒ No

Group of Individual Practitioners ☐ Yes or ☒ No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all ***individuals*** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of your organization if you are organized as a corporation; or
f) is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Jeff Forbes	President	76.0%	Confidential & Not for Public Disclosure		
Richard Walker	CFO	10.1%			
Travis Hersom	VP Technology	8.5%			

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of you if organized as a corporation; or
f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? ☐ Yes or ☒ No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

☐ Yes or ☒ No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
b) Any Medicare intermediary or carrier; and
c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

Table 7:

Name	Title	Address	DOB	SSN
Jeff Forbes	President	Confidential & Not for Public Disclosure		
Richard Walker	CFO			
Travis Hersom	VP Technology			
Dan Roy	VP Operations			
Lorie Whittemore	VP Quality			

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Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? ☐ Yes or ☒ No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

   [X] None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

   [X] None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

   [X] None

Name:

Please copy this page if additional space is needed.

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4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

   [X] None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

   [X] None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory Richard Walker	
Signature of Authorized Signatory	Date 4/13/15

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4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

   ■ None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

   ■ None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory Mesfin Tegenu	
Signature of Authorized Signatory	Date 4/20/15

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3.2.7.2 Financial Statements

All necessary financial statements have been provided and are bound separately.

3.2.7.3 Resumes

AmeriHealth Caritas has engaged recruitment agencies to build a talent pipeline of highly-skilled, qualified candidates for key roles, which positions the organization to hire candidates quickly once the award is announced. AmeriHealth Caritas Iowa will submit the resumes to DHS within 10 calendar days of the execution of the contract.

3.2.7.4 Contract Lists

3.2.7.4.2 Table

Table of publically-funded managed care contracts for Medicaid, CHIP, and other low-income populations within the last five years.

AmeriHealth Caritas Pennsylvania, Pennsylvania	
Contract Duration	1997 to present
Contact Name / Phone Number / Email	Margaret Angello, Market President 717-651-3552 mangello@amerihealthcaritaspa.com
# Members Served by Population Type	More than 143,000 serving: • Medicaid managed care. • Temporary Assistance for Needy Families (TANF). • Supplemental Security Income (SSI) with and without Medicare. • State and Federal General Assistance and Medically Needy.
Annual Contract Payment & Description if payment was capitated	Primarily capitation $684,599,411
Improvements in Utilization Trends and Quality Indicators - Examples*	• The health plan achieved a 10 percent decrease in 30-day hospital readmissions for members with targeted chronic conditions in 2014. • Focused program on asthma medication adherence yielded a 13 percent decline in asthma-related hospital admissions. • Members engaged in telephonic care management: 36 percent decrease in emergency room (ER) visits, 27 percent decrease in ER costs and 30 percent decrease in inpatient costs.

AmeriHealth Caritas Pennsylvania, Pennsylvania	
How Contract Emphasizes Member Choice**	• Members proactively choose their primary care provider (PCP) to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access**	• The Rapid Response team is available to help members in need of assistance with specialty needs. Supports are available through discharge planning to identify resources for preventative care in community setting. • We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety**	• Member newsletters are published quarterly with focused areas targeting member safety. • Community Education representatives meet members at community events to educate about availability of services from plan and other resources. • The health plan connects members with resources from the Care Management team resources to assist families with more intense healthcare needs to navigate the system.
How Contract Emphasizes Independence & Responsibility**	• The healthy rewards program provides gift cards to members who access key preventative care. • The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. • The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	• Administration of pharmacy, dental, and routine vision and eye wear benefits. • Utilization management for radiology services. • Nurse triage line. • Payment Integrity services include retrospective data mining and complex medical record reviews, TPL cost avoidance, carrier recoveries of retroactive TPL (pharmacy only) and subrogation.

AmeriHealth District of Columbia, District of Columbia	
Contract Duration	2013 to present
Contact Name / Phone Number / Email	Karen Dale, Market President 202-326-8741 kdale@amerihealthdc.com
# Members Served by Population Type	More than 108,000 serving: • Medicaid managed care. • TANF. • Children's Health Insurance Program (CHIP). • Previously uninsured adults.
Annual Contract Payment & Description if payment was capitated	Primarily capitation $445,412,466
Improvements in Utilization Trends and Quality Indicators - Examples*	• Focusing on members with dominant chronic conditions, the health plan achieved a 57 percent decrease in potentially preventable events, driven by a 63 percent decrease in potentially preventable admissions. • The health plan achieved the following results for members participating in Integrated Care Management: 60 percent decline in inpatient (IP) costs; 50 percent in IP admissions; 47 percent decline in IP Days; and 66 percent decline in potentially preventable admissions, six months post-engagement.
How Contract Emphasizes Member Choice**	• Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services. • The health plan solicits information regarding language and cultural preferences regarding providers.
How Contract Emphasizes Access**	• The Rapid Response Team is available to assist members in need of assistance with specialty needs. • Supports are available through discharge planning to identify resources for preventive care in community setting. • We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans. • The health plan offers a telepsych program for access to behavioral health services at medical provider offices.

AmeriHealth District of Columbia, District of Columbia	
How Contract Emphasizes Safety**	• Member newsletters are published quarterly with focused areas targeting member safety. • Community Education representatives meet members at community events to educate about availability of services from plan and other resources. • The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system.
How Contract Emphasizes Independence & Responsibility**	• The healthy rewards program provides gift cards to members who access key preventative care. • The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. • The health plan is currently implementing smart phone technology to make such resources more readily available for members. The "I am Healthy" campaign takes a holistic approach to providing members with small steps they can take to be healthy.
Role of Subcontractors, if any	• Administration of pharmacy, dental, and routine vision and eye wear benefits. • Utilization management for radiology services. • Nurse triage line. • Payment Integrity services include retrospective data mining and complex medical record reviews, TPL cost avoidance, carrier recoveries of retroactive TPL and subrogation.

AmeriHealth Caritas Louisiana, Louisiana	
Contract Duration	2012 to present
Contact Name / Phone Number / Email	Kyle Viator, Market President 225-300-9238 kviator@amerihealthcaritasla.com
# Members Served by Population Type	More than 153,000 serving: • Medicaid managed care. • SSI. • FITAP (TANF). • Home and community-based services (HCBS) Waiver population. • Foster children. • Breast and cervical cancer. • LaCHIP (LAP).
Annual Contract Payment & Description if payment was capitated	Primarily capitation $536,886,831
Improvements in Utilization Trends and Quality Indicators - Examples*	• The health plan achieved an 18 percent decrease in 30-day hospital readmissions for members with targeted chronic conditions in 2014. • The health plan's focused program on diabetes management yielded a 17 percent decline in hospital admissions for diabetic members. • Focusing on members with dominant chronic conditions achieved a 37 percent decrease in potentially preventable events, driven by a 52 percent decrease in potentially preventable admissions • Year-over-year decreases in NICU utilization, primarily related to overall decrease in births and slight reduction in C-section rates. The health plan is aggressively promoting the use of 17-P to reduce pre-term births in both.
How Contract Emphasizes Member Choice**	• Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access**	• The Rapid Response Team is available to assist members in need of assistance with specialty needs. • Supports are available through discharge planning to identify resources for preventive care in community setting.

AmeriHealth Caritas Louisiana, Louisiana	
	• The health plan closely monitors availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety**	• Member newsletters are published quarterly with focused areas targeting member safety. • Community Education representatives meet members at community events to educate about availability of services from plan and other resources. • The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system.
How Contract Emphasizes Independence & Responsibility**	• The healthy rewards program provides gift cards to members who access key preventative care. • The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. • The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	• Administration of pharmacy, dental, non-emergency medical transportation and routine vision and eye wear benefits. • Utilization management for radiology services. • Nurse triage line. • Payment Integrity services include retrospective data mining and complex medical record reviews, TPL cost avoidance, carrier recoveries of retroactive TPL and subrogation.

AmeriHealth Northeast, Pennsylvania	
Contract Duration	1997 to present
Contact Name / Phone Number / Email	Margaret Angello, Market President 717-651-3552 mangello@amerihealthcaritaspa.com
# Members Served by Population Type	More than 55,000 serving: • Medicaid managed care. • TANF. • SSI with and without Medicare. • State and federal GA and Medically Needy.
Annual Contract Payment & Description if payment was capitated	Primarily capitation $276,799,706
Improvements in Utilization Trends and Quality Indicators - Examples*	The health plan focused on reducing 30-day hospital readmissions for members with targeted chronic conditions in 2014, and yielded a 13 percent reduction.
How Contract Emphasizes Member Choice**	• Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access**	• The Rapid Response Team is available to assist members in need of assistance with specialty needs. • Supports are available through discharge planning to identify resources for preventive care in community setting. • We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety**	• Member newsletters are published quarterly with focused areas targeting member safety. • Community Education representatives meet members at community events to educate about availability of services from plan and other resources. • The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system

AmeriHealth Northeast, Pennsylvania	
How Contract Emphasizes Independence & Responsibility**	• The healthy rewards program provides gift cards to members who access key preventative care. • The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. • The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	• Administration of pharmacy, dental, and routine vision and eye wear benefits. • Utilization management for radiology services. • Nurse triage line. • Payment Integrity services include retrospective data mining and complex medical record reviews, TPL cost avoidance, carrier recoveries of retroactive TPL and subrogation.

Arbor Health Plan, Nebraska	
Contract Duration	2012 to present
Contact Name / Phone Number / Email	Thomas Smith, Market President 402-507-5995 tpsmith@arborhealthplan.com
# Members Served by Population Type	More than 24,000 serving: • Medicaid managed care. • TANF. • SSI with and without Medicare. • State and federal GA and Medically Needy.
Annual Contract Payment & Description if payment was capitated	Primarily capitation $69,007,000
Improvements in Utilization Trends and Quality Indicators - Examples*	• The health plan achieved a 29 percent decrease in 30-day hospital readmissions for members with targeted chronic conditions in 2014. • The health plan focused members with dominant chronic conditions and achieved a 48 percent decrease in potentially preventable events, driven by a 69 percent decrease in potentially preventable Admissions.
How Contract Emphasizes Member Choice**	• Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services. • The health plan has a fully contracted network both statewide in Nebraska and also in all of the contiguous state for referral purposes.
How Contract Emphasizes Access**	• The Rapid Response Team is available to assist members in need of assistance with specialty needs. • Supports are available through discharge planning to identify resources for preventive care in community setting. • We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety**	• Member newsletters are published quarterly with focused areas targeting member safety. • Community Education representatives meet members at community events to educate about availability of services from plan and other resources. • The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system.

Arbor Health Plan, Nebraska	
How Contract Emphasizes Independence & Responsibility**	• The healthy rewards program provides gift cards to members who access key preventative care. • The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. • The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	• Administration of dental as well as routine vision and eye wear benefits. • Utilization management for radiology services. • Nurse triage line. • Payment Integrity services include retrospective data mining and complex medical record reviews, TPL cost avoidance, carrier recoveries of retroactive TPL and subrogation.

First Choice by Select Health, South Carolina	
Contract Duration	1996 - present
Contact Name / Phone Number / Email	Rebecca Engelman, Market President 843-569-4606 rengelman@selecthealthofsc.com
# Members Served by Population Type	More than 340,000 serving: • Medicaid managed care. • SSI without Medicare. • TANF. • OCWI. • Foster children.
Annual Contract Payment & Description if payment was capitated	Primarily capitation $1,127,423,370
Improvements in Utilization Trends and Quality Indicators - Examples*	• The health plan is a statewide sponsor of the Premature Birth Campaign in South Carolina. Recent data on C-Section deliveries indicate a 10 percent decrease for the health plan. • Members participating in integrated healthcare management (IHM) yielded a 40 percent decrease in inpatient admissions, statistically significantly greater than the experience of a control group of non-enrolled members. • Community Care Hubs targeting Super Utilizers achieved a 28 percent decline in IP dollars, 40 percent decline in IP admissions, and 15 percent decline in total dollars (excluding prescriptions). • YOY decreases in NICU utilization, primarily related to overall decrease in births and slight reduction in C-section rates. The health plan is aggressively promoting the use of 17-P to reduce pre-term births in both.
How Contract Emphasizes Member Choice**	• Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services

First Choice by Select Health, South Carolina	
How Contract Emphasizes Access**	• The Rapid Response Team is available to assist members in need of assistance with specialty needs. • Supports are available through discharge planning to identify resources for preventive care in community setting. • We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans. • The health plan monitors member gaps in care and outreach to encourage services and evaluate barriers to access (i.e., transportation).
How Contract Emphasizes Safety**	• Continual monitoring of pharmacy utilization data for drug interactions, drug utilization review (DUR) edits, recalls, and drug/diagnosis conditions. • Member newsletters are published quarterly with focused areas targeting member safety. • Community Education representatives meet members at community events to educate about availability of services from plan and other resources. • The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system.
How Contract Emphasizes Independence & Responsibility**	• The healthy rewards program provides gift cards to members who access key preventative care. • The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history.
Role of Subcontractors, if any	• Administration of pharmacy benefit. • Utilization management for radiology services. • Payment Integrity services include retrospective data mining and complex medical record reviews, TPL cost avoidance, carrier recoveries of retroactive TPL and subrogation.

Keystone First, Pennsylvania	
Contract Duration	1996 –to present
Contact Name / Phone Number / Email	Joanne McFall, Market President 215-863-6467 JMcFall@amerihealthcaritas.com
# Members Served by Population Type	More than 318,000 serving: • Medicaid managed care. • TANF. • SSI with and without Medicare. • State and federal GA and Medically Needy.
Annual Contract Payment & Description if payment was capitated	• Primarily capitation $2,088,513,546
Improvements in Utilization Trends and Quality Indicators - Examples*	• The "For Your Kids" community education program on how to care for sick children, effective home treatments, and when to seek medical or emergency care. The average number of non-urgent ER visits decreased -46.3 percent for members participating in the class versus a -14.6 percent reduction for a control group of non-participants. • The focused program on diabetes management yielded a 22 percent decline in hospital admissions for diabetic members. • There was a 21 percent decline in hospital admissions for members with heart failure. • Community Care Hubs targeting Super Utilizers achieved 14 percent decline in IP dollars, 18 percent decline in IP admissions and 12 percent decline in total dollars (excluding prescriptions).
How Contract Emphasizes Member Choice**	• Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access**	• The Rapid Response Team is available to assist members in need of assistance with specialty needs. • Supports are available through discharge planning to identify resources for preventive care in community setting. • We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.

Keystone First, Pennsylvania	
How Contract Emphasizes Safety**	• Member newsletters are published quarterly with focused areas targeting member safety. • Community Education representatives meet members at community events to educate about availability of services from plan and other resources. • The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system.
How Contract Emphasizes Independence & Responsibility**	• The healthy rewards program provides gift cards to members who access key preventative care. • The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. • The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	• Administration of pharmacy, dental, and routine vision and eye wear benefits. • Utilization management for radiology services. • Nurse triage line. • Payment Integrity services include retrospective data mining and complex medical record reviews, TPL cost avoidance, carrier recoveries of retroactive TPL and subrogation.

MDwise Hoosier Alliance, Indiana	
Contract Duration	2007 to June 2015
Contact Name / Phone Number / Email	Susan Overton, Interim Market President 317-412-6463 soverto@hoosieralliance.org
# Members Served by Population Type	More than 127,000 serving: • Medicaid managed care and Healthy Indiana Uninsured Program. • TANF. • CHIP. • State and federal GA and Medically Needy. • Previously uninsured adults.
Annual Contract Payment & Description if payment was capitated	• Primarily capitation $238,808,625
Improvements in Utilization Trends and Quality Indicators - Examples*	• The focused program on asthma medication adherence yielded a 13 percent decline in asthma-related hospital admissions. • Our overall integrated healthcare management program was independently evaluated by the Milliman, Inc. The evaluation showed a 4.3 percent reduction over the expected cost trend, estimated to amount to over $20 million in savings for the Indiana Aged-Blind-Disabled (ABD) population.
How Contract Emphasizes Member Choice**	• Freedom of MCE selection at annual redetermination period. • Unlimited PCP selections made available to member. • Members are allowed to visit any physician extender if MCE does not have adequate availability.
How Contract Emphasizes Access**	• Members may self-refer to certain providers. • The health plan offers open access to all federally quailed health center (FQHC) and rural health center (RHC) providers throughout the state. • The health plan has strict Geo-Access standards for providers. • PCP 24/7 accessibility requirements.
How Contract Emphasizes Safety**	• MCE must maintain strict monitoring of provider network for exclusions and disbarments. • MCE must make available electronic means for member to submit an IQ (Internet Quorum) inquiry about provider fraud/abuse, PQI (Potential Quality Incident). • The health plan is required to refer all suspected member abuse or child abuse cases to DOH (Department of Health).

MDwise Hoosier Alliance, Indiana	
How Contract Emphasizes Independence & Responsibility**	• MCEs are required to develop member incentive program to encourage members to be personally accountable for preventive care. • Behavioral health drug therapy • Well-child visits. • Member cost-sharing requirements for HIP (Healthy Indiana Plan) based on income. • Prescription co-pays for some Medicaid membership.
Role of Subcontractors, if any	• Pharmacy, 24-hour nurse triage line, and transportation are subcontracted. • Payment Integrity services include data mining and subrogation.

PerformCare Pennsylvania - Capital Area HealthChoices (Cumberland, Dauphin, Lancaster, Lebanon, Perry counties)	
Contract Duration	October 2001 to present
Contact Name / Phone Number / Email	Jim Laughman, Executive Director 717-909-2171 jlaughman@performcare.org
# Members Served by Population Type	155,312 (February 2015) All Medicaid rating groups including ABD.
Annual Contract Payment & Description if payment was capitated	ASO $15,955,975
Improvements in Utilization Trends and Quality Indicators - Examples*	• The health plan saw a significant increase in overall access evidenced by penetration rates for behavioral health services. • The health plan saw significant utilization reduction of out-of-home placements for children and adolescents (RTF). • The health plan achieved decreased wait times for children's wraparound services. • Over 70 percent of routine behavioral health services were offered within seven days. • There were multiple implementations of evidence-based and supplemental programs including ACT, DBT, FFT, MST, PCIT, Incredible Years, Certified Peer Support.
How Contract Emphasizes Member Choice**	• The contract requires freedom of choice of multiple provider options. • The "no wrong door" policy includes access directly to a provider, County-based Case Management units, crisis intervention units or emergency room, or telephonically through the plan's 24/7 Member Services.
How Contract Emphasizes Access**	• The contract contains stringent requirements and measurement for timely access, including emergent, urgent, and routine access measures. • The contract specifies clear requirements and annual measurement and action plans for geographic access, both urban and rural.
How Contract Emphasizes Safety**	• Safety initiatives include: • Critical Incident reporting required of all providers. • Multi-year restraint reduction initiative. • Ongoing treatment quality of care and complaint monitoring.

PerformCare Pennsylvania - Capital Area HealthChoices (Cumberland, Dauphin, Lancaster, Lebanon, Perry counties)	
How Contract Emphasizes Independence & Responsibility**	• Recovery-oriented services including certified peer support, clubhouses, and psychiatric rehabilitation services. • Consumer/family satisfaction teams are run by consumer organizations who complete face-to-face and telephonic surveys and interviews regarding the member's experience of care and treatment satisfaction. .
Role of Subcontractors, if any	• Allan Collautt Associates, Inc. (IS services related to file transfers and encounter reporting). • Emdeon (AmeriHealth Caritas corporate contract for electronic claims clearinghouse services). • Xerox (terminated) and SourceHOV (current) (AmeriHealth Caritas corporate contract for paper claim intake services).

PerformCare Pennsylvania - Franklin-Fulton HealthChoices	
Contract Duration	July 2007 to present
Contact Name / Phone Number / Email	Jim Laughman, Executive Director 717-909-2171 jlaughman@performcare.org
# Members Served by Population Type	20,740 (February 2015) All Medicaid rating groups including ABD
Annual Contract Payment & Description if payment was capitated	ASO $2,271,397
Improvements in Utilization Trends and Quality Indicators - Examples*	• The health plan saw a significant increase in overall access evidenced by penetration rates for behavioral health services. • The health plan saw significant utilization reduction of out-of-home placements for children and adolescents (RTF). • The health plan achieved decreased wait times for children's wraparound services. • Over 70 percent of routine behavioral health services were offered within seven days. • There were multiple implementations of evidence-based and supplemental programs including ACT, DBT, FFT, MST, PCIT, Incredible Years, Certified Peer Support.
How Contract Emphasizes Member Choice**	• The contract requires freedom of choice of multiple provider options. • The "no wrong door" policy includes access directly to a provider, County-based Case Management units, crisis intervention units or emergency room, or telephonically through the plan's 24/7 Member Services.
How Contract Emphasizes Access**	• The contract contains stringent requirements and measurement for timely access, including emergent, urgent, and routine access measures. • The contract specifies clear requirements and annual measurement and action plans for geographic access, both urban and rural.
How Contract Emphasizes Safety**	• Safety initiatives include: • Critical Incident reporting required of all providers. • Multi-year restraint reduction initiative. • Ongoing treatment quality of care and complaint monitoring.
How Contract Emphasizes Independence & Responsibility**	• Recovery-oriented services including certified peer support, clubhouses, and psychiatric rehabilitation services. • Consumer/family satisfaction teams are run by consumer organizations who complete face-to-face and telephonic surveys and interviews regarding the member's experience of care and treatment satisfaction.

PerformCare Pennsylvania - Franklin-Fulton HealthChoices	
Role of Subcontractors, if any	• Allan Collautt Associates, Inc. (IS services related to file transfers and encounter reporting). • Emdeon (AmeriHealth Caritas corporate contract for electronic claims clearinghouse services). • Xerox (terminated) and SourceHOV (current) (AmeriHealth Caritas corporate contract for paper claim intake services).

PerformCare Pennsylvania - Bedford-Somerset HealthChoices	
Contract Duration	July 2007 to present
Contact Name / Phone Number / Email	Jim Laughman, Executive Director 717-909-2171 jlaughman@performcare.org
# Members Served by Population Type	18,119 (February 2015) All Medicaid rating groups including ABD.
Annual Contract Payment & Description if payment was capitated	ASO $2,015,236
Improvements in Utilization Trends and Quality Indicators - Examples*	• The health plan saw a significant increase in overall access evidenced by penetration rates for behavioral health services. • The health plan saw significant utilization reduction of out-of-home placements for children and adolescents (RTF). • The health plan achieved decreased wait times for children's wraparound services. • Over 70 percent of routine behavioral health services were offered within seven days. • There were multiple implementations of evidence-based and supplemental programs including ACT, DBT, FFT, MST, PCIT, Incredible Years, and Certified Peer Support.
How Contract Emphasizes Member Choice**	• The contract requires freedom of choice of multiple provider options. • The "no wrong door" policy includes access directly to a provider, County-based Case Management units, crisis intervention units or emergency room, or telephonically through the plan's 24/7 Member Services.
How Contract Emphasizes Access**	• The contract contains stringent requirements and measurement for timely access, including emergent, urgent, and routine access measures. • The contract specifies clear requirements and annual measurement and action plans for geographic access, both urban and rural.
How Contract Emphasizes Safety**	• Safety initiatives include: • Critical Incident reporting required of all providers. • Multi-year restraint reduction initiative. • Ongoing treatment quality of care and complaint monitoring.

PerformCare Pennsylvania - Bedford-Somerset HealthChoices	
How Contract Emphasizes Independence & Responsibility**	• Recovery-oriented services including certified peer support, clubhouses, and psychiatric rehabilitation services. • Consumer/family satisfaction teams are run by consumer organizations who completes face-to-face and telephonic surveys and interviews regarding the member's experience of care and treatment satisfaction.
Role of Subcontractors, if any	• Allan Collautt Associates, Inc. (IS services related to file transfers and encounter reporting). • Emdeon (AmeriHealth Caritas corporate contract for electronic claims clearinghouse services). • Xerox (terminated) and SourceHOV (current) (AmeriHealth Caritas corporate contract for paper claim intake services).

PerformCare Pennsylvania - Blair HealthChoices	
Contract Duration	July 2007 to June 2013
Contact Name / Phone Number / Email	Jim Laughman, Executive Director 717-909-2171 jlaughman@performcare.org
# Members Served by Population Type	22,018 (June 2013) All Medicaid rating groups including aged, blind and disabled (ABD)
Annual Contract Payment & Description if payment was capitated	At-Risk Capitation $30,647,680
Improvements in Utilization Trends and Quality Indicators - Examples*	• The health plan saw a significant increase in overall access evidenced by penetration rates for behavioral health services. • The health plan saw significant utilization reduction of out-of-home placements for children and adolescents (RTF). • The health plan achieved decreased wait times for children's wraparound services. • Over 70 percent of routine behavioral health services were offered within seven days. • There were multiple implementations of evidence-based and supplemental programs including ACT, DBT, FFT, MST, PCIT, Incredible Years, and Certified Peer Support.
How Contract Emphasizes Member Choice**	• The contract requires freedom of choice of multiple provider options. • The "no wrong door" policy includes access directly to a provider, County-based Case Management units, crisis intervention units or emergency room, or telephonically through the plan's 24/7 Member Services.
How Contract Emphasizes Access**	• The contract contains stringent requirements and measurement for timely access, including emergent, urgent, and routine access measures. • The contract specifies clear requirements and annual measurement and action plans for geographic access, both urban and rural.
How Contract Emphasizes Safety**	• Safety initiatives include: • Critical Incident reporting required of all providers. • Multi-year restraint reduction initiative. • Ongoing treatment quality of care and complaint monitoring.

PerformCare Pennsylvania - Blair HealthChoices	
How Contract Emphasizes Independence & Responsibility**	• Recovery-oriented services including certified peer support, clubhouses, and psychiatric rehabilitation services. • Consumer/family satisfaction teams are run by consumer organizations • The health plan completes face-to-face and telephonic surveys and interviews regarding the member's experience of care and treatment satisfaction.
Role of Subcontractors, if any	• Allan Collautt Associates, Inc. (IS services related to file transfers and encounter reporting). • Emdeon (AmeriHealth Caritas corporate contract for electronic claims clearinghouse services). • Xerox (terminated) and SourceHOV (current) (AmeriHealth Caritas corporate contract for paper claim intake services).

PerformCare Pennsylvania - Lycoming-Clinton HealthChoices	
Contract Duration	July 2007 to June 2013
Contact Name / Phone Number / Email	Jim Laughman, Executive Director 717-909-2171 jlaughman@performcare.org
# Members Served by Population Type	22,554 (June 2013) All Medicaid rating groups including ABD
Annual Contract Payment & Description if payment was capitated	At-Risk Capitation $22,849,886
Improvements in Utilization Trends and Quality Indicators - Examples*	• The health plan saw a significant increase in overall access evidenced by penetration rates for behavioral health services. • The health plan saw significant utilization reduction of out-of-home placements for children and adolescents (RTF). • The health plan achieved decreased wait times for children's wraparound services. • Over 70 percent of routine behavioral health services were offered within seven days. • There were multiple implementations of evidence-based and supplemental programs including ACT, DBT, FFT, MST, PCIT, Incredible Years and Certified Peer Support.
How Contract Emphasizes Member Choice**	• The contract requires freedom of choice of multiple provider options. • The "no wrong door" policy includes access directly to a provider, County-based Case Management units, crisis intervention units or emergency room, or telephonically through the plan's 24/7 Member Services.
How Contract Emphasizes Access**	• The contract contains stringent requirements and measurement for timely access, including emergent, urgent, and routine access measures. • The contract specifies clear requirements and annual measurement and action plans for geographic access, both urban and rural.
How Contract Emphasizes Safety**	• Safety initiatives include: • Critical Incident reporting required of all providers. • Multi-year restraint reduction initiative. • Ongoing treatment quality of care and complaint monitoring.

PerformCare Pennsylvania - Lycoming-Clinton HealthChoices	
How Contract Emphasizes Independence & Responsibility**	• Recovery-oriented services including certified peer support, clubhouses, and psychiatric rehabilitation services. • Consumer/family satisfaction teams are run by consumer organizations. These teams complete face-to-face and telephonic surveys and interviews regarding the member's experience of care and treatment satisfaction.
Role of Subcontractors, if any	• Allan Collautt Associates, Inc. (IS services related to file transfers and encounter reporting). • Emdeon (AmeriHealth Caritas corporate contract for electronic claims clearinghouse services). • Xerox (terminated) and SourceHOV (current) (AmeriHealth Caritas corporate contract for paper claim intake services).

PerformCare New Jersey- Children's System of Care	
Contract Duration	September 2009 to present
Contact Name / Phone Number / Email	Kathleen Enerlich, Executive Director 609-689-5401 KEnerlich@performcarenj.org
# Members Served by Population Type	61,809 (calendar year 2014)
Annual Contract Payment & Description if payment was capitated	$12,976,404
Improvements in Utilization Trends and Quality Indicators - Examples*	Utilization Trends: • The average length of stay in residential programs decreased by 28 percent from 2012 to 2014. • The number of child welfare foster families calling for services increased by percent. • Ninety-six percent of 17,028 youth receiving Mobile Response Services remained at home, not requiring hospitalization (2014).
How Contract Emphasizes Member Choice**	• Members have a choice of providers (i.e., family support services, outpatient services, in-home intensive community services and in-home habilitation services.
How Contract Emphasizes Access**	• The health plan has a 24/7/365 call center. • Members have access to Mobile Response and Care Management 24/7/365. • Clinical criteria are used to authorize right intensity of service. Reviews are expedited as needed.
How Contract Emphasizes Safety**	• The health plan provides regular screening for life threatening emergencies and rapid triage of calls. • Referral to psychiatric screening services and request for police dispatch for youth presenting a danger for self or others. • Referral to child welfare Central Registry for potential neglect or abuse. • Utilization management review is provided for: Suicide ideation or attempt; self-injury requiring medical intervention; physically assaultive to a parent or other authority figure; psychiatric hospitalization; mental health screening; victim of human trafficking; threat to harm others; victim of bullying.

PerformCare New Jersey- Children's System of Care	
How Contract Emphasizes Independence & Responsibility**	• Values and principles driving the system of care: • Child-centered and family-driven care. • Strength-based. • Individualized care based on need. • Culturally competent. • Promotes independence. • Collaborative.
Role of Subcontractors, if any	• The health plan uses Tidgewell Associates Inc. for information technology services.

PerformRx, Pennsylvania	
Contract Duration	September 2010 to August 2015
Contact Name / Phone Number / Email	Mesfin Tegenu, President 215-937-5013 MTegenue@performrx.com
# Members Served by Population Type	15,364 California Department of Corrections and Rehabilitation Parolees including Juveniles and Adult Parolees.
Annual Contract Payment & Description if payment was capitated	ASO $289,811
Improvements in Utilization Trends and Quality Indicators - Examples*	The health plan provides clinical and cost containment programs including: • Concurrent drug utilization review (DUR). • Retrospective DUR. • Physician profiling. • Prior authorization. • Step therapy. • Dose optimization/efficiency. • Quality/dosing limitations.
How Contract Emphasizes Member Choice**	• The health plan works with Department of Government Services and participating entity to develop an enrollment report detailing the patients eligible to receive pharmacy benefits.
How Contract Emphasizes Access**	• Provide patients access to two (2) pharmacies within a five (5) mile radius for each California zip code or a reasonable travel distance for rural areas. • Provide mail order pharmacy services if requested by participating entity. • Work with participating entity to identify pharmacies that will be accessed for emergency fill agreements, which require 24-hour services.
How Contract Emphasizes Safety**	• The health plan develops, implements and administers DURs. • Work with DGS and participating entity to develop DUR edits (i.e., drug-drug interactions, poly-pharmacy, dosing level, etc.). • Conduct prospective and retrospective DURs to reduce the cost of medication treatment to the state and prevent significant medication interactions and complications for patients of participating entities.

PerformRx, Pennsylvania	
How Contract Emphasizes Independence & Responsibility**	• The health plan provides a dedicated toll-free telephone line with live caller support 24/7 for at least 360 days per year. • Interactive Voice Response (IVR) and Web support 24/7 for at least 360 days per year. • Customer Service Representatives will have access to a pharmacist in the event the call requires the attention of a clinician.
Role of Subcontractors, if any	• Pharmacy claims processing is subcontracted to Argus Health Systems, Inc. to process claims and reporting associated with claims processing systems.

AmeriHealth Caritas VIP, Pennsylvania (Dual Eligible Special Need Medicare Advantage Plan)	
Contract Duration	January 2013 to present
Contact Name / Phone Number / Email	Tonya Moody, Vice President Medicare 215-863-5700 tmoody@amerihealthcaritas.com
# Members Served by Population Type	Projected 161
Annual Contract Payment & Description if payment was capitated	Projected $1,720 Capitated
Improvements in Utilization Trends and Quality Indicators - Examples*	• As a newer plan with small enrollment, there were fluctuations in utilization and quality data is not yet available. But in 2014, the health plan's efforts to engage members resulted in a 65 percent engagement rate. • Gaps in care were identified and an outreach program was performed. This outreach included a home visit initiative for members with a gap in care and the need for hemoglobin A1C or BMI level measurement.
How Contract Emphasizes Member Choice**	• Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access**	• The Rapid Response Team is available to assist members in need of assistance with specialty needs. • Supports are available through discharge planning to identify resources for preventive care in community setting. • We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety**	• Member newsletters are published quarterly with focused areas targeting member safety. • Community Education representatives meet members at community events to educate about availability of services from plan and other resources. • The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system

AmeriHealth Caritas VIP, Pennsylvania (Dual Eligible Special Need Medicare Advantage Plan)	
How Contract Emphasizes Independence & Responsibility**	• The healthy rewards program provides gift cards to members who access key preventative care. • The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. • The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	• Administration of pharmacy, dental, non-emergency medical transportation and routine vision and eye wear benefits. • Utilization management for radiology services. • Nurse triage line. • Payment Integrity services include date mining and subrogation.

Keystone VIP Choice, Pennsylvania (Dual Eligible Special Need Medicare Advantage Plan	
Contract Duration	January 2013 to present
Contact Name / Phone Number / Email	Tonya Moody, Vice President Medicare 215-863-5700 tmoody@amerihealthcaritas.com
# Members Served by Population Type	Project 3,569
Annual Contract Payment & Description if payment was capitated	Projected $54,012 Yes
Improvements in Utilization Trends and Quality Indicators - Examples*	• As a newer plan with small enrollment, there were fluctuations in utilization and quality data is not yet available. But in 2014, the health plan's efforts to engage members resulted in a 65 percent engagement. • Gaps in care were identified and an outreach program was performed. This outreach included a home visit initiative for members with a gap in care and the need for hemoglobin A1C or BMI level measurement.
How Contract Emphasizes Member Choice**	• Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access**	• The Rapid Response Team is available to assist members in need of assistance with specialty needs. • Supports are available through discharge planning to identify resources for preventive care in community setting. • We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety**	• Member newsletters are published quarterly with focused areas targeting member safety. • Community Education representatives meet members at community events to educate about availability of services from plan and other resources. • The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system.
How Contract	• The healthy rewards program provides gift cards to members who access

Keystone VIP Choice, Pennsylvania (Dual Eligible Special Need Medicare Advantage Plan	
Emphasizes Independence & Responsibility**	key preventative care. • The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. • The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	• Administration of pharmacy, dental, non-emergency medical transportation and routine vision and eye wear benefits. • Fulfillment of the over-the-counter benefit. • Nurse triage line. • Payment Integrity services include data mining, complex medical record reviews, and subrogation.

AmeriHealth VIP Care Plus, Michigan (Medicare Medicaid Plan)	
Contract Duration	May 2015 to present
Contact Name / Phone Number / Email	Marcia Laleman, Market President 215-817-4521 mlaleman@amerihealthcaritas.com
# Members Served by Population Type	Projected 7,750
Annual Contract Payment & Description if payment was capitated	Projected $83,879 Capitated
Improvements in Utilization Trends and Quality Indicators - Examples*	This is a new Medicare-Medicaid Plan with the goal to assess and actively engage in care planning each member who enrolls.
How Contract Emphasizes Member Choice**	• Integrated care plans are developed with member input and agreement and supported by the integrated care team with a primary focus on person-centered planning and self-determination. • All Members proactively chose their PCP to serve as medical home and who are included in the Integrated Care Team. • Provide broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access**	• Personal Care Connectors are embedded in the care coordination team and available via phone 8:00 am - 8:00 pm Monday through Friday • The Rapid Response team available 24-7 Monday through Friday to assist members in need of assistance with specialty needs. • Community Health Navigators are assigned caseload stratified by acuity and assist member in accessing all care. • Care Coordinators support discharge planning and transition to community through in-home support and identification of resources for preventative care in community setting. • Closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety**	• Community Heath Navigators and Care Coordinators assess home safety needs during home visits scheduled according to risk stratification. • Community based services brought to home to modify unsafe conditions. Member newsletters published quarterly with focused areas targeting member safety. • Community Education representatives meeting members at community events to educate about availability of services from plan and other resources.

AmeriHealth VIP Care Plus, Michigan (Medicare Medicaid Plan)	
How Contract Emphasizes Independence & Responsibility**	• Care coordination program guided by person-centered planning and self-determination. • The healthy rewards program provides gift cards to members who access key preventative care. • The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. • The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	• Administration of pharmacy, dental, routine vision and eye wear, and non-emergency medical transportation benefits. • Administration of behavioral health and LTSS benefits. • Nurse triage line. • Payment Integrity Services include retrospective data mining and complex medical record reviews and subrogation.

First Choice VIP Care Plus, South Carolina (Medicare Medicaid Plan)	
Contract Duration	February 2015 to present
Contact Name / Phone Number / Email	Jay Powell, Market President 843-414-5135 JPowell@FirstChoiceVIPCarePlus.com
# Members Served by Population Type	Projected 4,500
Annual Contract Payment & Description if payment was capitated	Projected $26,150 Capitated
Improvements in Utilization Trends and Quality Indicators - Examples*	This is a new Medicare-Medicaid Plan with the goal to assess and actively engage in care planning each member who enrolls.
How Contract Emphasizes Member Choice**	• Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access**	• Community Health Navigator team available to assist members in need of assistance with specialty needs. • Supports available through discharge planning to identify resources for preventative care in community setting. • Closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety**	• Member newsletters are published quarterly with focused areas targeting member safety. • Community Education representatives meet members at community events to educate about availability of services from plan and other resources. • The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system.
How Contract Emphasizes Independence & Responsibility**	• The healthy rewards program provides gift cards to members who access key preventative care. • The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. • The health plan is currently implementing smart phone technology to make such resources more readily available for members.

First Choice VIP Care Plus, South Carolina (Medicare Medicaid Plan)	
Role of Subcontractors, if any	• Administration of pharmacy, dental, routine vision and eye wear, and non-emergency medical transportation benefits. • Administration of behavioral health and LTSS benefits. • Nurse triage line. • Payment Integrity Services include retrospective data mining and complex medical records reviews and subrogation.

Notes:

*The Plan Quality Assessment and Performance Improvement (QAPI) program provides a framework for the evaluation of the delivery of healthcare, behavioral health and long term services and supports provided to members. The QAPI Program description defines the quality improvement structure, function, scope and goals defined for the health plan. The Board of Directors approves the QAPI program annually. All AmeriHealth Caritas VIP plans utilize a local advisory committee consisting of the health plan's medical director, a behavioral health professional and licensed practitioners participating in the health plan's network to provide oversight and direction to the QAPI Program for use in the delivery of health care services to the health plans. The goal of the QAPI Program is to link together knowledge, structure and processes as well as to assess and improve quality of care, safety and service. The QAPI Program, in conjunction with the medical director and director of Quality Management, are responsible for addressing and correcting any problems identified through internal surveillance, complaints or other mechanisms. Each year the QAPI Program establishes quality improvement goals. These may be regionally established and/or may tie in to a national quality improvement goal such as readmission reduction. The quality programs are data driven and Medical Economics provides reports to highlight any variance from national or plan established standards. The following is a list of some of the data reviewed:

- Access and availability.
- Membership demographics and utilization of services (including assessment for ambulatory care sensitive services for follow up).
- Appeal categories and timeliness of processing.
- Decision making timeliness for utilization management.
- Member, practitioner and provider satisfaction surveys.
- PCP change trends and practitioner/provider complaints.
- Review, approval and monitoring of subcontractor and delegate activities associated with service. standards, access and availability;
- Member communication.
- Quality of care review based upon member concerns or sentinel events.
- Service standard compliance.
- Language services utilization, access/availability and timeliness.

**The QAPI Program is helps to engage and improve the health of members, stratify members according to their conditions and needs, identify members with potential future avoidable health care needs and

develop a comprehensive risk-specific plan of care with the member to optimize care of their chronic conditions, prevent adverse outcomes and avoidable episodes of care.

The goals of the Program are:

- To improve member's access to PCP, specialists and other medically necessary services through collaboration with providers.
- To reduce preventable inpatient hospital admissions and inappropriate emergency room visits.
- To delay or avoid nursing home admissions, when the beneficiary prefers a community-based option.
- To empower the member to accept responsibility for their ongoing health care needs including: self-managed and informed medical decision making.
- To improve clinical outcomes, including HEDIS rates, and increase the quality of life for our members.
- To improve care coordination and access to appropriate care and reduce unnecessary or duplicative services and improve health outcomes

Parent Guarantee

We have used the experience of our parent company and its affiliates. We are therefore including the following Parent Guarantee.

PERFORMANCE GUARANTEE

The undersigned, AmeriHealth Caritas Health Plan, as the parent company of AmeriHealth Caritas Iowa, Inc., hereby unconditionally guarantees AmeriHealth Caritas Iowa, Inc.'s performance of each and every obligation, covenant, term and condition arising under the contract executed by AmeriHealth Caritas Iowa, Inc. and the Iowa Department of Human Services pursuant to the Iowa High Quality Healthcare Initiative RFP #MED-16-009, for as long as AmeriHealth Caritas Health Plan is the parent company of AmeriHealth Caritas Iowa, Inc.

Dated this 8th day of May, 2015

Signature

Steven H. Bohner
Print Name

Senior Vice President & Chief Financial Officer
Title

Debarment or suspension, regulatory action, or sanction

The following describes instances where AmeriHealth Caritas Iowa, Inc., its parent organization, affiliates or subsidiaries were notified of being non-compliant with a publicly funded managed care contract.

Organization Trade Name: AmeriHealth Caritas Pennsylvania /AmeriHealth Northeast AmeriHealth Northeast/Keystone First (KF)

AmeriHealth Caritas operates its Pennsylvania Medicaid plans (AmeriHealth Caritas Health Plan, AmeriHealth Northeast and Keystone First) pursuant to the contract between the Pennsylvania Department of Human Services (PADHS) and Vista Health Plan, Inc. (Vista). Vista is an indirect subsidiary of Independence Health Group, Inc., which is AmeriHealth Caritas' parent company. Vista is also subject to regulatory oversight by the Pennsylvania Department of Health for these Pennsylvania Medicaid plans.

Regulatory Agency: Pennsylvania Department of Human Services (PADHS) / Pennsylvania Department of Health (PADOH), Medicaid

Sanctions

1. For the months of May 2010 to November 2010, AmeriHealth Caritas Pennsylvania and Keystone First were each sanctioned a total of $9,000 by the PADHS for non-compliance with the timeframe for mailing provider claim checks after the checks were printed. The operational issues leading to this sanction were corrected by both AmeriHealth Caritas Pennsylvania and Keystone First. These sanctions did not result in an administrative proceeding or litigation.
2. For the month of December 2012, AmeriHealth Caritas Pennsylvania incurred sanctions from the PADHS totaling $13,333, and Keystone First incurred sanctions totaling $8,000 for failure to comply the HealthChoices contract requirement pertaining to provider claims adjudication timeliness standards. These sanctions did not result in an administrative proceeding or litigation.
3. For the month of December 2013, AmeriHealth Caritas Pennsylvania incurred sanctions from the PADHS totaling $10,000, AmeriHealth Northeast incurred sanctions totaling $6,000, and Keystone First incurred sanctions totaling $8,000 for failure to comply with the HealthChoices contract requirements pertaining to provider claims adjudication timeliness standards. These sanctions did not result in an administrative proceeding or litigation.
4. For the month of August 2014, AmeriHealth Northeast and Keystone First were each sanctioned $1,000 for failure to comply with the HealthChoices contract requirements pertaining to provider claims adjudication timeliness standards. For the month of September 2013, AmeriHealth Caritas Pennsylvania incurred sanctions from the PADHS totaling $1,333. These sanctions did not result in an administrative proceeding or litigation.

Organization: Florida True Health

Regulatory Agency: Florida Agency for Health Care Administration (AHCA), Medicaid

Sanctions

1. In January 2014, liquidated damages in the amount of $500 were imposed on Florida True Health by AHCA for failure to timely file an unaudited Child Health Check-Up Program (CHCUP) report with AHCA. It was later determined that the CHCUP was in fact filed on time, but the report file was incorrectly named. The sanction did not result in an administrative proceeding or litigation.

2. In February 2014, liquidated damages in the amount of $25,000 were imposed on Florida True Health by AHCA for failure to comply with the federal 80 percent participation rate requirement. Florida True Health submitted a CAP addressing the participation ratio, which AHCA accepted on February 20, 2014. The sanction did not result in an administrative proceeding or litigation.

Organization: AmeriHealth Caritas of Louisiana

Regulatory Agency: Louisiana Department of Health and Hospitals (LADHH), Medicaid

Sanctions

1. In May 2013, monetary penalties were assessed against AmeriHealth Caritas Louisiana by the LADHH for non-compliance with contract requirements. A total of $170,000 was assessed for failure to meet pharmacy encounter claims submission requirements and $240,000 was assessed for failure to meet encounter data submission requirements. These sanctions did not result in an administrative proceeding or litigation.

Letters of deficiency issued by or corrective actions requested or required by any federal or state regulatory entity within the last five years

The following describes instances where AmeriHealth Caritas Iowa, Inc., its parent organization, affiliates, or subsidiaries were notified of being non-compliant with a publicly funded managed care contract.

Medicaid/CHIP

Organization Trade Name: AmeriHealth Caritas Pennsylvania (AmeriHealth Caritas Pennsylvania) / AmeriHealth Northeast (AmeriHealth Northeast) / Keystone First (Keystone First)

AmeriHealth Caritas operates its Pennsylvania Medicaid plans (AmeriHealth Caritas Health Plan, AmeriHealth Northeast and Keystone First) pursuant to the contract between the Pennsylvania Department of Human Services (PADHS) and Vista Health Plan, Inc. (Vista). Vista is an indirect subsidiary of Independence Health Group, Inc., which is AmeriHealth Caritas' parent company. Vista is also subject to regulatory oversight by the Pennsylvania Department of Health for these Pennsylvania Medicaid plans.

Regulatory Agency: Pennsylvania Department of Human Services (PADHS) / Pennsylvania Department of Health (PADOH), Medicaid

Letters of Deficiency / Corrective Action Plans (CAP)

1. February 2010. PADHS issued a CAP related to ensuring that expedited Member Grievance decisions are consistently made within required timeframes. The plans identified and addressed weekend and holiday staffing issues and implemented an on-call system to ensure weekend and holiday staffing for expedited grievances. PADHS approved the plans' response and closed the CAP on February 23, 2011, without imposing sanctions.
2. In November 2010, the PADHS requested a CAP as a result of a reportable privacy breach that occurred earlier in the year when a thumb drive containing protected health information (PHI) of members was lost. The CAP required AmeriHealth Caritas Pennsylvania and Keystone First to address the following areas: 1) implementation of encryption software; 2) information security protocols; 3) policies and procedures regarding the use of removable media, the collection of PHI at community events, and notification of PHI breaches; 4) HIPAA training; 5) monitoring of utilization by affected members to detect fraud, waste, and abuse; and 6) the logistics of member notifications, call center processes, and the handling of complaints stemming from the breach.

AmeriHealth Caritas Pennsylvania and Keystone First comprehensively responded to all items addressed in the CAP. This CAP was closed by the PADHS as of June 23, 2011. No financial sanctions were imposed.

3. August 19, 2013. PADHS requested a CAP stemming from an October 2012 on-site review of the plans' Program Integrity efforts. On October 3, 2013, AmeriHealth Caritas Pennsylvania and Keystone First submitted a response to items that scored below standard; and PADHS closed the CAP on March 20, 2014, indicating that all requests had been satisfied. No financial sanctions were imposed and the CAP did not result in an administrative proceeding or litigation.
4. On October 1, 2013, PADHS requested a CAP regarding timeliness, accuracy, and completeness of encounter data. AmeriHealth Caritas Pennsylvania and Keystone First submitted the response on October 31, 2013, which was accepted by PADHS on November 21, 2013. This CAP was closed on July 1, 2014. No financial sanctions were imposed and the CAP did not result in an administrative proceeding or litigation.
5. February 6, 2014. PADHS issued a CAP arising from issues related to the health plans' dental subcontractor. The issues identified included inaccurate eligibility and MCO membership information; unclear, incomplete, unpublished, or not appropriately reviewed and approved denial standards and criteria; inappropriate denials; insufficient access to specialty dental care; and insufficient education and outreach regarding the denial notification and appeals process. The CAP responses were timely submitted and accepted by PADHS, who closed this CAP on September 9, 2014. No financial sanctions were imposed and the CAP did not result in an administrative proceeding or litigation.
6. In April 2014, the PADOH issued a CAP stemming from the plans' missing PADOH regulatory timeframes for the external Grievance process. PADOH requested that AmeriHealth Caritas Pennsylvania and Keystone First review the processes involved to ensure timely notification to PADOH of all external Grievance requests. PADOH continues to monitor performance on a quarterly basis. No financial sanctions were imposed and the CAP did not result in an administrative proceeding or litigation.

Organization: Florida True Health

Regulatory Agency: Florida Agency for Health Care Administration (AHCA), Medicaid

Letters of Deficiency / Corrective Action Plans (CAP)

1. April 2014. This CAP stemmed from the inaccurate submission of encounter data. The plan's corrective actions, which resulted from a cross-functional problem-solving approach, resulted in improved statistics in encounter submission statistics. While the CAP remains open, AHCA did not impose financial sanctions, and the CAP did not result in an administrative proceeding or litigation.

Organization: AmeriHealth Nebraska d.b.a. Arbor Health Plan

Regulatory Agency: Nebraska Department of Health & Human Services (NEDHHS), Medicaid

Letters of Deficiency / Corrective Action Plans (CAP)

1. In January 2014, NEDHHS issued a corrective action plan (CAP) in response to AmeriHealth Nebraska's negative net income for state fiscal year 2013. AmeriHealth Nebraska received a capital contribution from AmeriHealth Caritas to reinforce its financial position, and addressed other elements contributing to financial under-performance; and NEDHHS approved closure of the CAP in September 2014.
2. In April 2015, NEDHHS issued a CAP to Arbor Health Plan in response to issues related to the encounter submission process. AmeriHealth Nebraska submitted a response to the CAP on May 1,

2015. AmeriHealth Nebraska does not expect the CAP to result in an administrative proceeding or litigation.

Organization: AmeriHealth Caritas of Louisiana

Regulatory Agency: Louisiana Department of Health and Hospitals (LADHH), Medicaid

Letters of Deficiency / Corrective Action Plans (CAP)

1. In January 2013, AmeriHealth Caritas Louisiana received a Notice of Deficiency for failure to timely submit a TPL batch file submission. The deficiency was cured within the timeframe requested by the LADHH and no sanctions were imposed. The notice did not result in an administrative proceeding or litigation.
2. In October 2013, AmeriHealth Caritas Louisiana received a request for a CAP outlining the process AmeriHealth Caritas Louisiana would follow to improve the quality and completeness of its Cash Disbursement Journal (CDJ) and Supplemental Paid Date (SPD) files. AmeriHealth Caritas Louisiana submitted a CAP, and the steps outlined within were completed by the agreed upon due date; therefore, the CAP was closed with no monetary penalties imposed. It did not result in an administrative proceeding or litigation.
3. In February 2015, AmeriHealth Caritas Louisiana, and all health plans within the Bayou Health System, received a CAP regarding non-compliance with the Wells stipulation for a denial/partial denial notice issued by a contractor. In March, AmeriHealth Caritas Louisiana submitted a CAP and timeline to address the deficiencies found in its sample denial notices.

Medicare

Regulatory Agency: Centers for Medicare & Medicaid Services (CMS)

Sanctions

QCC Insurance Company ("QCC"), Keystone Health Plan East, Inc. and AmeriHealth HMO, Inc. ("AmeriHealth"). In 2014, QCC, Keystone Health Plan East, and AmeriHealth paid to CMS a combined civil monetary penalty in the amount of $50,000, imposed on QCC, Keystone Health Plan East, and AmeriHealth as a result of incorrect processing of enrollments and dis-enrollments in accordance with CMS requirements.

KHPE. Keystone Health Plan East. In October 2013, KHPE paid to CMS a civil monetary penalty of $47,945 as a result of listing the incorrect Part D prescription drug deductible on a 2013 Annual Notice of Change sent to certain Medicare Advantage Members.

QCC, AmeriHealth and KHPE are all subsidiaries of AmeriHealth Caritas Iowa's parent company Independence Health Group. AmeriHealth Caritas has not been the subject of a CMS sanction; but certain of AmeriHealth Caritas Iowa's affiliates have received CMS notices of non-compliance as detailed in the following:

CMS Notice of Non-Compliance

None of the following resulted in an administrative proceeding or litigation by CMS; nor did CMS impose a corrective action plan or financial sanctions for any of the following.

1. **Vista Health Plan, Inc.** (Vista is the plan sponsor of the Medicare dual-eligible special needs plans (D-SNPs) operated as Keystone VIP Choice and AmeriHealth VIP Care in Pennsylvania.)
   A. 2/4/13 - failure to adhere to upload requirements for scheduled marketing events.
   B. 7/3/13 - Inaccurate annual notice of change/evidence of coverage (ANOC/EOC) for calendar year 2013 (errata sheet to correct a typographical error).
   C. 2/14/14 - Prompt pay violation (network pharmacies paid late).
   D. 2/18/14 - failure to comply with the less than 5 percent Part C disconnect rate requirement.
   E. 8/8/14 - late submission of agent/broker compensation data.
   F. 12/11/14 - Part D drug coverage non-compliance (Cialis).
2. **Select Health of South Carolina, Inc.** (plan sponsor of the Medicare dual-eligible special needs plan (D-SNP) operated as First Choice VIP Care in South Carolina).
   A. 2/4/13 - failure to adhere to upload requirements for scheduled marketing events.
   B. 7/3/13 - Inaccurate annual notice of change/evidence of coverage (ANOC/EOC) for calendar year 2013 (errata sheet to correct a typographical error).
   C. 12/3/13 - Incomplete/inaccurate bid submission, related to incorrect pre-authorization requirements for outpatient diagnostic/therapeutic radiologic services).
   D. 2/14/14 - Prompt pay violation (network pharmacies paid late).
   E. 2/18/14 - failure to comply with the less than 5 percent Part C disconnect rate requirement.
   F. 8/8/14 - late submission of agent/broker compensation data.
3. **AmeriHealth Caritas Louisiana, Inc.** (plan sponsor of the Medicare Advantage plan and the Medicare dual-eligible special needs plan (D-SNP) operated, respectively , as AmeriHealth VIP Care and AmeriHealth VIP Select in Louisiana).
   A. 2/3/13 - Incomplete/inaccurate bid submission regarding preferred DME vendors/manufacturers.
   B. 2/19/14 - Incorrect formulary filed with CMS prior to bid submission, deemed by CMS to be non-compliance with bid instructions.
4. **AmeriHealth District of Columbia, Inc.** (plan sponsor of the Medicare Advantage plan and the Medicare dual-eligible special needs plan (D-SNP) operated, respectively, as AmeriHealth VIP Care and AmeriHealth VIP Select in the District of Columbia).
   A. 2/19/14 - Incorrect formulary filed with CMS prior to bid submission, deemed by CMS to be non-compliance with bid instructions.
5. **AmeriHealth Michigan, Inc.** (plan sponsor of the Medicare-Medicaid Plan under the dual demonstration program, operated as AmeriHealth Caritas VIP Care Plus, in Michigan).
   A. 8/8/14 - late submission of agent/broker compensation data.

3.2.7.4.3 Description of all contracts and projects currently undertaken by the bidder

There are no active contracts currently undertaken by AmeriHealth Caritas Iowa, Inc. The full list of contracts and descriptions currently undertaken by AmeriHealth Caritas is provided in the table in 3.2.7.4.2. The active contracts and projects are:

- AmeriHealth Caritas Pennsylvania.
- AmeriHealth District of Columbia.

- AmeriHealth Caritas Louisiana.
- AmeriHealth Northeast (Pennsylvania).
- Arbor Health Plan (Nebraska).
- Select Health of South Carolina.
- Keystone First (Pennsylvania).
- PerformCare Pennsylvania
  - Capital Area HealthChoices.
  - Franklin-Fulton HealthChoices.
  - Bedford-Somerset HealthChoices.
- PerformCare New Jersey (Children's System of Care).
- AmeriHealth Caritas VIP (Pennsylvania): Dual Eligible Special Need Medicare Advantage plan.
- Keystone VIP Choice (Pennsylvania): Dual Eligible Special Need Medicare Advantage plan.
- AmeriHealth VIP Care Plus (Michigan): Medicare-Medicaid plan.
- First Choice VIP Care Plus (South Carolina): Medicare-Medicaid plan.

3.2.7.5 Select Attachments

The following are attached to support our response:

- EQRO Report: Select Health of South Carolina.
- Implementation plan.
- HEDIS scores.
- Provider contract agreement templates
  - Hospital,
  - Physician.
  - Ancillary services.

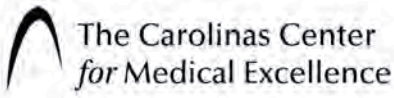
EQRO Report: Select Health of South Carolina

The State of South Carolina
Department of Health and Human Services

Select Health of South Carolina

2013 External Quality Review

FEBRUARY 28, 2014



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Attachment 1: Initial Notice, Materials Requested for Desk Review
Attachment 2: Materials Requested for Onsite Review
Attachment 3: EQR Validation Worksheets
Attachment 4: Tabular Spreadsheet

Executive Summary

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations to evaluate their compliance with the state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. The following report contains a description of the process and the results of the 2013 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS). The purpose of this review was to determine the level of performance demonstrated by Select Health of South Carolina (Select Health) since the EQR was completed in 2012.

Goals of the review were:

- To determine if Select Health was in compliance with service delivery as mandated in the Managed Care Organization (MCO) contract with SCDHHS.
- To evaluate the status of deficiencies identified during the 2012 annual review and any ongoing actions taken to remedy those deficiencies.
- To provide feedback for potential areas of further improvement. The overriding goal of the annual EQR process is to assure that contracted health care services are actually being delivered and are of good quality.

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid Managed Care Organization. The review included a desk review of documents, a three-day onsite visit to the Select Health office, validation of performance improvement projects, and validation of performance improvement measures.

Findings

The findings of the 2013 EQR showed an overall reduction in Met scores of 7.69 percent and Partially Met scores increased by 8.25 percent over the prior year. Some of the deficiencies were in the areas of credentialing and recredentialing, utilization decisions, delegation, and timeliness of grievance resolutions. Also, Select Health did not fully implement the quality improvement plan which addressed the deficiencies identified during the previous EQR. As a result, the standard for addressing or correcting any of the previously identified deficiencies received a Not Met score.

STRENGTHS

Strengths of Select Health's performance at the time of this review include the following:

- Select Health is currently staffing a new Regulatory Affairs and Compliance department that will be located in SC.
- Select Health has a solid disaster recovery plan and testing regimen.

- AmeriHealth has contracted with a third party firm to conduct ethical hacking of its systems. This is an excellent practice and should be continued.
- Select Health measures specialty care providers as within 30 miles for urban/suburban areas and within 50 miles for rural areas. The state only requires specialists to be available within 50 miles.
- The Credentialing Committee has four network providers that have been long-standing members of the committee.
- Select Health has extensive training available for providers. A provider education consultant conducts educational seminars in various regions of the state. Provider-specific HEDIS trainings are conducted and account executives frequently visit provider offices to conduct ongoing education.
- The Call Center is responsible for contacting new members for telephone orientation. The call script for this process is comprehensive and includes an explanation of benefits and services provided by Select Health.
- Call Center statistics continually meet or exceed goals for abandonment rate and speed of answer.
- Preventive health guidelines are communicated to members in the Member Handbook, the First Choice website, member newsletters, and targeted mailings. These guidelines are reviewed and approved annually, measured for compliance, and the results conveyed to providers in meaningful ways.
- The grievance process is well documented, acknowledged, and investigated as required. The newly created Member Advocate role supports and assists members through the grievance process as needed. Select Health evaluates grievances twice a year, which enables early identification of trends or issues.
- Select Health has committed to multiple performance improvement projects and has identified member satisfaction as a concern. They are currently tracking progress through a member satisfaction performance improvement project.
- NCQA-certified software is used for HEDIS® calculations.
- Documentation indicates that very detailed explanations are given to members when a verbal request for an appeal is received, including basic appeal requirements, processes, and timelines; offers of assistance; and explanation that a written appeal will be mailed for the member to complete and return to the plan.
- Select Health demonstrates excellent turnaround times when processing authorization and appeal requests.
- The appeals information in the annual Grievances and Appeal Summary is thorough and includes a detailed appeals analysis, including the percentage of change in the number of appeals as well as specific opportunities for improvement and interventions.

WEAKNESSES

Weaknesses identified included:

- The credentialing policy file names received in the desk materials and the Master List of Policies Index did not include the new policy number prefix naming convention (QI 210).
- Some policies still referred to the old policy number prefix naming convention when making references to a policy (e.g., Policy NM 159.101 references policy QI (CR) 205.100.)
- Policy CR 210.100, Health Care Professional Credentialing and Re-credentialing, references ownership disclosure form 1513 on page 11 but should reference form 1514.
- All of the credentialing/recredentialing policies, the 2013 Credentials Program document, and the Provider Manual have the following issues:

  - References the Healthcare Integrity Protection Data Bank (HIPDB) which was merged into the National Practitioner Data Bank (NPDB) on May 6, 2013. The HIPDB references should be removed.
  - References to the Excluded Parties List System (EPLS) should be replaced with the System for Award Management (SAM). The EPLS records were moved to SAM and the old EPLS was phased out in 2012.
- The 2013 Credentials Program document had some information that should be corrected.
- Credentialing and/or recredentialing files reviewed onsite lacked the following information:
  - The SCDHHS specified ownership disclosure form.
  - A copy of the original signed attestation statement. The CAQH electronic signature page that shows the provider re-attested is acceptable to use as long as a copy of the original signed attestation is in the file.
  - Proof that queries of the SAM, formerly EPLS, and the SC Excluded Providers List have been performed.
  - A copy of the CLIA certificate or waiver when the application indicates that laboratory services are being performed.
  - Proof of an office site visit was not in the credentialing files.
- Policy CR 210.107, Actions and Reporting Against Health Care Professional/Provider for Quality, references a retired policy and mentions the HIPDB in several places.
- The Total Quality Management Committee which is now called the Quality Assessment Performance Improvement Committee was incorrectly referenced in policies NM 159.204, Availability of Services, and NM 159.203, Accessibility of Services, and the Provider Manual, page 10.
- Several issues were identified in the Provider Manual that should be corrected or updated.
- Policy PNO 170.406, Informal Provider Disputes, does not state a timeframe for filing informal disputes, but the Provider Manual and the Provider Kit state a 90 calendar day timeframe.
- Select Health does not address in policy MED (UM) 150.314, Continuity of Care, or any other policy, how they monitor continuity and coordination of care between PCPs and other providers.
- The Member Handbook does not include complete coverage information or inform the member that materials are available in alternate formats, upon request.
- Correct the language on page 15 of the Member Handbook removing the requirement for a member, relative, or friend to call the plan following an emergency room visit that results in hospitalization.
- Coverage information in the Member Services Training Manual is not correct.
- The websites co-payment grid for outpatient hospital services (Spanish version) contains an error.
- No policy was found which explains how members and providers obtain specialty and referral care.
- The member is not informed of Select Health's service area.
- Several grievance files reviewed were not completed in a timely fashion.
- One possible Quality of Care grievance was not reviewed by a physician.
- Items with a status of "ongoing" were not carried over to the new Quality Improvement work plan.
- Discrepancies were noted in documentation of the number of members of the QAPI Committee and in which members of the QAPI Committee have voting rights.

- Attendance is not accurately documented in the minutes for QAPI Committee meetings and several members of the QAPI Committee were listed as guests in the attendance documentation.
- Although the frequency of QAPI meetings held in 2013 was compliant, the 2013 QAPI Program Description lists a possible frequency for meetings that falls short of the quarterly requirement.
- Two of the performance improvement projects validated did not demonstrate sustained improvement.
- Inconsistencies were noted in the documentation of criteria used for medical necessity determinations.
- Multiple issues were identified with Select Health's documentation of processes and requirements for timeliness of UM determinations, notifications, and use of extensions.
- Onsite review of denial files confirmed that in some instances, incorrect criteria was used for medical necessity review. Also, denial rationales documented in notice of action letters were inappropriate and inconsistent with the clinical information submitted and/or the type of request received.
- Select Health no longer operates under the ethical limitations section of the SCDHHS MCO Contract, yet they have no policy/procedure regarding coverage of and claims filing requirements for hysterectomies, sterilizations, and abortions.
- Incorrect and/or inadequate documentation of Select Health's inter-rater reliability (IRR) auditing processes were noted.
- Issues were noted with the appeals processes, including discrepancies in whether consent is needed for a representative to act on a member's behalf for a plan-level appeal, and documentation of incorrect timeframes for requesting a State Fair Hearing and continuation of benefits pending an appeal or State Fair Hearing.
- The sample delegated contract received in the desk materials was dated 8-24-11 and credentialing/recredentialing responsibilities did not appear to address South Carolina specific requirements such as collecting the ownership disclosure form 1514, query of the SC Excluded Provider's List, CLIA certificate/waiver when laboratory services are being performed, or guidelines for NPs acting as PCPs. In addition, the contract specifies verification of sanctions by Medicare/Medicaid but does not spell out what queries are to be performed
- Evidence of oversight monitoring was presented for the delegated entities; however, the monitoring tool does not appear to address the SC specific credentialing/recredentialing criteria and all the required queries.
- Several issues identified as deficiencies on the previous EQR were not corrected.

Comparative Data

A comparison review of the scored standards by review category for the previous EQR conducted by CCME in 2012 with the current review results is shown in the table that follows.

TABLE 1

	MET	PARTIALLY MET	NOT MET	NOT EVALUATED	TOTAL STANDARDS
Administration					
2012	17	0	0	0	17
2013	17	0	0	0	17
Provider Services					
2012	62	1	4	0	67
2013	51	13	3	0	67
Member Services					
2012	36	1	0	0	37
2013	34	3	0	0	37
Quality Improvement					
2012	15	0	0	0	15
2013	12	3	0	0	15
Utilization Management					
2012	31	7	1	0	39
2013	32	5	2	0	39
Delegation					
2012	0	2	0	0	2
2013	0	2	0	0	2
State-Mandated Services					
2012	3	0	2	0	5
2013	4	0	1	0	5

Recommendations for Improvement

CCME made the following recommendations that Select Health should implement to improve their processes and comply with state and federal requirements.

- Update the Master List of Policies Index and credentialing file names to reflect the updated naming convention (QI 210) that is listed in each credentialing policy. Also, update any policies

that reference other policies using the old naming convention (e.g., Policy NM 159.101 references policy QI (CR) 205.100).

- Update all the credentialing/recredentialing policies, the 2013 Credentials Program document, and the Provider Manual to remove references to the Healthcare Integrity Protection Data Bank (HIPDB), and references to the Excluded Parties List System (EPLS) should be replaced with the System for Award Management (SAM).
- Correct page 11 of policy CR 210.100, Health Care Professional Credentialing and Re-credentialing, to reflect the correct ownership disclosure form (#1514).
- Correct the issues identified in the 2013 Credentials Program document.
- Add Dr. Kirt Caton (new member) to the list of Credentialing Committee members and also designate who has voting privileges on that list.
- Ensure that credentialing/recredentialing files include the following:
  - The SCDHHS specified ownership disclosure form.
  - A copy of the original signed attestation statement. The CAQH electronic signature page that shows the provider re-attested is acceptable to use as long as a copy of the original signed attestation is in the file.
  - Proof that queries of the SAM, formerly EPLS, and the SC Excluded Providers List have been performed.
  - A copy of the CLIA certificate or waiver when the application indicates that laboratory services are being performed.
- Credentialing files for PCPs and OB/GYNs acting as PCPs must contain a copy of the office site visit and made available for the credentialing committee decision, if applicable. Correct the issues identified in policy CR 210.107, Actions and Reporting Against Health Care Professional/Provider for Quality.
- Update policy CR 210.103, Hospital & Ancillary Provider Credentialing and Recredentialing, to remove references to the HIPDB and change the EPLS references to reflect the SAM.
- Update policies NM 159.204, Availability of Services, and NM 159.203, Accessibility of Services, as well as the Provider Manual to include the correct committee reference.
- Correct the Provider Manual to address the other identified issues.
- Address the discrepancy between policy PNO 170.406, the Provider Manual, and the Provider Kit regarding whether providers have 90 days to file an informal dispute. Update documents to reflect consistent information.
- Update the Provider Manual to include all medical record documentation standards that are specified in policy QI 205.009.
- Update policy MED (UM) 150.314, Continuity of Care, or another policy to address how Select Health monitors continuity and coordination of care between PCPs and other providers.
- Update the Member Handbook as follows:
  - Include coverage information for members regarding non-elective, medically necessary hysterectomies; outpatient pediatric aids clinics, and preventive and rehabilitative services for primary care.
  - Correct the language on page 15 of the Member Handbook regarding hospital admissions following an emergency room visit. Select Health should receive notification from the hospital and cannot require a member, relative, or friend to call.
- Update the Member Services Training Manual as follows:
  - Remove the requirement for prior authorization for family planning services found on page 53.
  - Clarify your coverage for hysterectomies, abortions, mental health and substance abuse treatment.

- Correct the co-payment amount listed on the FirstChoice website for outpatient hospital services, (Spanish version) from $3.30 to $ 3.40.
- Create a policy and procedure, or add to an existing policy, the process members and providers use to obtain specialty/referral care, including when a prior authorization is needed.
- Include a map or description of Select Health's service area in member materials, the Member Handbook, or Provider Directory.
- Inform the member in the Member Handbook that materials can be provided in alternate formats, such as Braille, upon request.
- Remove the reference to an appeals process for grievances from the member grievance and appeals policy.
- Develop a process to monitor the timely resolution of grievances.
- Ensure that any questionable quality of care issues are reviewed by a Select Health physician that has the appropriate clinical expertise in accordance with Select Health's policy 154.300, Review of Potential Quality of Care Concerns and *Federal Regulation § 438.406 (a) (3) (ii) (C).*
- Ensure that newly-created work plans contain all applicable "ongoing" items from the previous year's work plans.
- Update the Quality Assurance Performance Improvement (QAPI) Program Description to reflect a correct listing of members for the QAPI Committee. Update all applicable documents to indicate which members of the committee have voting rights.
- Update the QAPI Committee meeting frequency requirement in the 2013 QAPI Program Description to be compliant with the *SCDHHS MCO P&P Guide, Section 13.0.*
- Develop a process to accurately document QAPI Committee member attendance. Non-voting members of the committee should not be listed as guests in the attendance documentation.
- Update the UM Program Description and Provider Manual to include all criteria used for utilization review determinations.
- Update the Determination of Timeliness policy, MED 153.308, with the following:
  - Clarify the policy to indicate that approval notification will not exceed the standard or expedited timeframe allowed by federal and state regulations.
  - Add information to the policy that unless an extension is requested by the member or provider, Select Health must justify the need for the extension to SCDHHS upon request.
  - Add information regarding the two-day extension that can be granted for determinations for inpatient services if requested information is not received.
- Correct the number of days allowed for extensions of expedited authorization determinations in the Member Grievances and Appeals Process policy, MEM 129.101.
- Document the timeframe for notification of adverse determinations in either the Adverse Determinations policy, MED 153.303, or the Determination of Timeliness policy, MED 153.308.
- Correct all applicable documents to indicate that timeframes for determinations of authorization requests begin on the day of the request and not on the day all necessary information is received.
- Include approval information on the approval page of the Integrated UM Program Description.
- Re-educate staff and continue to reinforce the importance of selecting appropriate criteria sets when performing medical necessity reviews.
- Ensure that rationales for denial decisions are appropriate to the patient's condition and the type of request.
- Create a policy and procedure which details the requirements for medical necessity review of, and the requirements for filing claims for, hysterectomies, sterilizations, and abortions.

- Update the UM Inter-rater Reliability Auditing policy, MED 153.306, to contain clear and complete information on the IRR process used for physician reviewers. The benchmark for physician reviewers should be included also.
- Correct the frequency of IRR auditing for non-physician reviewers in the UM Program Description.
- Correct the Provider Manual to indicate that written consent is not required for a representative to act on a member's behalf for an expedited appeal.
- Correct the timeframes for requesting State Fair Hearings and continuation of benefits pending the outcomes of a State Fair Hearing in all the appeal determination letters.
- The delegated contract should include the SC specific credentialing/recredentialing criteria and the plan should ensure all required queries are being performed.
- Update the delegation monitoring tools to reflect the SC specific credentialing/ recredentialing criteria and all the required queries.
- Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.

Background

The Balanced Budget Act of 1997 (BBA) requires that a state which contracts with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) conduct an External Quality Review (EQR) of each entity. In January 2003, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to specify the requirement for external quality reviews of a Medicaid MCO/PIHP. In this final rule, federal regulation requires that external quality reviews include three mandatory activities: validation of performance improvement projects, validation of performance measures, and compliance monitoring. In addition, federal regulations allow states to require optional activities which may include validation of encounter data, administration and validation of member and provider surveys, calculation of additional performance measures, and conduct performance improvement projects and quality of care studies. After completing the required activities, a detailed technical report is submitted to the state. This report describes the data aggregation and analysis and the way in which conclusions were drawn as to the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses; comparative information from previous reviews; recommendations for improvement; and the degree to which the plan has addressed the quality improvement recommendations made during the prior year's review.

Introduction

In July 2009, the South Carolina Department of Health and Human Services (SCDHHS) contracted with The Carolinas Center for Medical Excellence (CCME), an external quality review organization (EQRO), to conduct External Quality Review (EQR) for all Managed Care Organizations and Medical Home Networks participating in the Medicaid Managed Care Program. The purpose of this review was to determine the level of performance demonstrated by Select Health of South Carolina (Select Health) since the EQR completed in 2012.

Goals of the review were:

1. To determine Select Health's compliance with service delivery as mandated in the contract with SCDHHS.
2. To evaluate the status of deficiencies identified during the 2012 EQR.
3. To provide feedback on potential areas for further improvement.

The overriding goal of the annual EQR process is to ensure that contracted health care services are actually being delivered and are of good quality.

Process

The process used by CCME for the EQR activities was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.
On November 18, 2013, CCME sent notification to Select Health that the annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review

and an invitation for a teleconference to allow Select Health to ask questions regarding the EQR process and the desk materials being requested. On November 19th, CCME received an email from Select Health requesting the dates for the annual review be changed. With SCDHHS' approval, the dates were changed.

The review consisted of two segments. The first was a desk review of materials and documents received from Select Health on December 16, 2013 and reviewed in the offices of CCME (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs.

The second segment was an onsite review conducted on February 5th, 6th, and 7th, at the Select Health office located in Charleston, South Carolina. The onsite visit focused on areas not covered in the desk review or needing clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with Select Health's administration and staff; and a review of denial, appeal, utilization approval, case management, credentialing, recredentialing, and grievance files. At the conclusion of the onsite review, an exit conference was held to discuss preliminary evaluation results and to address areas of concern. All interested parties were invited to the entrance and exit conferences.

Findings

The findings of the EQR are summarized below and are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the contract requirements between Select Health and SCDHHS. Strengths and weaknesses are identified where applicable. Areas of review were identified as meeting a standard (Met), acceptable but needing improvement (Partially Met), or failing a standard (Not Met), and are recorded on the tabular spreadsheet. (Attachment 4)

I. ADMINISTRATION

The Administration review focused on the health plan's policies and procedures, staffing, information system, compliance, and confidentiality. Select Health is a part of the AmeriHealth Caritas family of companies which administers benefits for SC Medicaid members under a contract with the SCDHHS. Select Health has developed a comprehensive list of policies which are written and organized in a consistent manner. Policies are reviewed annually and revised as needed.

Organizational charts demonstrate sufficient staff is in place to meet the needs of Select Health members. The Director of Regulatory Affairs and the Compliance Coordinator were noted as open positions on the organizational chart. Onsite discussion revealed that the Director of Regulatory Affairs is a new position that will be located in SC and will report to their Corporate Compliance Officer, Barbara Jones. In the interim, Cindy Helling is functioning as the Director of Regulatory Affairs until staffing for this new department is completed. A compliance committee is in place and meets at regular intervals.

In meeting the contractual standard for claims processing, Select Health has opted to exceed the standard by shortening the timeframe, rather than increasing the processing percentage. This speaks to their confidence in their claims processing operation; specifically, that they can beat the time requirements significantly and regularly. They also do an excellent job of tracking enrollment and demographic data. Select Health has the systems and processes in place to ensure that they can

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Credentialing and Recredentialing	Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load	Met	Not Met
	Query of the National Practitioner Data Bank (NPDB); Health Integrity and Protection Databank (HIPDB); State Board of Examiners by the MCO (for the specific discipline); GSA Excluded Parties List Service	Not Met	Partially Met
	Query for state sanctions and/or license or DEA limitations; State Excluded Provider's Report	Met	Partially Met
	Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures	Met	Not Met
	Requery the National Practitioner Data Bank; Health Integrity and Protection Databank; State Board of Examiners; GSA Excluded Parties List Service	Not Met	Met
	Requery for state sanctions and/or license limitations since the previous credentialing event; State Excluded Provider's Report	Met	Partially Met
	The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues	Met	Partially Met
	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Met	Partially Met
Adequacy of the Provider Network	The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Partially Met
Provider Education	Medical record documentation requirements	Met	Partially Met
	Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Met	Partially Met

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Provider Education	Provider and member grievance and appeal procedures	Met	Partially Met
Continuity of Care	The MCO monitors continuity and coordination of care between the PCPs and other providers	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

PROVIDER ACCESS AND AVAILABILITY STUDY

As a part of the annual EQR process for Select Health, a provider access study was performed focusing on primary care physicians as described in the SCDHHS MCO Policy and Procedure Guide. A list of current providers was given to CCME by the plan, from which a population of 1917 unique PCPs was found. A sample of 325 providers was randomly selected from this population for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access that Select Health members have with the contracted providers.

Calls were successfully answered 51 percent of the time by personnel at the correct practice, which estimates to between 49 and 54 percent for the entire population. For those not answered successfully, 37 percent of the time (estimates to 34 and 39 percent for the entire population) the caller was informed that the physician was no longer at the practice or phone number provided by the plan. Of the successful calls, 73 percent (70, 76) of the providers indicated they specifically accept Select Health. Of those that accept Select Health, 82 percent (78, 85) responded they are accepting new Medicaid patients. When asked about the process for new patients, 46 percent (39, 52) indicated that an application or prescreen was necessary. Twenty-four percent (15, 32) of those with a prescreening process require a medical record review prior to accepting the patient. When the office was asked about the next available routine appointment, 60 percent (56, 65) of the appointment answers met within contract requirements.

STRENGTHS

- Select Health measures specialty care providers as within 30 miles for urban/suburban areas and within 50 miles for rural areas. The state only requires specialists to be available within 50 miles.
- The Credentialing Committee has four network providers that have been long-standing members of the committee.
- Select Health has extensive training available for providers. A provider education consultant conducts educational seminars in various regions of the state. Provider-specific HEDIS trainings are conducted and account executives frequently visit provider offices to conduct ongoing education.

WEAKNESSES

- The policy naming convention for the credentialing policies has been changed since the last EQR. The file names listed in the credentialing folder and the Master List of Policies Index did not match the updated policy numbers. The credentialing policies file name and the Master

List of Policies Index listed the prefix as CR 205. The prefix listed on the policies was CR 210. Also, some policies still referred to the old policy naming convention when making references to other policies (e.g., Policy NM 159.101 references policy QI (CR) 205.100.)

- Policy CR 210.100, Health Care Professional Credentialing and Re-credentialing, references ownership disclosure form 1513 on page 11. It should reference form 1514.
- The following issues were found in the credentialing/recredentialing policies, the 2013 Credentials Program document, and the Provider Manual:
  - References the HIPDB which was merged into the NPDB on May 6, 2013.
  - References to the EPLS. The EPLS records were moved to the SAM and the old EPLS was phased out in 2012.
- The 2013 Credentials Program document had the following issues:
  - Page 8 references ownership disclosure form 1415 when it should reference 1514.
  - Page 22 (#4, 1st bullet) has an incomplete sentence. It should include the wording defined in policy CR 210.102 (page 2, #5) that states, "or may choose to be represented by legal counsel or another person of his/her choice." This is also an issue in the Provider Manual, page 10.
  - Page 24 has outdated information in the delegated entities section as follows: Partners Health Network is no longer a delegated entity; Med-Advantage (CVO) is incorrectly included as a delegate; and the Medical College of Georgia's name has changed to Georgia Health Services University.
- Credentialing and recredentialing files reviewed had the following issues:
  - Two credentialing files reviewed onsite did not contain an ownership disclosure form.
  - The majority of the credentialing and recredentialing files reviewed did not have a copy of the original signed attestation in the file. The files did have the CAQH electronic signature page that shows the provider re-attested; however, the file must also contain a copy of the original attestation statement with the provider's signature.
  - Two credentialing files reviewed onsite did not contain proof that the SAM, formerly EPLS, had been queried.
  - Credentialing and recredentialing files reviewed did not contain evidence that the SC Excluded Providers List was queried. During the onsite visit, Select Health provided a screen print of their system to show that the query is included in their process.
  - Three credentialing files reviewed onsite did not contain the CLIA certificate or waiver even though the application indicated laboratory services were being performed.
- Select Health's policy (NM 159.107) states that office site visits will be conducted for PCPs and OB/GYNs; however, the credentialing files did not contain proof that a site visit had been performed.
- Policy CR 210.107, Actions and Reporting Against Health Care Professional/Provider for Quality, had the following issues:
  - Page 2 references policy QI 205.007, Review of Potential Quality of Care Concerns, which is a retired policy. Onsite discussion confirmed that policy 154-300, Review of Potential Quality of Care Concerns, is the correct policy to reference.
  - Mentions the HIPDB in several places.
- Policy CR 210.103, Hospital & Ancillary Provider Credentialing and Recredentialing, had the following issues:
  - References the HIPDB which was merged into the NPDB on May 6, 2013.
  - References the EPLS. The EPLS records were moved to SAM and the data base was phased out in 2012.

- The Total Quality Management Committee, which is now called the Quality Assessment Performance Improvement Committee, was incorrectly referenced in policies NM 159.204, Availability of Services, and NM 159.203, Accessibility of Services, as well as in the Provider Manual, page 10.
- The following issues were identified in the Provider Manual:
  - Page 34 does not include Substance Abuse Services in the list of covered benefits as specified in the *SCDHHS MCO P&P Guide, Section 10.27*.
  - The Home and Community Based Waiver Services section does not address all of the special needs populations that are specified in the *SCDHHS MCO P&P Guide Section 11.6*. Missing are "Persons enrolled in the Medically Complex Children's waiver" and "Women at or below 185% of federal poverty level for Family Planning Services only".
  - Page 51, Mental Health and Alcohol/Drug Services, is missing "inpatient psychiatric hospital" which is specified in the *SCDHHS MCO P&P Guide, Section 11.1*.
  - Vision Services listed on pages 50 and 52 need to be updated.
  - The Provider Manual specifies the medical record documentation standards but does not include signed and dates consent forms, if applicable as mentioned in policy QI 205.009.
- The Provider Manual, page 21, and the Provider Kit listed on the website state that providers can register an informal dispute either verbally or in writing within 90 calendar days from original denial notification or action; however, policy PNO 170.406, Informal Provider Disputes, does not state a timeframe for filing informal disputes.
- Policy MED (UM) 150.314, Continuity of Care, defines the process for continuity of care for members continuing treatment with a practitioner that has terminated for up to ninety days. Onsite discussion confirmed that Select Health monitors continuity and coordination of care between PCPs and other providers through medical record audits and various processes; however, they are not addressed in this policy.

III. MEMBER SERVICES

The review of Member Services included all policies and procedures; member rights; member training and educational materials; and the handling of grievances, disenrollments and practitioner changes. The Member Services department is available Monday-Friday 8:00 am to 9:00 pm; Saturday and Sunday 8:00 am to 6:00 pm. The Nurse Help Line is available 24/7 and provides support for Member Services after hours. Members have direct access to a representative at PerformCare for behavioral health issues when calling after hours.

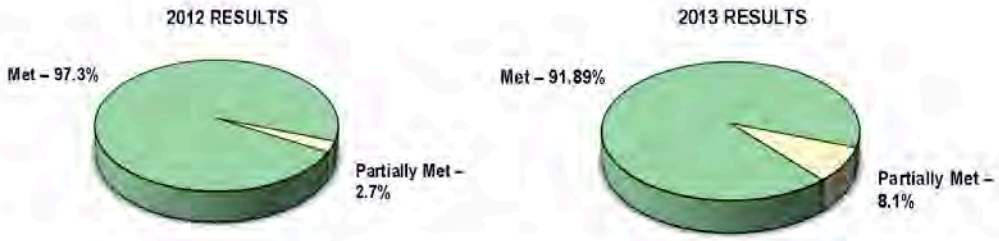
Select Health provides a comprehensive training program for their member services staff. The member services department is responsible for new member orientation calls, and successfully reaches 58 percent of new members to provide an introduction to Select Health services and benefits. In addition, they consistently meet or exceed call center goals for call abandonment rate and average speed of answer.

The First Choice website is easily navigated and provides valuable health information for Select Health members. Members can securely access their personal health information and receive notifications about recommended preventive health screenings.

The grievance logs submitted with the desk materials contained the required elements and sufficient detail about the nature of grievances, investigations, and resolutions. The grievance files reviewed onsite reflected appropriate acknowledgement and investigation; however, some grievances were not resolved within the 90 day timeframe. Resolution letters provide sufficient detail for the member to

understand the steps taken to resolve their grievance. Select Health has taken a proactive approach to grievances by creating a Member Advocate position, whose role is to assist and support members who ask for help with the grievance process.

The charts below show 91.89 percent of the standards received a Met score for Member Services. The Partially Met scores were in the areas of member program education and grievances.



Percents may not total 100% due to rounding.

TABLE 3: MEMBER SERVICES COMPARATIVE DATA

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Member MCO Program Education	Members are informed in writing within 14 business days of enrollment of all benefits to which they are contractually entitled	Met	Partially Met
Grievances	The procedure for filing and handling a grievance	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

STRENGTHS

- The Call Center is responsible for contacting new members for telephone orientation. The call script for this process is comprehensive and includes an explanation of benefits and services provided by Select Health.
- Call Center statistics continually meet or exceed goals for abandonment rate and speed of answer.
- Preventive health guidelines are communicated to members in the Member Handbook, the First Choice website, member newsletters, and targeted mailings. These guidelines are reviewed and approved annually, measured for compliance, and the results conveyed to providers in meaningful ways.
- The grievance process is well documented, acknowledged, and investigated as required. The newly created Member Advocate role supports and assists members through the grievance process as needed. Select Health evaluates grievances twice a year, which enables early identification of trends or issues.

WEAKNESSES

- Issues identified in the Member Handbook are as follows:
  - There is no coverage information for members regarding non-elective, medically necessary hysterectomies; outpatient pediatric aids clinics, or preventive and rehabilitative services for primary care.
  - Page 15 of the Member Handbook regarding a hospital admission following an emergency room visit states the member; a relative, or a friend must call First Choice by the next business day. Select Health should receive notification from the hospital and cannot require a member, relative, or friend to call.
  - Policy COM 220.105, The Production of Vital Documents in Alternative Formats, states that alternate formats available include Braille, large font, and audio tape, among others. This information is not conveyed to the member in the Member Handbook as required by *Federal Regulation § 438.10 (d) (1) (ii) and (2).*
- The following issues were identified in the Member Services Training Manual:
  - Page 53 states non-participating providers must obtain prior authorization for family planning services; however, the Member Handbook page 10 states prior approval is not required.
  - Page 54 describes elective therapeutic abortions in two places on the same page; one paragraph says they are not covered by First Choice and in another paragraph it states they are a covered benefit.
  - Pages 45 and 58 state that mental health, alcohol, and substance abuse treatment services are provided by Medicaid outside of the health plan; however, these services are the responsibility of the health plan.
- A discrepancy was noted in the copayment for outpatient hospital services in the English and Spanish versions of the copayment guide on the First Choice website. The copayment is listed as $3.40 on the English version and $3.30 on the Spanish version.
- No policy and procedure was found that explains the process members or providers use to obtain referrals to in or out of network specialists.
- Member materials do not inform the member of Select Health's service area.
- Several grievance files reviewed onsite were not resolved within the 90 day timeframe. In addition, one grievance file had a questionable quality of care (QOC) issue for care received in a hospital. Select Health forwarded this grievance to the hospital and no review by a medical director or evidence that Select Health followed-up on this grievance was found.

IV. QUALITY IMPROVEMENT

Select Health's Quality Improvement Program provides the infrastructure for continuous monitoring, evaluation, and improvement of care and services rendered to members. The 2013 program description outlines the goals, strategies and processes for the program, and includes a number of data collection activities. Clinical and Service Improvement Goals for 2013 are included in the program description. The Quality Assurance Performance Improvement (QAPI) Committee has the responsibility for planning, designing, implementing, and coordinating all quality improvement activities.

The 2013 Quality Improvement Work Plan includes all required elements. It was noted that some items listed with a status of "ongoing" on the 2012 Quality Improvement Work Plan were not carried over to the 2013 work plan. This was discussed onsite and plan staff indicated this was an oversight. CCME recommended that the work plan be updated to include all quality improvement activities.

Select Health met 80 percent of the standards in the Quality Improvement section. The standards receiving Partially Met scores were related to the QI work plan, the composition of the QAPI Committee, and documentation of the QAPI Committee meeting minutes.

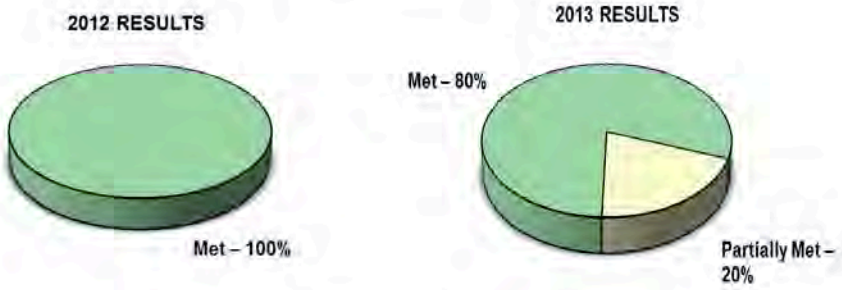


TABLE 4: QUALITY IMPROVEMENT COMPARATIVE DATA

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
The Quality Improvement (QI) Program	An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s)	Met	Partially Met
Quality Improvement Committee	The composition of the QI Committee reflects the membership required by the contract	Met	Partially Met
	Minutes are maintained that document proceedings of the QI Committee	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

CCME conducted a validation review of the performance measures and performance improvement projects (PIP) following the protocols developed by CMS. The health plan received a validation score of *Fully Compliant* for their performance measures and met the CMS validation requirements.

The performance improvement projects included topics for Coordination of Inpatient Care to Postpartum Visit, Follow Up for Children Prescribed ADHD Medication, Appropriate Testing of Children with Pharyngitis, Use of Appropriate Medications for People with Asthma, Post Discharge Follow-up for Members with Asthma Exacerbation, CAHPS QIA for Adults, CAHPS QIA for Child, Comprehensive Diabetes Care, Improving Women's Health, Prenatal /Postpartum Care and Prenatal Outcomes, Well Child Visits, and Performance Measurement for Heart Failure. CCME conducted a validation review for three of the projects submitted. The following table is a summary of the validation scores.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION SCORES

PROJECT	VALIDATION SCORE
Follow Up for Children Prescribed ADHD Medication	72 / 77 = 94% HIGH CONFIDENCE
Improving Women's Health	84 / 96 = 86% CONFIDENCE
Well Child Visits	91 / 96 = 95% HIGH CONFIDENCE

All of the validated projects met the CMS validation protocol requirements. Two received a score within the *High Confidence* range and one received a score within the *Confidence* range. Some of the recommendations for improving the documentation of these studies are listed in the table that follows.

Follow Up for Children Prescribed ADHD Medications		
Section	**Reasoning**	**Recommendation**
Results Presentation	For the Continuation and Maintenance Phase measure, the baseline numerator and denominator do not return the rate presented. The rate, numerator, and/or denominator are incorrect. Correct the numerator and/or denominator for the Continuation and Maintenance Phase measure and update the presented results.	The rate, numerator, and/or denominator are incorrect. Correct the numerator and/or denominator for the Continuation and Maintenance Phase measure and update the presented results.
Improving Women's Health		
Section	**Reasoning**	**Recommendation**
Measure Definition	This project uses three HEDIS measures to track women's health screenings [BCS, CCS, CHL]. BCS has the age range documented differently than the HEDIS Specifications list (42-64 versus 42-69 in the specifications).	For consistency with the HEDIS specifications these references should be fixed.
Results Presentation	For the Cervical Cancer Screening measure – Re-measurement 6, the numerator and denominator do not return the rate presented in the documentation.	Correct the numerator and/or denominator for re-measurement 6 and update the presented results.

Sustained Improvement	Two out of the three measures showed sustained improvement during the time periods documented.	The plan should continue to work on the Chlamydia screening measure to ensure consistent improvement over multiple re-measurement periods.
Well Child Visit		
Section	**Reasoning**	**Recommendation**
Sustained Improvement	None of the project's three measures are showing sustained improvement. This was discussed during the onsite and the interventions were changed for 2013. The plan is now awaiting the 2013 HEDIS results to see if any improvements have been made. CCME recommends that work continue on these measures to see consistent improvement over multiple re-measurement periods.	Work should continue on these measures to see consistent improvement over multiple re-measurement periods.

Details of the validation of the performance measures and performance improvement projects may be found in the *CCME EQR Performance Validation Worksheets, Attachment 3.*

STRENGTHS

- Select Health has committed to multiple performance improvement projects and has identified member satisfaction as a concern. They are currently tracking progress through a member satisfaction performance improvement project.
- NCQA-certified software is used for HEDIS® calculations.

WEAKNESSES

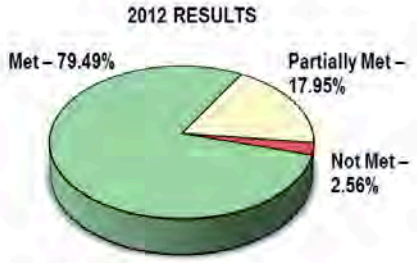
- Items with a status of "ongoing" on the 2012 Quality Work Plan were not carried over to the 2013 Quality Work Plan.
- Documents contained discrepancies in the number of members on the QAPI Committee and inconsistent information on which members have voting rights.
- Attendance is not accurately documented in the minutes for QAPI Committee meetings and several members of the committee were listed as guests in the attendance documentation.
- It was noted that page 11 of the 2013 QAPI Program Description states that the QAPI Committee meets quarterly or at a minimum of 3 times a year. The *SCDHHS MCO P&P Guide, Section 13.0 (2) (g)* requires these meetings to be held at least quarterly.
- Two of the performance improvement projects validated did not demonstrate sustained improvement.

V. UTILIZATION MANAGEMENT

The Utilization Management review included a review of policies, program descriptions, utilization management approval and denial files, case management files, and appeal files. Select Health's Utilization Management (UM) program functions include intake, prior authorization, concurrent review, discharge planning, retrospective review, provider disputes, and member appeals. The Utilization Management Program Description for 2013 details the scope and structure of the UM Program, as well as processes used to evaluate the medical necessity of covered benefits. There were several deficiencies identified in the description, and they are discussed in the weaknesses section that follows.

Files reviewed during the onsite visit were well-documented and demonstrated that utilization and case management activities occur as required. Some of the resolution letters in the appeal files reviewed onsite incorrectly documented the timeframes allowed for requesting State Fair Hearings and for requesting continuation of benefits pending the outcome of an appeal. Requirements for the timeframe for requesting a State Fair Hearing can be found in the *SCDHHS MCO Contract, Section 9.6.5.1*. Requirements for the timeframe for requesting continuation of benefits can be found in *Federal Regulation § 438.420* and in the *SCDHHS MCO Contract, Sections 9.8.1.1* and *9.8.1.2*.

The charts below show that 82.05 percent of the Utilization Management standards were scored as Met. The Partially Met and Not Met scores were related to Select Health's process for timely utilization decisions medical necessity determinations, and appeals



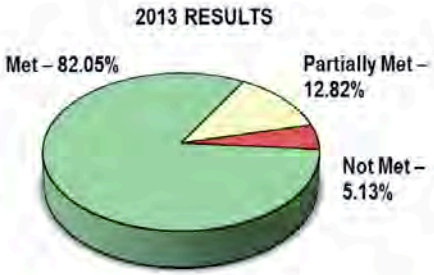


TABLE 5: UTILIZATION MANAGEMENT COMPARATIVE DATA

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program	Partially Met	Met
	Guidelines / standards to be used in making utilization management decisions	Met	Partially Met

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
The Utilization Management (UM) Program	Timeliness of UM decisions, initial notification, and written (or electronic) verification	Partially Met	Not Met
Medical Necessity Determinations	Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations	Partially Met	Met
	Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	Met	Partially Met
	Utilization management standards/criteria are consistently applied to all members across all reviewers	Partially Met	Not Met
	Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Met	Partially Met
Appeals	The definitions of an action and an appeal and who may file an appeal	Met	Partially Met
	The procedure for filing an appeal	Not Met	Met
	Written notice of the appeal resolution as required by the contract	Partially Met	Met
	Other requirements as specified in the contract	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

STRENGTHS

- Documentation indicates that very detailed explanations are given to members when a verbal request for an appeal is received, including basic appeal requirements, processes, and timelines; offers of assistance; and explanation that a written appeal will be mailed for the member to complete and return to the plan.
- Select Health demonstrates excellent turnaround times when processing authorization and appeal requests.
- The appeals information in the annual Grievances and Appeal Summary is thorough and includes a detailed appeals analysis, including the percentage of change in the number of appeals as well as specific opportunities for improvement and interventions.

MCO Contract, Section 9.5.3.3 and Section 9.5.3.7, the timeframe for determinations begins on the day the request is received, not the date of receipt of all information.

- The Integrated UM Program Description 2013 has an approval page (page 2) for documentation of approvals along with corresponding signatures and dates; however, none of the approvals were documented on this page.
- Onsite Utilization Management denial file reviews revealed the following:
  - Several initial medical necessity reviews were performed using incorrect InterQual criteria sets.
  - Some denial rationales documented in the notice of action letters didn't match the patient's clinical information and/or the criteria used for the medical necessity review.
- Select Health has no policy and procedure that addresses requirements for medical necessity review of, or claims filing requirements for, hysterectomies, sterilizations, and abortions. SCDHHS has very specific requirements for these services as defined in the *SCDHHS MCO P&P Guide, Section 10.12*.
- Incorrect and/or inadequate documentation of Select Health's inter-rater reliability (IRR) auditing processes were noted in the following:
  - The Integrated UM Program Description states on pages 17 and 19 that UM staff (non-physician) involved in medical necessity decisions are assessed for consistent application of criteria twice a year. Policy MED 153.306, Utilization Management Inter-rater Reliability Auditing, documents that IRR auditing is performed on clinical care reviewers on a quarterly basis. Onsite discussion confirmed that IRR auditing is performed on non-physician reviewers quarterly. Incorrect documentation of the frequency of IRR auditing was identified as a deficiency on the previous EQR and has not been corrected.
  - Policy MED 153.306, Utilization Management Inter-rater Reliability Auditing, does not provide adequate information on the IRR auditing process for physician reviewers, and no benchmark for physician reviewers is documented.
- Issues identified regarding Select Health's appeals processes include:
  - The Provider Manual states that for expedited appeals, written consent to act as a member's representative is required. Onsite discussion confirmed that as of August, 2013, no written consent is required for another person to act as a member's representative for plan-level appeals.
  - The timeframes for requesting a State Fair Hearing and for requesting that benefits continue pending the outcome of a State Fair Hearing were documented incorrectly in some of the appeal determination letters found in files reviewed onsite.

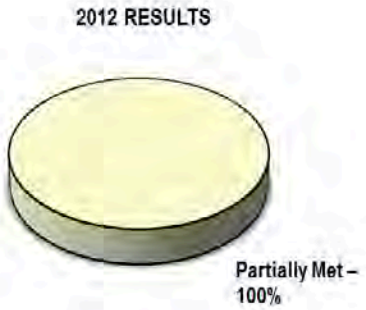
VI. DELEGATION

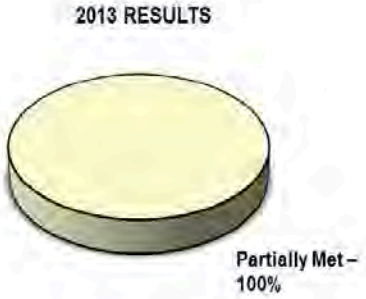
Select Health has delegated contracts with the following entities for credentialing and recredentialing: Health Network Solutions (HNS), Medical University of South Carolina (MUSC), St. Francis Physician Services (SFPS), Regional Health Plus (RHP), Memorial Health Partners (MHP), Georgia Health Sciences University and Greenville Hospital System (GHS). The sample delegated contract received in the desk materials was dated 8-24-11 and credentialing/recredentialing responsibilities did not appear to address South Carolina specific requirements such as collecting the ownership disclosure form 1514, query of the SC Excluded Provider's List, CLIA certificate/waiver when laboratory services are being performed, or guidelines for NPs acting as PCPs. In addition, the contract specifies verification of sanctions by Medicare/Medicaid but does not spell out what queries are to be performed.

Evidence of oversight monitoring was presented for the delegated entities; however, the monitoring tool does not appear to address the SC specific credentialing/recredentialing criteria. Oversight monitoring is performed on an annual basis. In the previous EQR it was noted that both MUSC and MHP have sub-delegates that are not accredited as required by the State. This issue is being held as "tabled with no action required" in the Credentialing Committee minutes. Onsite discussion confirmed that Select Health is awaiting clarification from the State regarding this issue.

Select Health contracts with Med-Advantage, an NCQA certified credentialing verification organization (CVO). While Select Health has a delegated contract with Med-Advantage, onsite discussion confirmed that no credentialing functions are delegated to this company. Med-Advantage provides access to a database that Select Health utilizes to verify education. Select Health has indicated they are considering changing the delegated contract with Med-Advantage to one that does not indicate the services they are providing are delegated.

The two standards in the Delegation section received Partially Met scores due to the aforementioned issues.





WEAKNESSES

- The sample delegated contract received in the desk materials was dated 8-24-11 and credentialing/recredentialing responsibilities did not appear to address South Carolina specific requirements such as collecting the ownership disclosure form 1514, query of the SC Excluded Provider's List, CLIA certificate/waiver when laboratory services are being performed, or guidelines for NPs acting as PCPs. In addition, the contract specifies verification of sanctions by Medicare/Medicaid but does not spell out what queries are to be performed.
- Evidence of oversight monitoring was presented for the delegated entities; however, the monitoring tool does not appear to address the SC specific credentialing/recredentialing criteria and all the required queries.

VII. STATE-MANDATED

Select Health tracks compliance with Well Child/EPSDT visits and immunizations, and provides a summary of the results to providers.

Several deficiencies identified in prior external quality reviews (EQR) have not been corrected. Select Health was informed they needed to include at least the date a site visit was performed

in the credentialing and recredentialing files, if applicable; however, this was not implemented. The timeframes for inter-rater reliability testing in the UM Program Description have not been corrected. In addition, the review of Policy MED 153.308 for the current EQR still lacks the documentation of an extension of the timeframe for initial inpatient authorization review and determination.

One standard is scored as Not Met in the State-Mandated Services section, and is due to uncorrected deficiencies identified in the previous external quality review.

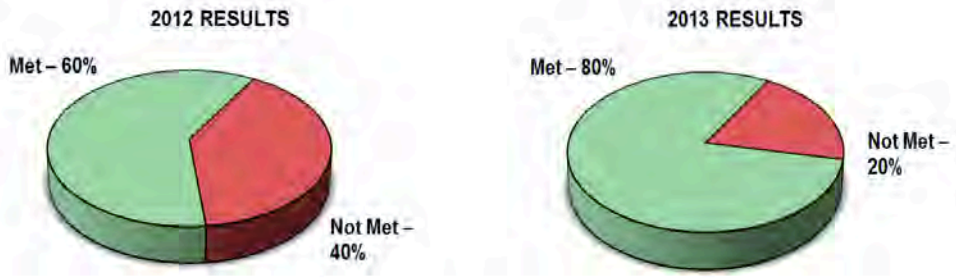


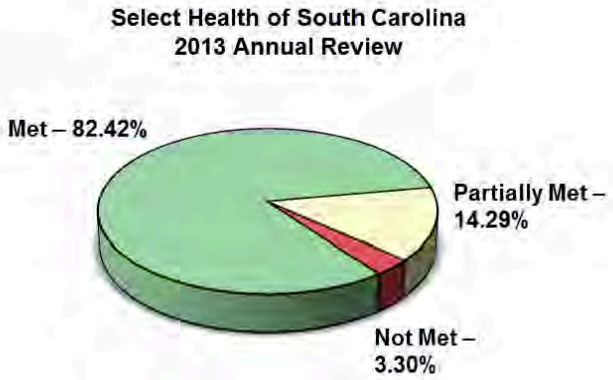
TABLE 6: STATE – MANDATED SERVICES COMPARATIVE DATA

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Core benefits provided by the MCO include all those specified by the contract.	Core benefits provided by the MCO include all those specified by the contract	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

Summary and Recommendations

The findings of the 2013 EQR showed an overall reduction in Met scores of 7.69 percent and Partially Met scores increased by 8.25 percent over the prior year. Deficiencies were in the areas of credentialing and recredentialing, utilization decisions, delegation, and timeliness of grievance resolutions. Select Health did not fully implement the quality improvement plan which addressed the deficiencies identified during the previous EQR. As a result, the standard for addressing or correcting any of the previously identified deficiencies received a Not Met score.



Percents may not total 100% due to rounding

CCME recommends that Select Health implement the following recommendations to improve their processes and comply with all federal regulations and contract requirements.

1. Update the Master List of Policies Index and credentialing file names to reflect the updated naming convention (QI 210) that is listed in each credentialing policy. Also, update any policies that reference other policies using the old naming convention (e.g., Policy NM 159.101 references policy QI (CR) 205.100).

2. Update all the credentialing/recredentialing policies, the 2013 Credentials Program document, and the Provider Manual to remove references to the Healthcare Integrity Protection Data Bank (HIPDB), and references to the Excluded Parties List System (EPLS) should be replaced with the System for Award Management (SAM).

3. Correct page 11 of policy CR 210.100, Health Care Professional Credentialing and Re-credentialing, to reflect the correct ownership disclosure form (#1514).

4. Correct the issues identified in the 2013 Credentials Program document.

5. Add Dr. Kirt Caton (new member) to the list of Credentialing Committee members and also designate who has voting privileges on that list.

6. Ensure that credentialing/recredentialing files include the following:
   a. The SCDHHS specified ownership disclosure form.

b. A copy of the original signed attestation statement. The CAQH electronic signature page that shows the provider re-attested is acceptable to use as long as a copy of the original signed attestation is in the file.
c. Proof that queries of the SAM, formerly EPLS, and the SC Excluded Providers List have been performed.
d. A copy of the CLIA certificate or waiver when the application indicates that laboratory services are being performed.

7. Credentialing files for PCPs and OB/GYNs acting as PCPs must contain a copy of the office site visit and made available for the credentialing committee decision, if applicable.

8. Correct the issues identified in policy CR 210.107, Actions and Reporting Against Health Care Professional/Provider for Quality.

9. Update policy CR 210.103, Hospital & Ancillary Provider Credentialing and Recredentialing, to remove references to the HIPDB and change the EPLS references to reflect the SAM.

10. Update policies NM 159.204, Availability of Services, and NM 159.203, Accessibility of Services, as well as the Provider Manual to include the correct committee reference.

11. Correct the Provider Manual to address the other identified issues.

12. Address the discrepancy between policy PNO 170.406, the Provider Manual, and the Provider Kit regarding whether providers have 90 days to file an informal dispute. Update documents to reflect consistent information.

13. Update the Provider Manual to include all medical record documentation standards that are specified in policy QI 205.009.

14. Update policy MED (UM) 150.314, Continuity of Care, or another policy to address how Select Health monitors continuity and coordination of care between PCPs and other providers.

15. Update the Member Handbook as follows:
    a. Include coverage information for members regarding non-elective, medically necessary hysterectomies; outpatient pediatric aids clinics, and preventive and rehabilitative services for primary care.
    b. Correct the language on page 15 of the Member Handbook regarding hospital admissions following an emergency room visit. Select Health should receive notification from the hospital and cannot require a member, relative, or friend to call.

16. Update the Member Services Training Manual as follows:
    a. Remove the requirement for prior authorization for family planning services found on page 53.
    b. Clarify your coverage for hysterectomies, abortions, mental health and substance abuse treatment.

17. Correct the co-payment amount listed on the FirstChoice website for outpatient hospital services, (Spanish version) from $3.30 to $ 3.40.

18. Create a policy and procedure, or add to an existing policy, the process members and providers use to obtain specialty/referral care, including when a prior authorization is needed.

19. Include a map or description of Select Health's service area in member materials, the Member Handbook, or Provider Directory.

20. Inform the member in the Member Handbook that materials can be provided in alternate formats, such as Braille, upon request.

21. Remove the reference to an appeals process for grievances from the member grievance and appeals policy.

22. Develop a process to monitor the timely resolution of grievances.

23. Ensure that any questionable quality of care issues are reviewed by a Select Health physician that has the appropriate clinical expertise in accordance with Select Health's policy 154.300, Review of Potential Quality of Care Concerns and *Federal Regulation § 438.406 (a) (3) (ii) (C).*

24. Ensure that newly-created work plans contain all applicable "ongoing" items from the previous year's work plans.

25. Update the Quality Assurance Performance Improvement (QAPI) Program Description to reflect a correct listing of members for the QAPI Committee. Update all applicable documents to indicate which members of the committee have voting rights.

26. Update the QAPI Committee meeting frequency requirement in the 2013 QAPI Program Description to be compliant with the *SCDHHS MCO P&P Guide, Section 13.0.*

27. Develop a process to accurately document QAPI Committee member attendance. Non-voting members of the committee should not be listed as guests in the attendance documentation.

28. Update the UM Program Description and Provider Manual to include all criteria used for utilization review determinations.

29. Update the Determination of Timeliness policy, MED 153.308, with the following:
    a. Clarify the policy to indicate that approval notification will not exceed the standard or expedited timeframe allowed by federal and state regulations.
    b. Add information to the policy that unless an extension is requested by the member or provider, Select Health must justify the need for the extension to SCDHHS upon request.
    c. Add information regarding the two-day extension that can be granted for determinations for inpatient services if requested information is not received.

30. Correct the number of days allowed for extensions of expedited authorization determinations in the Member Grievances and Appeals Process policy, MEM 129.101.

31. Document the timeframe for notification of adverse determinations in either the Adverse Determinations policy, MED 153.303, or the Determination of Timeliness policy, MED 153.308.

32. Correct all applicable documents to indicate that timeframes for determinations of authorization requests begin on the day of the request and not on the day all necessary information is received.

33. Include approval information on the approval page of the Integrated UM Program Description.

34. Re-educate staff and continue to reinforce the importance of selecting appropriate criteria sets when performing medical necessity reviews.

35. Ensure that rationales for denial decisions are appropriate to the patient's condition and the type of request.

36. Create a policy and procedure which details the requirements for medical necessity review of, and the requirements for filing claims for, hysterectomies, sterilizations, and abortions.

37. Update the UM Inter-rater Reliability Auditing policy, MED 153.306, to contain clear and complete information on the IRR process used for physician reviewers. The benchmark for physician reviewers should be included also.

38. Correct the frequency of IRR auditing for non-physician reviewers in the UM Program Description.

39. Correct the Provider Manual to indicate that written consent is not required for a representative to act on a member's behalf for an expedited appeal.

40. Correct the timeframes for requesting State Fair Hearings and continuation of benefits pending the outcomes of a State Fair Hearing in all the appeal determination letters.

41. The delegated contract should include the SC specific credentialing/recredentialing criteria and the plan should ensure all required queries are being performed.

42. Update the delegation monitoring tools to reflect the SC specific credentialing/ recredentialing criteria and all the required queries.

43. Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.

The Carolinas Center *for* Medical Excellence

Select Health of South Carolina

2013 External Quality Review

Attachment 1

Initial Notice

February 28, 2014

The Carolinas Center *for* Medical Excellence
246 Stoneridge Drive, Suite 200, Columbia, SC 29210 • 803.212.7500 • 800.922.3089 • www.thecarolinascenter.org

November 18, 2013

Ms. Cindy Helling
Chief Operations Officer
Select Health of South Carolina, Inc.
4390 Belle Oaks Drive, Suite 400
North Charleston, South Carolina 29405

Dear Ms. Helling:

This letter serves as your notification that the annual external quality review of Select Health of South Carolina for 2013 is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with the South Carolina Department of Health and Human Services (SCDHHS) in relation to your organization's administration of a managed care program for Medicaid recipients. The annual EQR is being initiated at this time at the request of SCDHHS. It will include both a desk review at CCME and a multi-day onsite review at the Select Health office in Charleston SC, and will address all contractually required services as well as follow up of any areas of weakness identified during the annual review in 2012. Please note that CCME's review methodology will include the protocols required by the Centers for Medicare and Medicaid Services for the external quality review of Medicaid managed care organizations.

In preparation for the desk review, the items on the enclosed list are due at CCME no later than December 2, 2013. The CCME EQR team plans to conduct the onsite visit on January 15th, 16th, and 17th. To prepare your organization for the upcoming review, we would like to schedule a conference call with your management staff, in conjunction with SCDHHS, to describe our process and answer any questions you may have. Please contact me at (803) 212-7582 with dates your staff will be available for this conference call.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure

cc: SCDHHS

AmeriHealth Caritas Iowa

CARE IS THE HEART OF OUR WORK

The Carolinas Center *for* Medical Excellence

Select Health of South Carolina

2013 External Quality Review

Attachment 1

Materials Requested for Desk Review

February 28, 2014

Select Health of South Carolina

External Quality Review 2013

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet and include the practitioner's name, title (MD, NP, PA etc.), specialty, practice name, address, phone number, counties served, if the provider is accepting new patients, and any age restrictions. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan.

9. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2012 and 2013.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the 2012 annual review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc...).

13. Reports of any Quality of Care Studies completed or planned since the 2012 annual review, if not included in #12 above.

14. Minutes of all committee meetings since the 2012 annual review for all committees reviewing or taking action on Select Health-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

15. Membership lists and a committee matrix for all committees in #14 above, including the professional specialty of any non-staff members. Please indicate which members are voting members.

16. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

17. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

18. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

19. A complete list of all members enrolled in the case management program from January 2013 through September 2013. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

20. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

21. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

22. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract or other documentation of the requested scope of work.

23. A copy of any member and provider newsletters, educational materials and/or other mailings.

24. A copy of the Grievance, Complaint and Appeal logs for the months of October 2012 through October 2013.

25. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

26. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

27. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

29. A list of physicians currently available for utilization consultation/review and their specialty.

30. A copy of the provider handbook or manual.

31. A sample provider contract.

32. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A description of the data security policy with respect to email and PHI.

33. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

34. Sample contract used for delegated entities. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

35. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.
36. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    b. reporting frequency and format;
    c. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD-9/CPT-4 codes, member months/years calculation, other specified parameters);

d. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
e. denominator calculations methodology, including:
    1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the denominator;
f. numerator calculations methodology, including:
    1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the numerator;
g. calculated and reported rates.

These materials:

- **should be organized and submitted on a CD or flash drive (any material not available electronically maybe submitted hardcopy);**
- **should be submitted in the categories listed.**

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The Carolinas Center *for* Medical Excellence

Select Health of South Carolina

2013 External Quality Review

Attachment 2

Materials Requested for Onsite Review

February 28, 2014

Attachment 2

Select Health of South Carolina

External Quality Review 2013

MATERIALS REQUESTED FOR ONSITE REVIEW

Items with an * should be provided as copies that can be retained by CCME.

1. *Copies of all committee minutes for committees that have met since the desk materials were copied.

2. Credentialing files (including signed Ownership Disclosure Forms) for:
   a. Ten PCP's (Include two NP's acting as PCP's, if applicable);
   b. Two OB/GYNs;
   c. Two specialists;
   d. Two network hospitals; and
   e. One file for each additional type of facility in the network.

3. Recredentialing (including signed Ownership Disclosure Forms) files for:
   a. Ten PCP's (Include two NP's acting as PCP's, if applicable);
   b. Two OB/GYNs;
   c. Two specialists;
   d. Two network hospitals; and
   e. One file for each additional type of facility in the network.

4. Grievance and Case Management files for members on the attached list.

5. Documentation of any involuntary disenrollments for cause, including documentation of counseling provided and notices issued.

6. Appeal files for members on the attached list. Please include all information related to the initial denial.

7. All files for requests for State Fair Hearings.

8. Twenty medical necessity denial files made in the months of October 2012 through December 2013. Include any medical information and physician review documentations used in making the denial determination. Please include two behavioral health files and 2 acute inpatient rehabilitation files.

9. Twenty-five utilization approval files (acute care and behavioral health) made in the months of October 2012 through December 2013, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

10. *QAPI Committee minutes for 09/10/13 and 11/14/13.
11. *Copy of the 2013 Credentials Program for Select Health of South Carolina.
12. *Copy of information provided to members about advance directives.
13. *Copy of all new member materials mailed to members. (No need for Provider List or Member Handbook already provided.)
14. *Example of marketing materials for potential members.
15. *Pharmacy Program Description, if available.
16. *Copy of policy QI 205.007, Review of Potential Quality of Care (mentioned in policy CR 210.107)

The Carolinas Center *for* Medical Excellence

Select Health of South Carolina

2013 External Quality Review

Attachment 3

EQR Validation Worksheets

February 28, 2014

Attachment 3

EQR PIP Validation Worksheets

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Select Health
Name of PIP	FOLLOW UP FOR CHILDREN PRESCRIBED ADHD MEDICATION
Validation Period	2013
Review Performed	12/2013

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on research and analysis of enrollee care needs.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	A broad spectrum of enrollee care and services are addressed.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All relevant populations are included.

STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	An appropriate study question was noted in the project documentation.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Project uses both parts of the HEDIS® ADD measure.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measure tracks how successful members are being followed up after being prescribed ADHD medications.
STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Study population was clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Administrative HEDIS measure captured the relevant population.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling used.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Study design clearly specifies data.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Study design describes the sources of the data.

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6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection is consistent.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is provided.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff was used.
STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	While just beginning, reasonable interventions are in place for this project's start.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was performed according to plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	For the Continuation and Maintenance Phase measure, the baseline numerator and denominator do not return the rate presented. The rate, numerator, and / or denominator are incorrect. **RECOMMENDATION** Please update the presented results with the correct information.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Project too young to judge at the time of this review.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	Project too young to judge at the time of this review.

STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Project too young to judge at the time of this review.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Project too young to judge at the time of this review.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Project too young to judge at the time of this review.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Project too young to judge at the time of this review.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Project too young to judge at the time of this review.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	0	NA
5.2	0	NA
5.3	0	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	5
8.3	0	NA
8.4	0	NA
Step 9		
9.1	0	NA
9.2	0	NA
9.3	0	NA
9.4	0	NA
Step 10		
10.1	0	NA

Project Score	72
Project Possible Score	77
Validation Findings	94%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Select Health
Name of PIP	IMPROVING WOMEN'S HEALTH
Validation Period	2013
Review Performed	12/2013

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on research and analysis of enrollee needs.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	A broad spectrum of enrollee care and services are addressed.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All relevant populations are included.

STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	An appropriate study question was noted in the project documentation.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**PARTIALY MET**	This project uses three HEDIS measures to track women's health screenings [BCS, CCS, CHL]. BCS has the age range documented differently than the HEDIS Specifications (42-64 vs 42-69 in the specifications). For consistency with the HEDIS specifications these references should be fixed. **RECOMMENDATION** Update documentation to reflect the correct HEDIS age groups for the breast cancer screening measure
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Project is tracking three health screenings for women.
STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Study population was clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	HEDIS measures captured relevant population.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling used.

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5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling used.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Study design clearly specifies data.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection is consistent.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is provided.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff was used.
STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Reasonable interventions are in place.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was performed according to analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	For the Cervical Cancer Screening measure – Remeasurement 6, the numerator and denominator do not return the rate presented in the documentation. **RECOMMENDATION** Please update the presented results with the correct information.

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Plan documented the changes in guidelines that could impact those that receive the screenings.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	An interpretation of the projects interventions was included in the documentation along with future planned interventions.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Same methodology was used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Both the breast cancer and cervical cancer screening measures showed improvement from last measurement.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Reported improvement is deemed valid.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Project is measuring the plans entire eligible population. Observed improvement is deemed true improvement.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**PARTIALLY MET**	Two out of the three measures in the project are showing sustained improvement during the time periods documented. **RECOMMENDATION** Continue working on the Chlamydia screening to have consistent improvement over multiple remeasurements.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	NA	NA

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	5
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	0	NA
5.2	0	NA
5.3	0	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	5
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	5	3

Project Score	84
Project Possible Score	96
Validation Findings	88%

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AUDIT DESIGNATION
CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Select Health
Name of PIP	WELL CHILD VISITS
Validation Period	2013
Review Performed	12/2013

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on research and analysis of enrollee needs.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	A broad spectrum of enrollee care and services are addressed.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All relevant populations are included.
STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Line Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	An appropriate study question was noted in the project documentation.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Project is using three HEDIS measures (W15, W34, AWC) to track and improve the rate of Well Child visits among its members.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Project is tracking well child visit rates among three age groups.

STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Study population was clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	HEDIS measures captured relevant population.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling used.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Study design clearly specifies data.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection is consistent.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is provided.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff was used.

STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Reasonable interventions are in place.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was performed according to analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Numerical results are presented clearly and accurately.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Plan has noted changes in the accepted guidelines that may impact the measures they are tracking.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	An interpretation of the projects interventions was included in the documentation along with future planned interventions.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Same methodology was used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Plan saw a slight increase from the previous remeasurement for the Adolescent Well Child Visits.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Reported improvement is deemed valid.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Project is measuring the plans entire eligible population. Observed improvement is deemed true improvement.

STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NOT MET**	None of the projects three measures are showing sustained improvement during the time periods reported in the documentation. Plan is aware of this and had some major initiatives in place for 2013. **RECOMMENDATION** Plan is now awaiting the 2013 results to see if those planned initiatives were successful. Continue to work on these measures to see consistent improvement over multiple remeasurement periods.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	0	NA
5.2	0	NA
5.3	0	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	5	0

Project Score	91
Project Possible Score	96
Validation Findings	95%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

EQR PM Validation Worksheets

CCME EQR PM VALIDATION WORKSHEET

Plan Name	Select Health
Name of PM	ALL HEDIS MEASURES
Reporting Year	2013
Review Performed	12/2013

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2013

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	MET	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.
S2. Sampling	Sample treated all measures independently.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.
R2. Reporting	Was the measure reported according to State specifications?	**NA**	NA

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	0	NA	NA
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	0	NA	NA

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

The Carolinas Center *for* Medical Excellence

Select Health of South Carolina

2013 External Quality Review

Attachment 4
Tabular Spreadsheet

February 28, 2014

Select Health of South Carolina
February 28, 2014

MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

Attachment 4

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Select Health has developed a comprehensive list of policies which are written and organized in a consistent manner. Policies are reviewed annually and revised as needed.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						Organizational charts demonstrate sufficient staff is in place to meet the needs of Select Health members.
1.1 A full time administrator of day-to-day business activities;	X					Cindy Helling, Executive Director, is responsible for the day-to-day business activities. She reports to Mike Jernigan, the Southern Region President in the AmeriHealth Caritas Family of Companies.
1.2 Information Systems personnel;	X					Several staff members provide IT support in the Charleston office, but the overall IT support for Select Health is managed out of the Pennsylvania office which is a part of the AmeriHealth Caritas Family of Companies.
1.3 Intake, investigation, resolution, and reporting of member and provider grievances;	X					The call center located in Charleston, SC is responsible for the intake of member and provider grievances.

Select Health of South Carolina
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MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

Attachment 4

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Utilization management functions;	X					There is sufficient staff to carry out utilization management functions including intake, prior authorization, concurrent and behavioral health authorizations and appeals. The Medical Directors' responsibilities include, but are not limited to, review for medical necessity, denials, educating staff and providers, and coordinating external review activities.
1.5 Quality assurance activities;	X					Quality Improvement staff is located in SC. Cindy Capps is the Director of Quality Management and reports to Tina Morton, Director Corporate Clinical Quality.
1.6 Provider credentialing and education;	X					Provider credentialing is conducted in SC within the Quality Management department.
1.7 Member service and education;	X					Kevin Vaughan is the Director of Member Services.
1.8 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					Dr. Fred Volkman is the Regional Chief Medical Officer and Dr. William Burnham is the Senior Medical Director. Dr. Greg Barabell is the SC plan-specific Medical Director.
1.9 A designated compliance officer and a compliance committee that are accountable to senior management and that have effective lines of communication with all the MCO's employees.	X					Barbara Jones is the designated corporate compliance officer. Onsite discussion revealed that Select Health is in the process of staffing a new Regulatory Affairs and Compliance department that will be located in SC. Cindy Helling is currently functioning in the role of the Director of Regulatory Affairs until staffing for this new department is completed. A compliance committee is in place and meets at regular intervals.
2. Operational relationships of MCO staff are clearly delineated.	X					

MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all MCO staff positions.	X					
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					In meeting the contractual standard for claims processing, Select Health has opted to exceed the standard by shortening the timeframe, rather than increasing the processing percentage. This speaks to their confidence in their claims processing operation; specifically, that they can surpass the time requirements significantly and regularly.
2. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Select Health does an excellent job of tracking enrollment and demographic data. They have plotted – for all of the major medical specialties – the locations of the providers and overlaid that with the locations of their members. They can show the driving distance to each type of provider and thus ensure that the members have at least one provider of each type within a 50 mile radius.
3. The MCO management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Select Health has the systems and processes in place to ensure that they can meet state requirements for reporting, quality improvement, and utilization monitoring. They maintain a well-documented system, monitor its performance consistently, and have disaster recovery plans in place to ensure its continued operation.

MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

Attachment 4

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					Select Health, as part of the AmeriHealth Caritas Family of Companies, is able to take advantage of the disaster recovery (DR) capabilities of the parent company, which has a very solid DR plan in place. The plan covers all the key elements needed, lays out requirements for participants in the plan, and specifies the duties each team member is responsible for addressing. The DR plan has been tested in a meaningful way (i.e., the testing has simulated the type of situation that might be encountered in an actual disaster), and perhaps most importantly, the failure of individual aspects of the test have each been examined, investigated, and addressed. Stated another way, they have learned from the exercise – exactly what should happen in a DR test.
I D. Confidentiality						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Select Health has policies and procedures in place that address confidentiality and privacy. Members receive the notice of privacy practices with their enrollment materials and the notice is posted to the Select Health/First Choice website. Employees receive compliance and HIPAA training annually.
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						

MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

Attachment 4

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.		X				The 2013 Credentials Program document and several policies define the procedures for credentialing and recredentialing. The policy number naming convention prefix has been changed on the policies from the previous EQR. The file names for the policies received in the desk materials and the Master List of Policies Index (CR 205) did not match the updated policy numbers on the actual policies (CR 210). Also, some policies still referred to the old policy naming convention when making references to a policy (e.g., Policy NM 159.101 references policy QI (CR) 205.100). Additional issues were identified as follows: • Policy CR 210.100 references ownership disclosure form 1513 on page 11 but should reference form 1514. •All of the credentialing/recredentialing policies, the 2013 Credentials Program document, and the Provider Manual have the following issues: › References the Healthcare Integrity Protection Data Bank (HIPDB), which was merged into the National Practitioner Data Bank (NPDB) on May 6, 2013. The HIPDB references should be removed. › References to the Excluded Parties List System (EPLS) should be replaced with the System for Award Management (SAM). The EPLS records were moved to SAM and the old EPLS was phased out in 2012. • The 2013 Credentials Program document had the following issues: › Page 8 references ownership disclosure form 1415, but should reference 1514. › Page 22 (#4, 1st bullet) has an incomplete sentence. It should include the wording defined in policy CR 210.102 (page 2, #5) that states, "or may choose to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						be represented by legal counsel or another person of his/her choice." This is also an issue in the Provider Manual, page 10. › Page 24 has outdated information in the delegated entities section as follows: PHN is no longer a delegated entity; Med-Advantage (CVO) is incorrectly included as a delegate; and the Medical College of Georgia's name has changed to Georgia Health Services University. *Quality Improvement Plan: Update the issues identified in this standard.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					Dr. James G. Baldwin is the chair of the Credentialing Committee. The committee also includes eight additional voting members; Dr. Fred Volkman, Regional Chief Medical Director; Dr. William Burnham, Regional Medical Director; Dr. Greg Barabell, Medical Director; Dr. Kirt Caton, Medical Director; and four contracted providers that specialize in Pediatrics, OB/GYN and Family Practice. Committee minutes reflect the quorum of 50% was met at each meeting and only physicians have voting privileges. *Recommendation: Add Dr. Kirt Caton (new member) to the list of Credentialing Committee members and designate who has voting privileges on that list.*
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.		X				Credentialing files reviewed onsite were organized but several files lacked appropriate documentation. Two credentialing files reviewed onsite did not contain the ownership disclosure form. Additional issues are discussed below.

Select Health of South Carolina
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MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

Attachment 4

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Credentialing files should contain a copy of the SCDHHS specified ownership disclosure form.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;			X			The majority of the credentialing files reviewed did not have a copy of the original signed attestation in the file. The files did have the CAQH electronic signature page that shows the provider re-attested; however, the file must also contain a copy of the original attestation statement with the provider's signature. *Quality Improvement Plan: Credentialing files must include a copy of the original signed attestation statement. The CAQH electronic signature page that shows the provider re-attested is acceptable to use as long as a copy of the original signed attestation is in the file.*

MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.7 Query of the National Practitioner Data Bank (NPDB); Health Integrity and Protection Databank (HIPDB); State Board of Examiners by the MCO (for the specific discipline); GSA Excluded Parties List Service;		X				Two credentialing files reviewed onsite did not contain proof the SAM, formerly EPLS, had been queried. *Quality Improvement Plan: Credentialing files should include proof that a query of the SAM (formerly EPLS) has been performed.*
3.1.8 Query for state sanctions and/or license or DEA limitations; State Excluded Provider's Report;		X				Credentialing files reviewed did not contain evidence that the SC Excluded Providers List was queried. During the onsite Select Health provided a screen print of their system to show that queries of the SC Excluded Providers List is included in their process. *Quality Improvement Plan: Credentialing files must contain proof that a query of the SC Excluded Providers List has been performed.*
3.1.9 Query for Medicare and/or Medicaid sanctions; OIG List of Excluded Individuals and Entities;	X					
3.1.10 In good standing at the hospital designated by the provider as the primary admitting facility.	X					
3.1.11 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures.		X				Three credentialing files reviewed onsite did not contain the CLIA certificate or waiver even though the application indicated laboratory services were being performed. *Quality Improvement Plan: Credentialing files must contain a copy of the CLIA certificate or waiver when the application indicates that laboratory services are being performed.*

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.			X			Policy NM 159.107, Site Visit, states that site visits are performed in the credentialing of new physician office sites for PCPs and OB/GYNs and when a participating OB/GYN or PCP opens a new office site. Site visits are also performed when a complaint has been lodged against a specific provider for concerns regarding office environment, as explained in policy NM 159.108, Member Quality Of Service Grievance Against a Provider/Practitioner. PCP and OB/GYN credentialing files reviewed onsite did not contain proof that a site visit had been performed. The site visits are conducted and maintained in another department and when the proof of onsite visits was requested, Select Health was only able to provide a few of the site visits. Discussion revealed that the site visit process is not integrated with the credentialing process. A recommendation was made in the previous EQR that the credentialing files should indicate the date a site visit had been performed. *Quality Improvement Plan: Credentialing files for PCPs and OB/GYNs acting as PCPs must contain a copy of the office site visit and made available for the credentialing committee decision, if applicable.*
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Recredentialing files reviewed onsite were organized but several files lacked appropriate documentation as explained below.

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS Certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;			X			The majority of the recredentialing files reviewed did not have a copy of the original signed attestation in the file. The files did have the CAQH electronic signature page that shows the provider re-attested; however, the file must also contain a copy of the original attestation statement with the provider's signature. *Quality Improvement Plan: Recredentialing files must contain a copy of the original signed attestation. The CAQH electronic signature page that shows the provider re-attested is acceptable as long as a copy of the original signed attestation is in the file.*
4.2.6 Requery the National Practitioner Data Bank; Health Integrity and Protection Databank; State Board of Examiners; GSA Excluded Parties List Service;	X					

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.7 Requery for state sanctions and/or license limitations since the previous credentialing event; State Excluded Provider's Report;		X				Recredentialing files reviewed did not contain evidence that the SC Excluded Providers List was queried. During the onsite, Select Health provided a screen print of their system to show that a query of the SC Excluded Providers List is included in their process. *Quality Improvement Plan: Recredentialing files should contain at least the date of the SC Excluded Providers List search to show the query has been performed.*
4.2.8 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities;	X					
4.2.9 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures.	X					
4.3 Site reassessment if the provider location has changed since the previous credentialing activity.	X					Policy NM 159.107, Site Visit, states that site visits are performed in the credentialing of new physician office sites for PCPs and OB/GYNs and when a participating OB/GYN or PCP opens a new office site. Site visits are also performed when a complaint has been lodged against a specific provider for concerns regarding office environment as explained in policy NM 159.108, Member Quality Of Service Grievance Against a Provider/Practitioner. There was no indication in the PCP and OB/GYN recredentialing files reviewed onsite that a site visit was needed.
4.4 Review of practitioner profiling activities.	X					

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.		X				Policy CR 210.107, Actions and Reporting Against Health Care Professional/Provider for Quality, defines Select Health's sanctioning process that could include dismissal from the network. The following issues were identified: • Page 2 references policy QI 205.007, Review of Potential Quality of Care Concerns, which is a retired policy. Onsite discussion confirmed that policy 154-300, Review of Potential Quality of Care Concerns, is the correct policy to reference. • Mentions the HIPDB in several places. *Quality Improvement Plan: Correct the issues identified in policy CR 210.107, Actions and Reporting Against Health Care Professional/Provider for Quality.*
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.		X				Policy CR 210.103, Hospital & Ancillary Provider Credentialing and Recredentialing, had the following issues: • References the HIPDB which was merged into the NPDB on May 6, 2013. The HIPDB references should be removed from the policies. • References to the EPLS should be replaced with the SAM. The EPLS records were moved to SAM and the old EPLS was phased out in 2012. *Quality Improvement Plan: Update policy CR 210.103, Hospital & Ancillary Provider Credentialing and Recredentialing, to remove references to the HIPDB and change the EPLS references to reflect the SAM.*
II B. Adequacy of the Provider Network						

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy NM 159.104, Provider/Practitioner Geographic Access Policy, states that Select Health measures Family Practice/General Practice and Pediatric types of providers as two PCPs within 20 miles in urban/suburban areas and one within 30 miles for rural areas. Internal medicine providers are measured as one within 30 miles for both urban/suburban and rural. OB/GYNs are measured as one OB/GYN within 20 miles in urban/suburban and within 30 miles in rural areas. Results of the 2013 Geographic Accessibility Report show 100 percent of members have access to providers within these standards.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy NM 159.104 states that specialists are measured as one specialist of each identified specialty type within 30 miles for urban/suburban and within 50 miles for rural areas. Results of the 2013 Geographic Accessibility Report show that for dermatology and rheumatology, Select Health does not meet their 95 percent goal for specialists. Onsite discussion confirmed a lack of available providers in some areas and lack of providers willing to contract in other counties. Select Health continues efforts to negotiate with identified specialists in counties not meeting the standards, where available.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least biennially.	X					

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. Practitioner Accessibility						
2.1 The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				The provider access standards comply with contract requirements and are defined in policy NM 159.204, Availability of Services. The policy incorrectly references the Total Quality Management Committee (TQM), which is now called the Quality Assessment Performance Improvement Committee. The TQM committee is also incorrectly referenced in policy NM 159.203, Accessibility of Services and the Provider Manual, page 10. An after- hours study was completed in March and April 2013 to determine if the plan goal of 90 percent compliance was being met by providers. One hundred percent of the PCP locations (918) were called and 97.2 percent of the providers met the standards for after- hours availability. Twenty-five provider locations (2.8 percent) did not meet the standards and the report indicated some follow up steps were taken. Two reports were received for Behavioral Healthcare Access. Emergent/Urgent care and routine care were measured and of the 210 BH providers, 86 providers were contacted to determine if members could access routine care. Only 56.98 percent provided a routine office visit

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						within 10 business days. Barriers were identified with interventions to improve the results. *Quality Improvement Plan: Update policies NM 159.204, Availability of Services, and NM 159.203, Accessibility of Services, as well as the Provider Manual to include the correct committee reference.*
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy 159.105, Provider Orientation, states that orientations will be conducted for all new physician providers groups and that participation of all office staff and providers is encouraged. The Provider Manual is utilized as the basis for the orientations. The Provider Manual is updated on annual basis, or as necessary, per policy PR 170.203, Provider Manual Policy. Select Health has a provider education consultant that conducts training seminars in various regions across the state. They have very good attendance at these meetings. They also do HEDIS® specific training to providers, and deliver and explain the Provider Report Cards. Account Executives visit the provider offices on a regular basis.
2. Initial provider education includes:						The Provider Manual is very detailed and contains sufficient information for a provider to navigate the plan; however; the following issues were noted:
2.1 MCO health care program goals;	X					
2.2 Billing and reimbursement practices;	X					

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;		X				• Page 34 does not list Substance Abuse Services in the list of covered benefits as specified in the *SCDHHS P&P Guide, Section 10.27.* • The Home and Community Based Waiver Services section does not address all of the special needs populations that are specified in the *SCDHHS P&P Guide Section 11.6.* Missing are the following: › Persons enrolled in the Medically Complex Children's waiver › Women at or below 185% of federal poverty level for Family Planning Services only. • Page 51, Section Mental Health and Alcohol/Drug Services, is missing "inpatient psychiatric hospital" which is specified in the *SCDHHS P&P Guide, Section 11.1.* • Vision Services listed on pages 50 and 52 need to be updated. *Quality Improvement Plan: Correct the Provider Manual to address the identified issues.*
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;		X				The Provider Manual, page 21, and the Provider Kit listed on the website state that providers can register an informal dispute either verbally or in writing within 90 calendar days from original denial notification or action; however, policy PNO 170.406, Informal Provider

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Disputes, does not state a timeframe for filing informal disputes. *Quality Improvement Plan: Address the discrepancy between policy PNO 170.406, the Provider Manual, and Provider Kit regarding whether providers have 90 days to file an informal dispute. Update documents to reflect consistent information.*
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.		X				The Provider Manual specifies the medical record documentation standards, but the following standard mentioned in policy QI 205.009 is not listed: "Signed and dated consent forms, if applicable". *Quality Improvement Plan: Update the Provider Manual to include all medical record documentation standards that are specified in policy QI 205.009.*
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Ongoing training is provided in the form of site visits, letters, newsletters, Provider Manual updates, and/or Corrective Action Plan per policy NM 159.102, Ongoing Training.
II D. Primary and Secondary Preventive Health Guidelines						

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy QI 205.004, Preventive Health Guidelines, defines the process for developing and maintaining preventative guidelines for children, adults and obstetrical care. Guidelines are developed utilizing criteria established by nationally recognized professional organizations and with input from network PCPs and specialists. Clinical practice and preventive guidelines are developed based on demographic composition of the population. All guidelines are reviewed and approved by the Quality of Clinical Care Committee annually and more frequently if national guidelines change.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Guidelines are distributed to practitioners via the Provider Manual, the web and through direct mailings.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups.	X					

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data.	X					
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The MCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Select Health has developed and maintains clinical practice guidelines for asthma, diabetes, heart failure, pharyngitis, sickle cell disease, hypertension, upper respiratory tract infection, ADHD, depression, overweight and obesity. This is defined in policy MED (CM) 150.210.
2. The MCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for MCO members to providers.	X					Information is listed in the Provider Manual and the clinical practice guidelines are listed on the website. Annually, providers are reminded through the website and the provider newsletter.
3. The MCO assesses practitioner compliance with clinical practice guidelines for disease and chronic illness management through direct medical record audit and/or review of utilization data.	X					
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.		X				Policy MED (UM) 150.314, Continuity of Care, defines the process for continuity of care for members continuing treatment for up to 90 days with a practitioner that has terminated. Onsite discussion confirmed that Select Health monitors continuity and coordination of care between PCPs and other providers through medical record audits and various processes; however, they are not

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						addressed in this policy. *Quality Improvement Plan: Update policy MED (UM) 150.314, Continuity of Care, or another policy to address how Select Health monitors continuity and coordination of care between PCPs and other providers.*
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Policy QI 205.009, Medical Record Review, defines this standard.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Medical record standards defined in policy QI 205.009, Medical Record Review, comply with contract guidelines.
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Select Health's Medical Record Review was completed in May 2013. The audit was completed in coordination with the annual HEDIS® survey. The overall 2013 Medical Record Review compliance rate was 99.70 percent, exceeding the plan's goal of 90 percent. Results in 2013 demonstrated an increase of 0.66 percent from the 2012 measure of 99.05 percent.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					
III. MEMBER SERVICES						

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Member rights and responsibilities are present in the Member Handbook, the Provider Manual, and policy MEM 129.100, Member Rights and Responsibilities. Select Health publishes member rights and responsibilities annually in the member newsletter and they can be found on the website.
2. Member rights include, but are not limited to, the right:	X					All member rights and responsibilities are present as found in the *SCDHHS MCO Policy and Procedure (P&P) Guide, Appendix 1.*
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						The Privacy Notice is mailed as an insert with Member Handbook.
2.3 To be provided with full information concerning the MCO, its services, and the providers who participate in their care;						Member Services is available by phone Monday-Friday 8 am to 9 pm and Saturday/Sunday 8 am to 6 pm. The Nurse Help Line is available 24/7 and supports member services after hours. The TTY number is well documented. Phone calls received in member services regarding behavioral health are routed to PerformCare during regular business hours. After hours calls are handled by the behavioral health team located in Harrisburg, Pennsylvania. Member service representatives have policies that guide their handling of crisis calls. The Provider Directory contains the required information.

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.5 To participate in decision-making regarding their health care without prohibitions or restrictions on the clinical dialogue between patient and provider;						
2.6 To full disclosure of all treatment options;						
2.7 To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition;						
2.8 To voice grievances about the MCO or about the medical care and/or services they receive;						
2.9 To appeal decisions adversely affecting coverage, benefits, services, or their relationship with the MCO;						
2.10 To formulate advance directives;						
2.11 To access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.12 To receive oral interpretation services free of charge;						
2.13 To refuse treatment;						
2.14 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations.						

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III B. Member MCO Program Education						
1. Members are informed in writing within 14 business days of enrollment of all benefits to which they are contractually entitled, including:		X				Policy MEM 129.107, New Member Orientation, confirms that members will be mailed the Member Handbook, the Provider Directory, and other new member materials within 14 calendar days of the plans receipt of enrollment data. The Select Health Member Services department makes welcome calls to all new members to provide an orientation to Select Health services and benefits. The goal is to reach 60% of new members while the actual percentage achieved is 58 percent. Issues identified in this section are noted below.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						The following deficiencies were identified in the Member Handbook: • There is no coverage information provided for members about non-elective hysterectomies. • There is no mention of coverage for Outpatient Pediatric Aids Clinics (OPAC). • There is no information on PSPCE/RSPCE - Preventive and Rehabilitative Services for Primary Care Enhancement which is addressed in the *SCDHHS MCO P&P Guide, Section 10.22.* The following issues were identified in the Member Services Training Manual: • Page 53 states non-participating providers must obtain prior authorization for family planning services; however, the Member Handbook page 10 states prior approval is not required. • Page 54 describes elective therapeutic abortions in two places on the same page: one paragraph says they are not covered by First Choice and in another paragraph it states they are a covered benefit

MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Pages 45 and 58 state that mental health, alcohol, and substance abuse treatment services are provided by Medicaid outside of the health plan; however, these services are the responsibility of the MCO per the *SCDHHS MCO P&P Guide, Sections 10.23 and 10.27.* *Quality Improvement Plan:* *• Include coverage for non-elective, medically necessary hysterectomies in the Member Handbook, as found in the SCDHHS MCO P&P Guide, Section 10.12.* *• Include visits to an OPAC (Outpatient Pediatric Aids Clinics) in benefit information as found in the SCDHHS MCO P&P Guide, Section 10.18.* *• Include a brief description of PSPCE/RSPCE services, Preventive and Rehabilitative Services for Primary Care Enhancement as found in the SCDHHS MCO P&P Guide, Section 10.22.* *• Remove the requirement for prior authorization for family planning services found on page 53 of the Member Services Training Manual.* *• Clarify your coverage of hysterectomies, abortions, mental health, and substance abuse treatment in the member services training manual.*
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Any applicable deductibles, copayments, limits of coverage, maximum allowable benefits and claim submission procedures;						Services that may require a copayment are listed in the Member Handbook. Members are directed to a copayment reference guide supplied with new member materials. The First Choice website contains both English and Spanish versions of the copayment guide; however the copayment for outpatient hospital services is listed as $3.40 on the English version and $3.30 on the Spanish version. *Quality Improvement Plan: Correct the co-payment for outpatient hospital services in the Spanish-version copayment guide on the FirstChoice webstie.*
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						Documented in Select Health's Member Handbook and the Provider Manual.
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						Page 15 of the Member Handbook regarding hospital admissions following an emergency room visit states the member, relative or friend must call First Choice by the next business day following a hospital admission. Select Health should receive notification of the admission from the hospital and cannot require a member, relative or friend to call. *Quality Improvement Plan: Correct the wording on page 15 of the Member Handbook to reflect that Select Health requests, but does not require notification by a member, friend or relative following an ER visit that results in hospitalization.*

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Policies and procedures for accessing specialty/referral care;						The Provider Manual, page 16, and the Member Handbook, page 9, state that no prior authorizations from Select Health is required for referrals to participating plan specialists. However, no policy or procedure was found that explains Select Health's process for members and providers to obtain referrals for in network or out of network specialists. *Recommendation: Create a policy and procedure, or add to an existing policy, the process members and providers use to obtain specialty/referral care, including when prior authorization is needed.*
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						Select Health uses PerformRx as their Pharmacy Benefit Manager. The Member Handbook provides information on prescription medications, and pharmacy limitations, restrictions and copayments.
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						
1.9 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.10 Procedures for disenrolling from the MCO;						Located in policy MEM 129.102, Disenrollment-Voluntary and Involuntary.
1.11 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DHHS;						Located in policy MEM 129.101, Member Grievances and Appeals Process.

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.12 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						
1.13 Additional information as required by the contract and by federal regulation.						The service area for Select Health includes all counties in South Carolina according to the Member Services Training Manual, page 45; however, this information is not communicated to members in the Member Handbook, the Provider Directory or other materials submitted for review. The *SCDHHS MCO P&P Guide, Section 14.3,* states that the MCO's written materials shall include a map or description of the MCO's service area. *Recommendation: Include a map or description of the Select Health service area in member materials, the Member Handbook or the Provider Directory.*
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					Policy COM 220.105, The Production of Vital Documents in Alternative Formats, states alternate formats available include Braille, large font, and audio tape, among others. This information is not conveyed to the member in the Member Handbook as required by *Federal Regulation § 438.10 (d) (ii) (2).* *Recommendation: Inform the member in the Member Handbook that materials can be provided in alternate format, such as Braille, upon request.*

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the MCO, including the availability of free oral translation services for all languages.	X					Toll free numbers are on the member ID cards and throughout the Member Handbook, and are available 24 hours a day. Members are informed in the Member Handbook that translation services are available at no cost. Select Health's Member Services has a dedicated Spanish queue available for Spanish speaking members.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the MCO program, with reeducation occurring as needed.	X					There is evidence of provider and member education in the grievance logs.
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to enrollees and members.	X					
III C. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits.	X					The Member Handbook, the Select Health website, member newsletters, and targeted mailings contain information on preventive health guidelines and disease management services.

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program.	X					Select Health provides prenatal outreach as defined in policy MED 150.104, Prenatal Outreach Services.
4. The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits.	X					Policy QI 205.006, EPSDT/Prevention and Screening Outreach, describes the many ways Select Health educates members about well child visits and preventive health guidelines.
5. The MCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					Educating members includes now due postcards, past due automated reminders, non-established with PCP reminder, and birthday cards. Outreach phone calls, Journey to Wellness magazine for women and flu shot reminders are others ways Select Health educates and informs its members.
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. Such assessment includes, but is not limited to:	X					Select Health used an NCQA® certified survey vendor (MORPACE) to perform their 2013 CAHPS Adult and Child surveys.
1.1 Statistically sound methodology, including probability sampling to insure that it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse decisions regarding MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					
3. The MCO implements significant measures to address quality problems identified through the member satisfaction survey.	X					
4. The MCO reports the results of the member satisfaction survey to providers.	X					Summarized results of both the CAHPS and the HEDIS measures were published in the provider newsletter and available to the provider on Select Health's website.
5. The MCO reports to the Quality Improvement Committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					
III F. Grievances						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MEM 129.101, Member Grievances and Appeals Process, details the grievance and appeals processes. Select Health has created a position called a Member Advocate whose role is to assist members, upon request, with more complex grievance issues and monitor the grievance process.

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Attachment 4

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Definition of a grievance and who may file a grievance;	X					
1.2 The procedure for filing and handling a grievance;		X				Per page 8 of policy MEM 129.101, Member Grievances and Appeals Process, Select Health acknowledges grievances with a letter within 1 business day of the receipt of a grievance. Grievance files reviewed onsite confirmed adherence to this policy. Page 8, item 12 of this policy states that a member services representative will attempt to notify a member of the resolution by phone if the notification is urgent and advise of their right to file an appeal if dissatisfied with the resolution. Per onsite discussion, an appeal of a grievance is no longer part of the process. *Quality Improvement Plan: Remove the reference to appeals related to grievances from the member grievance and appeals policy.*
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					Select Health utilizes a 90 day timeframe for resolution of grievances which complies with contract guidelines.
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Notification to the member of the right to request a Fair Hearing from SCDHHS when a covered service is denied, reduced, and/or terminated.	X					

MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					The grievance logs document ample detail of grievance investigation and resolution.
2. The MCO applies the grievance policy and procedure as formulated.		X				Per policy MEM 129.101, Member Grievances and Appeals, page 3 and defined in the *SCDHHS MCO Contract, Section 9.6.1.1*, standard disposition of grievances is 90 days from the day Select Health received the grievance. • Several grievance files reviewed onsite were not resolved within the 90 day timeframe. • One grievance file had a questionable quality of care (QOC) issue for care received in a hospital. Select Health forwarded this grievance to the hospital and no review by a medical director or evidence that Select Health followed-up on this grievance was found. *Quality Improvement Plan:* *• Develop a process to monitor the timely resolution of grievances.* *• Ensure that any questionable quality of care issues are reviewed by a Select Health physician that has the appropriate clinical expertise in accordance with Select Health's policy 154.300, Review of Potential Quality of Care Concerns and Federal Regulation § 438.406 (a) (3) (ii) (C).*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III G. Practitioner Changes						
1. The MCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					The reason for changing a PCP is documented in the grievance logs. The Manager of Member Services tracks PCP changes due to dissatisfaction and reports them to the Quality of Service Committee.
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					The 2013 Quality Assurance and Performance Improvement (QAPI) Program Description details the purpose, goals, objectives, scope and structure of the QAPI Program. Lines of responsibility and accountability are included in the program description.
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	X					
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).		X				The 2012 and 2013 Quality Work Plans were submitted for review and contain all required elements. The 2012 work plan (pages 9 and 18) had two items with a status of "ongoing" that were not carried over to the 2013 work plan. The items are: • Collect, analyze, and implement activities as necessary in response to identified trends from formal Provider Disputes. • Identify and implement member and practitioner outreach activities to increase immunization rates for children. *Quality Improvement Plan: Update the 2013 Quality Work Plan with the missing items. Check newly-created work plans to make sure that all applicable "ongoing" items are carried over from previous work plans.*
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Assurance and Performance Improvement (QAPI) Committee oversees all aspects of Select Health's quality activities.
2. The composition of the QI Committee reflects the membership required by the contract.		X				An inconsistency in the number of members on the QAPI Committee was noted when comparing the 2013 QAPI Program Description, page 10, and the Select Health Committee Listing – 2013. Onsite discussion confirmed that the 2013 QAPI Program Description is incorrect. Also, the Select Health Committee Listing – 2013 document indicates that all members of the QAPI Committee have voting rights. Minutes from the QAPI Meeting held on 09/10/13 indicate, and onsite discussion

MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						confirmed, that some members do not have voting rights. *Quality Improvement Plan: Update the QAPI Program Description to reflect a correct listing of members for the QAPI Committee. Update all applicable documents to indicate which members have voting rights.*
3. The QI Committee meets at regular quarterly intervals.	X					Review of meeting minutes confirmed that meetings are held at least quarterly. All meetings for which minutes were submitted had a quorum present. It was noted that page 11 of the 2013 QAPI Program Description states that the QAPI Committee meets quarterly or at a minimum of 3 times a year. The *SCDHHS MCO P&P Guide, Section 13.0 (2) (g)* requires these meetings to be held at least quarterly. *Recommendation: Update the QAPI Committee meeting frequency requirement in the 2013 QAPI Program Description to be compliant with the SCDHHS MCO P&P Guide, Section 13.0.*
4. Minutes are maintained that document proceedings of the QI Committee.		X				QAPI meeting minutes from 8/30/12, 11/8/12, 3/28/13, and 05/28/13 were reviewed prior to the onsite visit. Minutes for 09/10/19 and 12/16/13 were presented and reviewed onsite. Issues identified with documentation on the minutes include: • Attendance is not accurately documented in the minutes for QAPI Committee meetings. • The minutes for 09/10/13 contain symbolic designations for voting members (Δ) and non-voting members (•). Several members who were indicated to be non-voting

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members of the committee were listed as guests in the attendance documentation for this meeting. This is confusing as guests are typically non-members who are attending the meeting. *Quality Improvement Plan: Develop a process to accurately document QAPI Committee member attendance. Non-voting members of the committee should not be listed as guests in the attendance documentation.*
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					Plan uses Quality Spectrum Insight™ for their HEDIS® measure calculations.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All of the projects reviewed met the CMS validation protocol requirements. CCME chose to validate the Follow-up for Children Prescribed Asthma Medication, Improving Women's Health, and Well Child Visits projects. Two of the projects scored within the High Confidence range, and one scored within the Confidence range. For further details, see CCME's *EQR Validation Worksheet, Attachment 3*.

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Providers are required to participate in QI activities, including record-keeping, inspections, and audits, etc.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Providers are sent an annual Provider Performance Report that contains HEDIS® data and goals with the provider's rating.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					The 2012 Quality Assessment Performance Improvement Evaluation was approved by the QAPI Committee on 03/28/13. It contains detailed information on all aspects of Select Health's quality program resources, structure, accreditations, service initiatives and indicators, member and provider satisfaction, clinical performance goals and initiatives, strengths, challenges and opportunities, and goals for the next year. QAPI activities are reported throughout the year to the QAPI Committee, and updates are provided quarterly to Select Health's Board of Directors. The QAPI Program is evaluated at least annually and as needed to measure effectiveness and to formulate recommendations for improvement, goals, and objectives for the next year.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					QAPI activities are reported throughout the year to the QAPI Committee, and updates are provided quarterly to Select Health's Board of Directors.

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					Select Health's Integrated Utilization Management 2013 Program Description provides a detailed description of Select Health's Utilization Management (UM) program.
1.1 structure of the program;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;		X				Guidelines and criteria used for UM decisions are discussed in the UM Program Description and in policies and procedures. Onsite discussion confirmed that in addition to InterQual® criteria and South Carolina State Medicaid guidelines, internal criteria have been developed and are used for 17-hydroxyprogesterone, Zofran pump, apnea monitors, cardiac rehabilitation, and pulmonary rehabilitation. Inconsistencies in the documentation of criteria used by Select Health were noted as follows: •The UM Program Description, page 12, fails to list that internal criteria is used for pulmonary rehabilitation. •The Provider Manual lists InterQual criteria and South Carolina State Medicaid guidelines but does not inform providers that some internal criteria are used. *Quality Improvement Plan: Update the UM Program*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Description and Provider Manual to include all criteria used for utilization review determinations.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;			X			Many issues were identified with Select Health's processes for UM determination timeliness and notification. Policy MED 153.308, Determination of Timeliness, discusses processes for approval decisions. Issues identified include: • Page 2 indicates that faxes received after 5:00 pm will be logged as received on the next business day. However, there are no Federal or State Medicaid regulations that allow this. Therefore, the timeframe for review of all authorization requests begins on the date the request was actually received. • Page 2 states that approval notification is provided within 1 calendar day of making a decision, but does not include information that the notification date will not exceed the standard timeframe allowed. Refer to *Federal Regulation § 438.210 (d) (1) and (2)* as well as the *SCDHHS MCO P&P Guide, Section 9* to view the requirements. • Page 2 states that determination timeframes may be extended by 14 calendar days if the member or provider request the extension or if matters arise beyond Select Health's control. This fails to mention that unless the extension is requested by the member or provider, the plan must justify the need for the extension to SCDHHS upon request. See the *SCDHHS MCO Contract, Section 9.5.3.3.2.* • The policy does not address that for determinations for inpatient services, a two-calendar-day extension can be granted if requested clinical information is not received.

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The extension is mentioned in the UM Program Description, page 22. This issue was identified as a deficiency on the previous EQR and has not been corrected. There is a discrepancy in documentation of the number of days allowed for expedited authorization decisions. The Member Grievances and Appeals Process policy, MEM 129.101, page 4, documents that the allowable extension for expedited authorization decisions is 14 calendar days. Policy MED 153.308, Determination of Timeliness, states the allowable extension as only two calendar days. Onsite discussion confirmed that the plan allows only 2 calendar days for extensions of expedited pre-service authorization requests. Policy MED 153.303, Adverse Determinations lists no timeframe for notification of adverse determinations of authorization requests. Policy MED 153.308, Determination of Timeliness, lists the timeframe for notifications of approvals only. The Provider Manual, page 20, states that prior authorization of non-urgent care will be made within 14 calendar days of receiving all necessary information, and concurrent review determinations will be made within 24-72 hours, depending on the expiration of the certified concurrent period, of receiving all information. The PerformCare/Select Health Behavioral Health Medical Management Program Evaluation states on page 8 that determinations are made within either 1 or 14 days (depending on the type of request) of receiving all the information to support the request. The timeframe for determinations begins on the day the request is received.

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						not the date of receipt of all information. See *Federal Regulation 438.210 (d) (1)* and *(2)* as well as the *SCDHHS MCO Contract, Section 9.5.3.3 and Section 9.5.3.7.* *Quality Improvement Plan: Correct the deficiencies identified in the processes for UM determination timeliness and notifications.*
1.5 consideration of new technology;	X					Addressed in the Evaluation of New Medical Technologies, MED 153.316.
1.6 the appeal process, including a mechanism for expedited appeal;	X					
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					
1.8 the absence of quotas establishing a number or percentage of claims to be denied.	X					

MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The QAPI Committee provides direction for all aspects of clinical and service quality assurance processes, including those related to utilization management. Dr. Fred Volkman, the Regional Chief Medical Officer (CMO), facilitates communication between regional and local leadership and the board of directors. He and Select Health's medical directors are responsible for the development, implementation and oversight of all aspects of the Select Health Integrated UM program.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The Integrated UM Program Description 2013 confirms that the UM program is reviewed and updated annually and approved by the QAPI Committee. Recommendations are made to improve the effectiveness of the program and ability to reach established goals and objectives. Note: The Integrated UM Program Description 2013 has an approval page (page 2) for documentation of approvals along with corresponding signatures and dates; however, this page contains no documentation of any approvals. The 2012 Utilization Management Summary document contains an overview of the UM program, documentation of staffing, call metrics and timeliness of decision-making, inter-rater reliability, appeals data, utilization monitoring, and member/provider satisfaction data. All areas contain analysis of barriers, opportunities for improvement, and interventions and resources that will be used. *Recommendation: Include approval information on the approval page of the UM Program Description document.*
V B. Medical Necessity Determinations						

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					It was noted during reviews of denial file that several initial medical necessity reviews were performed using incorrect InterQual criteria sets. Onsite discussion confirmed that staff receive yearly training on InterQual. *Recommendation: Re-educate staff and continue to reinforce the importance of selecting appropriate criteria when performing reviews.*
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.		X				Appropriate information is provided in the Provider Manual. During onsite discussion, it was confirmed that Select Health has no specific policy and procedure that addresses the requirements for coverage hysterectomies, sterilizations, and abortions. Requirements can be found in the *SCDHHS MCO P&P Guide, Section 10.12.* *Quality Improvement Plan: Create a policy and procedure which details the requirements and processes for reviewing and covering hysterectomies, sterilizations, and abortions.*
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.			X			Policy MED 153.306, Utilization Management Inter-rater Reliability Auditing, indicates on page two that quarterly inter-rater reliability (IRR) audits will be performed on each clinical care reviewer. A passing score is 90%. The process for IRR for the clinical care reviewers (non-physician) is well-documented. This policy doesn't provide detailed information on the IRR process for physician reviewers, and no benchmark for physician reviewers is documented. Onsite discussion confirmed that physicians do participate in IRR twice yearly, that there is a benchmark for performance, and follow-up testing, training, and corrective action as needed. By stating that IRR testing is performed twice yearly, the UM Program Description, pages 17 and 19, contradicts the IRR frequency that is listed in the MED 153.306 policy. Onsite discussion confirmed that IRR is performed quarterly. This issue was identified as a deficiency on the previous EQR and has not been corrected. *Quality Improvement Plan: Update the UM Inter-rater Reliability Auditing policy to contain clear and complete information on the IRR process used for physician reviewers. The benchmark for physician reviewers should be included also. Correct the frequency of IRR auditing in the UM Program Description.*
6. Pharmacy Requirements						

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					The online (printable) preferred drug list was last updated in December 2013. The Pharmacy Benefits and Management policy, MED (PA) 150.400, describes the pharmacy benefits coverage and management. Formulary restrictions are reasonable and include quantity limits, generic substitutions, and limits on the number of prescriptions per month (with available overrides in certain circumstances).
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					
10. Initial utilization decisions are made promptly after all necessary information is received.	X					
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.		X				It was noted during onsite file review that some of the denial rationales placed in the notice of action letters didn't match the patient, the clinical information, and/or the criteria used for the review. *Quality Improvement Plan: Ensure that rationales for denial decisions are appropriate to the patient's condition and the type of request.*
V C. Appeals						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the MCO in a manner consistent with contract requirements, including:	X					Appeals processes are detailed in policy MEM 129.101, Member Grievances and Appeals Process.
1.1 The definitions of an action and an appeal and who may file an appeal;		X				Onsite discussion confirmed that as of August, 2013, members are not required to sign authorization for a representative to act on their behalf for plan-level appeals. However, the Provider Manual states that written consent to act as a member's representative is required for expedited appeals. *Quality Improvement Plan: Correct the Provider Manual to indicate that written consent is not required for a representative to act on a member's behalf for an expedited appeal.*
1.2 The procedure for filing an appeal;	X					

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					The Member Grievances and Appeals policy, MEM 129.101, includes correct timeliness guidelines for appeal resolutions and notifications.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.		X				Onsite review of appeals files revealed several issues: • The timeframe for requesting a State Fair Hearing is incorrect in the appeal determination letters. The letters state that the timeframe is 30 calendar days, but the correct timeframe is 30 calendar days from the date the member receives the notice of appeal resolution. See the *SCDHHS MCO Contract, Section 9.6.5.1*. • The timeframe for requesting continuation of benefits was incorrect in the appeal determination letters. Some of the letters stated that members must request continuation of benefits within 20 calendar days from the date of the letter or 20 calendar days from when services are stopped. Others indicated that continuation of benefits must be requested within 10 days of the date of the letter or within 10 calendar days from when services are stopped. The *SCDHHS MCO Contract, Sections 9.8.1.1 and 9.8.1.2*,

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specifies that benefit continuation must be requested within ten (10) calendar days of the Contractor mailing the notice of Action or within 10 calendar days of the intended effective date of the Contractor's proposed Action. *Quality Improvement Plan: Correct the timeframes for requesting a State Fair Hearing and for requesting continuation of benefits in all the appeal determination letters.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The 2012 Grievances and Appeals Summary was presented in the desk materials, and contains a detailed analysis of the appeals and grievances for the year 2012, including identification of interventions used in 2012 and documentation of opportunities for the year 2013. The report was submitted to the Administrative Appeal and Grievance Committee on 3/22/13, and subsequently to the QAPI Committee on 05/30/13.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Case Management						
1. The MCO utilizes case management techniques to insure comprehensive, coordinated care for members with complex health needs or high-risk health conditions, including populations specified in the contract.	X					
V E. Evaluation of Over/ Underutilization						

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO monitors and analyzes utilization data for over/underutilization as required by the contract.	X					
2. Tracking of emergency room utilization and the authorizations/denials for such services occurs, as required by the contract.	X					
V I. DELEGATION						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.		X				Select Health has delegated contracts with the following entities for credentialing/recredentialing: Health Network Solutions (HNS), Medical University of South Carolina (MUSC), St. Francis Physician Services (SFPS), Regional Health Plus (RHP), Memorial Health Partners (MHP), Georgia Health Sciences University, and Greenville Hospital System (GHS). The sample delegated contract received in the desk materials was dated 8-24-11 and credentialing/recredentialing responsibilities did not appear to address South Carolina (SC) specific credentialing/recredentialing requirements such as collecting the ownership disclosure form 1514, query of the SC Excluded Provider's List, CLIA certificate/waiver when laboratory services are performed, or guidelines for NPs acting as PCPs. In addition, the contract specifies verification of sanctions by Medicare/Medicaid but does not spell out what queries are to be performed. *Quality Improvement Plan: The delegated contract should include the SC specific credentialing/recredentialing criteria and the plan should ensure all required queries are being performed.*

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				Corporate policy 277.010, Delegation Oversight, defines the procedures for pre-delegation assessment and annual oversight. Evidence of oversight monitoring was presented for the delegated entities; however, the monitoring tool does not appear to address the SC credentialing/recredentialing criteria. Also, the monitoring tool does not specify which queries are required for Medicare/Medicaid sanctions. Oversight monitoring is performed on an annual basis. In the previous EQR it was noted that both MUSC and MHP have sub-delegates that are not accredited as required by the State. This issue is being held as "tabled with no action required" in the Credentialing Committee minutes. Onsite discussion confirmed that Select Health is awaiting clarification from the State regarding this issue. *Quality Improvement Plan: Update the delegation monitoring tools to reflect the SC specific credentialing/recredentialing criteria and all the required queries.*
V I I. STATE-MANDATED SERVICES						
A. The MCO tracks provider compliance with:						
1. administering required immunizations;	X					
2. performing EPSDTs/Well Care	X					Select Health tracks Well Child visits annually as a HEDIS measure.
B. Core benefits provided by the MCO include all those specified by the contract.	X					

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
C. The MCO tracks and submits service reports to the State in compliance with contract requirements.	X					
D. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			The following deficiencies identified in the previous external quality review have not been corrected: • During the 2012 external quality review, it was noted that there was a lack of documentation of extension of timeframes for authorization requests for inpatient services. A quality Improvement plan (QIP) was submitted by Select Health that included adding the following statement to policy MED (UM) 153.308, "A two-calendar-day extension can be granted if requested clinical information is not received". Upon review of policy MED 153.308 for the current EQR, it is noted that the policy still contains no mention of an extension of the timeframe for initial inpatient review and determination. • It was noted on the previous EQR that incorrect timeframes were listed in the UM Program Description for inter-rater reliability audits. Incorrect timeframes are still found in the UM Program Description. • A recommendation was made in the previous EQR for Select Health to include at least the date a site visit was performed in the credentialing files and recredentialing files, if applicable. This was not implemented. *Quality Improvement Plan: Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.*

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HEDIS Scores

Keystone First

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 QC Percentile*	HEDIS 2014 Final	Denom	Num Total	Num Admin	Num MR Hits	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Preventive Screenings																	
Adult BMI Assessment (ABA)		R	A	29.93	40.18	58.85	70.68	25th	78.44	450	289	61	228	7.76	Y	50th	50th
Weight Assessment and Counseling (WCC)	BMI Screening - Total	R	A	36.01	45.13	61.59	62.07	50th	69.78	450	285	31	254	7.71	Y	75th	50th
	Counseling on Nutrition - Total	R	A	55.96	59.29	71.52	68.28	75th	69.56	450	265	16	249	1.28	N	75th	75th
	Counseling on Physical Activity - Total	R	A	41.12	48.67	60.49	54.25	50th	63.56	450	234	6	228	9.31	Y	75th	75th
Childhood Immunization Status (CIS)	Combination 2 Immunizations	R	A	73.97	79.76	82.63	82.12	75th	81.90	453	344	278	66	-0.22	N	75th	50th
Immunizations for Adolescents (IMA)	Combination 1 Immunizations	R		49.39	75.50	81.45	87.06	90th	86.73	226	196	182	14	-0.33	N	90th	NA
HPV for Female Ad 13 (HPV)		R		NA	NA	15.85	22.74	NA	24.28	453	102	88	14	1.54	N	NA	NA
Lead Screening (LSC)		R		67.15	69.03	74.39	73.51	50th	74.61	453	331	325	6	1.10	N	50th	NA
Breast Cancer (BCS)		R	A	57.87	58.03	58.31	59.42	75th	66.19					6.77	Y	90th	75th
Cervical Cancer (CCS)**				70.98	70.10	69.79	71.46	50th	70.95	453	317	297	20	-0.51	N	NA	NA
Chlamydia Screening (CHL)		R	A	58.36	66.25	67.94	59.23	50th	63.27					4.04	Y	50th	50th
Respiratory Conditions																	
Appropriate Testing for Children with Pharyngitis (CWP)		R	A	56.75	58.51	63.30	66.16	25th	64.60					-1.56	N	25th	25th

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Appropriate Treatment for Children with URI (URI)		R	A	86.70	87.13	87.38	88.86	50th	89.20					0.34	N	50th	50th
Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)		R	A	25.32	26.14	25.70	25.26	50th	27.03					1.77	N	50th	50th
Use of Spirometry Testing in Assessment and Diagnosis of COPD (SPR)		R	A	22.32	24.84	26.00	29.33	25th	25.82					-3.51	N	<25th	<25th
Pharmacotherpay Management of COPD Exacerbation (PCE)	Systemic Corticosteriod	R	A	62.56	69.62	73.00	76.36	75th	78.30					1.94	N	90th	90th
	Bronchodilator	R	A	88.44	88.56	89.89	89.99	75th	91.39					1.40	N	90th	90th
Use of Appropriate Medications with People with Asthma (ASM)	Total		A	91.62	91.11	87.72	87.37	50th	86.91					-0.46	N	50th	50th
Medication Management for People with Asthma (MMA)	75% Compliance	R		NA	NA	35.17	29.11	50th	37.59					8.48	Y	75th	NA
Asthma Medication Ratio (AMR)	Total Population Ratio > 50%	R		NA	NA	ND	55.87	NA	63.12					7.25	Y	NA	NA
Cardiovascular																	
Cholesterol Mgmt (CMC) √	LDL-C Screening √	R	A	82.97	84.26	82.52	81.68	25th	79.20	453	353	344	9	-2.48	N	25th	25th
	LDL-C Level < 100 √	R		46.23	48.56	44.47	44.59	50th	43.14	453	168	151	17	-1.45	N	50th	NA
Controlling High BP (CBP)	Total	R	A	66.58	63.12	64.01	64.41	75th	60.44	414	148	0	148	-3.97	N	50th	50th
Diabetes																	

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 QC Percentile*	HEDIS 2014 Final	Denom	Num Total	Num Admin	Num MR Hits	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Comp Diabetes Care (CDC)	HbA1c Testing	R	A	82.26	83.79	80.59	83.09	25th	82.51	630	516	503	13	-0.58	N	25th	50th
	HbA1c Poor Control (>9)*** √		A	36.29	36.14	40.91	33.97	75th	36.72	630	279	266	13	2.75	N	50th	50th
	HbA1c Adequate Control (<8)	R		54.52	55.92	51.22	53.59	50th	55.17	630	308	291	17	1.58	N	75th	NA
	LDL-C Screening	R	A	80.00	81.04	78.32	80.54	75th	79.81	630	496	479	17	-0.73	N	50th	50th
	LDL-C Level < 100 √	R		41.45	44.57	38.99	40.99	75th	37.68	630	209	189	20	-3.31	N	50th	NA
	Monitoring for Nephropathy	R	A	79.35	83.79	80.24	81.34	50th	80.92	630	508	498	10	-0.42	N	50th	50th
	Eye Exam	R	A	49.03	54.13	52.45	54.55	50th	51.67	630	287	253	34	-2.88	N	25th	25th
	Blood Pressure Control (<140/80)	R		NA	33.06	35.84	39.23	50th	40.22	630	163	2	161	0.99	N	50th	NA
	Blood Pressure Control (<140/90)	R		62.74	59.16	63.29	64.27	50th	66.93	630	267	2	265	2.66	N	50th	NA
Musculoskeletal Conditions																	
Use of Imaging for Low Back Pain (LBP)		R	A	78.49	77.73	79.63	78.87	50th	78.53					-0.34	N	50th	50th
Disease-Modifying Anti-Rheumatic Drug Therapy (DRT)		R		71.84	68.82	70.25	71.82	50th	73.94					2.12	N	50th	NA
Behavioral Health																	
Antidepressant Medication Management (AMM)	Acute Phase	R	A	NB	NB	NB	54.12	50th	54.75					0.63	N	50th	75th
	Continuation	R	A	NB	NB	NB	43.06	75th	41.25					-1.81	N	75th	75th
Follow-up with Children Prescribed ADHD Medication (ADD)	Initiation	R	A	18.72	17.51	17.59	18.21	<25th	15.68					-2.53	Y	<25th	<25th
	Continuation	R	A	16.34	14.09	12.68	15.51	<25th	14.58					-0.93	N	<25th	<25th

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 QC Percentile*	HEDIS 2014 Final	Denom	Num Total	Num Admin	Num MR Hits	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Diabetes Screening for People with Schizophrenia or Bi-Polar Disorder Who Are Using Antipsychotic Medications (SSD)		R		NA	NA	NB	83.03	NA	67.12					-15.91	Y	NA	NA
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		R		NA	NA	NB	72.83	NA	67.04					-5.79	N	NA	NA
Follow-up Care for Hospitalization for Mental Illness (FUH)	7 Day	R	A	NB	NB	NB	NB	NB	NB	NB	NB	NB	NB	NA	NA	NB	NB
	30 Day			NB	NB	NB	NB	NB	NB	NB	NB	NB	NB	NA	NA	NB	NB
CVD Monitoring for People with CVD and Schizophrenia (SMC)		R		NA	NA	NB	64.44	NA	74.49					10.05	N	NA	NA
Adherence to Antipsychiotic Medications for People with Schizophrenia (SAA)	80% Coverage	R		NA	NA	NB	68.04	NA	75.35					7.31	Y	NA	NA
Access/Availability of Care																	
Prenatal Postpart Care (PPC)	Timeliness of Prenatal Care (Hybrid) √	R	A	81.08	78.67	81.66	82.96	25th	84.00	453	327	323	4	1.04	N	25th	25th
	Postpartum Care	R	A	61.43	54.03	62.19	62.11	25th	58.67	453	220	217	3	-3.44	N	25th	<25th
Adults Access to Preventative/Ambulatory Health Services (AAP)	Total			84.25	84.26	84.80	81.75	25th	85.57					3.82	Y	50th	NA

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Children and Adolescents' Access to Primary Care Practitioners (CAP)	7-11 years	R		89.29	90.43	91.19	92.07	50th	92.29					0.22	N	50th	NA
Alcohol/Drug Dependence (IET)	Initiation of Treatment			NB	NB	NB	NB	NB	NB	NB	NB	NB	NB	NB	NA	NB	NB
	Initiation of Engagement			NB	NB	NB	NB	NB	NB	NB	NB	NB	NB	NB	NA	NB	NB
Utilization																	
Annual Monitoring for Patients with Persistent Medications (MPM)	Combined Rate	R		83.27	84.23	84.42	83.00	25th	79.75					-3.25	Y	<25th	NA
Freq of Ongoing PNC (FPC) √	81+ Percent of Expected Visits (Hybrid)			67.08	54.50	64.65	68.39	50th	63.11	453	201	199	2	-5.28	N	25th	NA
Well Child 15 Months (W15)	6+ Well Child Visits	R		57.04	63.43	63.83	63.36	25th	68.10	442	284	248	36	4.74	N	50th	NA
Well Child 3-6 Years (W34)		R		74.77	73.16	74.52	77.57	50th	80.80	427	334	321	13	3.23	N	75th	NA
Adolescent Well Care (AWC) √		R		57.47	61.26	61.34	62.31	75th	62.42	447	260	243	17	0.11	N	75th	NA
Annual Dental Visit (ADV) √	Total √			50.75	54.91	58.34	61.23	75th	62.73					1.50	Y	75th	NA
Ambulatory Care (AMB) √	ER Visits/1000 √***			69.21	64.52	67.88	67.05	50th	68.60					1.55	Y	50th	NA

***lower rate is better

AmeriHealth Caritas Pennsylvania

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 QC Percentile	HEDIS 2014 Final	Denom	Num Total	Num Admin	Num MR Hits	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Preventive Screenings																	
Adult BMI Assessment (ABA)		R	A	36.74	60.34	72.41	77.61	50th	87.08					9.47	Y	90th	90th
Weight Assessment and Counseling (WCC)	BMI Screening - Total	R	A	37.71	50.85	67.77	71.90	75th	74.54					2.64	N	75th	75th
	Counseling on Nutrition - Total	R	A	44.77	57.42	65.34	68.35	75th	69.91					1.56	N	75th	75th
	Counseling on Physical Activity - Total	R	A	40.15	54.26	60.26	61.27	50th	63.43					2.16	N	50th	50th
Childhood Immunization Status (CIS)	Combination 2 Immunizations	R	A	75.43	77.13	83.44	79.32	50th	79.91					0.59	N	75th	25th
Immunizations for Adolescents (IMA)	Combination 1 Immunizations	R		41.40	69.34	67.95	77.05	75th	81.96					4.91	N	75th	NA
HPV for Female Ad 13 (HPV)		R		NA	NA	24.29	31.87	NA	32.96					1.09	N	NA	NA
Lead Screening (LSC)		R		72.02	73.72	73.29	72.02	25th	70.42					-1.60	N	25th	NA
Breast Cancer (BCS)		R	A	61.49	61.39	59.92	62.53	75th	68.72					6.19	Y	90th	75th
Cervical Cancer (CCS)**				70.43	71.84	71.35	70.18	50th	69.04					-1.14	N	NA	NA
Chlamydia Screening (CHL)	Total	R	A	46.58	49.14	47.10	52.58	25th	53.45					0.87	N	25th	25th
Respiratory Conditions																	
Appropriate Testing for Children with Pharyngitis (CWP)		R	A	53.09	47.24	57.35	55.78	<25th	58.28					2.50	N	<25th	<25th
Appropriate Treatment for Children with URI (URI)		R	A	84.72	86.58	85.27	85.47	25th	85.90					0.43	N	50th	25th

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Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)		R	A	16.79	19.52	20.99	21.31	25th	**21.48**					0.17	N	25th	25th
Use of Spirometry Testing in Assessment and Diagnosis of COPD (SPR)		R	A	27.27	31.30	29.61	23.05	<25th	**28.52**					5.47	N	25th	25th
Pharmacotherapy Management of COPD Exacerbation (PCE)	Systemic Corticosteroid	R	A	67.83	73.29	67.74	81.94	90th	**78.76**					-3.18	N	90th	90th
	Bronchodilator	R	A	82.52	82.88	81.29	87.50	75th	**89.87**					2.37	N	75th	75th
Use of Appropriate Medications with People with Asthma (ASM)	Total		A	90.08	89.55	86.97	84.81	50th	**84.05**					-0.76	N	25th	25th
Medication Management for People with Asthma (MMA)	Total 75% Compliance	R		NA	NA	39.27	33.21	75th	**44.99**					11.78	Y	90th	NA
Asthma Medication Ratio (AMR)	Total Population Ratio > 50%	R		NA	NA	ND	55.70	NA	**64.88**					9.18	Y	NA	NA
Cardiovascular																	
Cholesterol Mgmt (CMC) √	LDL-C Screening √	R	A	88.34	85.60	86.30	87.10	75th	**86.77**					-0.33	N	75th	75th
	LDL-C Level < 100 √	R		53.35	52.00	50.00	52.31	75th	**52.67**					0.36	N	75th	NA
Controlling High BP (CBP)	Total	R	A	64.84	66.58	67.66	66.39	75th	**65.59**					-0.80	N	75th	<25th
Diabetes																	
Comp Diabetes Care (CDC)	HbA1c Testing	R	A	86.31	88.87	88.54	85.04	50th	**84.83**					-0.21	N	50th	50th
	HbA1c Poor Control (>9)*** √		A	35.40	33.03	31.92	38.32	50th	**33.33**					-4.99	N	75th	75th
	HbA1c Adequate Control (<8)	R		52.74	55.29	56.08	50.36	50th	**56.17**					5.81	Y	75th	NA
	LDL-C Screening	R	A	82.48	84.85	81.83	81.02	75th	**77.83**					-3.19	N	50th	50th
	LDL-C Level < 100 √	R		40.15	42.15	40.74	41.97	75th	**39.00**					-2.97	N	50th	NA

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	Monitoring for Nephropathy	R	A	81.93	86.50	81.31	79.56	50th	80.50					0.94	N	50th	50th
	Eye Exam	R	A	69.53	70.26	68.78	65.15	75th	65.50					0.35	N	75th	75th
	Blood Pressure Control (<140/80)	R		NA	48.36	45.86	44.53	75th	45.50					0.97	N	75th	<25th
	Blood Pressure Control (<140/90)	R		66.79	71.53	70.9	71.35	75th	69.50					-1.85	N	75th	<25th
Musculoskeletal Conditions																	
Use of Imaging for Low Back Pain (LBP)		R	A	70.76	73.64	72.04	71.84	25th	73.43					1.59	N	25th	<25th
Disease-Modifying Anti-Rheumatic Drug Therapy (DRT)		R		78.22	81.82	72.28	77.27	75th	77.69					0.42	N	75th	NA
Behavioral Health																	
Antidepressant Medication Management (AMM)	Acute Phase	R	A	NB	NB	ND	NB	NB	53.63					NA	NA	50th	50th
	Continuation	R	A	NB	NB	ND	NB	NB	40.73					NA	NA	75th	75th
Follow-up with Children Prescribed ADHD Medication (ADD)	Initiation	R	A	25.68	24.38	22.02	26.41	<25th	19.54					-6.87	Y	<25th	<25th
	Continuation	R	A	22.96	22.04	21.56	22.12	<25th	20.25					-1.87	N	<25th	<25th
Diabetes Screening for People with Schizophrenia or Bi-Polar Disorder Who Are Using Antipsychotic Medications (SSD)		R		NA	NA	NB	88.00	NA	85.12					-2.88	N	NA	NA
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		R		NA	NA	NB	66.33	NA	74.77					8.44	N	NA	NA

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Follow-up Care for Hospitalization for Mental Illness (FUH)	7 Day	R	A	NB	NB	NB	NB	NB	NB					NA	NA	NA	NA
	30 Day			NB	NB	NB	NB	NB	NB					NA	NA	NA	NA
CVD Monitoring for People with CVD and Schizophrenia (SMC)		R		NA	NA	NB	NB	NB	NA					NA	NA	NA	NA
Adherence to Antipsychotic Medications for People with Schizophrenia (SAA)	80% Coverage	R		NA	NA	NB	70.43	NA	72.04					1.61	N	NA	NA
Access/Availability of Care																	
Prenatal Postpart Care (PPC)	Timeliness of Prenatal Care √	R	A	89.89	90.28	92.84	90.51	75th	92.22					1.71	N	75th	75th
	Postpartum Care	R	A	68.58	68.61	67.26	65.94	50th	68.00					2.06	N	50th	50th
Adults Access to Preventative/Ambulatory Health Services (AAP)	Total			83.27	82.81	83.83	87.04	75th	86.55					-0.49	N	50th	NA
Children and Adolescents' Access to Primary Care Practitioners (CAP)	7-11 years	R		89.83	89.00	89.28	90.32	25th	91.94					1.62	Y	50th	NA
Alcohol/Drug Dependence (IET)	Initiation of Treatment			NB	NB	NB	NB	NB	NB					NA	NA	NA	NA
	Engagement of Treatment			NB	NB	NB	NB	NB	NB					NA	NA	NA	NA
Utilization																	
Annual Monitoring for Patients on Persistent Medications (MPM)	Combined Rate	R		85.63	87.27	86.23	85.87	50th	86.11					0.24	N	50th	NA

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Freq of Ongoing PNC (FPC) √	81+ Percent of Expected Visits √			78.96	83.06	87.60	84.91	90th	**82.67**					**-2.24**	**N**	**90th**	**NA**
Well Child 15 Months (W15)	6+ Well Child Visits	**R**		70.73	72.70	73.71	77.44	90th	**71.52**					**-5.92**	**N**	**75th**	**NA**
Well Child 3-6 Years (W34)		**R**		78.05	74.65	72.88	78.51	50th	**76.50**					**-2.01**	**N**	**50th**	**NA**
Adolescent Well Care (AWC) √		**R**		57.78	56.08	57.40	64.76	75th	**62.70**					**-2.06**	**N**	**75th**	**NA**
Annual Dental Visit (ADV) √	Total √			44.96	50.27	52.50	55.59	50th	**54.80**					**-0.79**	**Y**	**50th**	**NA**
Ambulatory Care (AMB) √	ER Visits/1000 √***			86.68	80.85	83.28	83.43	75th	**85.21**					**1.78**	**Y**	**75th**	**NA**

***lower rate is better

Select Health of South Carolina

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Admin Rate	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Preventive Screenings													
Adult BMI Assessment (ABA)		R	A	3.35	3.65	4.26	58.28	<25th	**65.84**	7.56	Y	25th	25th
Weight Assessment and Counseling (WCC)	BMI Screening - Total	R	A	0.30	20.09	0.07	15.67	<25th	**25.06**	9.39	Y	<25th	<25th
	Counseling on Nutrition - Total	R	A	0.22	31.13	0.33	40.40	<25th	**39.90**	-0.50	N	<25th	<25th
	Counseling on Physical Activity - Total	R	A	0.00	21.41	0.05	30.68	<25th	**34.06**	3.38	N	<25th	<25th
Childhood Immunization Status (CIS)	Combination 2 Immunizations	R	A	61.81	75.06	78.37	78.37	50th	**74.45**	-3.92	N	25th	25th
Immunizations for Adolescents (IMA)	Combination 1 Immunizations	R		2.73	11.65	50.99	51.88	<25th	**60.83**	8.95	Y	25th	NA
HPV for Female Ad 13 (HPV)		R		NA	NA	5.76	9.80	NA	**13.18**	3.38	Y	NA	NA
Lead Screening (LSC) √		R		53.69	55.28	59.12	60.61	25th	**61.31**	0.70	N	25th	NA
Breast Cancer (BCS) √		R	A	53.61	52.89	56.94	57.05	50th	**63.81**	6.76	Y	90th	50th
Cervical Cancer (CCS)**				60.40	70.86	70.86	68.75	50th	**65.31**	-3.44	Y	NA	NA
Chlamydia Screenings (CHL)	CHL Screening - Total	R	A	49.95	57.13	55.72	53.15	25th	**54.48**	1.33	N	25th	25th

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Admin Rate	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Respiratory Conditions													
Appropriate Testing for Children with Pharyngitis (CWP)		R	A	67.83	71.69	74.15	73.59	50th	**73.87**	0.28	N	50th	50th
Appropriate Treatment for Children with URI (URI)		R	A	84.67	84.24	82.49	79.54	<25th	**79.72**	0.18	N	<25th	<25th
Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)		R	A	24.95	21.09	24.32	19.50	25th	**18.39**	-1.11	N	25th	<25th
Use of Spirometry Testing in Assessment and Diagnosis of COPD (SPR)		R	A	32.84	48.05	34.29	35.24	50th	**32.16**	-3.08	N	50th	50th
Pharmacotherapy Management of COPD Exacerbation (PCE)	Systemic Corticosteroid	R	A	55.05	58.74	48.92	54.67	<25th	**57.14**	2.47	N	<25th	<25th
	Bronchodilator	R	A	80.30	77.18	71.43	77.75	<25th	**81.51**	3.76	N	25th	25th
Use of Appropriate Medications with People with Asthma (ASM) √	Combined Rate √		A	92.38	88.03	90.50	88.25	75th	**90.53**	2.28	Y	90th	75th
Medication Management for People with Asthma (MMA)	MMA - 75% Compliance	R		NA	NA	30.59	27.34	25th	**31.06**	3.72	Y	50th	NA
Asthma Medication Ratio (AMR)	Total Population Ratio > 50%	R		NA	NA	ND	60.32	NA	**72.67**	12.35	Y	NA	NA
Cardiovascular													
Cholesterol Mgmt (CMC)	LDL-C Screening	R	A	85.47	85.47	78.61	79.19	25th	**80.54**	1.35	N	25th	25th
	LDL-C Level < 100	R		31.62	31.62	37.43	34.84	<25th	**31.39**	-3.45	N	<25th	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Admin Rate	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Controlling High BP (CBP)	Total	R	A	35.21	41.72	53.98	54.20	25th	**42.05**	-12.15	Y	<25th	<25th
Diabetes													
Comp Diabetes Care (CDC)	HbA1c Testing	R	A	80.78	83.33	82.11	82.11	25th	**82.85**	0.74	N	25th	50th
	HbA1c Poor Control (>9)***		A	57.65	47.13	44.97	44.97	25th	**56.39**	11.42	Y	<25th	<25th
	HbA1c Adequate Control (<8)	R		34.89	45.02	55.03	55.03	75th	**35.77**	-19.26	Y	<25th	NA
	LDL-C Screening	R	A	70.15	72.61	74.11	74.11	25th	**70.62**	-3.49	N	<25th	25th
	LDL-C Level < 100	R		20.71	28.16	34.24	34.24	25th	**27.74**	-6.50	Y	<25th	NA
	Monitoring for Nephropathy	R	A	76.87	78.93	78.71	78.71	25th	**79.56**	0.85	N	50th	50th
	Eye Exam	R	A	55.22	61.69	56.05	56.05	50th	**50.73**	-5.32	N	25th	25th
	Blood Pressure Control (<140/80)	R		NA	26.05	27.94	27.94	<25th	**27.55**	-0.39	N	<25th	NA
	Blood Pressure Control (<140/90)	R		37.13	42.72	47.02	47.02	<25th	**46.17**	-0.85	N	<25th	NA
Musculoskeletal Conditions													
Use of Imaging for Low Back Pain (LBP)		R	A	71.77	72.11	72.92	72.63	25th	**74.77**	2.14	N	25th	<25th
Disease-Modifying Anti-Rheumatic Drug Therapy (DRT)		R		71.08	69.47	68.18	68.88	25th	**68.67**	-0.21	N	<25th	NA
Behavioral Health													
Antidepressant Medication Management (AMM)	Acute Phase	R	A	NB	NR	NB	48.67	25th	**45.65**	-3.02	N	<25th	25th
	Continuation	R	A	NB	NR	NB	33.71	25th	**30.53**	-3.18	N	<25th	25th
Follow-up with Children	Initiation	R	A	45.10	50.27	45.50	42.64	50th	**41.59**	-1.05	N	50th	50th

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Admin Rate	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Prescribed ADHD Medication (ADD)	Continuation	R	A	57.25	61.27	59.21	54.17	50th	**54.39**	0.22	N	50th	50th
Diabetes Screening for People with Schizophrenia or Bi-Polar Disorder Who Are Using Antipsychotic Medications (SSD)		R		NA	NA	NB	73.04	NA	**84.21**	11.17	Y	NA	NA
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		R		NA	NA	NB	68.56	NA	**73.45**	4.89	N	NA	NA
Follow-up Care for Hospitalization for Mental Illness (FUH)	7 Day	R	A	NB	NR	NB	NB	NB	**46.23**	NA	NA	50th	50th
	30 Day			NB	NR	NB	NB	NB	**66.32**	NA	NA	25th	NA
CVD Monitoring for People with CVD and Schizophrenia (SMC)		R		NA	NA	NB	NA	NA	NA	NA	NA	NA	NA
Adherence to Antipsychotic Medications for People with Schizophrenia (SAA)	80% Coverage	R		NA	NA	NB	72.58	NA	**73.15**	0.57	N	NA	NA
Access/Availability of Care													
Prenatal Postpart Care (PPC) √	Timeliness of Prenatal Care √	R	A	90.04	91.13	92.04	85.09	25th	**91.04**	5.95	N	75th	75th
	Postpartum Care √	R	A	69.03	71.62	71.24	66.82	75th	**74.63**	7.81	N	90th	75th
Adults Access to Preventative/Ambulatory Health Services (AAP) √	Total √			87.40	87.89	86.87	87.00	75th	**87.70**	0.70	Y	75th	NA
Children and Adolescents' Access to Primary Care Practitioners (CAP)	7-11 years	R		92.86	94.44	93.54	92.93	50th	**92.96**	0.03	N	50th	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Admin Rate	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Alcohol/Drug Dependence (IET)	Initiation of Treatment			NB	NR	NB	NB	NB	**NB**	**NB**	**NA**	**NB**	**NA**
	Engagement of Treatment			NB	NR	NB	NB	NB	**NB**	**NB**	**NA**	**NB**	**NA**
Utilization													
Annual Monitoring for Patients with Persistent Medications (MPM)	Combined Rate	R		86.72	86.70	87.02	86.21	50th	**87.57**	**1.36**	**Y**	**75th**	**NA**
Freq of Ongoing PNC (FPC)	81+ Percent of Expected Visits			66.46	70.10	69.23	72.93	50th	**67.44**	**-5.49**	**Y**	**50th**	**NA**
Well Child 15 Months (W15) √	6+ Well Child Visits √	R		56.62	56.42	60.60	59.68	25th	**63.82**	**4.14**	**N**	**25th**	**NA**
Well Child 3-6 Years (W34) √		R		62.49	66.03	62.58	60.52	<25th	**64.05**	**3.53**	**N**	**<25th**	**NA**
Adolescent Well Care (AWC) √		R		36.24	40.62	38.27	39.97	<25th	**48.66**	**8.69**	**N**	**50th**	**NA**
Annual Dental Visit (ADV)	Total			NB	NB	NB	NB	NA	**NB**	**NA**	**NA**	**NA**	**NA**
Ambulatory Care (AMB)	ER Visits/1000***			NA	56.83	56.23	58.61	**25th**	**59.42**	**0.81**	**Y**	**25th**	**NA**

***lower rate is better

MDWise Hoosier Alliance

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Final	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Preventive Screenings													
Adult BMI Assessment (ABA)		R	A	NA	NA	4.45	5.47	<25th	NA	NA	NA	NA	NA
Weight Assessment and Counseling (WCC)	BMI Screening - Total	R	A	0.00	0.20	0.43	0.00	<25th	NA	NA	NA	NA	NA
	Counseling on Nutrition - Total	R	A	0.00	0.40	0.32	50.36	25th	NA	NA	NA	NA	NA
	Counseling on Physical Activity - Total	R	A	0.00	0.00	0.01	37.47	25th	NA	NA	NA	NA	NA
Childhood Immunization Status (CIS)	Combination 2 Immunizations	R	A	17.40	12.42	69.59	69.59	<25th	NA	NA	NA	NA	NA
Immunizations for Adolescents (IMA)	Combination 1 Immunizations	R		22.70	32.30	90.75	88.44	90th	NA	NA	NA	NA	NA
HPV for Female Ad 13 (HPV)		R		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Lead Screening (LSC)		R		41.60	35.19	49.64	49.64	<25th	48.53	-1.11	NA	<25th	<25th
Breast Cancer (BCS)		R	A	41.30	38.03	35.68	35.25	<25th	40.94	5.69	NA	<25th	<25th
Cervical Cancer (CCS)**				63.50	64.92	57.53	61.57	25th	60.48	-1.09	NA	NA	NA
Chlamydia Screenings (CHL)	CHL Screening - Total	R	A	48.10	46.80	42.54	42.71	<25th	45.04	2.33	NA	<25th	<25th
Respiratory Conditions													
Appropriate Testing for Children with Pharyngitis (CWP)		R	A	52.70	51.43	54.42	57.07	<25th	54.56	-2.51	NA	<25th	<25th

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Final	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Appropriate Treatment for Children with URI (URI)		R	A	73.90	75.26	73.86	73.70	<25th	75.45	1.75	NA	<25th	<25th
Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)		R	A	24.00	21.45	19.48	18.72	25th	25.09	6.37	NA	25th	25th
Use of Spirometry Testing in Assessment and Diagnosis of COPD (SPR)		R	A	NA	NA	24.32	27.78	<25th	NA	NA	NA	NA	NA
Pharmacotherapy Management of COPD Exacerbation (PCE)	Systemic Corticosteroid	R	A	NA	NA	66.67	80.00	90th	NA	NA	NA	NA	NA
	Bronchodilator	R	A	NA	NA	78.57	91.43	90th	NA	NA	NA	NA	NA
Use of Appropriate Medications with People with Asthma (ASM)	Combined Rate		A	87.90	90.70	85.30	84.96	50th	84.44	-0.52	NA	<25th	25th
Medication Management for People with Asthma (MMA)	MMA - 75% Compliance	R		NA	NA	32.14	37.13	75th	31.47	-5.66	NA	50th	NA
Asthma Medication Ratio (AMR)	Total Population Ratio > 50%	R		NA	NA	NA	NA	NA	68.27	NA	NA	NA	NA
Cardiovascular													
Cholesterol Mgmt (CMC)	LDL-C Screening	R	A	78.40	61.36	63.64	68.25	<25th	NA	NA	NA	NA	NA
	LDL-C Level < 100	R		NA	0.00	0.00	38.10	25th	NA	NA	NA	NA	NA
Controlling High BP (CBP)	Total	R	A	NA	0.00	0.00	54.07	25th	NA	NA	NA	NA	NA
Diabetes													
Comp Diabetes Care (CDC)	HbA1c Testing	R	A	74.20	74.58	81.57	83.03	25th	77.33	-5.70	NA	<25th	<25th
	HbA1c Poor Control (>9)*		A	NA	95.15	44.53	42.70	<25th	NA	NA	NA	NA	NA
	HbA1c Adequate Control (<8)	R		NA	14.56	47.08	48.18	25th	NA	NA	NA	NA	NA

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	LDL-C Screening	R	A	72.50	63.86	66.97	66.24	<25th	64.68	-1.56	NA	<25th	<25th
	LDL-C Level < 100	R		NA	8.17	24.50	23.91	<25th	NA	NA	NA	NA	NA
	Monitoring for Nephropathy	R	A	81.60	55.17	58.88	67.15	<25th	61.15	-6.00	NA	<25th	<25th
	Eye Exam	R	A	40.70	40.74	59.49	59.49	50th	39.85	-19.64	NA	<25th	<25th
	Blood Pressure Control (<140/80)	R		NA	0.13	40.88	41.79	50th	NA	NA	NA	NA	NA
	Blood Pressure Control (<140/90)	R		NA	0.13	67.88	71.35	75th	NA	NA	NA	NA	NA
Musculoskeletal Conditions													
Use of Imaging for Low Back Pain (LBP)		R	A	71.20	72.95	68.02	71.69	25th	NA	NA	NA	NA	NA
Disease-Modifying Anti-Rheumatic Drug Therapy (DRT)		R		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Behavioral Health													
Antidepressant Medication Management (AMM)	Acute Phase	R	A	44.70	45.84	NB	NB	NB	49.26	NA	NA	25th	25th
	Continuation	R	A	27.60	30.18	NB	NB	NB	30.21	NA	NA	<25th	<25th
Follow-up with Children Prescribed ADHD Medication (ADD)	Initiation	R	A	46.60	55.02	42.17	55.77	90th	NA	NA	NA	NA	NA
	Continuation	R	A	69.20	62.36	52.01	66.67	90th	NA	NA	NA	NA	NA
Diabetes Screening for People with Schizophrenia or Bi-Polar Disorder Who Are Using Antipsychotic Medications (SSD)		R		NA	NA	NB	NB	NB	NA	NA	NA	NA	NA
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		R		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Follow-up Care for	7 Day	R	A	50.10	43.85	NB	NB	NB	44.52	NA	NA	25th	25th

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Hospitalization for Mental Illness (FUH)	30 Day			74.80	71.83	NB	NB	NB	**NA**	**NA**	**NA**	**NA**	**NA**
CVD Monitoring for People with CVD and Schizophrenia (SMC)		**R**		NA	NA	NB	NB	NB	**NA**	**NA**	**NA**	**NA**	**NA**
Adherence to Antipsychotic Medications for People with Schizophrenia (SAA)	80% Coverage	**R**		NA	NA	NB	NB	NB	**NA**	**NA**	**NA**	**NA**	**NA**
Access/Availability of Care													
Prenatal Postpart Care (PPC)	Timeliness of Prenatal Care	**R**	**A**	84.30	80.79	93.19	89.78	75th	**75.11**	**-14.67**	**NA**	**<25th**	**<25th**
	Postpartum Care	**R**	**A**	63.33	61.88	71.53	73.24	75th	**59.64**	**-13.60**	**NA**	**25th**	**<25th**
Adults Access to Preventative/Ambulatory Health Services (AAP)	Total			NA	NA	83.43	88.02	75th	**NA**	**NA**	**NA**	**NA**	**NA**
Children and Adolescents' Access to Primary Care Practitioners (CAP)	7-11 years	**R**		91.40	92.60	91.68	91.74	50th	**NA**	**NA**	**NA**	**NA**	**NA**
Alcohol/Drug Dependence (IET)	Initiation of Treatment			NA	NA	NB	NB	NB	**NA**	**NA**	**NA**	**NA**	**NA**
	Engagement of Treatment			NA	NA	NB	NB	NB	**NA**	**NA**	**NA**	**NA**	**NA**
Utilization													
Annual Monitoring for Patients with Persistent Medications (MPM)	Combined Rate	**R**		84.20	82.90	78.43	76.28	<25th	**NA**	**NA**	**NA**	**NA**	**NA**
Freq of Ongoing PNC (FPC)	81+ Percent of Expected Visits			68.70	67.19	59.04	83.21	90th	**57.72**	**NA**	**NA**	**NA**	**NA**
Well Child 15 Months (W15)	6+ Well Child Visits	**R**		48.40	54.08	62.77	65.21	50th	**60.98**	**NA**	**NA**	**NA**	**NA**

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Final	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Well Child 3-6 Years (W34)		**R**		69.30	68.43	63.45	69.34	25th	**68.78**	**NA**	**NA**	**NA**	**NA**
Adolescent Well Care (AWC)		**R**		52.00	59.22	47.17	50.85	50th	**49.40**	**NA**	**NA**	**NA**	**NA**
Ambulatory Care	ER Visits/1000***			NA	NA	67.45	66.58	50th	**NA**	**NA**	**NA**	**NA**	**NA**
	Outpatient/1000			NA	NA	NA	NA	NA	**NA**	**NA**	**NA**	**NA**	**NA**

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HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Final	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Preventive Screenings										
Adult BMI Assessment (ABA)		R	A	NA	NA	10.11	NA	NA	<25th	<25th
Weight Assessment and Counseling (WCC)	BMI Screening - Total	R	A	0.47	<25th	1.43	0.96	Y	<25th	<25th
	Counseling on Nutrition - Total	R	A	1.20	<25th	2.86	1.66	Y	<25th	<25th
	Counseling on Physical Activity - Total	R	A	0.01	<25th	0.26	0.25	Y	<25th	<25th
Childhood Immunization Status (CIS)	Combination 2 Immunizations	R	A	NA	NA	43.71	NA	NA	<25th	<25th
Immunizations for Adolescents (IMA)	Combination 1 Immunizations	R		73.68	50th	84.99	11.31	N	75th	NA
HPV for Female Ad 13 (HPV)		R		NA	NA	18.48	NA	NA	NA	NA
Lead Screening (LSC)		R		NA	NA	66.61	NA	NA	50th	NA
Breast Cancer (BCS)		R	A	NA	NA	NA	NA	NA	NA	NA
Cervical Cancer (CCS)**				44.49	<25th	49.93	5.44	Y	NA	NA
Chlamydia Screenings (CHL) √	CHL Screening - Total √	R	A	57.35	50th	55.84	-1.51	NA	25th	25th
Respiratory Conditions										
Appropriate Testing for Children with Pharyngitis (CWP)		R	A	NB	NB	50.57	NA	NA	<25th	<25th
Appropriate Treatment for Children with URI (URI)		R	A	NB	NB	71.43	NA	NA	<25th	<25th
Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)		R	A	NB	NB	25.52	NA	NA	50th	50th
Use of Spirometry Testing in Assessment and Diagnosis of COPD (SPR)		R	A	NA	NA	NA	NA	NA	NA	NA
Pharmacotherapy Management of COPD Exacerbation (PCE)	Systemic Corticosteroid	R	A	NB	NB	65.22	NA	NA	25th	25th
	Bronchodilator	R	A	NB	NB	85.77	NA	NA	75th	50th
Use of Appropriate Medications with People with Asthma (ASM)	Combined Rate		A	NB	NB	81.75	NA	NA	25th	25th
Medication Management for People with Asthma (MMA)	MMA - 75% Compliance	R		NB	NB	31.53	NA	NA	50th	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Final	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Asthma Medication Ratio (AMR)	Total Population Ratio > 50%	R		NB	NB	54.20	NA	NA	NA	NA
Cardiovascular										
Cholesterol Mgmt (CMC)	LDL-C Screening	R	A	NA	NA	78.95	NA	NA	25th	25th
	LDL-C Level < 100	R		NA	NA	6.02	NA	NA	<25th	<25th
Controlling High BP (CBP)	Total	R	A	NR	NR	0.00	NA	NA	<25th	<25th
Diabetes										
Comp Diabetes Care (CDC)	HbA1c Testing √	R	A	73.50	<25th	79.87	6.37	Y	25th	25th
	HbA1c Poor Control (>9)***		A	99.61	<25th	64.70	-34.91	Y	<25th	<25th
	HbA1c Adequate Control (<8)	R		0.39	<25th	30.51	30.12	Y	<25th	NA
	LDL-C Screening	R	A	66.63	<25th	73.96	7.33	Y	25th	25th
	LDL-C Level < 100	R		0.19	<25th	19.81	19.62	Y	<25th	<25th
	Monitoring for Nephropathy	R	A	79.79	50th	81.47	1.68	N	50th	50th
	Eye Exam	R	A	27.18	<25th	37.86	10.68	Y	<25th	<25th
	Blood Pressure Control (<140/80)	R		0.00	<25th	27.16	27.16	Y	<25th	<25th
	Blood Pressure Control (<140/90)	R		0.19	<25th	42.65	42.46	Y	<25th	<25th
Musculoskeletal Conditions										
Use of Imaging for Low Back Pain (LBP)		R	A	64.94	<25th	77.94	13.00	Y	50th	25th
Disease-Modifying Anti-Rheumatic Drug Therapy (DRT)		R		NB	NB	70.00	NA	NA	50th	NA
Behavioral Health										
Antidepressant Medication Management (AMM)	Acute Phase	R	A	NB	NB	41.87	NA	NA	<25th	<25th
	Continuation	R	A	NB	NB	31.82	NA	NA	<25th	<25th
Follow-up with Children Prescribed ADHD Medication (ADD)	Initiation	R	A	NB	NB	31.85	NA	NA	25th	<25th
	Continuation	R	A	NB	NB	35.49	NA	NA	25th	<25th
Diabetes Screening for People with Schizophrenia or Bi-Polar Disorder Who Are Using Antipsychotic Medications (SSD)		R		NB	NB	81.24	NA	NA	NA	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Final	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		R		68.09	NA	60.74	-7.35	N	NA	NA
Follow-up Care for Hospitalization for Mental Illness (FUH)	7 Day	R	A	NB	NB	NB	NA	NA	NA	NA
	30 Day			NB	NB	NB	NA	NA	NA	NA
CVD Monitoring for People with CVD and Schizophrenia (SMC)		R		NA	NA	NA	NA	NA	NA	NA
Adherence to Antipsychotic Medications for People with Schizophrenia (SAA)	80% Coverage	R		NB	NB	58.41	NA	NA	NA	NA
Access/Availability of Care										
Prenatal Postpart Care (PPC)	Timeliness of Prenatal Care	R	A	85.09	25th	77.83	-7.26	Y	<25th	<25th
	Postpartum Care	R	A	32.58	<25th	32.44	-0.14	N	<25th	<25th
Adults Access to Preventative/Ambulatory Health Services (AAP) √	Total √			77.71	<25th	83.16	5.45	Y	25th	NA
Children and Adolescents' Access to Primary Care Practitioners (CAP)	7-11 years	R		NA	NA	83.57	NA	NA	<25th	NA
Alcohol/Drug Dependence (IET)	Initiation of Treatment			NB	NB	NB	NA	NA	NA	NA
	Engagement of Treatment			NB	NB	NB	NA	NA	NA	NA
Utilization										
Annual Monitoring for Patients with Persistent Medications (MPM)	Combined Rate	R		NB	NB	86.48	NA	NA	50th	NA
Freq of Ongoing PNC (FPC)	81+ Percent of Expected Visits			58.14	25th	57.75	-0.39	N	25th	NA
Well Child 15 Months (W15)	6+ Well Child Visits	R		NA	NA	36.92	NA	NA	<25th	NA
Well Child 3-6 Years (W34) √		R		47.50	<25th	57.17	9.67	Y	<25th	NA
Adolescent Well Care (AWC) √		R		29.08	<25th	43.49	14.41	Y	25th	NA
Annual Dental Visit (ADV)	Total			NB	NA	51.95	NA	NA	50th	NA
Ambulatory Care (AMB)	ER Visits/1000***			NA	NA	76.85	NA	NA	75th	NA
***lower rate is better										

AmeriHealth District of Columbia

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2014 Final (Admin)	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Preventive Screenings						
Adult BMI Assessment (ABA)		R	A	NA	NA	NA
Weight Assessment and Counseling (WCC)	BMI Screening - Total	R	A	NA	NA	NA
	Counseling on Nutrition - Total	R	A	NA	NA	NA
	Counseling on Physical Activity - Total	R	A	NA	NA	NA
Childhood Immunization Status (CIS)	Combination 2 Immunizations	R	A	NA	NA	NA
Immunizations for Adolescents (IMA)	Combination 1 Immunizations	R		NA	NA	NA
HPV for Female Ad 13 (HPV)		R		NA	NA	NA
Lead Screening (LSC)		R		NA	NA	NA
Breast Cancer (BCS)		R	A	NA	NA	NA
Cervical Cancer (CCS)*				NA	NA	NA
Chlamydia Screenings (CHL)	CHL Screening - Total	R	A	NA	NA	NA
Respiratory Conditions						
Appropriate Testing for Children with Pharyngitis (CWP)		R	A	86.96	90th	90th
Appropriate Treatment for Children with URI (URI)		R	A	98.99	90th	90th
Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)		R	A	NA	NA	NA
Use of Spirometry Testing in Assessment and Diagnosis of COPD (SPR)		R	A	NA	NA	NA
Pharmacotherapy Management of COPD Exacerbation (PCE)	Systemic Corticosteroid	R	A	75.90	75th	75th
	Bronchodilator	R	A	93.98	90th	90th
Use of Appropriate Medications with People with Asthma (ASM)	Combined Rate		A	NA	NA	NA
Medication Management for People with Asthma (MMA)	MMA - 75% Compliance	R		NA	NA	NA
Asthma Medication Ratio (AMR)	Total Population Ratio > 50%	R		NA	NA	NA
Cardiovascular						
Cholesterol Mgmt (CMC)	LDL-C Screening	R	A	NA	NA	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2014 Final (Admin)	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
	LDL-C Level < 100	R		NA	NA	NA
Controlling High BP (CBP)	Total	R	A	NA	NA	NA
Diabetes						
Comp Diabetes Care (CDC)	HbA1c Testing	R	A	NA	NA	NA
	HbA1c Poor Control (>9)*		A	NA	NA	NA
	HbA1c Adequate Control (<8)	R		NA	NA	NA
	LDL-C Screening	R	A	NA	NA	NA
	LDL-C Level < 100	R		NA	NA	NA
	Monitoring for Nephropathy	R	A	NA	NA	NA
	Eye Exam	R	A	NA	NA	NA
	Blood Pressure Control (<140/80)	R		NA	NA	NA
	Blood Pressure Control (<140/90)	R		NA	NA	NA
Musculoskeletal Conditions						
Use of Imaging for Low Back Pain (LBP)		R	A	85.83	90th	90th
Disease-Modifying Anti-Rheumatic Drug Therapy (DRT)		R		NA	NA	NA
Behavioral Health						
Antidepressant Medication Management (AMM)	Acute Phase	R	A	NA	NA	NA
	Continuation	R	A	NA	NA	NA
Follow-up with Children Prescribed ADHD Medication (ADD)	Initiation	R	A	NA	NA	NA
	Continuation	R	A	NA	NA	NA
Diabetes Screening for People with Schizophrenia or Bi-Polar Disorder Who Are Using Antipsychotic Medications (SSD)		R		NA	NA	NA
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		R		NA	NA	NA
Follow-up Care for Hospitalization for Mental Illness (FUH)	7 Day	R	A	NA	NA	NA
	30 Day			NA	NA	NA
CVD Monitoring for People with CVD and Schizophrenia (SMC)		R		NA	NA	NA
Adherence to Antipsychotic Medications for People with Schizophrenia (SAA)	80% Coverage	R		NA	NA	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2014 Final (Admin)	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Access/Availability of Care						
Prenatal Postpart Care (PPC)	Timeliness of Prenatal Care	R	A	78.50	<25th	<25th
	Postpartum Care	R	A	42.14	<25th	<25th
Adults Access to Preventative/Ambulatory Health Services (AAP)	Total			NA	NA	NA
Children and Adolescents' Access to Primary Care Practitioners (CAP)	7-11 years	R		NA	NA	NA
Alcohol/Drug Dependence (IET)	Initiation of Treatment			NB	NB	NB
	Engagement of Treatment			NB	NB	NB
Utilization						
Annual Monitoring for Patients with Persistent Medications (MPM)	Combined Rate	R		NA	NA	NA
Freq of Ongoing PNC (FPC)	81+ Percent of Expected Visits			36.36	<25th	<25th
Well Child 15 Months (W15)	6+ Well Child Visits	R		NA	NA	NA
Well Child 3-6 Years (W34)		R		NA	NA	NA
Adolescent Well Care (AWC)		R		NA	NA	NA
Ambulatory Care (AMB)	ER Visits/1000***			69.18	50th	NA
Annual Dental Visit (ADV)	Total			NA	NA	NA
*lower is better						

Implementation Plan

ID	Task Name	Duration	Start	Finish	Staff Responsibilities
1	**New Business Activation (NBA) Implementation**	**330 days**	**Mon 2/9/15**	**Wed 5/25/16**	**ALL**
2	**Request For Proposal (RFP) - Contract**	**64 days**	**Mon 2/9/15**	**Fri 5/8/15**	**Opportunity**
3	**Proposal and Applications**	**64 days**	**Mon 2/9/15**	**Fri 5/8/15**	**Opportunity**
45	**RFP Contract: Proposal and Application - Complete**	0 days	Fri 5/8/15	Fri 5/8/15	Opportunity
46	**Pre-Implementation Phase**	**33 days**	**Tue 4/7/15**	**Fri 5/22/15**	**PMO**
47	**Project Management Office (PMO) Activities**	**33 days**	**Tue 4/7/15**	**Fri 5/22/15**	**PMO**
57	**Upfront Deliverables**	0 days	Fri 5/8/15	Fri 5/8/15	PMO, Opportunity
93	**Pre-Initiation Phase - Complete**	0 days	Fri 5/22/15	Fri 5/22/15	PMO
94	**Initiation Phase**	**115 days**	**Wed 4/8/15**	**Fri 9/18/15**	**PMO**
95	**New Business Activation (NBA) Activities**	**5 days**	**Fri 5/8/15**	**Thu 5/14/15**	**PMO**
119	**PMO Activities**	**115 days**	**Wed 4/8/15**	**Fri 9/18/15**	**PMO**
189	**IS Infrastructure Development Environement Builds (must be competed prior to formal planning begins)**	**42 days**	**Wed 5/13/15**	**Mon 7/13/15**	**IS**
215	**Initiation Phase - Complete**	0 days	Fri 9/18/15	Fri 9/18/15	IS
216	**Planning Phase**	**159 days**	**Fri 2/20/15**	**Mon 10/5/15**	**PMO,Human Resource, Facilities, Provider Network**
217	**Monitoring and Controlling**	**82 days**	**Thu 5/14/15**	**Wed 9/9/15**	**PMO**
276	**Business Cross Functional Information**	**6 days**	**Fri 7/31/15**	**Fri 8/7/15**	**PMO, Finance**
297	PMO Traceability Matrix Activities	15 days	Tue 6/30/15	Tue 7/21/15	PMO
298	**Business Associate Agreement (BAA)**	**16 days**	**Wed 5/20/15**	**Thu 6/11/15**	**PMO, All**
318	**Human Resources**	**26 days**	**Wed 4/8/15**	**Wed 5/13/15**	**Human Resources**
329	**Facilities**	**100 days**	**Thu 5/14/15**	**Mon 10/5/15**	**Facilities**
387	**Provider Network / Management / Operations / Credentialing**	**123 days**	**Fri 2/20/15**	**Thu 8/13/15**	**Provider Network**
421	**Configuration**	**10 days**	**Tue 4/28/15**	**Mon 5/11/15**	**Configuration**
443	**Finance**	**70 days**	**Wed 5/20/15**	**Thu 8/27/15**	**Finance**
463	**Communications**	**20 days**	**Wed 5/20/15**	**Wed 6/17/15**	**Communication**
495	**Enrollment**	**10 days**	**Wed 5/20/15**	**Wed 6/3/15**	**Enrollment**
532	**Claims**	**3 days**	**Wed 5/20/15**	**Fri 5/22/15**	**Claims**
542	**Contact Center**	**10 days**	**Wed 5/20/15**	**Wed 6/3/15**	**Contact Center**
598	**Medical Management**	**5 days**	**Wed 5/20/15**	**Wed 5/27/15**	**Medical Manageme**
607	**Payment Integrity**	**5 days**	**Fri 8/7/15**	**Thu 8/13/15**	**Payment Integrity**
630	**Provider Data Management**	**5 days**	**Wed 5/20/15**	**Wed 5/27/15**	**Provider Data**
640	**Business Continuity / Disaster Recovery**	**3 days**	**Wed 5/20/15**	**Fri 5/22/15**	**Business Continuity**

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ID	Task Name	Duration	Start	Finish	Staff Responsibilities
643	Sourcing	60 days	Wed 5/20/15	Thu 8/13/15	Sourcing
655	Information Technology / Solutions	95 days	Mon 4/27/15	Wed 9/9/15	IS
674	Planning Phase - Complete	0 days	Mon 10/5/15	Mon 10/5/15	Provider Network
675	Design Phase	156 days	Wed 2/25/15	Mon 10/5/15	ALL
676	Facilities	23 days	Fri 8/21/15	Wed 9/23/15	Facilities
684	Provider Network	105 days	Wed 2/25/15	Thu 7/23/15	Provider Network
702	Communications	38 days	Thu 5/21/15	Wed 7/15/15	Communications
709	Contact Center	16 days	Thu 6/4/15	Thu 6/25/15	Contact Center
722	Configuration	17 days	Tue 5/5/15	Thu 5/28/15	Configuration
742	Payment Integrity	10 days	Fri 8/14/15	Thu 8/27/15	Payment Integrity
750	Provider Data Management	15 days	Thu 5/28/15	Wed 6/17/15	Provider Data
760	Information Solutions	46 days	Mon 5/18/15	Wed 7/22/15	IS
776	Design Phase - Complete	0 days	Mon 10/5/15	Mon 10/5/15	All
777	Development Phase	267 days	Mon 2/9/15	Fri 2/26/16	All
778	HUMAN RESOURCES	228 days	Mon 2/9/15	Mon 1/4/16	Human Resources
1252	Facilities - Phase II	43 days	Wed 9/23/15	Mon 11/23/15	Facilities
1291	Provider Network / Management/Operations/Credentialing	148 days	Tue 5/26/15	Wed 12/23/15	Provider Network
1356	Configuration	52 days	Tue 5/12/15	Fri 7/24/15	Configuration
1393	Finance	204 days	Mon 2/9/15	Tue 11/24/15	Finance
1442	Communications	190 days	Wed 5/20/15	Fri 2/19/16	Communication
1738	Enrollment & Eligibility	195 days	Wed 5/20/15	Fri 2/26/16	Enrollment
1826	Claims	195 days	Wed 5/20/15	Fri 2/26/16	Claims
1929	Contact Center	116 days	Wed 5/20/15	Mon 11/2/15	Contact Center
2094	OLH (Online Help) Development	31 days	Mon 6/29/15	Tue 8/11/15	Online Help
2106	Medical Management	137 days	Wed 5/13/15	Tue 11/24/15	Medical Manageme
2247	Payment Integrity	125 days	Thu 5/7/15	Mon 11/2/15	Payment Integrity
2293	Provider Data Management	38 days	Mon 6/1/15	Thu 7/23/15	Provider Data
2325	Sourcing	118 days	Thu 5/28/15	Wed 11/11/15	Sourcing
2365	Compliance	181 days	Wed 5/20/15	Mon 2/8/16	Compliance
2463	Reports	126 days	Wed 5/20/15	Mon 11/16/15	Reports
2482	Information Technology / Solutions	209 days	Wed 4/29/15	Thu 2/25/16	IS
2612	Business Continuity / Disaster Recovery	45 days	Thu 6/11/15	Thu 8/13/15	Business Continuity
2615	Transition Plan	20 days	Wed 7/22/15	Tue 8/18/15	IS

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ID	Task Name	Duration	Start	Finish	Staff Responsibilities
2618	**Pharmacy**	**136 days**	**Wed 4/8/15**	**Mon 10/19/15**	**Pharmacy**
2636	**Development Phase - Complete**	0 days	Fri 2/26/16	Fri 2/26/16	IS
2637	**Testing Phase**	**179 days**	**Thu 6/11/15**	**Fri 2/26/16**	**All**
2638	Receive notice for all vendor BAAs	0 days	Thu 6/11/15	Thu 6/11/15	IS,Sourcing
2639	**Develop Test Plans**	**15 days**	**Tue 6/30/15**	**Tue 7/21/15**	**IS**
2643	**System Integration Testing (SIT)**	**45 days**	**Wed 7/22/15**	**Wed 9/23/15**	**IS**
2661	**Quality Assurance (QA) Environment**	**47 days**	**Tue 8/25/15**	**Thu 10/29/15**	IS
2680	**User Acceptance Testing (UAT) Environment**	**61 days**	**Wed 8/26/15**	**Thu 11/19/15**	IS
2703	**Testing Phase - Complete**	0 days	Fri 2/26/16	Fri 2/26/16	IS
2704	**Facility Final Preparations**	**186 days**	**Wed 4/8/15**	**Mon 1/4/16**	**IS**
2705	**Facilities Phase 3 Activities - Equipment Order (Non-TeleComm)**	10 days	Thu 9/24/15	Wed 10/7/15	Facilities
2706	**Facilities Phase 4 - Equipment Installation**	**65 days**	**Tue 9/29/15**	**Mon 1/4/16**	**Facilities**
2749	**Facility - Temporary Location**	**60 days**	**Wed 4/8/15**	**Wed 7/1/15**	**Facilities**
2754	**Facility Final Preparations - Complete**	0 days	Mon 1/4/16	Mon 1/4/16	Facilities
2755	**Readiness Review**	**27 days**	**Mon 10/19/15**	**Tue 11/24/15**	**Readiness**
2756	Receive notification from Iowa when Readiness will occur	0 days	Mon 10/19/15	Mon 10/19/15	Readiness
2757	Schedule debrief meeting for Readiness Participants	2 days	Thu 10/22/15	Fri 10/23/15	Readiness
2758	Coordinate Travel for on-site review	4 days	Mon 10/19/15	Thu 10/22/15	Readiness
2759	**AmeriHealth Readiness Review**	**20 days**	**Mon 10/19/15**	**Fri 11/13/15**	**Readiness**
2775	**State Readiness**	**25 days**	**Wed 10/21/15**	**Tue 11/24/15**	**Readiness**
2791	**Post Readiness Phase**	**10 days**	**Wed 11/25/15**	**Thu 12/10/15**	**Readiness, IS**
2792	Post Readiness Review follow-up to identify additional development and testing	10 days	Wed 11/25/15	Thu 12/10/15	Readiness, IS
2793	**Post Readiness Phase: Complete**	0 days	Thu 12/10/15	Thu 12/10/15	Readiness, IS
2794	**Deployment**	**190 days**	**Thu 5/28/15**	**Fri 2/26/16**	**IS**
2795	**System Access Requests (ACA Form Request)**	**31 days**	**Thu 5/28/15**	**Fri 7/10/15**	**IS**
2817	**Training Execution - Operations**	**153 days**	**Thu 6/4/15**	**Wed 1/13/16**	Human Resources, P
2851	**Open Enrollment**	**2 days**	**Fri 12/11/15**	**Mon 12/14/15**	**Enrollment, Contact**
2856	**Deployment Phase - Complete**	0 days	Fri 2/26/16	Fri 2/26/16	ALL
2857	**Go-Live**	**54 days**	**Thu 12/10/15**	**Fri 2/26/16**	**IS, All**
2858	**Go-Live - Day 0 - Enrollment, Call Center, etc**	**10 days**	**Thu 12/10/15**	**Wed 12/23/15**	**IS, All**
2868	**Go-Live - Day 1 - Claims Processing**	**13 days**	**Fri 12/11/15**	**Fri 1/1/16**	**IS, All**
2875	**Go-Live - Day 2 - Encounter Processing**	**3 days**	**Mon 2/15/16**	**Wed 2/17/16**	**IS, All**

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Provider Contract Agreement Templates (Hospital)

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

AMERIHEALTH CARITAS IOWA, INC.

HOSPITAL SERVICES AGREEMENT

with

[PROVIDER NAME]

AMERIHEALTH CARITAS IOWA, INC.
HOSPITAL SERVICES AGREEMENT

This Hospital Services Agreement (the "Agreement"), dated as of the Effective Date (defined below), is made by and between **AmeriHealth Caritas Iowa, Inc.**, a corporation organized under the laws of the State of Iowa, (hereinafter referred to as "ACIA") and the Hospital provider ("Hospital") identified on the signature page.

WHEREAS, ACIA is a managed care organization that is responsible for providing or arranging for the provision of health care services to its Members; and

WHEREAS, Hospital is duly licensed to furnish certain health care services; and

WHEREAS, Hospital and ACIA mutually desire to enter into this Agreement, whereby Hospital shall render services to Members enrolled with ACIA and be compensated by ACIA in accordance with the terms and conditions hereof.

NOW, THEREFORE, in consideration of the mutual promises made herein, it is mutually agreed by and between ACIA and Hospital as follows:

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1. DEFINITIONS

As used in this Agreement, each of the following terms shall have the meaning specified herein, unless the context clearly requires otherwise.

1.1 **AFFILIATES.** An Affiliate is any corporation or other organization that is identified as an Affiliate in a written notice to Hospital and is owned or controlled, either directly or through parent or subsidiary corporations, by or under common control with, ACIA. ACIA shall give Hospital thirty (30) days advance written notice of the addition of Affiliates added under this provision. Unless otherwise specified in this Agreement or any other attachment hereto, references to "ACIA" shall include the Affiliates referenced in **Appendix B**.

1.2 **AGENCY.** The State and/or Federal governmental agency that administers the Program(s) under which ACIA is obligated to provide or arrange for the provision of Covered Services.

1.3 **AGENCY CONTRACT.** The contract or contracts between ACIA and the Agency, as in effect from time to time, pursuant to which ACIA is responsible for coordinating health care services and supplies for Program recipients enrolled with ACIA.

1.4 **CLEAN CLAIM.** A claim for payment for a health care service, which has been received by ACIA, has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. Consistent with **42 CFR §447.45(b)**, the term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim, or a claim under review for medical necessity.

1.5 **COVERED SERVICES.** Those Medically Necessary health care services and supplies to which Members are entitled pursuant to the Agency Contract, and which shall be provided to Members by

Hospital, as described more specifically in **Appendix A**. Covered Services shall be furnished in the amount, duration and scope required under the Program.

1.6 **EFFECTIVE DATE.** The later of (i) the effective date on the signature page of this Agreement or (ii) the effective date of the Agency Contract, provided that Hospital has been successfully credentialed by ACIA and that all required regulatory approvals have been obtained by ACIA.

1.7 **EMERGENCY MEDICAL CONDITION.** Health care services provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the health of the Member (or with respect to a pregnant woman, the health of the Member or her unborn child) in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

1.8 **EMERGENCY SERVICES.** Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. Section 438.114(a) and 42 U.S.C. Section 1932(b)(2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition.

1.9 **MEDICALLY NECESSARY.** Those Covered Services that are, under the terms and conditions of the Agency Contract, determined through ACIA utilization management to be: (1) appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Member; (2) provided for the diagnosis or direct care and treatment of the condition of Member enabling the Member to make reasonable progress in treatment; (3) within standards of professional practice and given at the appropriate time and in the appropriate setting; (4) not primarily for the convenience of the Member, the Member's physician or other provider; and (5) the most appropriate level of Covered Services which can safely be provided. **(Ref. Agency Contract – Scope of Work document)**

1.10 **MEMBER.** An individual who is eligible for the Program and who has enrolled in ACIA under the Program.

1.11 **MEMBER APPEAL PROCEDURES.** The written procedures describing ACIA's standards for the prompt resolution of Member problems, grievances and appeals, as described in the Provider Manual.

1.12 **PARTICIPATING HOSPITAL.** A duly licensed hospital which has entered into an agreement with ACIA to provide hospital-based Covered Services to Members.

1.13 **PARTICIPATING PROVIDER.** A physician duly licensed to practice medicine in the State of Iowa, participating in or eligible to participate in the Iowa Medicaid program, and who is a member of the medical staff of a(n) ACIA- participating hospital, or a licensed, appropriately supervised allied health professional, either of whom has entered into, or who is recognized by ACIA as a member of a group which has entered into, an agreement with ACIA to provide medical services to Members under the Program.

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1.14 **PRIMARY CARE PROVIDER.** A duly licensed pediatrician, internist, family practitioner, or doctor of general medicine, obstetrician/gynecologist or group thereof or a licensed, appropriately supervised allied health professional, who has been successfully credentialed by, and is a Participating Provider with ACIA, and who is responsible for the supervision, coordination, and provision of primary care services to Members who have selected, or have been assigned to, that provider. The Primary Care Provider also is responsible for initiating any required referrals for specialty care needed by a Member and maintaining overall continuity of a Member's care.

1.15 **PROGRAM.** The Iowa High Quality Health Initiative procured by the Iowa Department of Human Services ("IDHS") under RFP #MED-16-009, for the delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (*hawk-i*) programs.

1.16 **PROVIDER MANUAL.** The ACIA manual of standards, policies, procedures and corrective actions together with amendments or modifications ACIA may adopt from time to time. The Provider Manual is herein incorporated by reference and made part of this Agreement. The Provider Manual may be amended or modified by ACIA from time to time in accordance with Section 3.3 herein below.

1.17 **QUALITY MANAGEMENT PROGRAM.** An ongoing review process and plan which functions to define, monitor, review, and recommend corrective action for managing and improving the quality of health care services to Members.

1.18 **UTILIZATION MANAGEMENT PROGRAM.** A process of review of the medical necessity, appropriateness and efficiency of health care services, procedures, equipment, supplies, and facilities rendered to Members.

2. OBLIGATIONS OF HOSPITAL:

2.1 Throughout the term of this Agreement, Hospital shall have and maintain, without restriction, all licenses, certificates, registrations and permits as are required under applicable State and federal statutes and regulations to provide the Covered Services furnished by Hospital and/or other related activities delegated by ACIA under this Agreement. Hospital shall obtain a unique identifier (national provider identifier) in accordance with the system established under Section 1173(b) of the Social Security Act, submit such identifier number to ACIA, and include such identifier on all claims. At all times during the term of this Agreement, Hospital shall be eligible for participation in the Iowa Medicaid program; and, if required by the Iowa Medicaid program as a condition of furnishing services to Iowa Medicaid recipients, Hospital shall participate in the Iowa Medicaid program. To the extent that Covered Services are furnished to Medicare beneficiaries under this Agreement, Hospital shall also participate in the Medicare program. Hospital shall ensure that all services provided pursuant to this Agreement are within the Hospital's scope of professional responsibility.

2.2 Hospital shall provide to Members the Covered Services described in **Appendix A** hereto; provided, however, that Hospital shall only be obligated to provide Covered Services to a Member upon an admission or referral of said Member to Hospital by a Participating Provider and otherwise in accordance with ACIA's admission policies as described in the Provider Manual, other than Emergency Services, which will be provided as needed. In providing Covered Services, Hospital agrees to abide by the relevant standards, policies and procedures of ACIA, including, but not limited to administrative, credentialing, quality management, utilization management, and Member Appeal Procedures set forth in the Provider Manual and other ACIA

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notices. Hospital shall provide Covered Services in the same manner and with the same availability as services provided to other patients without regard to reimbursement and shall further provide these services in the most cost effective setting in accordance with appropriate quality of care and performance standards which are professionally recognized as industry standards and/or otherwise adopted, accepted or established by ACIA.

2.3 Hospital shall ensure that any employed physician, or any physician practice which Hospital or Hospital affiliate owns or controls that has admitting privileges at or provides services at the Hospital, shall accept all Members. Hospital shall notify ACIA within sixty (60) days of the acquisition of any physician practice by Hospital or a Hospital affiliate if such practice has admitting privileges at or provides services at the Hospital. Hospital acknowledges that if any acquired physician practice is participating with ACIA at the time of such acquisition, appropriate addenda shall be executed by Hospital or Hospital affiliate, physician/physician practice and ACIA, as may be applicable. If the physician practice or new employed physician is not participating with ACIA at the time of such acquisition or employment, as applicable, upon request by ACIA, Hospital shall ensure that such physician promptly apply for ACIA participation, comply with ACIA credentialing requirements and execute an appropriate ACIA provider agreement. ACIA's credentialing process must be successfully completed prior to providing services to Members. In the event Hospital or Hospital affiliate must limit the growth of any such acquired physician practice due to capacity constraints, Hospital or the Hospital affiliate shall cause the practice to make itself available to Members on the same basis as it is to any other patients.

2.4 Hospital shall provide ACIA with complete and accurate statements of all Covered Services provided to Members in conformance with ACIA billing procedures, including without limitation, use of complete applicable diagnosis, procedure and revenue codes, and applicable Present on Admission (POA) indicators for primary and secondary diagnoses. ACIA will not be liable for any bills relating to services that are submitted the later of: (a) after twelve (12) months from the date the services were provided or the Member was discharged (consistent with **42 CFR §447.45(d)**), or (b) after sixty (60) days of the date of the Explanation of Benefits from another payor when services are first billed by Hospital to another payor. Any appeal or request for adjustment of a payment by Hospital must be made in accordance with applicable provisions of the Provider Manual and ACIA policies and procedures and, in any case, must be received by ACIA within sixty (60) days of the original payment or denial. Hospital may not bring legal action on claims which have not been appealed through the appeal mechanisms described herein.

Encounter Data and Other Reports. Hospital shall deliver all reports and clinical information required to be submitted to ACIA pursuant to this Agreement for reporting purposes, including but not limited to encounter data, Healthcare Effectiveness Data and Information Set (HEDIS), Agency for Healthcare Research and Quality (AHRQ), and EPSDT data in a format which will allow ACIA to transmit required data to the Agency electronically and in a format identical to or consistent with the format used or otherwise required by ACIA and the Agency. Hospital shall submit this information to ACIA within the time frames set forth in the Provider Manual or as otherwise required by the Agency. Hospital shall submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by ACIA.

2.5 Hospital's charges for Covered Services to Members shall be the same as its charges to all patients for the same services. During the term of this Agreement, Hospital shall maintain in its accounting records a system of recording gross charges by patient and payor. Hospital shall

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submit its then current schedule of charges by revenue code and procedure code to ACIA upon thirty (30) days prior written request.

2.6 Hospital may directly bill Members for non-Covered Services if the Member is advised in writing before the service is rendered: (i) the nature of the service(s) to be rendered; (ii) that ACIA does not cover the services; and (iii) that the Member will be financially responsible for the services if the Member elects to receive the services. Furthermore, Hospital shall hold harmless ACIA for any claim or expense arising from such services.

2.7 Hospital shall not bill or collect from any Member any amount or charges for any Covered Services provided hereunder, except for authorized co-payments, co-insurance, and/or deductibles. Hospital shall not deny Covered Services to a Member in the event that a Member is unable to pay any authorized co-payment amounts. **42 CFR §447.15.**

2.8 Under no circumstances, including ACIA's failure to pay for Covered Services, termination of this Agreement, or the insolvency of ACIA, will Hospital make any charges or claims against any Member directly or indirectly for Covered Services authorized by ACIA, except for authorized co-payments. Hospital shall look only to ACIA for compensation for Covered Services.

2.9 During the term of this Agreement and in the event of termination of this Agreement for any reason, Hospital agrees to fully cooperate with each Member and with ACIA in arranging for the transfer of copies of Member medical records to other ACIA participating providers.

2.10 Record Maintenance, Inspection, Reporting and Auditing

(a) Record Retention. As required by **42 CFR 434.6(a)(7)** and otherwise in accordance with the standards of ACIA, Hospital shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Members pursuant to this Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Agreement and the Agency Contract).

(b) All records originated or prepared in connection with Hospital's performance of its obligations under this Agreement will be retained and safeguarded by Hospital in accordance with the terms and conditions of the Agency Contract and other relevant State and federal law. Hospital agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Members relating to the delivery of care or service under the Agency Contract and as further required by the Agency, for a period of no less than seven (7) years from the expiration date of the Agency Contract, including any contract extension(s), and to retain all Member records, including but not limited to administrative, financial and medical records (whether electronic or paper) for a period of no less than seven (7) years after the last payment was made for services provide to the Member. If any audit, litigation, claim, or other actions involving the records have been initiated prior to the expiration of the seven (7) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the seven (7) year period, whichever is later. If Hospital stores records on microfilm or microfiche or other electronic means, Hospital agrees to produce, at its expense, legible hard copy records promptly upon the request of state or federal authorities.

(c) Medical Record Maintenance. Hospital shall ensure that all medical records are in compliance with the medical record keeping requirements set forth in the Provider Manual,

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the Agency Contract and Agency guides. Hospital shall maintain up-to-date medical records at the site where medical services are provided for each Member enrolled under this Agreement. Each Member's record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment.

(d) ACIA shall be entitled to audit, examine and inspect Hospital's books and records, including but not limited to medical records, financial information and administrative information pertaining to Hospital's relationship with ACIA, at any time during normal business hours, upon reasonable notice. Hospital agrees to provide ACIA, at no cost to ACIA, with such medical, financial and administrative information, and other records as may be necessary for ACIA to meet its obligations related to the Agency Contract and other regulatory obligations, Utilization Management Program and Quality Management Program standards, including NCQA standards, and other relevant accreditation standards which ACIA may require of ACIA participating providers.

2.11 Hospital authorizes ACIA to include Hospital's name, address, telephone number, information related to Hospital's facilities, services and staff, and other similar information relevant to Hospital, its operations and staff in the ACIA provider directory and in various marketing materials identifying Provider as a provider of services to Members. Hospital agrees to afford ACIA the same opportunity to display brochures, signs, or advertisements in Hospital's facilities as Hospital affords any other insurance company or other third party payor.

2.12 While both parties support Hospital's open and active communication with Members concerning Medically Necessary services, available treatment alternatives, benefit coverage information and/or any other information pertaining to the hospital-patient relationship, Hospital shall not, during the term of this Agreement, and any renewal thereof, solicit or require any Member, either orally or in writing, to subscribe to or enroll in any managed care plan other than ACIA. The provisions of this Section 2.12 shall similarly apply to Hospital's employees, agents and/or contractors.

2.13 Hospital shall cooperate with ACIA in the identification of other sources of payment available to Members, such as other health insurance, government programs, liability coverage, motor vehicle coverage or worker's compensation coverage, as applicable. Hospital shall be responsible for reporting all applicable third party resources to ACIA in a timely manner.

Hospital will cooperate with ACIA in coordinating benefits with other payors in accordance with coordination of benefits claim processing rules and requirements outlined in the Provider Manual, the Agency Contract, and applicable Program manuals, as amended from time to time. Hospital will make a reasonable attempt to determine whether any other payor has primary responsibility for the payment of a claim for services that Hospital rendered to a Member and bill that payor before billing ACIA. Unless otherwise prohibited by applicable law, ACIA retains the right to recover payments made to Hospital in the event ACIA determines that another payor is primarily responsible for all or a portion of the claim.

2.14 Hospital understands and agrees that any payments ACIA makes directly or indirectly to Hospital under this Agreement shall not be made as an inducement to reduce, limit or delay Medically Necessary services to any Member.

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2.15 Hospital will refer Members to ACIA-participating hospitals whenever Hospital is unable to provide Medically Necessary services and when consistent with sound medical judgment and accepted standards of care.

2.16 Hospital shall use best efforts to use ACIA's electronic utilization management and claims interfaces to improve the efficiency of utilization management and claims payment processes.

2.17 Hospital will assist ACIA in providing orientation services to Hospital staff to the extent ACIA may reasonably request.

2.18 Fraud and Abuse. Hospital recognizes that payments made by ACIA pursuant to this Agreement are derived from federal and State funds, and acknowledges that it may be held civilly and/or criminally liable to ACIA and/or the Agency, in the event of non-performance, misrepresentation, fraud or abuse for services rendered to Members, including but not limited to, the submission of false claims/statements for payment by Hospital, its employees or agents. Hospital shall be required to comply with all policies and procedures as developed by ACIA and the Agency, including but not limited to the requirements set forth in the Provider Manual and the Agency Contract, for the detection and prevention of fraud and abuse. Such compliance may include, but not be limited to, referral of suspected or confirmed fraud or abuse to ACIA.

3. OBLIGATIONS OF ACIA:

3.1 ACIA shall pay Hospital for Covered Services provided to Members pursuant to the terms of this Agreement. ACIA shall have the right to offset claims payments to Hospital by any amount owed by Hospital to ACIA, following at least thirty (30) days' written notice. Hospital shall not be entitled to reimbursement if the Member was not eligible at the time services were rendered.

3.2 ACIA shall compensate Hospital for Covered Services provided to Members upon receipt of a statement thereof, as defined in Section 2.4, and in accordance with Section 2.13 and the Covered Services Payment Schedule set forth in **Appendix A-1** but, in no event, will ACIA's payment exceed submitted charges. No additional charges will be made by Hospital to ACIA for Covered Services provided hereunder, and Hospital recognizes and accepts the fees set forth in **Appendix A-1** as payment in full.

3.2 ACIA will establish payment policies for inpatient and outpatient services including, but not limited to, policies with respect to pre-admission testing, services included in inpatient rates and services included in outpatient rates. ACIA will provide at least thirty (30) days' prior written notice of any modifications to such payment policies. ACIA may, based on changes in clinical practice and modifications to standard coding systems, add and/or delete outpatient fee schedule procedures and re-categorize outpatient surgery fee schedule procedures, upon thirty (30) days' prior written notice to Hospital.

3.3 ACIA shall furnish or otherwise make available to Hospital a copy of the Provider Manual, as amended from time to time. Provider Manual updates will become effective thirty (30) days from the date of notification, unless otherwise specified in writing by ACIA.

3.4 ACIA shall pay all Clean Claims for Covered Services in accordance with applicable laws, regulations and Agency requirements; and ACIA will in any event meet the claim payment timeframes required under **42 CFR §447.45(d)**.

3.5 Hospital Protections.

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(a) ACIA shall not exclude or terminate Hospital from ACIA's provider network because the Hospital advocated on behalf of a Member including in the context of a utilization management appeal or another dispute with ACIA over appropriate medical care, provided that such advocacy is consistent with the degree of learning and skill ordinarily possessed by a health care provider practicing in accordance with the applicable standard of care.

(b) No Hospital shall be excluded or terminated from participation with ACIA due to the fact that the Hospital has a practice that includes a substantial number of patients with expensive medical conditions.

(c) Hospital shall not be excluded from participation, nor shall this Agreement be terminated, because Hospital objects to the provision of or refuses to provide a healthcare service on moral or religious grounds.

4. QUALITY MANAGEMENT/UTILIZATION MANAGEMENT:

4.1 Whether announced or unannounced, Hospital agrees to cooperate with, participate in, and abide by internal or external quality assessment reviews, Member Appeal Procedures, Utilization Management Program procedures, and Quality Management Program procedures established by ACIA and/or the Agency or their designees, and to follow practice guidelines as described in the Provider Manual, the Agency Contract, and the applicable Program manuals. Hospital shall permit a representative of ACIA, or its designee, to review medical records concurrently as well as retrospectively. Hospital shall provide copies of such medical records, either in paper or electronic form, to ACIA or its designee upon request. The Utilization Management and Quality Management Programs are described in the Provider Manual.

4.2 ACIA's Quality Management Programs consist of review of credentials and performance of hospitals and other provider types that are applying for participation in, or are participating in, ACIA's network of providers to determine whether the hospital or other provider meets ACIA's standards for quality, availability, accessibility and cooperation.

4.3 ACIA's Utilization Management Programs include requirements for pre-authorization of certain services rendered in physicians' offices and in inpatient, outpatient and ancillary hospital settings. Utilization Management Programs include concurrent, retrospective and prospective review of certain services and procedures to assure that care is delivered in the most appropriate setting and is Medically Necessary. Certain Covered Services may require prior approval from ACIA. The Covered Services subject to prior approval are more fully described in the Provider Manual and other ACIA notices. ACIA is obligated to pay for and Hospital is entitled to reimbursement for only those services that are Medically Necessary. Where reimbursement for an admission, inpatient day or outpatient service is denied as not prior approved or Medically Necessary, the Hospital shall not charge either ACIA or the Member for any health care services rendered or furnished with respect to such admission, inpatient day or outpatient service. If Hospital disputes any such denial, the case in question shall be appealed through ACIA's provider appeal process. Hospital may not bring legal action for disputes which have not been appealed through the provider appeal process.

4.4 ACIA shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction, where necessary, to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the Hospital practices and/or the standards established by ACIA, the Agency, or their

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respective designees. Hospital shall cooperate with and abide by any corrective action plan initiated by ACIA and/or required by the Agency or any other State or federal regulatory agency with governing authority over the services provided under this Agreement.

4.6 Hospital agrees that to the extent penalties, fines or sanctions are assessed against ACIA by the Agency or another regulatory agency with governing authority over the services provided under this Agreement as a result of Hospital's failure to comply with Hospital's obligations under this Agreement, including but not limited to, Hospital's failure or refusal to respond to ACIA's the Agency's request for medical records, credentialing information, and other information required to be provided under this Agreement, Hospital shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACIA, ACIA shall have the right to offset claims payments to Hospital by the amount owed by Hospital to ACIA.

5. PROFESSIONAL LIABILITY INSURANCE/ADVERSE ACTIONS:

5.1 Hospital, at its sole expense, shall provide professional liability, comprehensive general liability, and, as applicable, medical malpractice insurance coverage (including coverage for vicarious liability, if any, for the acts of employees, agents and representatives of Hospital) upon execution of this Agreement and at all times during the term of this Agreement, as follows:

(a) Amounts and extent of such insurance coverage as deemed necessary by ACIA to adequately insure Members and ACIA against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with Hospital's performance of any service pursuant to this Agreement; in no event shall such coverage be less than the amounts required by law.

(b) Hospital shall provide ACIA with written verification of the existence of such coverage upon execution of this Agreement and as otherwise requested by ACIA throughout the term of the Agreement, which may include providing copies of face sheets of such coverage. Hospital shall notify ACIA reasonably in advance of any change or cancellation of such coverage.

5.2 Hospital shall immediately notify ACIA in writing, by certified mail, of any written or oral notice of any adverse action, including, without limitation, litigation, investigation, complaint, claim or transaction, regulatory action or proposed regulatory action, or other action naming or otherwise involving Hospital or ACIA, or any other event, occurrence or situation which may reasonably be considered to have a material impact on Hospital's ability to perform Hospital's duties or obligations under this Agreement. Hospital also shall immediately notify ACIA of any action against any applicable license, certification or participation under Title XVIII or other applicable provision of the Social Security Act or other State or federal law, State and/or DEA narcotic registration certificate, or medical staff privileges at any facility, and of any material change in the ownership or business operations of Hospital. All notices required by this Section 5.2 shall be furnished as provided in Section 10.6 of this Agreement.

5.3 Hospital agrees to defend, indemnify and hold harmless ACIA and its officers, directors and employees from and against any and all claims, costs and liabilities (including the fees and expenses of counsel) as a result of a breach of this Agreement by Hospital, the negligent or willful misconduct of Hospital and/or Hospital's employees, agents and representatives, and from and against any death, personal injury or malpractice arising in connection with the performance of any services by the Hospital in connection with this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

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ACIA agrees to defend, indemnify and hold harmless Hospital and its officers, directors and employees from and against all claims, costs and liabilities (including the fees and expenses of counsel) as a result of ACIA's breach of this Agreement or the negligent or willful misconduct of ACIA and/or ACIA's employees, agents and representatives in connection with ACIA's performance under this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

6. CONFIDENTIALITY:

ACIA and Hospital shall each comply with all applicable State and federal laws respecting the confidentiality of the medical, personal or business affairs of Members acquired in the course of providing services pursuant to this Agreement. Each party shall maintain as confidential and shall not disclose to third parties financial, operating, proprietary or business information relating to the other party which is not otherwise public information. The payment rates in this Agreement are confidential and proprietary and shall not be disclosed by either party. However, nothing herein shall prohibit either party from making any disclosure or transmission of information to the extent that such disclosure or transmission is required by the Agency or other applicable state regulatory agency, or is necessary or appropriate to enable the disclosing party to perform its obligations or enforce its rights under this Agreement, or is required by law or legal process. Should disclosure be required by law or legal process, the disclosing party shall immediately notify the other party of the disclosure.

7. COOPERATION; RESOLUTION OF DISPUTES:

7.1 Cooperation. To the extent compatible with separate and independent management of each, ACIA and Hospital shall at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Members at the most reasonable cost consistent with high standards of care. ACIA and Hospital shall use best efforts to exchange information regarding material matters directly or indirectly related to this Agreement.

7.2 Resolution of Disputes. ACIA and Hospital shall both fully cooperate in resolving any and all controversies among or between said parties, their employees, agents, or representatives pertaining to their respective duties under this Agreement. Such disputes shall be submitted for resolution in accordance with the provider appeal procedures as referenced in the Provider Manual and ACIA policies and procedures. Neither ACIA nor Hospital shall permit a dispute between the parties to disrupt or interfere with the provision of services to Members.

8. TERM; TERMINATION:

The term of this Agreement shall commence as of the Effective Date and continue for an initial one (1) year term (the "Initial Term"). After the Initial Term, the Agreement shall automatically renew for successive one (1) year terms unless the Agreement is terminated pursuant to this Section 8 as set forth herein.

Either party may terminate this Agreement without cause at the end of the Initial Term or at the end of the subsequent terms by providing the other party with at least one hundred twenty (120) days' prior written notice before the end of the then current term. The effective date of termination without cause will be on the first of the month following the expiration of the notice period. Either party may terminate this Agreement for cause due to a material breach by giving ninety (90) days' prior written notice. The notice of termination for cause will not be effective if the breaching party cures the breach within the first sixty (60) days of the ninety (90) day notice period. In the event that the breaching party does not cure the breach within the sixty

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(60) day period, the effective date of termination will be the first of the month following the expiration of the ninety (90) day notice period.

In the event any change in federal or State laws, rules and regulations or the Iowa Medicaid Program or the Medicare Advantage program would have a material adverse impact on either ACIA or Hospital in connection with the performance of this Agreement (the "Mandated Changes") such that the basis for the financial bargain of this Agreement is undermined, then the affected party shall have the right to require the other, by written notice, to enter into negotiations regarding the affected or pertinent terms of this Agreement while still maintaining the original Agreement purposes. If renegotiated, such terms shall become effective no later than thirty (30) days after the parties have reached agreement on the renegotiated terms. The parties agree to make a good faith attempt to renegotiate the Agreement to the extent necessary to comply with any Mandated Changes. If, after good faith renegotiations, the parties fail to reach an agreement satisfactory to both parties within thirty (30) days of the request for renegotiation, the party requesting such renegotiation may terminate this Agreement upon ninety (90) days prior written notice to the other party.

Notwithstanding the above, ACIA may terminate this Agreement immediately in the event any of the following occur:

8.1 If Hospital is expelled, disciplined, barred from participation or, or suspended from receiving payment under any state's Medicaid program, Children's Health Insurance Program (CHIP), the Medicare Program or any othe r federal health care program.

8.2 If Hospital is debarred, suspended or otherwise excluded from procurement or non-procurement activities under the Federal Acquisition Regulations.

8.3 Upon the loss or suspension of the Hospital's liability coverage set forth under Section 5 of this Agreement.

8.4 The suspension or revocation of Hospital's license or other certification or authorization, including Hospital's JCAHO accreditation, necessary for Hospital to render Covered Services, or upon ACIA's reasonable determination that the health, safety or welfare of any Member may be in jeopardy if this Agreement is not terminated.

Upon termination of this Agreement for any reason, ACIA shall notify affected Members of the termination of Hospital prior to the effective date of termination. Regardless of the reason for termination, Hospital shall promptly supply to ACIA all information necessary for the reimbursement of outstanding claims. **42 CFR 434.6(a)(6).**

9. REGULATORY AND PROGRAM-SPECIFIC PROVISIONS:

Attached hereto and incorporated herein by reference is **Schedule 9**, setting forth such terms and conditions as are necessary to meet State and Federal statutory and regulatory requirements, and other Agency requirements, of the Program. **Schedule 9** is consecutively sub-numbered as necessary for each Program under which Hospital is furnishing services under this Agreement. Hospital acknowledges that the specific terms as set forth in **Schedule 9** are subject to amendment in accordance with federal and/or State statutory and regulatory changes to the Program. Such amendment shall not require the consent of the Hospital or ACIA and will be effective immediately on the effective date thereof, as set forth in Section 10.3.

10. MISCELLANEOUS:

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10.1 It is understood that Hospital is an independent contractor and in no way is Hospital to be considered an employee, agent, or representative of ACIA. It is further understood that Hospital provides specified services to Members in exchange for an agreed upon fee. This Agreement shall not create, nor be deemed or construed to create any relationship between ACIA and Hospital other than that of independent contractors, contracting with each other solely for the purpose of performing this Agreement and each party shall be liable solely for their own activities and neither ACIA nor Hospital shall be liable to any third party for the activities of the other party to this Agreement.

10.2 This Agreement, being for the purpose of retaining the professional services of Hospital, shall not be assigned, subcontracted, or delegated by Hospital without the express written consent of ACIA.

10.3 No alterations or modifications of the terms of this Agreement shall be valid unless such alterations or modifications are incorporated into the Agreement through a written amendment, signed by both parties hereto, and attached to this Agreement; provided, however, ACIA may amend this Agreement with 30 days' notice to Hospital via a(n) ACIA bulletin or other written communication provided in accordance with the notice provisions in Section 10.6, and unless Hospital notifies ACIA, as applicable, of any objection, such amendment shall then take effect. Any amendment to this Agreement subject to prior regulatory approval(s) shall be effective once such regulatory approval(s) has been received.

Notwithstanding the foregoing, amendments required because of legislative, regulatory or governmental agency requirements do not require the consent of Hospital or ACIA and shall be effective immediately on the effective date thereof. This Agreement remains subject to the approval of the State of Iowa, and may be amended by ACIA to comply with any requirements of the State of Iowa. Hospital acknowledges that all Agency requirements, as may be amended from time to time, are incorporated to this Agreement.

10.4 This Agreement shall be deemed to have been made and shall be construed and interpreted in accordance with the laws of the State of Iowa.

10.5 This Agreement and its exhibits, appendices, schedules, addenda or other attachments constitute the entire understanding and agreement between the parties concerning the subject matter hereof. This Agreement supersedes all prior written or oral agreements or understandings existing between the parties concerning the subject matter hereof including, but not limited to, any such agreement which may have been previously executed between Hospital and ACIA or any of its Affiliates relating to the provision of Covered Services under the Program. In the event of a conflict between the terms of this Agreement and the Provider Manual, the terms of the later document shall control.

10.6 Written notices to be given hereunder shall be sent by Certified Mail, Return Receipt Requested, or by an overnight delivery service which provides a written receipt evidencing delivery to the address set forth by the party, or by confirmed facsimile followed by written notice through the U.S. postal service. All notices called for hereunder shall be effective upon receipt.

If to Hospital:

With a copy to:

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If to AmeriHealth Caritas Iowa:

With a copy to: General Counsel
AmeriHealth Caritas
200 Stevens Drive
Philadelphia, PA 19113

10.7 Both parties agree that there shall be no discrimination in the performance of this Agreement against any patient or other person as the result of that individual's race, color, religion, gender, sexual orientation, handicap, age, national origin, source of payment, or any other basis prohibited by law.

10.8 The failure of any of the parties to insist upon strict performance of any of the terms of this Agreement shall not be deemed a waiver of any of their respective rights or remedies, and shall not be deemed a waiver of any subsequent breach or default in any of the terms contained in this Agreement.

10.9 In the event that any provision under this Agreement is declared null or void, for any reason, the remaining provisions of this Agreement shall remain in full force and effect.

10.10 The parties will use reasonable care and due diligence in performing this Agreement. Hospital will be solely responsible for the services provided under this Agreement.

10.11 All captions contained in this Agreement are solely for the convenience of the parties hereto and shall not be deemed part of the content of this Agreement.

10.12 All terms used in this Agreement are deemed to refer to the masculine, feminine, neuter, singular or plural as the content may require.

10.13 Non-Discrimination. Hospital shall comply with (i) Title VI of the Civil Rights Act of 1964 and the rules, regulations, and order; (ii) the Rehabilitation Act of 1973 and the rules, regulations, and orders thereunder; (iii) the Americans With Disabilities Act of 1990 and the rules, regulations, and orders thereunder; and (iv) any and all applicable laws, rules and regulations prohibiting discriminatory practices. Furthermore, in accordance with Title VI of the Civil Rights Act of 1964 and the rules, regulations and orders thereunder, Hospital shall take adequate steps to ensure that Members with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement (see 42 U.S.C. 2000d et seq. and 45 C.F.R. Part 80, 2001 as amended).

10.14 No Offshore Contracting. No Covered Services under this Agreement may be performed outside of the United States without ACIA's prior written consent. In addition, Hospital will not hire any individual to perform any services under this Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

[SIGNATURES ON FOLLOWING PAGE; REMAINDER OF PAGE INTENTIONALLY BLANK]

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IN WITNESS WHEREOF, and intending to be legally bound hereby, the parties hereto, each by its officers duly authorized, hereby affix their hands as of the date written below.

HOSPITAL	AMERIHEALTH CARITAS IOWA, INC.
Print Name	Name
Signature	Signature
Title	Title
Address	Date
National Provider ID Number	**Effective Date of Agreement:** _____ [To be completed by AmeriHealth Caritas Iowa]
Medicaid ID Number / Medicare ID Number	
Tax ID Number	
Date	
Assignment of Payment (*applicable to Group Physician only*): **By signing below, Hospital hereby assigns and transfers all Hospital's right to and interest in compensation payable by ACIA pursuant to this Agreement to the party identified below, and Hospital therefore directs ACIA to pay such compensation to said party:**	
Hospital Signature	
Name of Group	
Address	
Group Tax ID Number	
Check and initial if Assignment of Payment Not Applicable: ☐ Hospital Initials	

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APPENDIX A

HOSPITAL SERVICES PROVIDER

COVERED SERVICES

Hospital services are those healthcare services that Hospital furnishes to patients who present themselves to Hospital for treatment as inpatients, outpatients, or emergency patients. Hospital shall provide the following hospital services to Members:

1. Inpatient hospital services;
2. Emergency Services;
3. Short procedure unit services and observation services; and
4. Ancillary and other outpatient services.

Hospital's compensation for Covered Services is set forth in **Appendix A-1.**

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APPENDIX A-1

HOSPITAL SERVICES PROVIDER

COVERED SERVICES COMPENSATION SCHEDULE

Commencing on the Effective Date, ACIA will compensate Hospital for Covered Services rendered by Hospital to Members in accordance with the terms of this Agreement at a rate of [___]. In no event will ACIA's payment exceed Hospital's charges.

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APPENDIX B

HOSPITAL SERVICES PROVIDER

ACIA AFFILIATES

[Insert ACIA Affiliates Covered by Agreement]

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Schedule 9-1

Federal Requirements – Medicaid and Medicaid Managed Care

1. No payment will be made to Hospital for provider-preventable conditions or health care-acquired conditions. For purposes hereof:

   a. **Health care-acquired condition** ("HAC") means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary of the U.S. Department of Health and Human Services ("HHS") under section 1886(d)(4)(D)(iv) of the Social Security Act (the "Act") for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act, other than deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

   b. **Other provider-preventable condition** means a condition occurring in any health care setting that meets the following criteria: (i) is identified in the Iowa Medicaid plain; (ii) has been found by the Iowa, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines (iii) has a negative consequence for the Member; (iv) is auditable; and (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.

   c. **Provider-preventable condition** ("PPC") means a condition that meets the definition of "health care-acquired condition" or an "other provider-preventable condition."

   No reduction in payment will be made for a PPC when the condition existed prior to the initiative of treatment for that patient by Hospital. Hospital shall identify PPCs when submitting claims for payment or, if no claim will be submitted, if Medicaid payment would otherwise be available for the course of treatment in which the PPC occurred, or as otherwise required by the State. **42 CFR §§438.6(f)(2), 434.6(a)(12) and 447.26.**

2. The State Agency and HHS may inspect and audit any financial records of Hospital or its subcontractors. **42 CFR §438.6(g).**

3. Physician Incentives. Hospital shall disclose to ACIA annually any Physician Incentive Plan (PIP) or risk arrangements Hospital may have with physicians, either within Hospital's group practice or other physicians not associated with Hospital's group practice, even if there is no substantial financial risk between ACIA and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for Covered Services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low. **42 CFR §§438.6(g), 422.208, 422.210.**

4. Provider Discrimination Prohibited. ACIA may not, with respect to Hospital compensation or indemnification under this Agreement, discriminate against Hospital to the extent that the Hospital is acting within the scope of his, her or its license or certification under applicable State law, solely on the basis of that license or certification. Without limiting the foregoing, ACIA shall not discriminate against Hospital for serving high-risk populations or specializing in

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conditions that require costly treatment. Nothing herein shall be construed to: (i) require ACIA to contract with Hospital if not necessary to meet the needs of Members; (ii) preclude ACIA from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (iii) preclude ACIA from establishing measures that are designed to maintain quality of services and control costs and are consistent with ACIA's responsibilities to Members. **42 CFR §438.12**.

5. Continued Treatment Obligation. Notwithstanding any other provision of this Agreement, in the event of either party's termination of this Agreement, insolvency of either ACIA, or other cessation of ACIA's operations, Hospital shall continue to provide Covered Services to Members (i) until the end of the month in which the effective date of termination of this Agreement falls, (ii) until the end of the month for which capitation or premium has been paid to ACIA by Agency, or (iii) until the date of a Member's discharge from an inpatient facility, whichever is later. **42 CFR §438.62**.

6. Member Rights. Hospital shall adhere to all applicable Federal and State laws that pertain to Member rights, and shall take such rights into account when furnishing services to Members. **42 CFR §438.100(a)(2)**.

7. Hospital-Member Communications. Nothing in this Agreement shall be construed to prohibit, restrict or impede Hospital's ability to freely and openly discuss with Members, within the Hospital's lawful scope of practice, all available treatment options and any information the Member may need in order to decide among all relevant treatment options, including but not limited to the risks, benefits and consequences of treatment or non-treatment, regardless of whether the services may be considered Covered Services in accordance with this Agreement. Further, nothing in this Agreement shall be construed to prohibit, restrict or impede Hospital from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member, including: information regarding the nature of treatment options, risks of treatment, alternative treatments or the availability of alternative therapies, consultation or tests that may be self-administered, and the Member's right to participate in decisions regarding his or her care, including the right to refuse treatment and to express preferences about future treatment decisions. **42 CFR §438.102(a)**.

8. Member Hold Harmless. Hospital shall accept the final payment made by ACIA as payment in full for Covered Services provided pursuant to this Agreement. Hospital agrees that in no event, including, but not limited to, nonpayment by the Agency to ACIA, nonpayment by ACIA to Hospital, the insolvency of ACIA, or breach of this Agreement, shall Hospital bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, solicit or accept any surety or guarantee of payment, or have any recourse against Members or persons other than ACIA acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the Member) for Covered Services listed in this Agreement. This provision shall not prohibit collection of supplemental charges or co-payments on ACIA's behalf made in accordance with terms of an enrollment agreement between ACIA and Members.

Hospital further agrees that:

a. this hold harmless provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members; and that

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b. this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Hospital and Members or persons acting on their behalf.

42 CFR §§438.106, 447.15.

9. Coverage and Payment for Emergency Services. ACIA shall cover and pay for Emergency Services rendered by Hospital and obtained when a Member had an Emergency Medical Condition, or when a representative of ACIA has instructed the Member to seek Emergency Services. **42 CFR §438.114(c)(1)(ii).**

10. Timely Access. Hospital shall meet Agency standards for timely access to care and services, taking into account the urgency of the need for services. Hospital shall offer hours operation to Members that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if Hospital serves only Medicaid enrollees. Hospital services shall be available 24 hours a day, 7 days a week, when medically necessary.

11. Excluded Providers. Pursuant to **42 CFR §438.214(d)**, ACIA may not employ or contract with providers excluded from participation in Federal health care programs under either Section 1128 or 1128A of the Act. In addition, section 2455 of the Federal Acquisition Streamlining Act of 1994 and he Federal Acquisition Regulations (including but not limited to 48 CFR §9.405), ACIA may not make payment to any person or entity or an affiliate thereof, who has been debarred or suspended form participation in federal procurement or non-procurement activities. Hospital shall comply with the disclosure requirements of **42 C.F.R. Section 455, Subpart B** and, upon reasonable request, provide such information to ACIA in accordance with the requirements specified therein.

Hospital represents and warrants that neither it, nor any of its contractors or employees who will furnish goods or services under the Agreement, directors or officers, or any person with an ownership interest in Hospital of five percent (5%) or more, is or ever has been: (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification; or (iv) debarred or suspended from participation in procurement or non-procurement activities by any federal agency (collectively, "Sanctioned Persons"). Hospital shall screen all employees and contractors who will furnish goods or services under this Agreement to determine whether they have been excluded from participation in any Federal health care program, by searching applicable Federal and State databases (including but not limited to the OIG's LEIE and the HIPDB) upon initial employment or engagement of or contracting with a contractor, employee, director or officer, and on a monthly basis thereafter.

Hospital shall immediately notify ACIA upon knowledge by Hospital that any of its contractors or employees who furnish goods or services under the Agreement, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that Subcontractor cannot provide reasonably satisfactory assurance to ACIA that a Sanctioned Person will not receive payment from ACIA under this Agreement, ACIA may immediately terminate this Agreement. ACIA reserves the right to recover all amounts paid by ACIA for items or services furnished by a Sanctioned Person.

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Further, and without limiting Hospital's indemnification obligations set forth elsewhere in this Agreement, to the extent penalties, fines or sanctions are assessed against ACIA as a result of Hospital's having a relationship with a Sanctioned Person, Hospital shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACIA, ACIA shall have the right to offset claims payments to Hospital by the amount owed by Hospital to ACIA.

12. State and Federal Regulator Access. Hospital acknowledges that the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Office of the Inspector General, the Comptroller, the Agency **[SPECIFY STATE AGENCIES/REPRESENTATIVES]**, and their designees have the right to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to this Agreement, including quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and Hospital claims submitted to ACIA. Such evaluation, when performed, shall be performed with the cooperation of the Hospital and ACIA. Upon request, Hospital and ACIA shall assist in such reviews. **42 CFR §434.6(a)(5)**.

13. Hospital shall safeguard information about Members as required by Part 431, Subpart D of 42 CFR. **42 CFR 434.6(a)(8)**.

14. Any permitted subcontracts entered into by Hospital in order to carry out its obligations under this Agreement must be in writing and fulfill the requirements of 42 CFR Part 434 that are appropriate to the service or activity delegated under the subcontract. **42 CFR 434.6(a)(11), (b)**.

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Schedule 9-2 (Hospital Form)

State of Iowa Requirements – Medicaid and Medicaid Managed Care

1. Unless defined in this Schedule 9-2 or elsewhere in the Agreement, all capitalized terms used herein shall have their respective meanings given to them in the contract between the Iowa Department of Human Services ("IDHS") and AmeriHealth Caritas Iowa, Inc., ("ACIA") dated as of [_____], 201[_] (the "State Contract").

2. In accordance with **191 IAC 40.18**, Hospital, or its assignee or subcontractor as applicable, hereby agrees that in no event, including but not limited to nonpayment by the ACIA, ACIA insolvency or breach of this Agreement, shall Hospital, or its assignee or subcontractor if applicable, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons other than ACIA acting on the Member's behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on ACIA's behalf made in accordance with terms of the Program.

   Hospital, or its assignee or subcontractor if applicable, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member; and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Hospital and Member or persons acting on behalf of the Member.

3. Pursuant to **191 IAC 40.22**:

   a. ACIA shall not prohibit Hospital from or penalize Hospital for discussing treatment options with Members, irrespective of ACIA's position on the treatment options, or from advocating on behalf of Members within the utilization review or grievance processes established by ACIA or a person contracting with ACIA.

   b. ACIA shall not penalize Hospital because Hospital, in good faith, reports to state or federal authorities any act or practice by ACIA that, in the opinion of Hospital, jeopardizes patient health or welfare.

4. Compliance with Pro-Children Act of 1994. Hospital hereby certifies compliance with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 ("Act"). The Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children's services that are provided in indoor facilities that are constructed, operated or maintained with such federal funds. The law does not apply to children's services provided in private residences, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable federal funds is Medicare or Medicaid,

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or facilities (other than clinics) where WIC coupons are redeemed. (**Ref. RFP Exhibit D**)

5. ACIA follows all applicable Federal and State laws pertinent to Member confidentiality and rights; Hospital shall take those rights into account when furnishing services to Members. (**SOW §1.4.1**)

6. Hospital shall not require any cost-sharing or Member liability responsibilities for Covered Services except to the extent that cost-sharing or Member liability responsibilities are required for those services in accordance with law and as described in the Agency Contract. Further, Hospital shall not charge Members for missed appointments. (**SOW §3.2.15.3**)

7. Hospital agrees that all applicable terms and conditions set out in the RFP, the Agency Contract, any incorporated documents and all applicable State and federal laws, as amended, govern the duties and responsibilities of Hospital with regard to the provision of services to Members. (**SOW §6.1.2**)

8. Hospital's responsibilities regarding third-party liability (TPL) include Hospital's obligations to identify TPL coverage, including Medicare and long-term care coverage as applicable, and except as otherwise required, seek such TPL payment before submitting claims to ACIA. (**SOW §6.1.2**)

9. Hospital shall submit claims which do not involve a third-party payer within **ninety (90) days** of the date of service. (**SOW §6.1.2**)

10. IDHS reserves the right to direct ACIA to terminate or modify this Agreement when IDHS determines it to be in the best interest of the State. (**SOW §6.1.2**)

11. ACIA may not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient regarding: (1) the Member's health status; (2) medical, behavioral health, or long-term care treatment options, including any alternative treatment that may be self-administered; (3) any information the Member needs in order to decide among all relevant treatment options; (4) the risks, benefits and consequences of treatment or non-treatment; or (5) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. (**SOW §6.1.5**)

12. Hospital shall maintain complete and legible medical and financial (fiscal) records as required pursuant to **IAC 441-79.3**. Without limiting the foregoing, Hospital's medical records shall document all medical services that the Member receives from Hospital. Medical records shall be maintained in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records must be legible, signed, dated and maintained as required by law. (**SOW §6.1.9**)

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As required pursuant to **IAC 441-79.3(3)**, Hospital shall maintain medical records: (1) during the time the Member is receiving services from Hospital; (2) for a minimum of five (5) years from the date when a claim for the service was submitted to ACIA for payment; and (3) as may required by any licensing authority or accrediting body associated with determining Hospital's qualification.

13. Each Member shall have the right to request and receive a copy of his her medical records, and to request that they be amended or corrected. Upon reasonable request of a Member, Hospital shall provide a copy of a Member's medical record at no charge. Hospital must facilitate the transfer of a Member's medical record to another provider at the Member's request. (**SOW §6.1.9.2**)

14. Within the timeframe designated by IDHS or other authorized entity, Hospital must permit ACIA, representatives of IDHS, and other authorized entities to review Members' records for the purpose of monitoring Hospitals' compliance with the records standards, capturing information for clinical studies, monitoring quality of care, or any other reason. (**SOW 6.1.9.3**)

15. All medical records of Members shall be confidential and shall not be released without the written consent of the Member or responsible party. Written consent is not required under the following circumstances: (1) for transmission of medical record information to physicians, other practitioners or facilities who are providing services to Members under contract with ACIA; and (2) for transmission of medical record information to physicians or facilities providing emergency care. Written consent is required for the transmission of the medical record information of a former Member to any physician not connected with ACIA. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the practitioner or facility requesting the information. All release of medical records shall be compliant with 45 CFR Parts 162 and 164. (**SOW §6.1.9.4**)

16. Hospital shall offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid members, if Hospital sees only the Medicaid population. Covered Services shall be available twenty0-four (24) hours a day, seven (7) days a week, when medically necessary. (**SOW 6.1.9.5**)

17. Upon determination by IDHS of a credible allegation of fraud for which an investigation is pending under the Medicaid program against Hospital and upon the approval of the Medicaid Fraud Control Unit (MFCU) and IDHS, ACIA shall suspend all payments to Hospital, in compliance with 42 CFR 455.23. ACIA shall issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 CFR 455.23(b) (including notice that payments are being withheld in accordance with 42 CFR 455.23), and shall maintain the suspension for the durational period set forth in 42 CFR 455.23(c). ACIA will afford a grievance process to Hospital in the event of payment suspension under this **paragraph 17**. (**SOW §12.7**)

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Provider Contract Agreement Templates (Physician)

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AMERIHEALTH CARITAS IOWA, INC.

PHYSICIAN PROVIDER AGREEMENT

With

[PROVIDER NAME]

AMERIHEALTH CARITAS IOWA, INC.
PHYSICIAN PROVIDER AGREEMENT

This Physician Provider Agreement (the "Agreement"), dated as of the Effective Date (defined below), is made by and between **AmeriHealth Caritas Iowa, Inc.**, a corporation organized under the laws of the State of Iowa, (hereinafter referred to as ("ACIA)" and the Provider ("Provider") identified on the signature page.

WHEREAS, ACIA is a managed care organization that is responsible for providing or arranging for the provision of health care services to its Members; and

WHEREAS, Provider and ACIA mutually desire to enter into this Agreement, whereby Provider shall render services to Members enrolled with ACIA and be compensated by ACIA in accordance with the terms and conditions hereof.

NOW, THEREFORE, in consideration of the mutual promises made herein, it is mutually agreed by and between ACIA and Provider as follows:

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1. DEFINITIONS

As used in this Agreement, each of the following terms shall have the meaning specified herein, unless the context clearly requires otherwise.

1.1 **AFFILIATES.** An Affiliate is any corporation or other organization that is identified as an Affiliate in a written notice to Provider and is owned or controlled, either directly or through parent or subsidiary corporations, by or under common control with, ACIA shall give Provider thirty (30) days advance written notice of the addition of Affiliates added under this provision. Unless otherwise specified in this Agreement or any other attachment hereto, references to "ACIA" shall include the Affiliates referenced in **Appendix D**.

1.2 **AGENCY.** The State and/or Federal governmental agency that administers the Program(s) under which ACIA is obligated to provide or arrange for the provision of Covered Services.

1.3 **AGENCY CONTRACT.** The contract or contracts between ACIA and the Agency, as in effect from time to time, pursuant to which ACIA is responsible for coordinating health care services and supplies for Program recipients enrolled with ACIA.

1.4 **CLEAN CLAIM.** A claim for payment for a health care service, which has been received by ACIA, has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. Consistent with **42 CFR §447.45(b)**, the term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim, or a claim under review for medical necessity.

1.5 **COVERED SERVICES.** Those Medically Necessary health care services and supplies to which Members are entitled pursuant to the Agency Contract, and which shall be provided to Members by Provider, as described more specifically in **Appendix A**. Covered Services shall be furnished in the amount, duration and scope required under the Program.

1.6 **EFFECTIVE DATE.** The later of (i) the effective date on the signature page of this Agreement or (ii) the effective date of the Agency Contract, provided that Provider has been successfully credentialed by ACIA and that all required regulatory approvals have been obtained by ACIA.

1.7 **EMERGENCY MEDICAL CONDITION.** Health care services provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the health of the Member (or with respect to a pregnant woman, the health of the Member or her unborn child) in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

1.8 **EMERGENCY SERVICES.** Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. Section 438.114(a) and 42 U.S.C. Section 1932(b)(2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition.

1.9 **GROUP PHYSICIAN.** A physician who practices with Provider as an employee, partner, shareholder, or contractor.

1.10 **MEDICALLY NECESSARY.** Those Covered Services that are, under the terms and conditions of the Agency Contract, determined through ACIA utilization management to be: (1) appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Member; (2) provided for the diagnosis or direct care and treatment of the condition of Member enabling the Member to make reasonable progress in treatment; (3) within standards of professional practice and given at the appropriate time and in the appropriate setting; (4) not primarily for the convenience of the Member, the Member's physician or other provider; and (5) the most appropriate level of Covered Services which can safely be provided. **(Ref. Agency Contract – Scope of Work document)**

1.11 **MEMBER.** An individual that is eligible for a Program and who has enrolled in ACIA under the Program.

1.12 **MEMBER APPEAL PROCEDURES.** The written procedures describing ACIA's standards for the prompt resolution of Member problems, grievances and appeals, as described in the Provider Manual.

1.13 **PARTICIPATING PROVIDER.** A physician duly licensed to practice medicine in the State of Iowa participating in or eligible to participate in the Iowa Medicaid program, and who is a member of the medical staff of a(n) ACIA- participating hospital, or a licensed, appropriately supervised allied health professional, either of whom has entered into, or who is recognized by ACIA as a member of a group which has entered into, an agreement with ACIA to provide medical services to Members under the Program.

1.14 **PRIMARY CARE PROVIDER.** A duly licensed pediatrician, internist, family practitioner, or doctor of general medicine, obstetrician/gynecologist or group thereof or a licensed, appropriately supervised allied health professional, who has been successfully credentialed by, and is a

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Participating Provider with ACIA, and who is responsible for the supervision, coordination, and provision of primary care services to Members who have selected, or have been assigned to, that provider. The Primary Care Provider also is responsible for initiating any required referrals for specialty care needed by a Member and maintaining overall continuity of a Member's care.

1.15 **PRIMARY CARE SERVICES.** Covered Services specified in **Appendix A** hereto and any additional services specified as Primary Care Services in the Provider Manual, as updated or amended from time to time. All Covered Services shall be provided in the amount, duration and scope set forth in the State Contract and as otherwise required under the Program.

1.16 **PROGRAM.** The Iowa High Quality Health Initiative procured by the Iowa Department of Human Services ("IDHS") under RFP #MED-16-009, for the delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (*hawk-i*) programs.

1.17 **PROVIDER MANUAL.** The ACIA manual of standards, policies, procedures and corrective actions together with amendments or modifications ACIA may adopt from time to time. The Provider Manual is herein incorporated by reference and made part of this Agreement. The Provider Manual may be amended or modified by ACIA from time to time in accordance with Section 4.8 herein below.

1.18 **QUALITY MANAGEMENT PROGRAM.** An ongoing review process and plan which functions to define, monitor, review, and recommend corrective action for managing and improving the quality of health care services to Members.

1.19 **SPECIALTY CARE PROVIDER.** A duly licensed physician who has been successfully credentialed by ACIA and who has entered into an agreement to provide Specialty Care Services to Members in accordance with the referral and preauthorization requirements of the Provider Manual.

1.20 **SPECIALTY CARE SERVICES.** Covered Services specified in **Appendix A** hereto and any additional specified as "Specialty Care Services" in the Provider Manual, as updated and amended from time to time.

1.21 **UTILIZATION MANAGEMENT PROGRAM.** A process of review of the medical necessity, appropriateness and efficiency of health care services, procedures, equipment, supplies, and facilities rendered to Members.

2. SERVICES:

2.1 Provider agrees to provide and cause its Group Physicians to provide, as applicable, (i) Primary Care Services to Members who have selected, or are otherwise assigned to, Provider as their Primary Care Provider, and (ii) Specialty Care Services to Members who have been referred to Provider. Covered Services shall be provided in accordance with the terms of this Agreement and ACIA referral, preauthorization and other Utilization Management Program policies as described in the Provider Manual, other than Emergency Services, which will be provided as needed. Provider will refer Members to providers participating in the ACIA network whenever Provider is unable to provide Medically Necessary services and/or when consistent with sound medical judgment and accepted standards of care. Provider and Group Physicians shall provide such services in the same manner and with the same availability as services provided to other patients without regard to reimbursement and shall further provide these services in accordance with the clinical quality of

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care and performance standards which are professionally recognized as industry practice and/or otherwise adopted, accepted or established by ACIA.

2.2 Provider will deliver office-based medical services to Members only at those office locations set forth in **Appendix B** hereto as such appendix is modified from time to time by mutual agreement of the parties. Provider shall notify ACIA at least sixty (60) days prior to making any addition or change to office locations.

2.3 Primary Care Providers shall accept as patients those Members who have selected or have been assigned to Provider, and Specialty Care Providers shall accept as patients those Members who have been referred to Provider, in either case without regard to the health status or medical condition of such Members. Primary Care Providers may decline to accept additional Members (excluding persons already in Provider's practice that enroll in ACIA) by giving ACIA written notice of such intent ninety (90) days in advance of the effective date of such closure. Provider agrees to accept any Members selecting the Primary Care Provider's practice during the ninety (90) day notice period.

2.4 Provider shall provide ACIA with complete and accurate statements of all Covered Services provided to Members in conformance with ACIA billing procedures, including without limitation, use of complete applicable diagnosis, procedure and revenue codes. ACIA will not be liable for any bills relating to services that are submitted the later of: (a) after twelve (12) months from the date the services were provided (consistent with **42 CFR §447.45(d)**), or (b) after sixty (60) days of the date of the Explanation of Benefits from another payor when services are first billed by Provider to another payor. Any appeal or request for adjustment of a payment by Provider must be made in accordance with applicable provisions of the Provider Manual and ACIA policies and procedures and, in any case, must be received by ACIA within sixty (60) days of the original payment or denial. Provider may not bring legal action on claims which have not been appealed through the appeal mechanisms described herein.

Encounter Data and Other Reports. Provider shall deliver all reports and clinical information required to be submitted to ACIA pursuant to this Agreement for reporting purposes, including but not limited to encounter data, Healthcare Effectiveness Data and Information Set (HEDIS), Agency for Healthcare Research and Quality (AHRQ), and EPSDT data in a format which will allow ACIA to transmit required data to the Agency electronically and in a format identical to or consistent with the format used or otherwise required by ACIA and the Agency. Provider shall submit this information to ACIA within the time frames set forth in the Provider Manual or as otherwise required by the Agency. Provider shall submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by ACIA.

2.5 In accordance with ACIA policies and procedures, only successfully credentialed Participating Providers may provide Covered Services to Members under this Agreement.

3. COMPENSATION:

3.1 ACIA shall pay Provider for Covered Services provided to Members pursuant to the terms of this Agreement. ACIA shall have the right to offset claims payments to Provider by any amount owed by Provider to ACIA, following at least thirty (30) days' written notice. Provider shall not be entitled to reimbursement if the Member was not eligible at the time services were rendered.

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3.2 ACIA agrees to pay Provider the amount set forth in **Appendix C** for Covered Services rendered by Provider to Members. Provider understands and agrees that any payments ACIA makes directly or indirectly to Provider under this Agreement shall not be made as an inducement to reduce, limit, or delay Medically Necessary Covered Services to any Member. Except as may be otherwise specifically set forth in **Appendix C**, in no event will ACIA's payment exceed submitted charges. Provider recognizes and accepts the fees set forth in **Appendix C** as payment in full, and no additional charges will be made by Provider to ACIA for Covered Services provided hereunder.

3.3 Under no circumstances, including ACIA's failure to pay for Covered Services, termination of this Agreement, or the insolvency of ACIA, will Provider or any Group Physician bill or collect from, or make any charges or claims against any Member directly or indirectly for Covered Services authorized by ACIA, except for authorized co-payments, co-insurance and/or deductibles. Provider and Group Physicians shall look only to ACIA for compensation for Covered Services. Provider shall not deny Covered Services to a Member in the event that a Member is unable to pay any authorized co-payment amounts. **42 CFR §447.15**.

3.4 Provider may directly bill Members for non-Covered Services if the Member is advised in writing before the service is rendered of: (i) the nature of the service(s) to be rendered; (ii) that ACIA does not cover the services; and (iii) that the Member will be financially responsible for the services if the Member elects to receive the services. Furthermore, Provider shall hold harmless ACIA for any claim or expense arising from such services.

3.5 ACIA shall pay all Clean Claims for Covered Services in accordance with applicable laws, regulations and Agency requirements; and ACIA will in any event meet the claim payment timeframes required under **42 CFR §447.45(d)**.

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4. ADMINISTRATION:

4.1 Throughout the term of this Agreement, Provider and all Group Physicians shall: (a) have and maintain, without restriction, all licenses, certificates, registrations and permits as are required under applicable State and federal statutes and regulations to provide the Covered Services furnished by Provider and/or other related activities delegated by ACIA under this Agreement. Provider shall obtain a unique identifier (national provider identifier) in accordance with the system established under Section 1173(b) of the Social Security Act, submit such identifier number to ACIA, and include such identifier on all claims. At all times during the term of this Agreement, Provider shall be eligible for participation in the Iowa Medicaid program; and, if required by the Iowa Medicaid program as a condition of furnishing services to Iowa Medicaid recipients, Provider shall participate in the Iowa Medicaid program. To the extent that Covered Services are furnished to Medicare beneficiaries under this Agreement, Provider shall also participate in the Medicare program. Provider shall ensure that all services provided pursuant to this Agreement are within the Provider's and, if applicable, Group Physicians' scope of professional responsibility.

4.2 During the term of this Agreement and in the event of termination of this Agreement for any reason, Provider and its Group Physicians will fully cooperate with each Member and with ACIA in arranging for the transfer of copies of Member medical records to other Participating Providers.

4.3 <u>Record Maintenance, Inspection, Reporting and Auditing</u>.

(a) <u>Record Retention</u>. As required by **42 CFR 434.6(a)(7)** and otherwise in accordance with the standards of ACIA, Provider and Group Physicians shall maintain an adequate record

system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Members pursuant to this Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Agreement and the Agency Contract).

(b) All records originated or prepared in connection with Provider's performance of its obligations under this Agreement will be retained and safeguarded by Provider in accordance with the terms and conditions of the Agency Contract and other relevant State and federal law. Provider agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Members relating to the delivery of care or service under the Agency Contract and as further required by the Agency, for a period of no less than seven (7) years from the expiration date of the Agency Contract, including any contract extension(s), and to retain all Member records, including but not limited to administrative, financial and medical records (whether electronic or paper) for a period of no less than seven (7) years after the last payment was made for services provide to the Member. If any audit, litigation, claim, or other actions involving the records have been initiated prior to the expiration of the seven (7) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the seven (7) year period, whichever is later. If Provider stores records on microfilm or microfiche or other electronic means, Provider agrees to produce, at its expense, legible hard copy records promptly upon the request of state or federal authorities.

(c) Medical Record Maintenance. Provider shall ensure that all medical records are in compliance with the medical record keeping requirements set forth in the Provider Manual, the Agency Contract and Agency guides. Provider shall maintain up-to-date medical records at the site where medical services are provided for each Member enrolled under this Agreement. Each Member's record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment.

(d) ACIA shall be entitled to audit, examine and inspect Provider's books and records, including but not limited to medical records, financial information and administrative information pertaining to Provider's relationship with ACIA, at any time during normal business hours, upon reasonable notice. Provider agrees to provide ACIA, at no cost to ACIA, with such medical, financial and administrative information, and other records as may be necessary for ACIA to meet its obligations related to the Agency Contract and other regulatory obligations, Utilization Management Program and Quality Management Program standards, including NCQA standards, and other relevant accreditation standards which ACIA may require of ACIA participating providers.

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4.4 Whether announced or unannounced, Provider agrees to, and shall cause its Group Physicians to, cooperate with, participate in, and abide by internal or external quality assessment reviews, Member Appeal Procedures, Utilization Management Program procedures, and Quality Management Program procedures established by ACIA, and to follow practice guidelines as described in the Provider Manual, the Agency Contract and the applicable Program manuals. Provider shall permit a representative of ACIA, or its designee, to review medical records concurrently as well as retrospectively. Provider shall provide copies of such medical records, either in paper or electronic

form, to ACIA or its designee upon request. The Utilization Management and Quality Management Programs are described in the Provider Manual.

4.5 Provider authorizes ACIA to include Provider's and its Group Physicians' name(s), address(es), telephone number(s), medical specialty(ies), hospital affiliations, and other similar information relevant to Provider and/or Group Physicians, Provider's operations and its staff in the ACIA provider directory and in various marketing materials identifying Provider and/or Group Physicians as a provider(s) of services to Members. Provider agrees to afford ACIA the same opportunity to display brochures, signs, or advertisements in Provider's office(s) as Provider affords any other insurance company or other third party payor.

4.6 While both parties support Provider's open and active communication with Members concerning Medically Necessary services, available treatment alternatives, benefit coverage information and/or any other information pertaining to the provider-patient relationship, neither Provider nor any of its Group Physicians shall, during the term of this Agreement, and any renewal thereof, solicit or require any Member, either orally or in writing, to subscribe to or enroll in any managed care plan other than ACIA. The provisions of this **Section 4.6** shall similarly apply to Provider's employees, agents and/or contractors (including all Group Physicians).

4.7 Provider shall cooperate with ACIA in the identification of other sources of payment available to Members, such as other health insurance, government programs, liability coverage, motor vehicle coverage or worker's compensation coverage, as applicable. Provider shall be responsible for reporting all applicable third party resources to ACIA in a timely manner.

Provider will cooperate with ACIA in coordinating benefits with other payors in accordance with coordination of benefits claim processing rules and requirements outlined in the Provider Manual, the Agency Contract and applicable Program manuals, as amended from time to time. Provider will make a reasonable attempt to determine whether any other payor has primary responsibility for the payment of a claim for services that Provider rendered to a Member and bill that payor before billing ACIA. Unless otherwise prohibited by applicable law, ACIA retains the right to recover payments made to Provider if ACIA determines that another payor is primarily responsible for all or a portion of the claim.

4.8 ACIA shall furnish or otherwise make available to Provider a copy of the Provider Manual, as amended from time to time. Provider Manual updates will become effective thirty (30) days from the date of notification, unless otherwise specified in writing by ACIA.

4.9 ACIA shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction, where necessary, to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the Provider practices and/or the standards established by ACIA, the Agency, or their respective designees. Provider shall cooperate with and abide by any corrective action plan initiated by ACIA and/or required by the Agency or any other State or federal regulatory agency with governing authority over the services provided under this Agreement.

4.9 Provider agrees that to the extent penalties, fines or sanctions are assessed against ACIA by the Agency or another regulatory agency with governing authority over the services provided under this Agreement as a result of Provider's or any Group Physician's failure to comply with their respective obligations under this Agreement, including but not limited to, failure or refusal to respond to the Agency's request for medical records, credentialing information, and other information required to be provided under this Agreement, Provider shall be responsible for the

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immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACIA, ACIA shall have the right to offset claims payments to Provider by the amount owed by Provider to ACIA.

4.10 Provider will assist ACIA in providing orientation services to Provider staff, to the extent ACIA may reasonably request.

4.11 Fraud and Abuse. Provider recognizes that payments made by ACIA pursuant to this Agreement are derived from federal and State funds, and acknowledges that it may be held civilly and/or criminally liable to ACIA and/or the Agency, in the event of non-performance, misrepresentation, fraud or abuse for services rendered to Members, including but not limited to, the submission of false claims/statements for payment by Provider, its employees or agents. Provider shall be required to comply with all policies and procedures as developed by ACIA and the Agency, including but not limited to the requirements set forth in the Provider Manual and the Agency Contract, for the detection and prevention of fraud and abuse. Such compliance may include, but not be limited to, referral of suspected or confirmed fraud or abuse to ACIA.

4.12 Provider Protections.

(a) ACIA shall not exclude or terminate Provider or a Group Physician from ACIA's provider network because the Provider or Group Physician advocated on behalf of a Member including in the context of a utilization management appeal or another dispute with ACIA over appropriate medical care, provided that such advocacy is consistent with the degree of learning and skill ordinarily possessed by a health care provider practicing in accordance with the applicable standard of care.

(b) Provider shall note be excluded or terminated from participation with ACIA due to the fact that the Provider may have a practice that includes a substantial number of patients with expensive medical conditions.

(c) Provider shall not be excluded from participation, nor shall this Agreement be terminated, because Provider objects to the provision of or refuses to provide a healthcare service on moral or religious grounds.

5. PROFESSIONAL LIABILITY INSURANCE/ADVERSE ACTIONS:

5.1 Provider, at his/her sole expense, shall provide professional liability, comprehensive general liability, and medical malpractice insurance coverage (including coverage for vicarious liability, if any, for the acts of employees, agents and representatives of Provider (including without limitation all Group Physicians)) upon execution of this Agreement and at all times during the term of this Agreement, as follows:

(a) Amounts and extent of such insurance coverage as deemed necessary by ACIA to insure against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with Provider's performance of any service pursuant to this Agreement; in no event shall such coverage be less than the amounts required by law.

(b) Provider shall provide ACIA with written verification of the existence of such coverage upon execution of this Agreement and as otherwise requested by ACIA throughout the term of the

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Agreement, which may include providing copies of face sheets of such coverage. Provider shall notify ACIA reasonably in advance of any change or cancellation of such coverage.

5.2 Provider shall immediately notify ACIA in writing, by certified mail, of any written or oral notice of any adverse action, including, without limitation, litigation, investigation, complaint, claim or transaction, regulatory action or proposed regulatory action, or other action naming or otherwise involving Provider or a Group Physician, or any other event, occurrence or situation which may reasonably be considered to have a material impact on Provider's or a Group Physician's ability to perform Provider's duties or obligations under this Agreement. Provider also shall immediately notify ACIA of any action against any applicable license, certification or participation under Title XVIII or other applicable provision of the Social Security Act or other State or federal law, State and/or DEA narcotic registration certificate, or medical staff privileges at any facility, and of any material change in the ownership or business operations of Provider or a Group Physician. All notices required by this Section 5.2 shall be furnished as provided in Section 10.6 of this Agreement.

5.3 Provider agrees to defend, indemnify and hold harmless ACIA and its officers, directors and employees from and against any and all claims, costs and liabilities (including the fees and expenses of counsel) as a result of a breach of this Agreement by Provider, the negligent or willful misconduct of Provider and/or Provider's employees, agents and representatives (including without limitation Group Physicians), and from and against any death, personal injury or malpractice arising in connection with the performance of any services by the Provider and all Group Physicians in connection with this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

ACIA agrees to defend, indemnify and hold harmless Provider and its officers, directors and employees from and against all claims, costs and liabilities (including the fees and expenses of counsel) as a result of ACIA's breach of this Agreement or the negligent or willful misconduct of ACIA and/or ACIA's employees, agents and representatives in connection with ACIA's performance under this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

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6. CONFIDENTIALITY:

ACIA and Provider shall each comply with all applicable State and federal laws respecting the confidentiality of the medical, personal or business affairs of Members acquired in the course of providing services pursuant to this Agreement. Each party shall maintain as confidential and shall not disclose to third parties financial, operating, proprietary or business information relating to the other party which is not otherwise public information. The payment rates in this Agreement are confidential and proprietary and shall not be disclosed by either party. However, nothing herein shall prohibit either party from making any disclosure or transmission of information to the extent that such disclosure or transmission is required by CMS or an applicable state regulatory agency, or is necessary or appropriate to enable the disclosing party to perform its obligations or enforce its rights under this Agreement, or is required by law or legal process. Should disclosure be required by law or legal process, the disclosing party shall immediately notify the other party of the disclosure.

7. COOPERATION; RESOLUTION OF DISPUTES:

7.1 Cooperation. To the extent compatible with separate and independent management of each, ACIA and Provider shall at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Members at the most reasonable cost consistent with

high standards of care. ACIA and Provider shall use best efforts to exchange information regarding material matters directly or indirectly related to this Agreement.

7.2 Resolution of Disputes. ACIA and Provider shall both fully cooperate in resolving any and all controversies among or between said parties, their employees, agents, or representatives pertaining to their respective duties under this Agreement. Such disputes shall be submitted for resolution in accordance with the provider appeal procedures as referenced in the Provider Manual and ACIA policies and procedures. Neither ACIA nor Provider shall permit a dispute between the parties to disrupt or interfere with the provision of services to Members.

8. TERM; TERMINATION:

8.1 The term of this Agreement shall commence as of the Effective Date and, unless earlier terminated in accordance herewith, shall continue for an initial one (1) year term. Thereafter, this Agreement shall automatically renew for successive one (1) year terms unless the Agreement is terminated pursuant to this Section 8 as set forth herein.

8.2 Either party may terminate this Agreement at the end of the initial term or at any time thereafter by providing the other party with at least ninety (90) days prior written notice of its intention to terminate this Agreement. The effective date of termination will be on the first of the month following the expiration of the notice period.

8.3 Either party may terminate this Agreement for cause due to a material breach by giving ninety (90) days' prior written notice. The notice of termination for cause will not be effective if the breaching party cures the breach within the first sixty (60) days of the ninety (90) day notice period. In the event that the breaching party does not cure the breach within the sixty (60) day period, the effective date of termination will be the first of the month following the expiration of the ninety (90) day notice period.

8.4 Termination of this Agreement for any reason, including without limitation the insolvency of ACIA, shall not release Provider from his or her obligations to serve Members when continuation of a Member's treatment is Medically Necessary.

8.5 In the event any change in federal or State laws, rules and regulations or the Iowa Medicaid Program or the Medicare Advantage program would have a material adverse impact on either ACIA or Provider in connection with the performance of this Agreement (the "Mandated Changes") such that the basis for the financial bargain of this Agreement is undermined, then the affected party shall have the right to require the other, by written notice, to enter into negotiations regarding the affected or pertinent terms of this Agreement while still maintaining the original Agreement purposes. If renegotiated, such terms shall become effective no later than thirty (30) days after the parties have reached agreement on the renegotiated terms. The parties agree to make a good faith attempt to renegotiate the Agreement to the extent necessary to comply with any Mandated Changes. If, after good faith renegotiations, the parties fail to reach an agreement satisfactory to both parties within thirty (30) days of the request for renegotiation, the party requesting such renegotiation may terminate this Agreement upon ninety (90) days prior written notice to the other party.

8.6 Notwithstanding the above, ACIA may terminate this Agreement immediately in the event any of the following occur:

(a) If Provider (or, if Provider is a group, any Group Physician) or a person with an ownership or control interest in Provider is expelled, disciplined, barred from participation in, or

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suspended from receiving payment under any state's Medicaid program, Children's Health Insurance Program (CHIP), the Medicare Program under Section 1128 or 1128A of the Social Security Act or any other federal health care program.

(b) If Provider (or, if Provider is a group, any Group Physician) is debarred, suspended or otherwise excluded from procurement or non-procurement activities under the Federal Acquisition Regulations.

(c) If Provider (or, if Provider is a group, any Group Physician) is convicted of any felony or of any crime related to the practice of medicine.

(d) Upon the loss or suspension of the Provider's professional liability coverage set forth under Section 5 of this Agreement.

(e) The suspension or revocation of Provider's license or other certification or authorization necessary for Provider to render Basic Health Services, or upon ACIA's reasonable determination that the health, safety or welfare of any Member may be in jeopardy if this Agreement is not terminated.

(f) If Provider (or, if Provider is a group, any Group Physician) fails to satisfy any or all of the credentialing requirements of ACIA or fails to cooperate with or abide by the Quality Management Program.

(g) If Provider (or, if Provider is a group, a Group Physician) breaches a material provision of this Agreement or is engaged in any conduct which would injure the business of ACIA.

8.7 With respect to a Group Physician, if ACIA decides to suspend or terminate the Agreement, ACIA shall give the Group Physician written notice, to the extent required under CMS regulations, of the reasons for the action, including, if relevant, the standards and the profiling data the organization used to evaluate the Group Physician and the numbers and mix of Participating Physicians ACIA needs. Such written notice shall also set forth the Group Physician's right to appeal the action and the process and timing for requesting a hearing.

8.8 Upon termination of this Agreement for any reason, ACIA shall notify affected Members of the termination of Provider (or, if Provider is a group, any Group Physician) in accordance with the notification requirements under **42 C.F.R. §422.111(e)**. Regardless of the reason for termination, Provider shall promptly supply to ACIA all information necessary for the reimbursement of outstanding claims. **42 CFR 434.6(a)(6)**.

9. PROGRAM REQUIREMENTS:

Attached hereto and incorporated herein by reference is **Schedule 9**, setting forth such terms and conditions as are necessary to meet State and Federal statutory and regulatory requirements, and other Agency requirements, of the Program. **Schedule 9** is consecutively sub-numbered as necessary for each Program under which Provider is furnishing services under this Agreement. Provider acknowledges that the specific terms as set forth in **Schedule 9** are subject to amendment in accordance with federal and/or State statutory and regulatory changes to the Program. Such amendment shall not require the consent of the Provider or ACIA and will be effective immediately on the effective date thereof, as set forth in Section 10.3.

10. MISCELLANEOUS:

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10.1 It is understood that Provider is an independent contractor and in no way is Provider to be considered an employee, agent, or representative of ACIA. It is further understood that Provider provides specified services to Members in exchange for an agreed upon fee. This Agreement shall not create, nor be deemed or construed to create any relationship between ACIA and Provider other than that of independent contractors, contracting with each other solely for the purpose of performing this Agreement and each party shall be liable solely for their own activities and neither ACIA nor Provider shall be liable to any third party for the activities of the other party to this Agreement.

10.2 This Agreement, being for the purpose of retaining the professional services of Provider, shall not be assigned, subcontracted, or delegated by Provider without the express written consent of ACIA.

10.3 No alterations or modifications of the terms of this Agreement shall be valid unless such alterations or modifications are incorporated into the Agreement through a written amendment, signed by both parties hereto, and attached to this Agreement; provided, however, ACIA may amend this Agreement with 30 days' notice to Provider via a(n) ACIA bulletin or other written communication provided in accordance with the notice provisions in Section 10.6, and unless Provider notifies ACIA, as applicable, of any objection, such amendment shall then take effect. Any amendment to this Agreement subject to prior regulatory approval(s) shall be effective once such regulatory approval(s) has been received.

Notwithstanding the foregoing, amendments required because of legislative, regulatory or governmental agency requirements do not require the consent of Provider or ACIA and shall be effective immediately on the effective date thereof. This Agreement remains subject to the approval of the State of Iowa, and may be amended by ACIA to comply with any requirements of the State of Iowa. Provider acknowledges that all Agency requirements, as may be amended from time to time, are incorporated to this Agreement.

10.4 This Agreement shall be deemed to have been made and shall be construed and interpreted in accordance with the laws of the State of Iowa.

10.5 This Agreement and its exhibits, appendices, schedules, addenda or other attachments constitute the entire understanding and agreement between the parties concerning the subject matter hereof. This Agreement supersedes all prior written or oral agreements or understandings existing between the parties concerning the subject matter hereof including, but not limited to, any such agreement which may have been previously executed between Provider and ACIA or any of its Affiliates relating to the provision of Covered Services under the Program. In the event of a conflict between the terms of this Agreement and the Provider Manual, the terms of the later document shall control.

10.6 Written notices to be given hereunder shall be sent by Certified Mail, Return Receipt Requested, or by an overnight delivery service which provides a written receipt evidencing delivery to the address set forth by the party, or by confirmed facsimile followed by written notice through the U.S. postal service. All notices called for hereunder shall be effective upon receipt.

If to Provider:

With a copy to:

If to AmeriHealth Caritas Iowa:

ATTN:

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With a copy to: General Counsel
AmeriHealth Caritas
200 Stevens Drive
Philadelphia, PA 19113

10.7 Both parties agree that there shall be no discrimination in the performance of this Agreement against any patient or other person as the result of that individual's race, color, religion, gender, sexual orientation, handicap, age, national origin, source of payment, or any other basis prohibited by law.

10.8 The failure of any of the parties to insist upon strict performance of any of the terms of this Agreement shall not be deemed a waiver of any of their respective rights or remedies, and shall not be deemed a waiver of any subsequent breach or default in any of the terms contained in this Agreement.

10.9 In the event that any provision under this Agreement is declared null or void, for any reason, the remaining provisions of this Agreement shall remain in full force and effect.

10.10 The parties will use reasonable care and due diligence in performing this Agreement. Provider will be solely responsible for the services provided under this Agreement.

10.11 All captions contained in this Agreement are solely for the convenience of the parties hereto and shall not be deemed part of the content of this Agreement.

10.12 All terms used in this Agreement are deemed to refer to the masculine, feminine, neuter, singular or plural as the content may require.

10.13 Non-Discrimination. Provider shall comply with (i) Title VI of the Civil Rights Act of 1964 and the rules, regulations, and order; (ii) the Rehabilitation Act of 1973 and the rules, regulations, and orders thereunder; (iii) the Americans With Disabilities Act of 1990 and the rules, regulations, and orders thereunder; and (iv) any and all applicable laws, rules and regulations prohibiting discriminatory practices. Furthermore, in accordance with Title VI of the Civil Rights Act of 1964 and the rules, regulations and orders thereunder, Provider shall take adequate steps to ensure that Members with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement (see 42 U.S.C. 2000d et seq. and 45 C.F.R. Part 80, 2001 as amended).

10.14 No Offshore Contracting. No Covered Services under this Agreement may be performed outside of the United States without ACIA's prior written consent. In addition, Provider will not hire any individual to perform any services under this Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

[SIGNATURES ON FOLLOWING PAGE; REMAINDER OF PAGE INTENTIONALLY BLANK]

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IN WITNESS WHEREOF, and intending to be legally bound hereby, the parties hereto, each by its officers duly authorized, hereby affix their hands as of the date written below.

PROVIDER	AMERIHEALTH CARITAS IOWA, INC.
_____ Print Name	_____ Name
_____ Signature	_____ Signature
_____ Title	_____ Title
_____ Address	_____ Date
_____ National Provider ID Number	**Effective Date of Agreement:** _____ [To be completed by AmeriHealth Caritas Iowa]
_____ Medicaid ID Number	
_____ Group Tax ID Number _____ Group Medicare #/PTAN	
_____ Date	
Assignment of Payment (*applicable to Group Physician only*): **By signing below, Provider hereby assigns and transfers all Provider's right to and interest in compensation payable by ACIA pursuant to this Agreement to the party identified below, and Provider therefore directs ACIA to pay such compensation to said party:**	
_____ Provider Signature	
_____ Name of Group	
_____ Address	
_____ Group Tax ID Number _____ Group Medicare #/PTAN	
Check and initial if Assignment of Payment Not Applicable: ☐ Provider Initials	

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APPENDIX A

COVERED SERVICES

Primary Care Services

In Provider's capacity as a Primary Care Provider, Provider shall provide all Basic Health Services to Members who have selected or been assigned to Provider as their Primary Care Provider including the following:

1. All primary ambulatory care visits and routine office procedures;
2. Periodic physical examinations;
3. Routine injections and immunizations, including vaccinations;
4. Arrange for and/or provide inpatient medical care at ACIA participating hospital providers;
5. Referrals, as required, to Specialty Care Providers;
6. Referrals, as required, to ACIA participating providers for lab, radiology and other appropriate services;
7. Provision or arrangement for Basic Health Services twenty-four (24) hours a day, seven (7) days a week; and
8. Exercise primary responsibility for arranging and coordinating the delivery of Medically Necessary health care services to Members.

Specialty Care Services

In Specialty Provider's capacity as a Specialty Care Provider, Provider shall provide all Specialty Care Services to Members including the following:

1. Ambulatory care visits;
2. Arrange for and/or provide inpatient medical care at ACIA participating hospital providers; and
3. Emergency or consultative Specialty Care Services twenty-four (24) hours a day, seven (7) days a week.

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APPENDIX B

PROVIDERS AND OFFICE LOCATIONS COVERED BY AGREEMENT

PRIMARY/SPECIALTY CARE PROVIDER(S)	PRIMARY/SPECIALTY CARE PROVIDER(S)
Name	Name
Name	Name
Name	Name
Name	Name
Name	Name
PRACTICE LOCATION ADDRESS	**PRACTICE LOCATION ADDRESS**
Address	Address
City, State, ZIP	City, State, ZIP
Phone Number	Phone Number

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APPENDIX C

COMPENSATION

Primary Care Provider Compensation
Commencing on the Effective Date, ACIA will compensate Provider for all Basic Health Services rendered by Provider to Members in accordance with the terms of this Agreement at a rate of [_____], in accordance with Medicare Payment Policies, less applicable co-insurance and deductibles. In no event will ACIA's payment exceed Provider's charges.

Specialty Care Provider Compensation
Commencing on the Effective Date, ACIA will compensate Provider for all Specialty Care Services rendered by Provider to Members in accordance with the terms of this Agreement at a rate of [___]. In no event will ACIA's payment exceed Specialty Provider's charges.

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APPENDIX D
PHYSICIAN PROVIDER

ACIA AFFILIATES

ACIA Affiliates Covered by Agreement

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Schedule 9-1

Federal Requirements – Medicaid and Medicaid Managed Care

1. No payment will be made to Provider for provider-preventable conditions or health care-acquired conditions. For purposes hereof:

   a. **Health care-acquired condition** ("HAC") means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary of the U.S. Department of Health and Human Services ("HHS") under section 1886(d)(4)(D)(iv) of the Social Security Act (the "Act") for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act, other than deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

   b. **Other provider-preventable condition** means a condition occurring in any health care setting that meets the following criteria: (i) is identified in the Iowa Medicaid plain; (ii) has been found by the Iowa, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines (iii) has a negative consequence for the Member; (iv) is auditable; and (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.

   c. **Provider-preventable condition** ("PPC") means a condition that meets the definition of "health care-acquired condition" or an "other provider-preventable condition."

   No reduction in payment will be made for a PPC when the condition existed prior to the initiative of treatment for that patient by Provider. Provider shall identify PPCs when submitting claims for payment or, if no claim will be submitted, if Medicaid payment would otherwise be available for the course of treatment in which the PPC occurred, or as otherwise required by the State. **42 CFR §§438.6(f)(2), 434.6(a)(12) and 447.26.**

2. The State Agency and HHS may inspect and audit any financial records of Provider or its subcontractors. **42 CFR §438.6(g).**

3. Physician Incentives. Provider shall disclose to ACIA annually any Physician Incentive Plan (PIP) or risk arrangements Provider may have with physicians, either within Provider's group practice or other physicians not associated with Provider's group practice, even if there is no substantial financial risk between ACIA and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for Covered Services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low. **42 CFR §§438.6(g), 422.208, 422.210.**

4. Provider Discrimination Prohibited. ACIA may not, with respect to Provider compensation or indemnification under this Agreement, discriminate against Provider to the extent that the Provider is acting within the scope of his, her or its license or certification under applicable State law, solely on the basis of that license or certification. Without limiting the foregoing, ACIA shall not discriminate against Provider for serving high-risk populations or specializing in

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conditions that require costly treatment. Nothing herein shall be construed to: (i) require ACIA to contract with Provider if not necessary to meet the needs of Members; (ii) preclude ACIA from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (iii) preclude ACIA from establishing measures that are designed to maintain quality of services and control costs and are consistent with ACIA's responsibilities to Members. **42 CFR §438.12**.

5. Continued Treatment Obligation. Notwithstanding any other provision of this Agreement, in the event of either party's termination of this Agreement, insolvency of either ACIA, or other cessation of ACIA's operations, Provider shall continue to provide Covered Services to Members (i) until the end of the month in which the effective date of termination of this Agreement falls, (ii) until the end of the month for which capitation or premium has been paid to ACIA by Agency, or (iii) until the date of a Member's discharge from an inpatient facility, whichever is later. **42 CFR §438.62**.

6. Member Rights. Provider shall adhere to all applicable Federal and State laws that pertain to Member rights, and shall take such rights into account when furnishing services to Members. **42 CFR §438.100(a)(2)**.

7. Provider-Member Communications. Nothing in this Agreement shall be construed to prohibit, restrict or impede Provider's ability to freely and openly discuss with Members, within the Provider's lawful scope of practice, all available treatment options and any information the Member may need in order to decide among all relevant treatment options, including but not limited to the risks, benefits and consequences of treatment or non-treatment, regardless of whether the services may be considered Covered Services in accordance with this Agreement. Further, nothing in this Agreement shall be construed to prohibit, restrict or impede Provider from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member, including: information regarding the nature of treatment options, risks of treatment, alternative treatments or the availability of alternative therapies, consultation or tests that may be self-administered, and the Member's right to participate in decisions regarding his or her care, including the right to refuse treatment and to express preferences about future treatment decisions. **42 CFR §438.102(a)**.

8. Member Hold Harmless. Provider shall accept the final payment made by ACIA as payment in full for Covered Services provided pursuant to this Agreement. Provider agrees that in no event, including, but not limited to, nonpayment by the Agency to ACIA, nonpayment by ACIA to Provider, the insolvency of ACIA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, solicit or accept any surety or guarantee of payment, or have any recourse against Members or persons other than ACIA acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the Member) for Covered Services listed in this Agreement. This provision shall not prohibit collection of supplemental charges or co-payments on ACIA's behalf made in accordance with terms of an enrollment agreement between ACIA and Members.

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Provider further agrees that:

a. this hold harmless provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members; and that

b. this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

42 CFR §§438.106, 447.15.

9. Coverage and Payment for Emergency Services. ACIA shall cover and pay for Emergency Services rendered by Provider and obtained when a Member had an Emergency Medical Condition, or when a representative of ACIA has instructed the Member to seek Emergency Services. **42 CFR §438.114(c)(1)(ii).**

10. Timely Access. Provider shall meet Agency standards for timely access to care and services, taking into account the urgency of the need for services. Provider shall offer hours operation to Members that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if Provider serves only Medicaid enrollees. Provider services shall be available 24 hours a day, 7 days a week, when medically necessary.

11. Excluded Providers. Pursuant to **42 CFR §438.214(d)**, ACIA may not employ or contract with providers excluded from participation in Federal healthcare programs under either Section 1128 or 1128A of the Act. In addition, section 2455 of the Federal Acquisition Streamlining Act of 1994 and he Federal Acquisition Regulations (including but not limited to 48 CFR §9.405), ACIA may not make payment to any person or entity, or an affiliate thereof, who has been debarred or suspended form participation in federal procurement or non-procurement activities. Provider shall comply with the disclosure requirements of **42 C.F.R. Section 455, Subpart B** and, upon reasonable request, provide such information to ACIA in accordance with the requirements specified therein.

Provider represents and warrants that neither it, nor any of its contractors or employees who will furnish goods or services under the Agreement, directors or officers, or any person with an ownership interest in Provider of five percent (5%) or more, is or ever has been: (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification; or (iv) debarred or suspended from participation in procurement or non-procurement activities by any federal agency (collectively, "Sanctioned Persons"). Provider shall screen all employees and contractors who will furnish goods or services under this Agreement to determine whether they have been excluded from participation in any Federal health care program, by searching applicable Federal and State databases (including but not limited to the OIG's LEIE and the HIPDB) upon initial employment or engagement of or contracting with a contractor, employee, director or officer, and on a monthly basis thereafter.

Provider shall immediately notify ACIA upon knowledge by Provider that any of its contractors or employees who furnish goods or services under the Agreement, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that Subcontractor cannot provide reasonably

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satisfactory assurance to ACIA that a Sanctioned Person will not receive payment from ACIA under this Agreement, ACIA may immediately terminate this Agreement. ACIA reserves the right to recover all amounts paid by ACIA for items or services furnished by a Sanctioned Person. Further, and without limiting Provider's indemnification obligations set forth elsewhere in this Agreement, to the extent penalties, fines or sanctions are assessed against ACIA as a result of Provider's having a relationship with a Sanctioned Person, Provider shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACIA, ACIA shall have the right to offset claims payments to Provider by the amount owed by Provider to ACIA.

12. State and Federal Regulator Access. Provider acknowledges that the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Office of the Inspector General, the Comptroller, the **Iowa Department of Human Services**, and their designees have the right to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to this Agreement, including quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and Provider claims submitted to ACIA. Such evaluation, when performed, shall be performed with the cooperation of the Provider and ACIA. Upon request, Provider and ACIA shall assist in such reviews. **42 CFR §434.6(a)(5)**.

13. Provider shall safeguard information about Members as required by Part 431, Subpart D of 42 CFR. **42 CFR 434.6(a)(8)**.

14. Any permitted subcontracts entered into by Provider in order to carry out its obligations under this Agreement must be in writing and fulfill the requirements of 42 CFR Part 434 that are appropriate to the service or activity delegated under the subcontract. **42 CFR 434.6(a)(11), (b)**.

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Schedule 9-2 (Physician Form)

State of Iowa Requirements – Medicaid and Medicaid Managed Care

1. Unless defined in this Schedule 9-2 or elsewhere in the Agreement, all capitalized terms used herein shall have their respective meanings given to them in the contract between the Iowa Department of Human Services ("IDHS") and AmeriHealth Caritas Iowa, Inc. ("ACIA") dated as of [_____], 201[_] (the "State Contract").

2. In accordance with **191 IAC 40.18**, Provider, or its assignee or subcontractor as applicable, hereby agrees that in no event, including but not limited to nonpayment by the ACIA, ACIA insolvency or breach of this Agreement, shall Provider, or its assignee or subcontractor if applicable, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons other than ACIA acting on the Member's behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on ACIA's behalf made in accordance with terms of the Program.

   Provider, or its assignee or subcontractor if applicable, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member; and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member or persons acting on behalf of the Member.

3. Pursuant to **191 IAC 40.22**:

   a. ACIA shall not prohibit Provider from or penalize Provider for discussing treatment options with Members, irrespective of ACIA's position on the treatment options, or from advocating on behalf of Members within the utilization review or grievance processes established by ACIA or a person contracting with ACIA.

   b. ACIA shall not penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by ACIA that, in the opinion of Provider, jeopardizes patient health or welfare.

4. Compliance with Pro-Children Act of 1994. Provider hereby certifies compliance with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 ("Act"). The Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children's services that are provided in indoor facilities that are constructed, operated or maintained with such federal funds. The law does not apply to children's services provided in private residences, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable federal funds is Medicare or Medicaid,

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or facilities (other than clinics) where WIC coupons are redeemed. (**Ref. RFP Exhibit D**)

5. ACIA follows all applicable Federal and State laws pertinent to Member confidentiality and rights; Provider shall take those rights into account when furnishing services to Members. (**SOW §1.4.1**)

6. Provider shall not require any cost-sharing or Member liability responsibilities for Covered Services except to the extent that cost-sharing or Member liability responsibilities are required for those services in accordance with law and as described in the Agency Contract. Further, Provider shall not charge Members for missed appointments. (**SOW §3.2.15.3**)

7. Provider agrees that all applicable terms and conditions set out in the RFP, the Agency Contract, any incorporated documents and all applicable State and federal laws, as amended, govern the duties and responsibilities of Provider with regard to the provision of services to Members. (**SOW §6.1.2**)

8. Provider's responsibilities regarding third-party liability (TPL) include Provider's obligations to identify TPL coverage, including Medicare and long-term care coverage as applicable, and except as otherwise required, seek such TPL payment before submitting claims to ACIA. (**SOW §6.1.2**)

9. Provider shall submit claims which do not involve a third-party payer within **ninety (90) days** of the date of service. (**SOW §6.1.2**)

10. IDHS reserves the right to direct ACIA to terminate or modify this Agreement when IDHS determines it to be in the best interest of the State. (**SOW §6.1.2**)

11. ACIA may not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient regarding: (1) the Member's health status; (2) medical, behavioral health, or long-term care treatment options, including any alternative treatment that may be self-administered; (3) any information the Member needs in order to decide among all relevant treatment options; (4) the risks, benefits and consequences of treatment or non-treatment; or (5) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. (**SOW §6.1.5**)

12. Provider shall maintain complete and legible medical and financial (fiscal) records as required pursuant to **IAC 441-79.3**. Without limiting the foregoing, Provider's medical records shall document all medical services that the Member receives from Provider. Medical records shall be maintained in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records must be legible, signed, dated and maintained as required by law. (**SOW §6.1.9**)

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As required pursuant to **IAC 441-79.3(3)**, Provider shall maintain medical records: (1) during the time the Member is receiving services from Provider; (2) for a minimum of five (5) years from the date when a claim for the service was submitted to ACIA for payment; and (3) as may required by any licensing authority or accrediting body associated with determining Provider's qualification.

13. Each Member shall have the right to request and receive a copy of his her medical records, and to request that they be amended or corrected. Upon reasonable request of a Member, Provider shall provide a copy of a Member's medical record at no charge. Provider must facilitate the transfer of a Member's medical record to another provider at the Member's request. (**SOW §6.1.9.2**)

14. Within the timeframe designated by IDHS or other authorized entity, Provider must permit ACIA, representatives of IDHS, and other authorized entities to review Members' records for the purpose of monitoring Providers' compliance with the records standards, capturing information for clinical studies, monitoring quality of care, or any other reason. (**SOW 6.1.9.3**)

15. All medical records of Members shall be confidential and shall not be released without the written consent of the Member or responsible party. Written consent is not required under the following circumstances: (1) for transmission of medical record information to physicians, other practitioners or facilities who are providing services to Members under contract with ACIA; and (2) for transmission of medical record information to physicians or facilities providing emergency care. Written consent is required for the transmission of the medical record information of a former Member to any physician not connected with ACIA. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the practitioner or facility requesting the information. All release of medical records shall be compliant with 45 CFR Parts 162 and 164. (**SOW §6.1.9.4**)

16. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid members, if Provider sees only the Medicaid population. Covered Services shall be available twenty0-four (24) hours a day, seven (7) days a week, when medically necessary. (**SOW 6.1.9.5**)

17. Upon determination by IDHS of a credible allegation of fraud for which an investigation is pending under the Medicaid program against Provider and upon the approval of the Medicaid Fraud Control Unit (MFCU) and IDHS, ACIA shall suspend all payments to Provider, in compliance with 42 CFR 455.23. ACIA shall issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 CFR 455.23(b) (including notice that payments are being withheld in accordance with 42 CFR 455.23), and shall maintain the suspension for the durational period set forth in 42 CFR 455.23(c). ACIA will afford a grievance process to Provider in the event of payment suspension under this **paragraph 17**. (**SOW §12.7**)

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AmeriHealth Caritas Iowa

CARE IS THE HEART OF OUR WORK

Provider Contract Agreement Templates (Ancillary Services)

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AMERIHEALTH CARITAS IOWA, INC.

ANCILLARY SERVICES AGREEMENT

with

[PROVIDER NAME]

AMERIHEALTH CARITAS IOWA, INC.
ANCILLARY SERVICES AGREEMENT

This Provider Services Agreement (the "Agreement"), dated as of the Effective Date (defined below), is made by and between **AmeriHealth Caritas Iowa, Inc.**, a corporation organized under the laws of the State of Iowa, (hereinafter referred to as "ACIA") and the provider ("Provider") identified on the signature page.

WHEREAS, ACIA is a managed care organization that is responsible for providing or arranging for the provision of health care services to its Members; and

WHEREAS, Provider is duly licensed to furnish certain health care services; and

WHEREAS, Provider and ACIA mutually desire to enter into this Agreement, whereby Provider shall render services to Members enrolled with ACIA and be compensated by ACIA in accordance with the terms and conditions hereof.

NOW, THEREFORE, in consideration of the mutual promises made herein, it is mutually agreed by and between ACIA and Provider as follows:

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1. DEFINITIONS

As used in this Agreement, each of the following terms shall have the meaning specified herein, unless the context clearly requires otherwise.

1.1 **AFFILIATES.** An Affiliate is any corporation or other organization that is identified as an Affiliate in a written notice to Provider and is owned or controlled, either directly or through parent or subsidiary corporations, by or under common control with, ACIA. ACIA shall give Provider thirty (30) days advance written notice of the addition of Affiliates added under this provision. Unless otherwise specified in this Agreement or any other attachment hereto, references to "ACIA" shall include the Affiliates referenced in **Appendix B**.

1.2 **AGENCY.** The State and/or Federal governmental agency that administers the Program(s) under which ACIA is obligated to provide or arrange for the provision of Covered Services.

1.3 **AGENCY CONTRACT.** The contract or contracts between ACIA and the Agency, as in effect from time to time, pursuant to which ACIA is responsible for coordinating health care services and supplies for Program recipients enrolled with ACIA.

1.4 **CLEAN CLAIM.** A claim for payment for a health care service, which has been received by ACIA, has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. Consistent with **42 CFR §447.45(b)**, the term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim, or a claim under review for medical necessity.

1.5 **COVERED SERVICES.** Those Medically Necessary health care services and supplies to which Members are entitled pursuant to the Agency Contract, and which shall be provided to Members by

Provider, as described more specifically in **Appendix A**. Covered Services shall be furnished in the amount, duration and scope required under the Program.

1.6 **EFFECTIVE DATE.** The later of (i) the effective date on the signature page of this Agreement or (ii) the effective date of the Agency Contract, provided that Provider has been successfully credentialed by ACIA, as applicable, and that all required regulatory approvals have been obtained by ACIA.

1.7 **EMERGENCY MEDICAL CONDITION.** Health care services provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the health of the Member (or with respect to a pregnant woman, the health of the Member or her unborn child) in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

1.8 **EMERGENCY SERVICES.** Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. Section 438.114(a) and 42 U.S.C. Section 1932(b)(2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition.

1.9 **MEDICALLY NECESSARY.** Those Covered Services that are, under the terms and conditions of the Agency Contract, determined through ACIA utilization management to be: (1) appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Member; (2) provided for the diagnosis or direct care and treatment of the condition of Member enabling the Member to make reasonable progress in treatment; (3) within standards of professional practice and given at the appropriate time and in the appropriate setting; (4) not primarily for the convenience of the Member, the Member's physician or other provider; and (5) the most appropriate level of Covered Services which can safely be provided. **(Ref. Agency Contract – Scope of Work document)**

1.10 **MEMBER.** An individual who is eligible for the Program and who has enrolled in ACIA under the Program.

1.11 **MEMBER APPEAL PROCEDURES.** The written procedures describing ACIA's standards for the prompt resolution of Member problems, grievances and appeals, as described in the Provider Manual.

1.12 **PARTICIPATING PROVIDER.** A duly licensed or certified, as applicable, health care provider that has entered into an agreement with ACIA to provide health care services to Members.

1.13 **PROGRAM.** The Iowa High Quality Health Initiative procured by the Iowa Department of Human Services ("IDHS") under RFP #MED-16-009, for the delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (*hawk-i*) programs.

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1.14 **PROVIDER MANUAL.** The ACIA manual of standards, policies, procedures and corrective actions together with amendments or modifications ACIA may adopt from time to time. The Provider Manual is herein incorporated by reference and made part of this Agreement. The Provider Manual may be amended or modified by ACIA from time to time in accordance with Section 3.3 herein below.

1.15 **QUALITY MANAGEMENT PROGRAM.** An ongoing review process and plan which functions to define, monitor, review, and recommend corrective action for managing and improving the quality of health care services to Members.

1.16 **UTILIZATION MANAGEMENT PROGRAM.** A process of review of the medical necessity, appropriateness and efficiency of health care services, procedures, equipment, supplies and facilities rendered to Members.

2. OBLIGATIONS OF PROVIDER:

2.1 Throughout the term of this Agreement, Provider shall have and maintain, without restriction, all licenses, certificates, registrations and permits as are required under applicable State and federal statutes and regulations to provide the Covered Services furnished by Provider and/or other related activities delegated by ACIA under this Agreement. Provider shall obtain a unique identifier (national provider identifier) in accordance with the system established under Section 1173(b) of the Social Security Act, submit such identifier number to ACIA, and include such identifier on all claims. At all times during the term of this Agreement, Provider shall be eligible for participation in the Iowa Medicaid program; and, if required by the Iowa Medicaid program as a condition of furnishing services to Iowa Medicaid recipients, Provider shall participate in the Iowa Medicaid program. To the extent that Covered Services are furnished to Medicare beneficiaries under this Agreement, Provider shall also participate in the Medicare program. Provider shall ensure that all services provided pursuant to this Agreement are within the Provider's scope of professional responsibility.

2.2 Provider shall provide to Members the Covered Services described in **Appendix A** hereto; provided, however, that Provider shall only be obligated to provide Covered Services to a Member in accordance with ACIA's pre-authorization and other Utilization Management Program policies as described in the Provider Manual, other than Emergency Services, which will be provided as needed. In providing Covered Services, Provider agrees to abide by the relevant standards, policies and procedures of ACIA, including, but not limited to administrative, credentialing, quality management, utilization management, and Member Appeal Procedures set forth in the Provider Manual and other ACIA notices. Provider shall provide Covered Services in the same manner and with the same availability as services provided to other patients without regard to reimbursement and shall further provide these services in the most cost effective setting in accordance with appropriate quality of care and performance standards which are professionally recognized as industry standards and/or otherwise adopted, accepted or established by ACIA.

2.3 Provider shall provide ACIA with complete and accurate statements of all Covered Services provided to Members in conformance with ACIA billing procedures as set forth in the applicable Program manuals, the Provider Manual and other written ACIA billing guidelines. ACIA will not be liable for any bills relating to services that are submitted the later of: (a) after twelve (12) months from the date the services were provided (consistent with **42 CFR §447.45(d)**), or (b) after sixty (60) days of the date of the Explanation of Benefits from another payor when services are first billed by Provider to another payor. Any appeal or request for adjustment of a payment

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by Provider must be made in accordance with applicable provisions of the Provider Manual and ACIA policies and procedures and, in any case, must be received by ACIA within sixty (60) days of the original payment or denial. Provider may not bring legal action on claims which have not been appealed through the appeal mechanisms described herein.

Encounter Data and Other Reports. Provider shall deliver all reports and clinical information required to be submitted to ACIA pursuant to this Agreement for reporting purposes, including but not limited to encounter data, Healthcare Effectiveness Data and Information Set (HEDIS), Agency for Healthcare Research and Quality (AHRQ), and EPSDT data in a format which will allow ACIA to transmit required data to the Agency electronically and in a format identical to or consistent with the format used or otherwise required by ACIA and the Agency. Provider shall submit this information to ACIA within the time frames set forth in the Provider Manual or as otherwise required by the Agency. Provider shall submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by ACIA.

2.4 Provider may directly bill Members for non-Covered Services if the Member is advised in writing before the service is rendered: (i) the nature of the service(s) to be rendered; (ii) that ACIA does not cover the services; and (iii) that the Member will be financially responsible for the services if the Member elects to receive the services. Furthermore, Provider shall hold harmless ACIA for any claim or expense arising from such services.

2.5 Provider shall not bill or collect from any Member any amount or charges for any Covered Services provided hereunder, except for authorized co-payments, co-insurance, and/or deductibles. Provider shall not deny Covered Services to a Member in the event that a Member is unable to pay any authorized co-payment amounts. **42 CFR §447.15.**

2.6 Under no circumstances, including ACIA's failure to pay for Covered Services, termination of this Agreement, or the insolvency of ACIA, will Provider make any charges or claims against any Member directly or indirectly for Covered Services authorized by ACIA, except for authorized co-payments. Provider shall look only to ACIA for compensation for Covered Services.

2.7 During the term of this Agreement and in the event of termination of this Agreement for any reason, Provider agrees to fully cooperate with each Member and with ACIA in arranging for the transfer of copies of Member medical records to other ACIA Participating Providers.

2.8 Record Maintenance, Inspection, Reporting and Auditing

(a) Record Retention. As required by **42 CFR 434.6(a)(7)** and otherwise in accordance with the standards of ACIA, Provider shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Members pursuant to this Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Agreement and the Agency Contract).

(b) All records originated or prepared in connection with Provider's performance of its obligations under this Agreement will be retained and safeguarded by Provider in accordance with the terms and conditions of the Agency Contract and other relevant State and federal law. Provider agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Members relating to the delivery of care or service under the Agency Contract and as further required by the Agency, for a period of no less than

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seven (7) years from the expiration date of the Agency Contract, including any contract extension(s), and to retain all Member records, including but not limited to administrative, financial and medical records (whether electronic or paper) for a period of no less than seven (7) years after the last payment was made for services provide to the Member. If any audit, litigation, claim, or other actions involving the records have been initiated prior to the expiration of the seven (7) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the seven (7) year period, whichever is later. If Provider stores records on microfilm or microfiche or other electronic means, Provider agrees to produce, at its expense, legible hard copy records promptly upon the request of state or federal authorities.

(c) Medical Record Maintenance. Provider shall ensure that all medical records are in compliance with the medical record keeping requirements set forth in the Provider Manual, the Agency Contract and Agency guides. Provider shall maintain up-to-date medical records at the site where medical services are provided for each Member enrolled under this Agreement. Each Member's record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment.

(d) ACIA shall be entitled to audit, examine and inspect Provider's books and records, including but not limited to medical records, financial information and administrative information pertaining to Provider's relationship with ACIA, at any time during normal business hours, upon reasonable notice. Provider agrees to provide ACIA, at no cost to ACIA, with such medical, financial and administrative information, and other records as may be necessary for ACIA to meet its obligations related to the Agency Contract and other regulatory obligations, Utilization Management Program and Quality Management Program standards, including NCQA standards, and other relevant accreditation standards which ACIA may require of ACIA Participating Providers.

2.9 Provider authorizes ACIA to include Provider's name, address, telephone number, information related to Provider's facilities, services and staff, and other similar information relevant to Provider, its operations and staff in the ACIA provider directory and in various marketing materials identifying Provider as a provider of services to Members. Provider agrees to afford ACIA the same opportunity to display brochures, signs, or advertisements in Provider's facilities as Provider affords any other insurance company or other third party payor.

2.10 While both parties support Provider's open and active communication with Members concerning Medically Necessary services, available treatment alternatives, benefit coverage information and/or any other information pertaining to the provider-patient relationship, Provider shall not, during the term of this Agreement, and any renewal thereof, solicit or require any Member, either orally or in writing, to subscribe to or enroll in any managed care plan other than ACIA. The provisions of this Section 2.10 shall similarly apply to Provider's employees, agents and/or contractors.

2.11 Provider shall cooperate with ACIA in the identification of other sources of payment available to Members, such as other health insurance, government programs, liability coverage, motor vehicle coverage or worker's compensation coverage, as applicable. Provider shall be responsible for reporting all applicable third party resources to ACIA in a timely manner.

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Provider will cooperate with ACIA in coordinating benefits with other payors in accordance with coordination of benefits claim processing rules and requirements outlined in the Provider Manual, the Agency Contract, and applicable Program manuals, as amended from time to time. Provider will make a reasonable attempt to determine whether any other payor has primary responsibility for the payment of a claim for services that Provider rendered to a Member and bill that payor before billing ACIA. Unless otherwise prohibited by applicable law, ACIA retains the right to recover payments made to Provider in the event ACIA determines that another payor is primarily responsible for all or a portion of the claim.

2.12 Provider understands and agrees that any payments ACIA makes directly or indirectly to Provider under this Agreement shall not be made as an inducement to reduce, limit or delay Medically Necessary services to any Member.

2.13 Provider will refer Members to ACIA-Participating Pospitals whenever Provider is unable to provide Medically Necessary services and when consistent with sound medical judgment and accepted standards of care.

2.14 Provider shall use best efforts to use ACIA's electronic utilization management and claims interfaces to improve the efficiency of utilization management and claims payment processes.

2.15 Provider will assist ACIA in providing orientation services to Provider staff to the extent ACIA may reasonably request.

2.16 Fraud and Abuse. Provider recognizes that payments made by ACIA pursuant to this Agreement are derived from federal and State funds, and acknowledges that it may be held civilly and/or criminally liable to ACIA and/or the Agency in the event of non-performance, misrepresentation, fraud or abuse for services rendered to Members, including but not limited to, the submission of false claims/statements for payment by Provider, its employees or agents. Provider shall be required to comply with all policies and procedures as developed by ACIA and the Agency, including but not limited to the requirements set forth in the Provider Manual and the Agency Contract, for the detection and prevention of fraud and abuse. Such compliance may include, but not be limited to, referral of suspected or confirmed fraud or abuse to ACIA.

2.17 Provider will deliver location-based services to Members only at those service locations set forth in **Appendix C** hereto as such appendix is modified from time to time by mutual agreement of the parties. Provider shall notify ACI at least sixty (60) days prior to making any addition or change to service locations.

3. OBLIGATIONS OF ACIA:

3.1 ACIA shall pay Provider for Covered Services provided to Members pursuant to the terms of this Agreement. ACIA shall have the right to offset claims payments to Provider by any amount owed by Provider to ACIA, following at least thirty (30) days' written notice. Provider shall not be entitled to reimbursement if the Member was not eligible at the time services were rendered.

3.2 ACIA shall compensate Provider for Covered Services provided to Members upon receipt of a statement thereof, as defined in Section 2.3, and in accordance with Section 2.11 and the Covered Services Payment Schedule set forth in **Appendix A-1** but, in no event, will ACIA's payment exceed submitted charges. No additional charges will be made by Provider to ACIA for Covered Services provided hereunder, and Provider recognizes and accepts the fees set forth in **Appendix A-1** as payment in full.

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3.2 ACIA will establish payment policies for inpatient and outpatient services including, but not limited to, policies with respect to pre-admission testing, services included in inpatient rates and services included in outpatient rates. ACIA will provide at least thirty (30) days' prior written notice of any modifications to such payment policies. ACIA may, based on changes in clinical practice and modifications to standard coding systems, add and/or delete outpatient fee schedule procedures and re-categorize outpatient surgery fee schedule procedures, upon thirty (30) days' prior written notice to Provider.

3.3 ACIA shall furnish or otherwise make available to Provider a copy of the Provider Manual, as amended from time to time. Provider Manual updates will become effective thirty (30) days from the date of notification, unless otherwise specified in writing by ACIA.

3.4 ACIA shall pay all Clean Claims for Covered Services in accordance with applicable laws, regulations and Agency requirements; and ACIA will in any event meet the claim payment timeframes required under **42 CFR §447.45(d)**.

3.5 Provider Protections.

(a) ACIA shall not exclude or terminate Provider from ACIA's provider network because the Provider advocated on behalf of a Member including in the context of a utilization management appeal or another dispute with ACIA over appropriate medical care, provided that such advocacy is consistent with the degree of learning and skill ordinarily possessed by a health care provider practicing in accordance with the applicable standard of care.

(b) No Provider shall be excluded or terminated from participation with ACIA due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.

(c) Provider shall not be excluded from participation, nor shall this Agreement be terminated, because Provider objects to the provision of or refuses to provide a healthcare service on moral or religious grounds.

4. QUALITY MANAGEMENT/UTILIZATION MANAGEMENT:

4.1 Whether announced or unannounced, Provider agrees to cooperate with, participate in, and abide by internal or external quality assessment reviews, Member Appeal Procedures, Utilization Management Program procedures, and Quality Management Program procedures established by ACIA and/or the Agency or their designees, and to follow practice guidelines as described in the Provider Manual, the Agency Contract, and the applicable Program manuals. Provider shall permit a representative of ACIA, or its designee, to review medical records concurrently as well as retrospectively. Provider shall provide copies of such medical records, either in paper or electronic form, to ACIA or its designee upon request. The Utilization Management and Quality Management Programs are described in the Provider Manual.

4.2 ACIA's Quality Management Programs consist of review of credentials and performance of ancillary and other provider types that are applying for participation in, or are participating in, ACIA's network of providers to determine whether the provider meets ACIA's standards for quality, availability, accessibility and cooperation.

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4.3 ACIA's Utilization Management Programs include requirements for pre-authorization of certain services rendered in physicians' offices and in inpatient, outpatient and ancillary settings. Utilization Management Programs include concurrent, retrospective and prospective review of certain services and procedures to assure that care is delivered in the most appropriate setting and is Medically Necessary. Certain Covered Services may require prior approval from ACIA. The Covered Services subject to prior approval are more fully described in the Provider Manual and other ACIA notices. ACIA is obligated to pay for and Provider is entitled to reimbursement for only those services that are Medically Necessary. Where reimbursement for an admission, inpatient day or outpatient service is denied as not prior approved or Medically Necessary, the Provider shall not charge either ACIA or the Member for any health care services rendered or furnished with respect to such admission, inpatient day or outpatient service. If Provider disputes any such denial, the case in question shall be appealed through ACIA's provider appeal process. Provider may not bring legal action for disputes which have not been appealed through the provider appeal process.

4.4 ACIA shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction, where necessary, to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the Provider practices and/or the standards established by ACIA, the Agency, or their respective designees. Provider shall cooperate with and abide by any corrective action plan initiated by ACIA and/or required by the Agency or any other State or federal regulatory agency with governing authority over the services provided under this Agreement.

4.6 Provider agrees that to the extent penalties, fines or sanctions are assessed against ACIA by the Agency or another regulatory agency with governing authority over the services provided under this Agreement as a result of Provider's failure to comply with Provider's obligations under this Agreement, including but not limited to, Provider's failure or refusal to respond to ACIA's the Agency's request for medical records, applicable credentialing information, and other information required to be provided under this Agreement, Provider shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACIA, ACIA shall have the right to offset claims payments to Provider by the amount owed by Provider to ACIA.

5. PROFESSIONAL LIABILITY INSURANCE/ADVERSE ACTIONS:

5.1 Provider, at its sole expense, shall provide professional liability, comprehensive general liability, and, as applicable, medical malpractice insurance coverage (including coverage for vicarious liability, if any, for the acts of employees, agents and representatives of Provider) upon execution of this Agreement and at all times during the term of this Agreement, as follows:

(a) Amounts and extent of such insurance coverage as deemed necessary by ACIA to adequately insure Members and ACIA against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with Provider's performance of any service pursuant to this Agreement; in no event shall such coverage be less than the amounts required by law.

(b) Provider shall provide ACIA with written verification of the existence of such coverage upon execution of this Agreement and as otherwise requested by ACIA throughout the term of the Agreement, which may include providing copies of face sheets of such coverage. Provider shall notify ACIA reasonably in advance of any change or cancellation of such coverage.

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5.2 Provider shall immediately notify ACIA in writing, by certified mail, of any written or oral notice of any adverse action, including, without limitation, litigation, investigation, complaint, claim or transaction, regulatory action or proposed regulatory action, or other action naming or otherwise involving Provider or ACIA, or any other event, occurrence or situation which may reasonably be considered to have a material impact on Provider's ability to perform Provider's duties or obligations under this Agreement. Provider also shall immediately notify ACIA of any action against any applicable license, certification or participation under Title XVIII or other applicable provision of the Social Security Act or other State or federal law, State and/or DEA narcotic registration certificate, or medical staff privileges at any facility, and of any material change in the ownership or business operations of Provider. All notices required by this Section 5.2 shall be furnished as provided in Section 10.6 of this Agreement.

5.3 Provider agrees to defend, indemnify and hold harmless ACIA and its officers, directors and employees from and against any and all claims, costs and liabilities (including the fees and expenses of counsel) as a result of a breach of this Agreement by Provider, the negligent or willful misconduct of Provider and/or Provider's employees, agents and representatives, and from and against any death, personal injury or malpractice arising in connection with the performance of any services by the Provider in connection with this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

ACIA agrees to defend, indemnify and hold harmless Provider and its officers, directors and employees from and against all claims, costs and liabilities (including the fees and expenses of counsel) as a result of ACIA's breach of this Agreement or the negligent or willful misconduct of ACIA and/or ACIA's employees, agents and representatives in connection with ACIA's performance under this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

6. CONFIDENTIALITY:

ACIA and Provider shall each comply with all applicable State and federal laws respecting the confidentiality of the medical, personal or business affairs of Members acquired in the course of providing services pursuant to this Agreement. Each party shall maintain as confidential and shall not disclose to third parties financial, operating, proprietary or business information relating to the other party which is not otherwise public information. The payment rates in this Agreement are confidential and proprietary and shall not be disclosed by either party. However, nothing herein shall prohibit either party from making any disclosure or transmission of information to the extent that such disclosure or transmission is required by the Agency or other applicable state regulatory agency, or is necessary or appropriate to enable the disclosing party to perform its obligations or enforce its rights under this Agreement, or is required by law or legal process. Should disclosure be required by law or legal process, the disclosing party shall immediately notify the other party of the disclosure.

7. COOPERATION; RESOLUTION OF DISPUTES:

7.1 Cooperation. To the extent compatible with separate and independent management of each, ACIA and Provider shall at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Members at the most reasonable cost consistent with high standards of care. ACIA and Provider shall use best efforts to exchange information regarding material matters directly or indirectly related to this Agreement.

7.2 Resolution of Disputes. ACIA and Provider shall both fully cooperate in resolving any and all controversies among or between said parties, their employees, agents, or representatives pertaining

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to their respective duties under this Agreement. Such disputes shall be submitted for resolution in accordance with the provider appeal procedures as referenced in the Provider Manual and ACIA policies and procedures. Neither ACIA nor Provider shall permit a dispute between the parties to disrupt or interfere with the provision of services to Members.

8. TERM; TERMINATION:

The term of this Agreement shall commence as of the Effective Date and continue for an initial one (1) year term (the "Initial Term"). After the Initial Term, the Agreement shall automatically renew for successive one (1) year terms unless the Agreement is terminated pursuant to this Section 8 as set forth herein.

Either party may terminate this Agreement without cause at the end of the Initial Term or at the end of the subsequent terms by providing the other party with at least ninety (90) days' prior written notice before the end of the then current term. The effective date of termination without cause will be on the first of the month following the expiration of the notice period. Either party may terminate this Agreement for cause due to a material breach by giving thirty (30) days' prior written notice. The notice of termination for cause will not be effective if the breaching party cures the breach within the thirty (30) day notice period. In the event that the breaching party does not cure the breach within the thirty (30) day period, the effective date of termination will be the first of the month following the expiration of the thirty (30) day notice period.

In the event any change in federal or State laws, rules and regulations or the Iowa Medicaid Program or the Medicare Advantage program would have a material adverse impact on either ACIA or Provider in connection with the performance of this Agreement (the "Mandated Changes") such that the basis for the financial bargain of this Agreement is undermined, then the affected party shall have the right to require the other, by written notice, to enter into negotiations regarding the affected or pertinent terms of this Agreement while still maintaining the original Agreement purposes. If renegotiated, such terms shall become effective no later than thirty (30) days after the parties have reached agreement on the renegotiated terms. The parties agree to make a good faith attempt to renegotiate the Agreement to the extent necessary to comply with any Mandated Changes. If, after good faith renegotiations, the parties fail to reach an agreement satisfactory to both parties within thirty (30) days of the request for renegotiation, the party requesting such renegotiation may terminate this Agreement upon ninety (90) days prior written notice to the other party.

Notwithstanding the above, ACIA may terminate this Agreement immediately in the event any of the following occur:

8.1 If Provider is expelled, disciplined, barred from participation in, or suspended from receiving payment under any state's Medicaid program, Children's Health Insurance Program (CHIP), the Medicare Program or any othe r federal health care program.

8.2 If Provider is debarred, suspended or otherwise excluded from procurement or non-procurement activities under the Federal Acquisition Regulations.

8.3 Upon the loss or suspension of the Provider's liability coverage set forth under Section 5 of this Agreement.

8.4 The suspension or revocation of Provider's license or other certification or authorization, including Provider's JCAHO or other applicable accreditation, necessary for Provider to render Covered Services, or upon ACIA's reasonable determination that the health, safety or welfare of any Member may be in jeopardy if this Agreement is not terminated.

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Upon termination of this Agreement for any reason, ACIA shall notify affected Members of the termination of Provider prior to the effective date of termination. Regardless of the reason for termination, Provider shall promptly supply to ACIA all information necessary for the reimbursement of outstanding claims. **42 CFR 434.6(a)(6)**.

9. REGULATORY AND PROGRAM-SPECIFIC PROVISIONS:

Attached hereto and incorporated herein by reference is **Schedule 9**, setting forth such terms and conditions as are necessary to meet State and Federal statutory and regulatory requirements, and other Agency requirements, of the Program. **Schedule 9** is consecutively sub-numbered as necessary for each Program under which Provider is furnishing services under this Agreement. Provider acknowledges that the specific terms as set forth in **Schedule 9** are subject to amendment in accordance with federal and/or State statutory and regulatory changes to the Program. Such amendment shall not require the consent of the Provider or ACIA and will be effective immediately on the effective date thereof, as set forth in Section 10.3.

10. MISCELLANEOUS:

10.1 It is understood that Provider is an independent contractor and in no way is Provider to be considered an employee, agent, or representative of ACIA. It is further understood that Provider provides specified services to Members in exchange for an agreed upon fee. This Agreement shall not create, nor be deemed or construed to create any relationship between ACIA and Provider other than that of independent contractors, contracting with each other solely for the purpose of performing this Agreement and each party shall be liable solely for their own activities and neither ACIA nor Provider shall be liable to any third party for the activities of the other party to this Agreement.

10.2 This Agreement, being for the purpose of retaining the professional services of Provider, shall not be assigned, subcontracted, or delegated by Provider without the express written consent of ACIA.

10.3 No alterations or modifications of the terms of this Agreement shall be valid unless such alterations or modifications are incorporated into the Agreement through a written amendment, signed by both parties hereto, and attached to this Agreement; provided, however, ACIA may amend this Agreement with 30 days' notice to Provider via a(n) ACIA bulletin or other written communication provided in accordance with the notice provisions in Section 10.6, and unless Provider notifies ACIA, as applicable, of any objection, such amendment shall then take effect. Any amendment to this Agreement subject to prior regulatory approval(s) shall be effective once such regulatory approval(s) has been received.

Notwithstanding the foregoing, amendments required because of legislative, regulatory or governmental agency requirements do not require the consent of Provider or ACIA and shall be effective immediately on the effective date thereof. This Agreement remains subject to the approval of the State of Iowa, and may be amended by ACIA to comply with any requirements of the State of Iowa. Provider acknowledges that all Agency requirements, as may be amended from time to time, are incorporated to this Agreement.

10.4 This Agreement shall be deemed to have been made and shall be construed and interpreted in accordance with the laws of the State of Iowa.

10.5 This Agreement and its exhibits, appendices, schedules, addenda or other attachments constitute the entire understanding and agreement between the parties concerning the subject matter hereof. This Agreement supersedes all prior written or oral agreements or understandings existing between the

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parties concerning the subject matter hereof including, but not limited to, any such agreement which may have been previously executed between Provider and ACIA or any of its Affiliates relating to the provision of Covered Services under the Program. In the event of a conflict between the terms of this Agreement and the Provider Manual, the terms of the later document shall control.

10.6 Written notices to be given hereunder shall be sent by Certified Mail, Return Receipt Requested, or by an overnight delivery service which provides a written receipt evidencing delivery to the address set forth by the party, or by confirmed facsimile followed by written notice through the U.S. postal service. All notices called for hereunder shall be effective upon receipt.

If to Provider:

With a copy to:

If to AmeriHealth Caritas Iowa

With a copy to: General Counsel
AmeriHealth Caritas
200 Stevens Drive
Philadelphia, PA 19113

10.7 Both parties agree that there shall be no discrimination in the performance of this Agreement against any patient or other person as the result of that individual's race, color, religion, gender, sexual orientation, handicap, age, national origin, source of payment, or any other basis prohibited by law.

10.8 The failure of any of the parties to insist upon strict performance of any of the terms of this Agreement shall not be deemed a waiver of any of their respective rights or remedies, and shall not be deemed a waiver of any subsequent breach or default in any of the terms contained in this Agreement.

10.9 In the event that any provision under this Agreement is declared null or void, for any reason, the remaining provisions of this Agreement shall remain in full force and effect.

10.10 The parties will use reasonable care and due diligence in performing this Agreement. Provider will be solely responsible for the services provided under this Agreement.

10.11 All captions contained in this Agreement are solely for the convenience of the parties hereto and shall not be deemed part of the content of this Agreement.

10.12 All terms used in this Agreement are deemed to refer to the masculine, feminine, neuter, singular or plural as the content may require.

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10.13 Non-Discrimination. Provider shall comply with (i) Title VI of the Civil Rights Act of 1964 and the rules, regulations, and order; (ii) the Rehabilitation Act of 1973 and the rules, regulations, and orders thereunder; (iii) the Americans With Disabilities Act of 1990 and the rules, regulations, and orders thereunder; and (iv) any and all applicable laws, rules and regulations prohibiting discriminatory practices. Furthermore, in accordance with Title VI of the Civil Rights Act of 1964 and the rules, regulations and orders thereunder, Provider shall take adequate steps to ensure that Members with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement (see 42 U.S.C. 2000d et seq. and 45 C.F.R. Part 80, 2001 as amended).

10.14 No Offshore Contracting. No Covered Services under this Agreement may be performed outside of the United States without ACIA's prior written consent. In addition, Provider will not hire any individual to perform any services under this Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

[SIGNATURES ON FOLLOWING PAGE; REMAINDER OF PAGE INTENTIONALLY BLANK]

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IN WITNESS WHEREOF, and intending to be legally bound hereby, the parties hereto, each by its officers duly authorized, hereby affix their hands as of the date written below.

ANCILLARY PROVIDER	AMERIHEALTH CARITAS IOWA, INC.
Print Name	Name
Signature	Signature
Title	Title
Address	Date
National Provider ID Number	**Effective Date of Agreement:** _____ [To be completed by AmeriHealth Caritas Iowa]
Medicaid ID Number / Medicare ID Number	
Tax ID Number	
Date	
Assignment of Payment (*applicable to Group Physician only*): **By signing below, Provider hereby assigns and transfers all Provider's right to and interest in compensation payable by ACIA pursuant to this Agreement to the party identified below, and Provider therefore directs ACIA to pay such compensation to said party:**	
Provider Signature	
Name of Group	
Address	
Group Tax ID Number	
Check and initial if Assignment of Payment Not Applicable: ☐ Provider Initials	

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APPENDIX A

ANCILLARY SERVICES PROVIDER

COVERED SERVICES

Provider shall furnish the following Covered Services to Members:

[Insert description of Covered Services – specific to Provider]

Provider's compensation for Covered Services is set forth in **Appendix A-1**.

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APPENDIX A-1

ANCILLARY SERVICES PROVIDER

COVERED SERVICES COMPENSATION SCHEDULE

Commencing on the Effective Date, ACIA will compensate Provider for Covered Services rendered by Provider to Members in accordance with the terms of this Agreement at a rate of [___]. In no event will ACIA's payment exceed Provider's charges.

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APPENDIX B

ANCILLARY SERVICES PROVIDER

ACIA AFFILIATES

[Insert ACIA Affiliates Covered by Agreement]

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APPENDIX C

ANCILLARY SERVICES PROVIDER

PROVIDERS AND SERVICE LOCATIONS COVERED BY AGREEMENT

PROVIDER AND SERVICE LOCATION

_____
Name

_____
Address

_____
City, State, Zip

_____
Phone Number

PROVIDER AND SERVICE LOCATION

_____
Name

_____
Address

_____
City, State, Zip

_____
Phone Number

PROVIDER AND SERVICE LOCATION

_____
Name

_____
Address

_____
City, State, Zip

_____
Phone Number

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Schedule 9-1

Federal Requirements – Medicaid and Medicaid Managed Care

1. No payment will be made to Provider for provider-preventable conditions or health care-acquired conditions. For purposes hereof:

   a. **Health care-acquired condition** ("HAC") means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary of the U.S. Department of Health and Human Services ("HHS") under section 1886(d)(4)(D)(iv) of the Social Security Act (the "Act") for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act, other than deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

   b. **Other provider-preventable condition** means a condition occurring in any health care setting that meets the following criteria: (i) is identified in the Iowa Medicaid plain; (ii) has been found by the Iowa, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines (iii) has a negative consequence for the Member; (iv) is auditable; and (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.

   c. **Provider-preventable condition** ("PPC") means a condition that meets the definition of "health care-acquired condition" or an "other provider-preventable condition."

   No reduction in payment will be made for a PPC when the condition existed prior to the initiative of treatment for that patient by Provider. Provider shall identify PPCs when submitting claims for payment or, if no claim will be submitted, if Medicaid payment would otherwise be available for the course of treatment in which the PPC occurred, or as otherwise required by the State. **42 CFR §§438.6(f)(2), 434.6(a)(12) and 447.26.**

2. The State Agency and HHS may inspect and audit any financial records of Provider or its subcontractors. **42 CFR §438.6(g).**

3. Physician Incentives. Provider shall disclose to ACIA annually any Physician Incentive Plan (PIP) or risk arrangements Provider may have with physicians, either within Provider's group practice or other physicians not associated with Provider's group practice, even if there is no substantial financial risk between ACIA and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for Covered Services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low. **42 CFR §§438.6(g), 422.208, 422.210.**

4. Provider Discrimination Prohibited. ACIA may not, with respect to Provider compensation or indemnification under this Agreement, discriminate against Provider to the extent that the Provider is acting within the scope of his, her or its license or certification under applicable State law, solely on the basis of that license or certification. Without limiting the foregoing, ACIA shall not discriminate against Provider for serving high-risk populations or specializing in

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conditions that require costly treatment. Nothing herein shall be construed to: (i) require ACIA to contract with Provider if not necessary to meet the needs of Members; (ii) preclude ACIA from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (iii) preclude ACIA from establishing measures that are designed to maintain quality of services and control costs and are consistent with ACIA's responsibilities to Members. **42 CFR §438.12**.

5. Continued Treatment Obligation. Notwithstanding any other provision of this Agreement, in the event of either party's termination of this Agreement, insolvency of either ACIA, or other cessation of ACIA's operations, Provider shall continue to provide Covered Services to Members (i) until the end of the month in which the effective date of termination of this Agreement falls, (ii) until the end of the month for which capitation or premium has been paid to ACIA by Agency, or (iii) until the date of a Member's discharge from an inpatient facility, whichever is later. **42 CFR §438.62**.

6. Member Rights. Provider shall adhere to all applicable Federal and State laws that pertain to Member rights, and shall take such rights into account when furnishing services to Members. **42 CFR §438.100(a)(2)**.

7. Provider-Member Communications. Nothing in this Agreement shall be construed to prohibit, restrict or impede Provider's ability to freely and openly discuss with Members, within the Provider's lawful scope of practice, all available treatment options and any information the Member may need in order to decide among all relevant treatment options, including but not limited to the risks, benefits and consequences of treatment or non-treatment, regardless of whether the services may be considered Covered Services in accordance with this Agreement. Further, nothing in this Agreement shall be construed to prohibit, restrict or impede Provider from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member, including: information regarding the nature of treatment options, risks of treatment, alternative treatments or the availability of alternative therapies, consultation or tests that may be self-administered, and the Member's right to participate in decisions regarding his or her care, including the right to refuse treatment and to express preferences about future treatment decisions. **42 CFR §438.102(a)**.

8. Member Hold Harmless. Provider shall accept the final payment made by ACIA as payment in full for Covered Services provided pursuant to this Agreement. Provider agrees that in no event, including, but not limited to, nonpayment by the Agency to ACIA, nonpayment by ACIA to Provider, the insolvency of ACIA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, solicit or accept any surety or guarantee of payment, or have any recourse against Members or persons other than ACIA acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the Member) for Covered Services listed in this Agreement. This provision shall not prohibit collection of supplemental charges or co-payments on ACIA's behalf made in accordance with terms of an enrollment agreement between ACIA and Members.

   Provider further agrees that:

   a. this hold harmless provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members; and that

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b. this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

42 CFR §§438.106, 447.15.

9. Coverage and Payment for Emergency Services. ACIA shall cover and pay for Emergency Services rendered by Provider and obtained when a Member had an Emergency Medical Condition, or when a representative of ACIA has instructed the Member to seek Emergency Services. **42 CFR §438.114(c)(1)(ii).**

10. Timely Access. Provider shall meet Agency standards for timely access to care and services, taking into account the urgency of the need for services. Provider shall offer hours operation to Members that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if Provider serves only Medicaid enrollees. Provider services shall be available 24 hours a day, 7 days a week, when medically necessary.

11. Excluded Providers. Pursuant to **42 CFR §438.214(d)**, ACIA may not employ or contract with providers excluded from participation in Federal health care programs under either Section 1128 or 1128A of the Act. In addition, section 2455 of the Federal Acquisition Streamlining Act of 1994 and he Federal Acquisition Regulations (including but not limited to 48 CFR §9.405), ACIA may not make payment to any person or entity, or an affiliate thereof, who has been debarred or suspended form participation in federal procurement or non-procurement activities. Provider shall comply with the disclosure requirements of **42 C.F.R. Section 455, Subpart B** and, upon reasonable request, provide such information to ACIA in accordance with the requirements specified therein.

Provider represents and warrants that neither it, nor any of its contractors or employees who will furnish goods or services under the Agreement, directors or officers, or any person with an ownership interest in Provider of five percent (5%) or more, is or ever has been: (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification; or (iv) debarred or suspended from participation in procurement or non-procurement activities by any federal agency (collectively, "Sanctioned Persons"). Provider shall screen all employees and contractors who will furnish goods or services under this Agreement to determine whether they have been excluded from participation in any Federal health care program, by searching applicable Federal and State databases (including but not limited to the OIG's LEIE and the HIPDB) upon initial employment or engagement of or contracting with a contractor, employee, director or officer, and on a monthly basis thereafter.

Provider shall immediately notify ACIA upon knowledge by Provider that any of its contractors or employees who furnish goods or services under the Agreement, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that Subcontractor cannot provide reasonably satisfactory assurance to ACIA that a Sanctioned Person will not receive payment from ACIA under this Agreement, ACIA may immediately terminate this Agreement. ACIA reserves the right to recover all amounts paid by ACIA for items or services furnished by a Sanctioned Person. Further, and without limiting Provider's indemnification obligations set forth elsewhere in this

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Agreement, to the extent penalties, fines or sanctions are assessed against ACIA as a result of Provider's having a relationship with a Sanctioned Person, Provider shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACIA, ACIA shall have the right to offset claims payments to Provider by the amount owed by Provider to ACIA.

12. State and Federal Regulator Access. Provider acknowledges that the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Office of the Inspector General, the Comptroller, the Agency **[SPECIFY STATE AGENCIES/REPRESENTATIVES]**, and their designees have the right to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to this Agreement, including quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and Provider claims submitted to ACIA. Such evaluation, when performed, shall be performed with the cooperation of the Provider and ACIA. Upon request, Provider and ACIA shall assist in such reviews. **42 CFR §434.6(a)(5)**.

13. Provider shall safeguard information about Members as required by Part 431, Subpart D of 42 CFR. **42 CFR 434.6(a)(8)**.

14. Any permitted subcontracts entered into by Provider in order to carry out its obligations under this Agreement must be in writing and fulfill the requirements of 42 CFR Part 434 that are appropriate to the service or activity delegated under the subcontract. **42 CFR 434.6(a)(11), (b)**.

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Schedule 9-2 (Ancillary Provider Form)

State of Iowa Requirements – Medicaid and Medicaid Managed Care

1. Unless defined in this Schedule 9-2 or elsewhere in the Agreement, all capitalized terms used herein shall have their respective meanings given to them in the contract between the Iowa Department of Human Services ("IDHS") and AmeriHealth Caritas Iowa, Inc., ("ACIA") dated as of [_____], 201[_] (the "State Contract").

2. In accordance with **191 IAC 40.18**, Provider, or its assignee or subcontractor as applicable, hereby agrees that in no event, including but not limited to nonpayment by the ACIA, ACIA insolvency or breach of this Agreement, shall Provider, or its assignee or subcontractor if applicable, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons other than ACIA acting on the Member's behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on ACIA's behalf made in accordance with terms of the Program.

   Provider, or its assignee or subcontractor if applicable, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member; and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member or persons acting on behalf of the Member.

3. Pursuant to **191 IAC 40.22**:

   a. ACIA shall not prohibit Provider from or penalize Provider for discussing treatment options with Members, irrespective of ACIA's position on the treatment options, or from advocating on behalf of Members within the utilization review or grievance processes established by ACIA or a person contracting with ACIA.

   b. ACIA shall not penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by ACIA that, in the opinion of Provider, jeopardizes patient health or welfare.

4. Compliance with Pro-Children Act of 1994. Provider hereby certifies compliance with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 ("Act"). The Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children's services that are provided in indoor facilities that are constructed, operated or maintained with such federal funds. The law does not apply to children's services provided in private residences, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable federal funds is Medicare or Medicaid,

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or facilities (other than clinics) where WIC coupons are redeemed. (**Ref. RFP Exhibit D**)

5. ACIA follows all applicable Federal and State laws pertinent to Member confidentiality and rights; Provider shall take those rights into account when furnishing services to Members. (**SOW §1.4.1**)

6. Provider shall not require any cost-sharing or Member liability responsibilities for Covered Services except to the extent that cost-sharing or Member liability responsibilities are required for those services in accordance with law and as described in the Agency Contract. Further, Provider shall not charge Members for missed appointments. (**SOW §3.2.15.3**)

7. Provider agrees that all applicable terms and conditions set out in the RFP, the Agency Contract, any incorporated documents and all applicable State and federal laws, as amended, govern the duties and responsibilities of Provider with regard to the provision of services to Members. (**SOW §6.1.2**)

8. Provider's responsibilities regarding third-party liability (TPL) include Provider's obligations to identify TPL coverage, including Medicare and long-term care coverage as applicable, and except as otherwise required, seek such TPL payment before submitting claims to ACIA. (**SOW §6.1.2**)

9. Provider shall submit claims which do not involve a third-party payer within **ninety (90) days** of the date of service. (**SOW §6.1.2**)

10. IDHS reserves the right to direct ACIA to terminate or modify this Agreement when IDHS determines it to be in the best interest of the State. (**SOW §6.1.2**)

11. ACIA may not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient regarding: (1) the Member's health status; (2) medical, behavioral health, or long-term care treatment options, including any alternative treatment that may be self-administered; (3) any information the Member needs in order to decide among all relevant treatment options; (4) the risks, benefits and consequences of treatment or non-treatment; or (5) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. (**SOW §6.1.5**)

12. Provider shall maintain complete and legible medical and financial (fiscal) records as required pursuant to **IAC 441-79.3**. Without limiting the foregoing, Provider's medical records shall document all medical services that the Member receives from Provider. Medical records shall be maintained in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records must be legible, signed, dated and maintained as required by law. (**SOW §6.1.9**)

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As required pursuant to **IAC 441-79.3(3)**, Provider shall maintain medical records: (1) during the time the Member is receiving services from Provider; (2) for a minimum of five (5) years from the date when a claim for the service was submitted to ACIA for payment; and (3) as may required by any licensing authority or accrediting body associated with determining Provider's qualification.

13. Each Member shall have the right to request and receive a copy of his her medical records, and to request that they be amended or corrected. Upon reasonable request of a Member, Provider shall provide a copy of a Member's medical record at no charge. Provider must facilitate the transfer of a Member's medical record to another provider at the Member's request. (**SOW §6.1.9.2**)

14. Within the timeframe designated by IDHS or other authorized entity, Provider must permit ACIA, representatives of IDHS, and other authorized entities to review Members' records for the purpose of monitoring Providers' compliance with the records standards, capturing information for clinical studies, monitoring quality of care, or any other reason. (**SOW 6.1.9.3**)

15. All medical records of Members shall be confidential and shall not be released without the written consent of the Member or responsible party. Written consent is not required under the following circumstances: (1) for transmission of medical record information to physicians, other practitioners or facilities who are providing services to Members under contract with ACIA; and (2) for transmission of medical record information to physicians or facilities providing emergency care. Written consent is required for the transmission of the medical record information of a former Member to any physician not connected with ACIA. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the practitioner or facility requesting the information. All release of medical records shall be compliant with 45 CFR Parts 162 and 164. (**SOW §6.1.9.4**)

16. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid members, if Provider sees only the Medicaid population. Covered Services shall be available twenty0-four (24) hours a day, seven (7) days a week, when medically necessary. (**SOW 6.1.9.5**)

17. Upon determination by IDHS of a credible allegation of fraud for which an investigation is pending under the Medicaid program against Provider and upon the approval of the Medicaid Fraud Control Unit (MFCU) and IDHS, ACIA shall suspend all payments to Provider, in compliance with 42 CFR 455.23. ACIA shall issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 CFR 455.23(b) (including notice that payments are being withheld in accordance with 42 CFR 455.23), and shall maintain the suspension for the durational period set forth in 42 CFR 455.23(c). ACIA will afford a grievance process to Provider in the event of payment suspension under this **paragraph 17**. (**SOW §12.7**)

18. Nursing Facility Provisions. (**SOW §6.1.2.1**)

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a. Provider shall promptly notify ACIA of a Member's admission or request for admission to the Provider nursing facility as soon as Provider has knowledge of such admission or request for admission.

b. Provider shall notify ACIA immediately and consult with the Member's care coordinator if Provider is considering discharging a Member.

c. Provider shall notify the Member and/or the Member's representative (if applicable) in writing prior to discharge in accordance with State and Federal requirements.

d. Provider shall be responsible for the collection of any patient liability (also referred to as "client participation") amounts, as such amounts are determined by the State of Iowa. The patient liability amount must be met before reimbursement from ACIA will be available under this Agreement, and ACIA's payment obligations under this Agreement are net of the applicable payment liability amount.

e. Provider shall notify ACIA of any change in a Member's medical or functional condition that could impact the Member's level of care eligibility for the currently authorized level of nursing facility services.

f. Provider must comply with the federal Preadmission Screening and Resident Review (PASSR) requirements to provide or arrange to provide specialized services, and all applicable Iowa state law governing admission, transfer and discharge policies.

g. Notwithstanding any other termination provision set forth in Section 8 of the Agreement, this Agreement shall automatically terminate in accordance with federal requirements in the event Provider is involuntarily decertified by the State or CMS.

19. Home & Community Based Services (HCBS) Providers. (**SOW §6.1.2.2**)

a. Provider shall furnish ACIA with at least thirty (30) days' advance written notice when Provider is no longer willing or able to provide services to a Member. Provider will cooperate with the Member's care coordinator to facilitate a seamless transition to another provider.

In the event of a change from Provider to another HCBS provider, regardless of any other provision in this Agreement, Provider shall continue to provide services to the Member in accordance with the Member's plan of care until the Member has been transitioned to a new provider, as determined by ACIA, or as otherwise directed by ACIA, which may exceed the thirty (30)-day notice period.

b. Provider shall immediately report to the Member's care coordinator any deviations from a Member's service schedule.

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c. Provider shall comply with ACIA's critical incident reporting requirements. Provider's obligations thereunder shall include, at minimum: (1) the reporting of critical incidents to ACIA and other appropriate entities within required timeframes; (2) addressing and responding to critical incidents; (3) documentation of critical incidents; and (4) cooperating with any critical incident investigation by ACIA or an outside agency.

d. Provider shall comply with all child and dependent adult abuse reporting requirements.

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