

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

- 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.

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

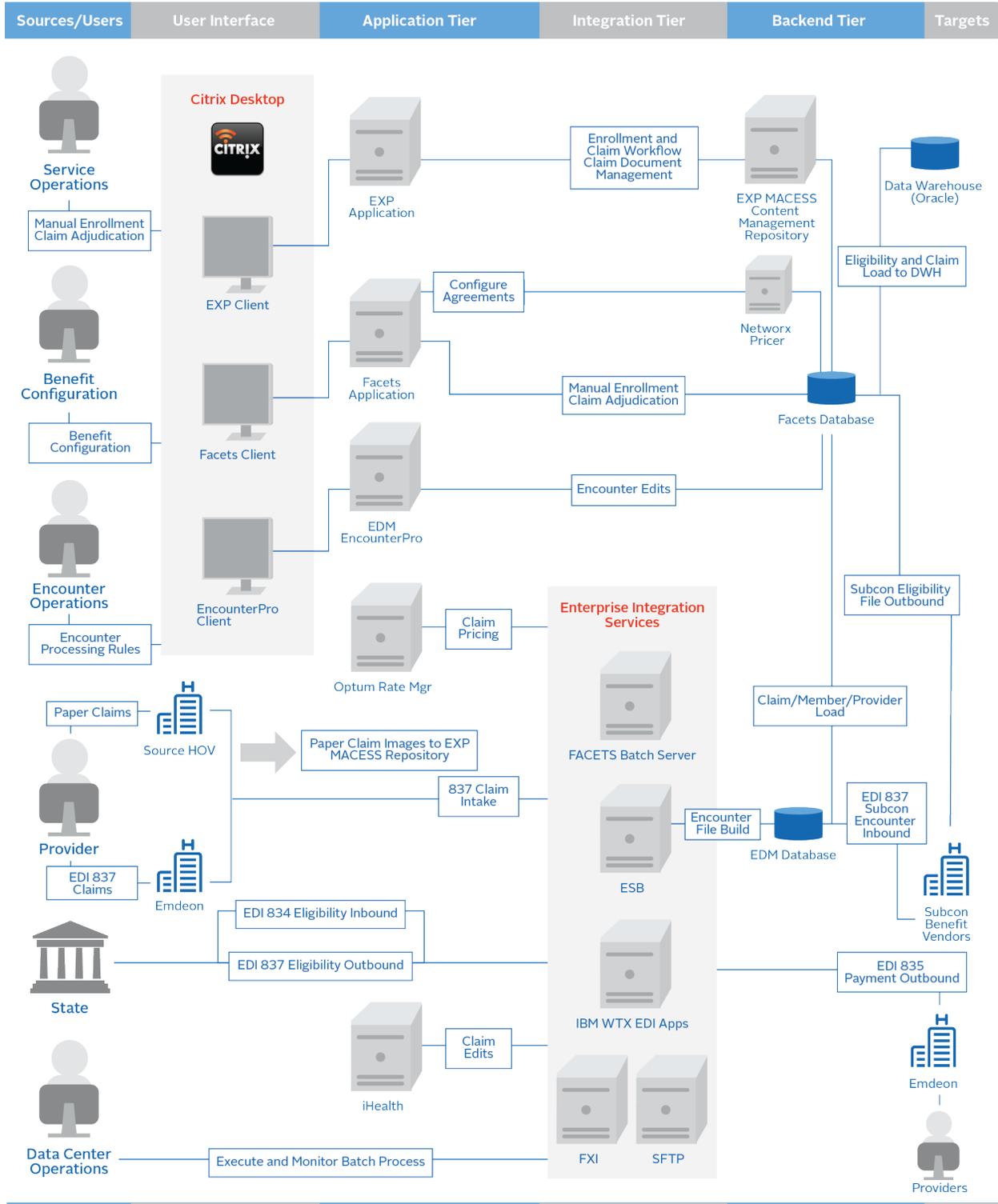


Exhibit 13.1-A: Core administration transaction flows

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:

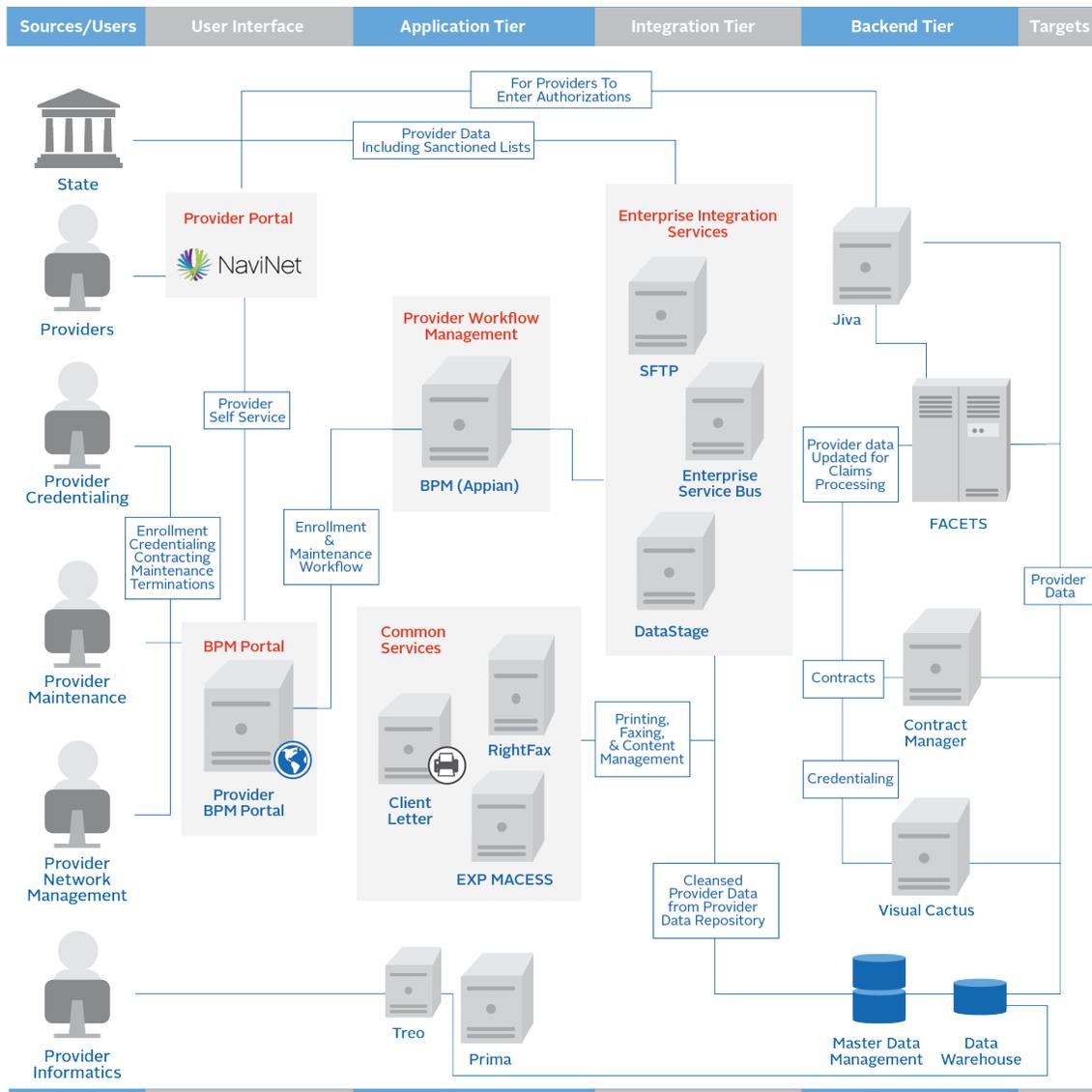


Exhibit 13.1-B: Provider Network Management transaction flow diagram

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	DataCleaner™ 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

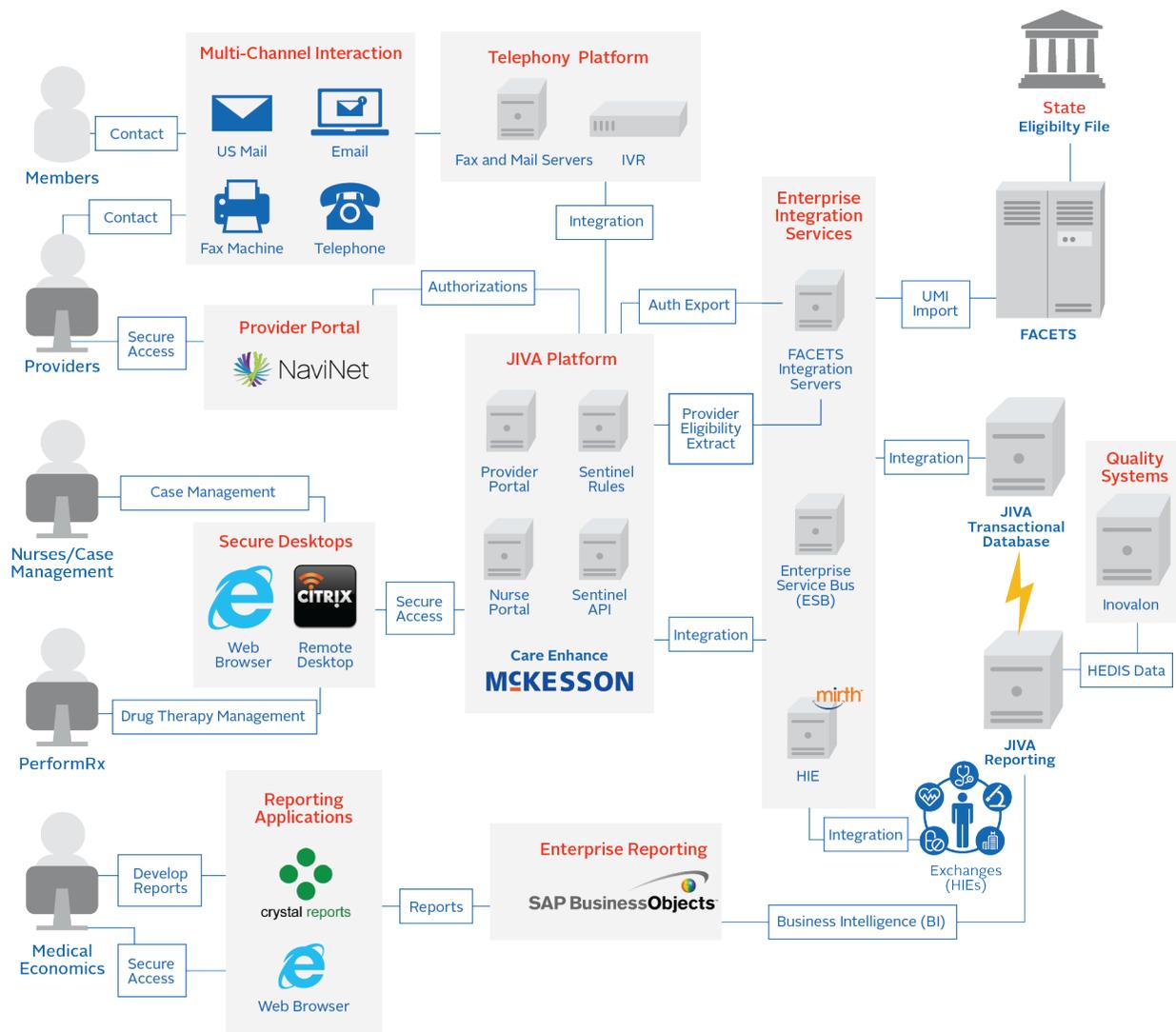


Exhibit 13.1-C: Care management transaction flow diagram

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), STEPHEN F.	43	M	Other Nondominant Malignancy and Other Moderate Chronic Disease	JOAN J. THOMPSON (DE-ID) MD	2

Exhibit 13.1-D: Panel summary – patients with preventable events

Patient Profile

Patient: **EDNA U. MARTIN (DE-ID)** (DOB: 10/11/1971) Period: 10/01/2013 to 09/30/2014

General Professional Visit History Frequently Used Inpatient History Outpatient History Pharmacy

GENERAL INFORMATION

Member
Name: EDNA U. MARTIN (DE-ID)
County: Lake
Zip code: 44060
DOB: 10/11/1971
Age: 42
Gender: Female

Insurance
Primary Payer: Commercial
Enrolled Since: 04/09/2007

Primary Care Physician
Name: PAMELA Y. KING (DE-ID) MD
VIS: 64.8

Medical Summary
Member Risk Group: Moderate Chronic Substance Abuse and Other Moderate Chronic Disease Level - 4
Treo Population Health Segment: Simple Chronic

UTILIZATION SUMMARY

Visit Summary
Inpatient visits: 7
Outpatient visits: 13
ER: 13
Non-ER: 4
Professional: 3 - last visit: 11/30/2013
Specialist: 204 - distinct specialties: 26
Total visits: 231

Prescriptions
Total prescriptions: 50
Unique prescriptions: 32

Exhibit 13.1-E: Patient detail via AmeriHealth Caritas Iowa Provider Portal

PerformPlus

MidState Doctor and Hospital PHO 08/2013-07/2014 (Claims paid through 10/31/2014)

PPR Rate Actual vs Expected

Measure	PPR Rate Actual vs Expected	Target	Score
ACSC Rate	23.99%	21.30%	112.16%
PPA Rate	36.13%	28.80%	125.46%
ER Visits	173.8 PDPY	168.4 PDPY	103.24%
NICU Days Per K	688	702	98.15%
C-Section Rate	24.79%	26.73%	92.74%

C-Section Rate

Measure	C-Section Rate	Target	Score
ACSC Rate	23.99%	21.30%	112.16%
PPA Rate	36.13%	28.80%	125.46%
ER Visits	173.8 PDPY	168.4 PDPY	103.24%
NICU Days Per K	688	702	98.15%
C-Section Rate	24.79%	26.73%	92.74%

KPI Measures

Key Performance Measure	Rolling 12 months	Baseline
ACSC Rate	23.99 %	21.30 %
PPA Rate	36.13 %	28.80 %
PPR Rate Actual vs Expected	9.91 %	(13.76) %
ER Visits	173.8 PDPY	168.4 PDPY
NICU Days Per K	688	702
C-Section Rate	24.79 %	26.73 %

Obstetrics & Primary Care Measures

Key Performance Measure	Rolling 12 months	Baseline
Chlamydia Screening in Women (CHL)	77.82 %	81.32 %
Postpartum Care (PPC)	47.35 %	51.38 %
Prenatal Care (PPC)	80.01 %	80.82 %
Frequency of Ongoing Prenatal (PPC)	57.84 %	58.69 %
Comprehensive Diabetes Care (CDC)	79.77 %	83.21 %
Use of Appropriate Medications for People With Asthma (ASH)	85.04 %	86.81 %

Appropriate Care Measures

The protected health information in this data set has been redacted to remove highly sensitive protected health information in accordance with applicable state and/or federal law.

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

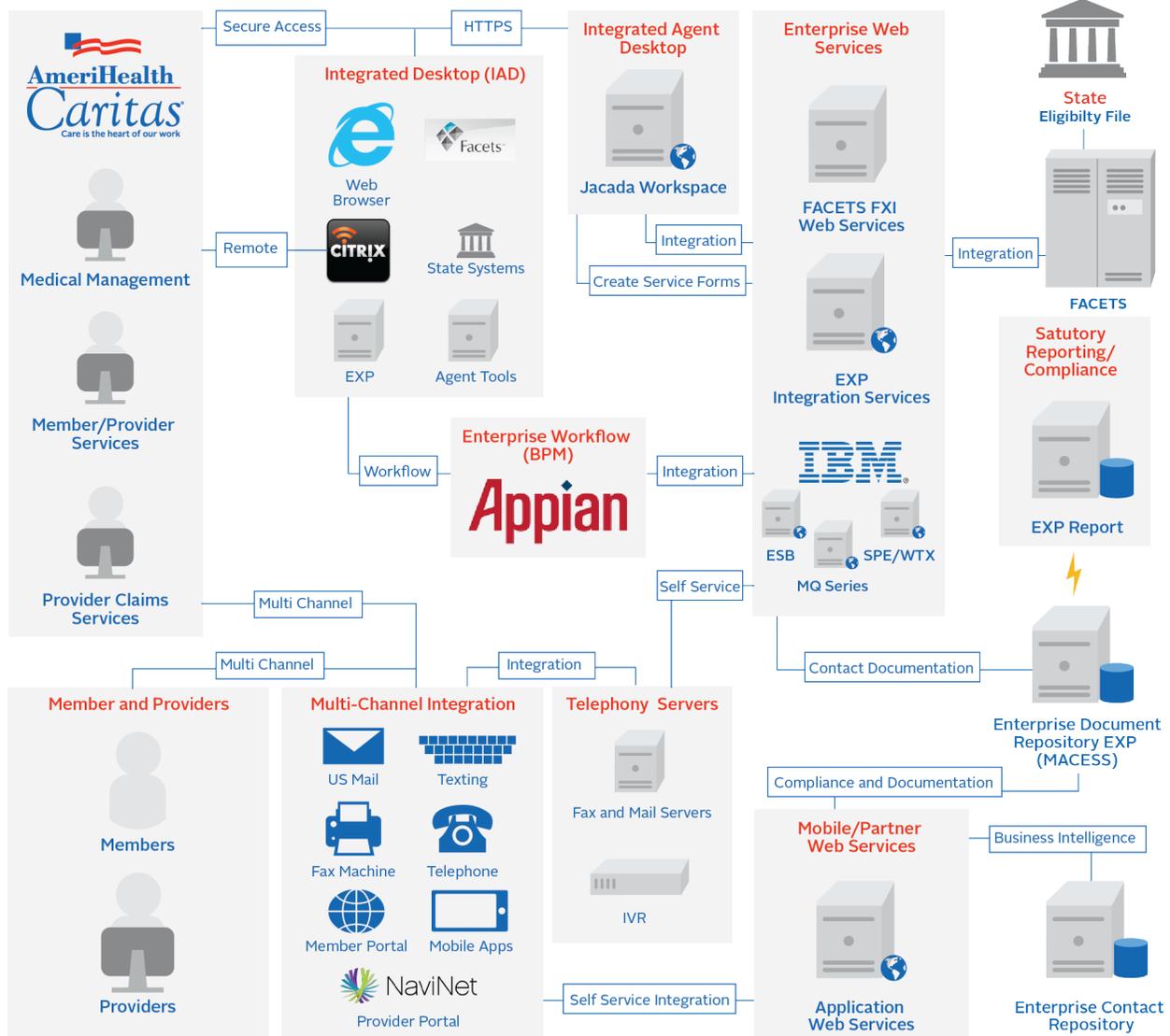


Exhibit 13.1-G: Common business services transaction flow diagram

Enterprise document management – SunGard EXP MACCESS™

SunGard EXP MACCESS™ 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 MACCESS to support plan operations and care management staff with automated workflows in managing documents across corporate and regional functions and locations.

EXP MACCESS 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 as EXP MACCESS 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 MACCESS. 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.

Provider Network Excellence - Enterprise Service Bus Integration

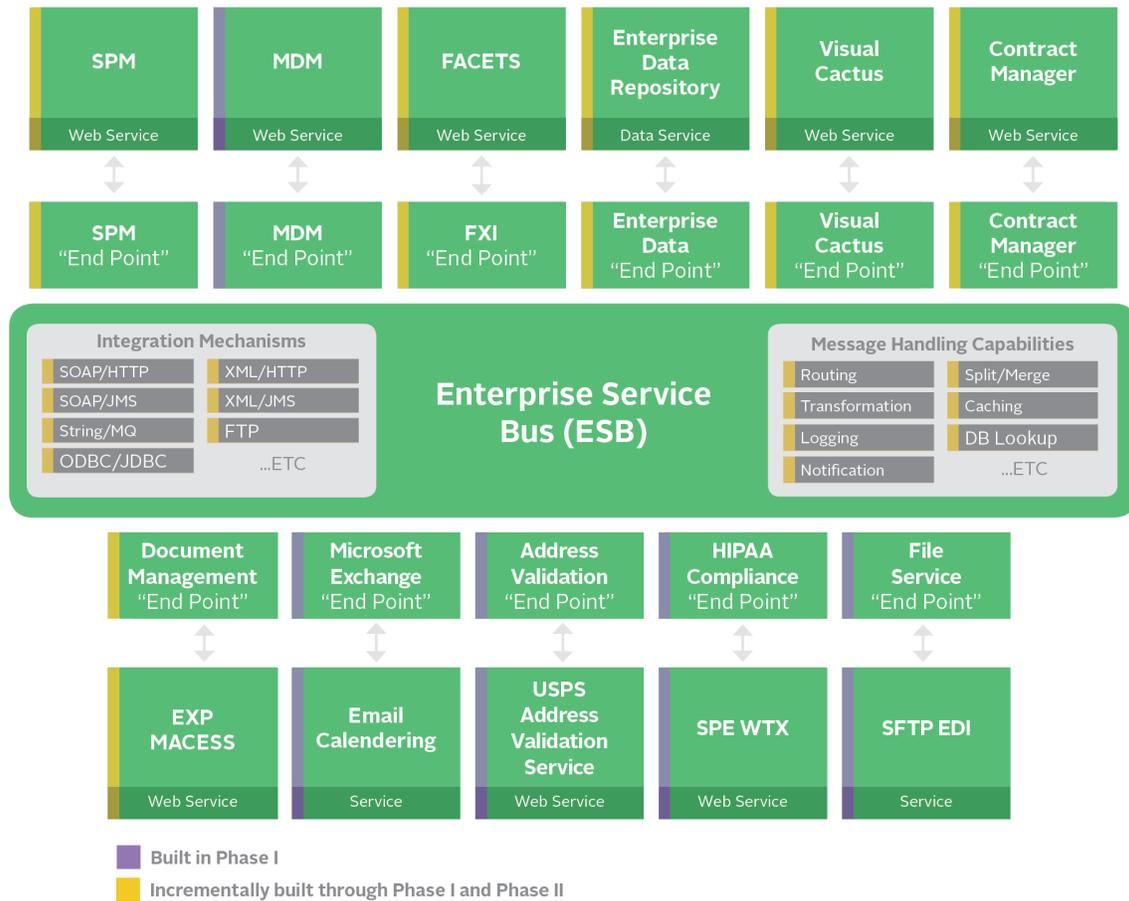


Exhibit 13.1-I:Enterprise service bus

- 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.

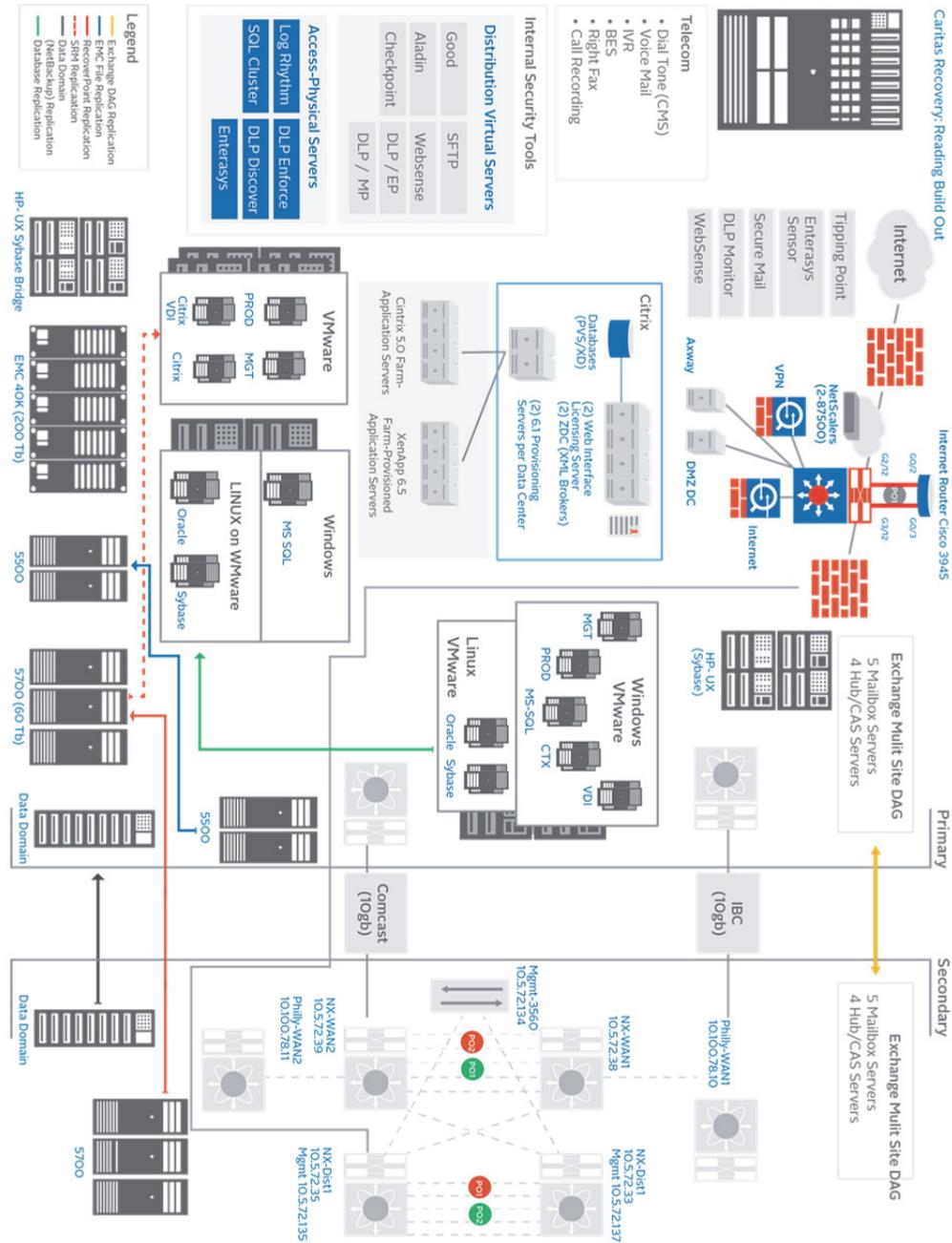


Exhibit 13.1-J:Data Center Architecture

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.

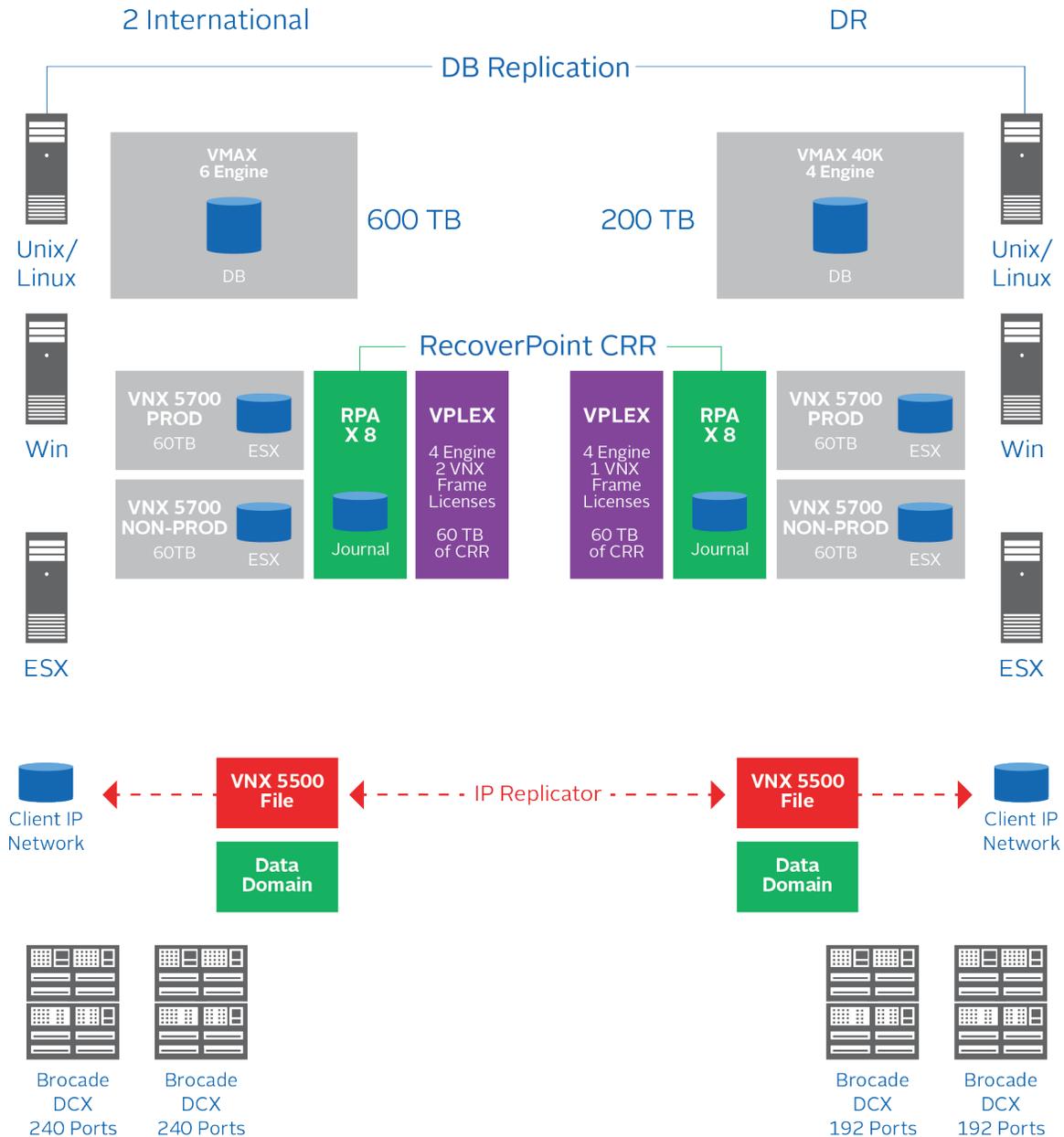


Exhibit 13.1-K: AmeriHealth Caritas’ Enterprise Storage Solutions

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

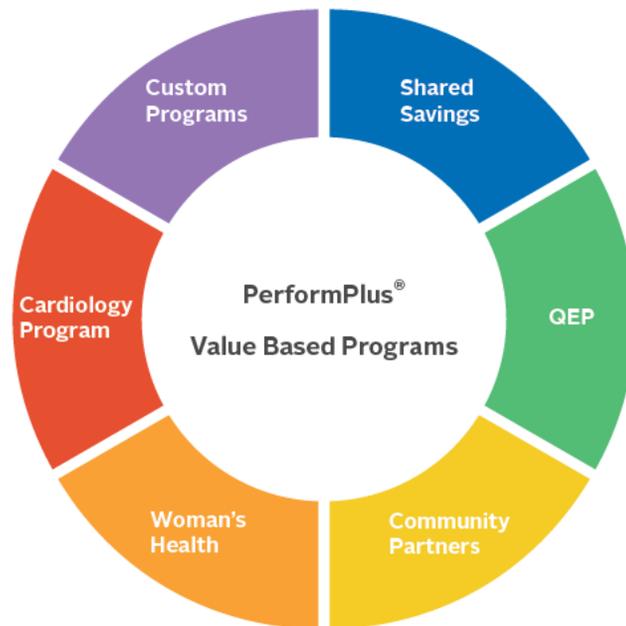


Exhibit 13.1-L: AmeriHealth Caritas' PerformPlus® Value Based Programs

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 Council 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.

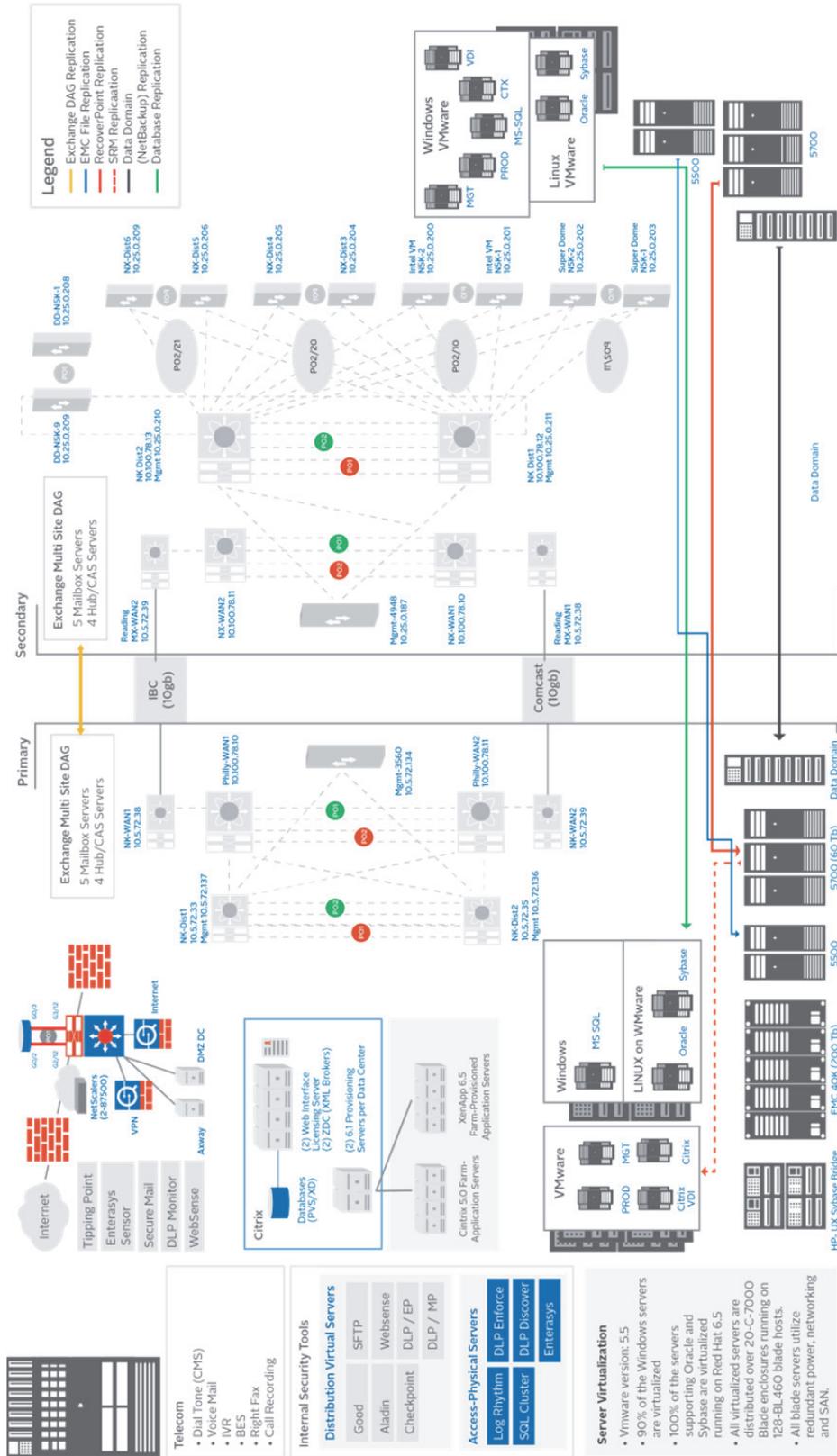


Exhibit 13.1-M: AmeriHealth Caritas System Architecture Availability

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 Advantage™ 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.

Intake/Change/Release Management Process Flow 2015

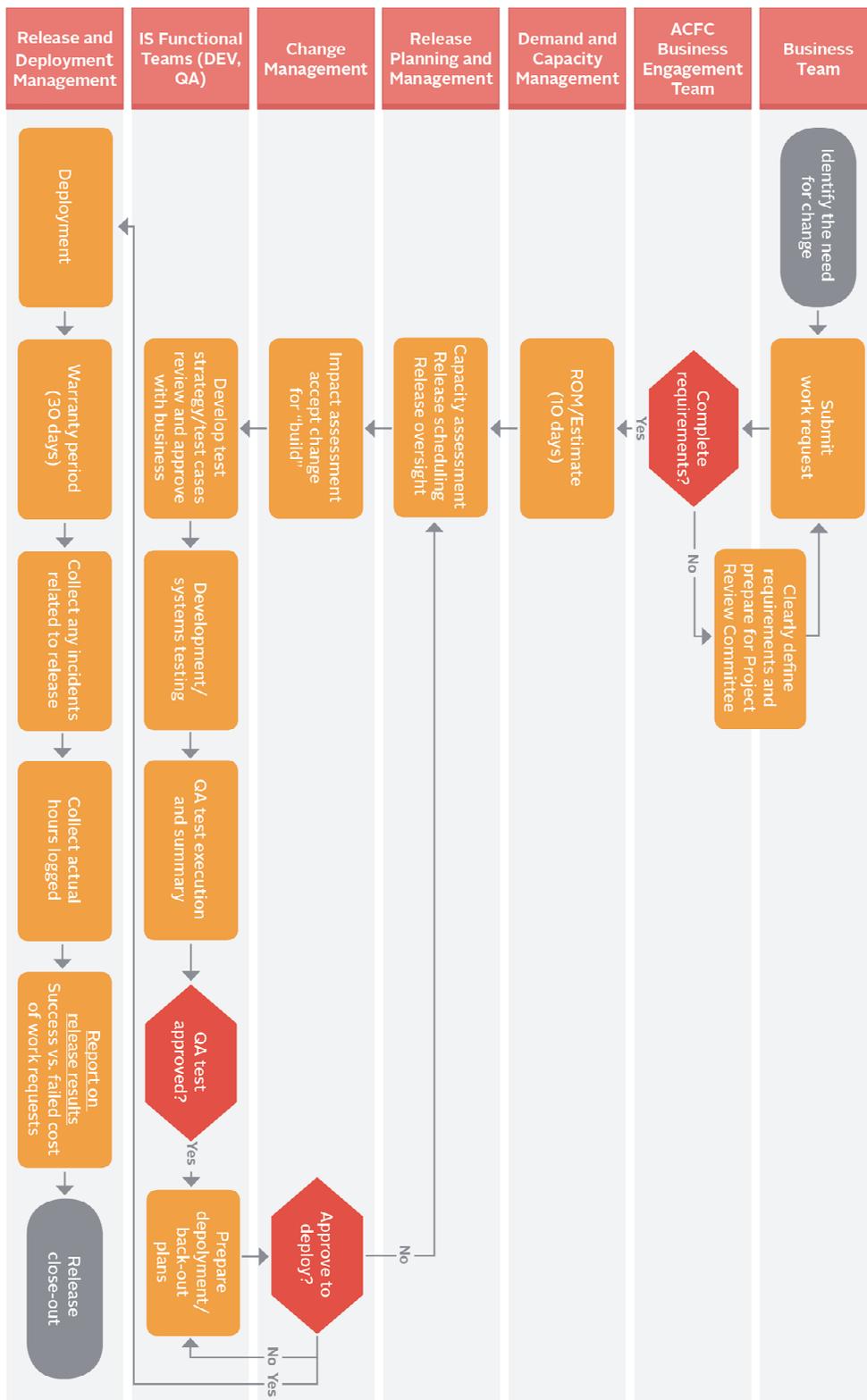


Exhibit 13.1-N: Systems change and release management process flow

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 pending for additional information.
- Provide detailed reporting for current inventory, aging inventory and pending 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.

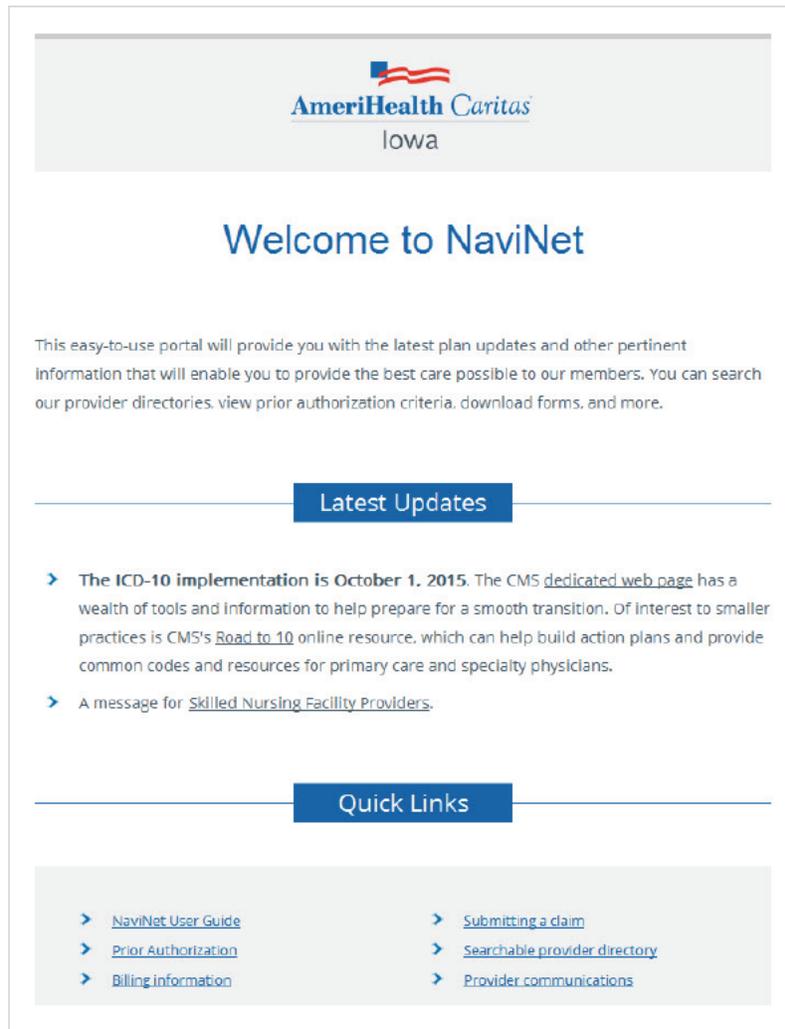


Exhibit 13.4-A: View of NaviNet Portal

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

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 pending, 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.

Billing Updates and Reminders

- Claim edits are in place to deny claims based on age/diagnosis code restrictions.
- Claim edits are in place to deny for missing blood values on UB-04 claim forms.
 - 37 - Pints blood furnished.
 - 38 - Blood not replaced.
 - 39 - Blood pints replaced.
- 99173 – Screening test of visual acuity, quantitative, bilateral age restriction edit: has been removed.
- Physical therapy (PT) and occupational therapy (OT) services are to be billed in 15-minute increments. Indicate the units in 24G on the CMS-1500.

Value codes must be input in sequential order.

Billing reminders that will prevent unnecessary rejections:

- Claims submitted on a UB-04 as an inpatient service with the admission date (*field 12*), or an outpatient service with the date of service (*field 45*) missing will be rejected.
- Claims submitted on a CMS-1500 (*field 24A*) with the date of service missing will be rejected.
- Claims with illegible data will be rejected.



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.

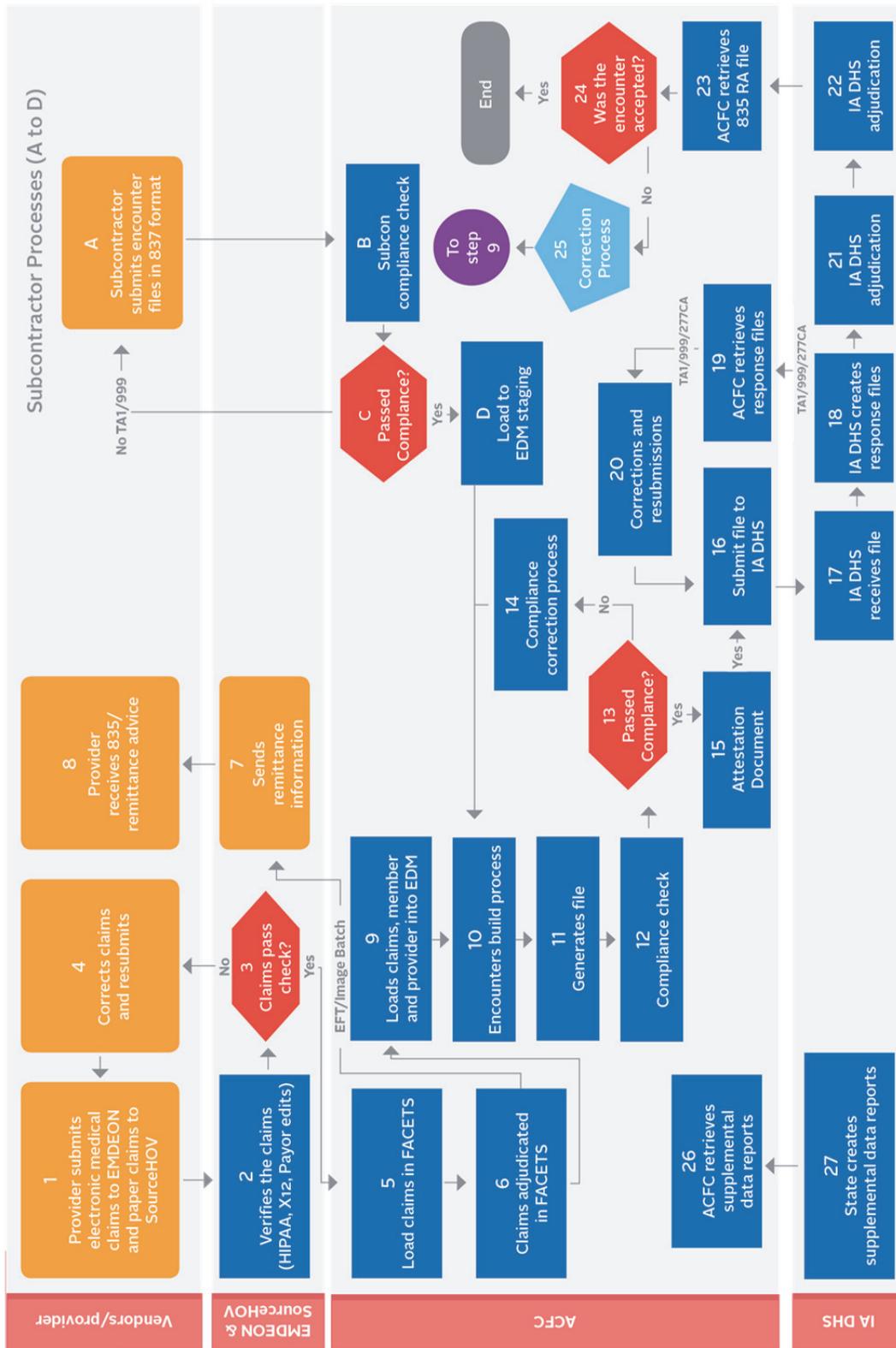
b. Your operational plan to transmit encounter data to the State, indicating any internal checks and balances, edits or audits you will use to verify and improve the timeliness, completeness and accuracy of encounter data submitted to the State.

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



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.

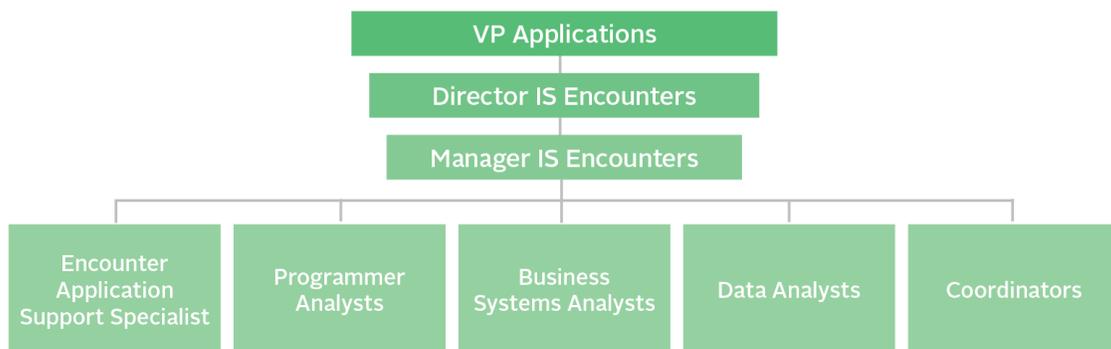
To ensure timely, accurate and complete encounter submissions, AmeriHealth Caritas Iowa will utilize AmeriHealth Caritas' leading practice approach to reconcile encounters data to provider payments. We will use a standard methodology to reconcile claims, encounters and cash on a monthly basis. Our dedicated 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.

Information Solutions



Enterprise Service Operations

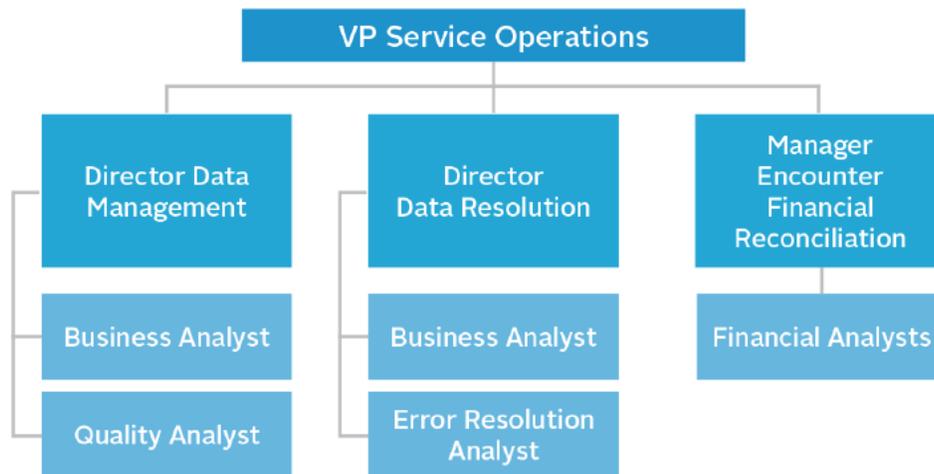


Exhibit 13.5-B: Enterprise Encounter team

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.

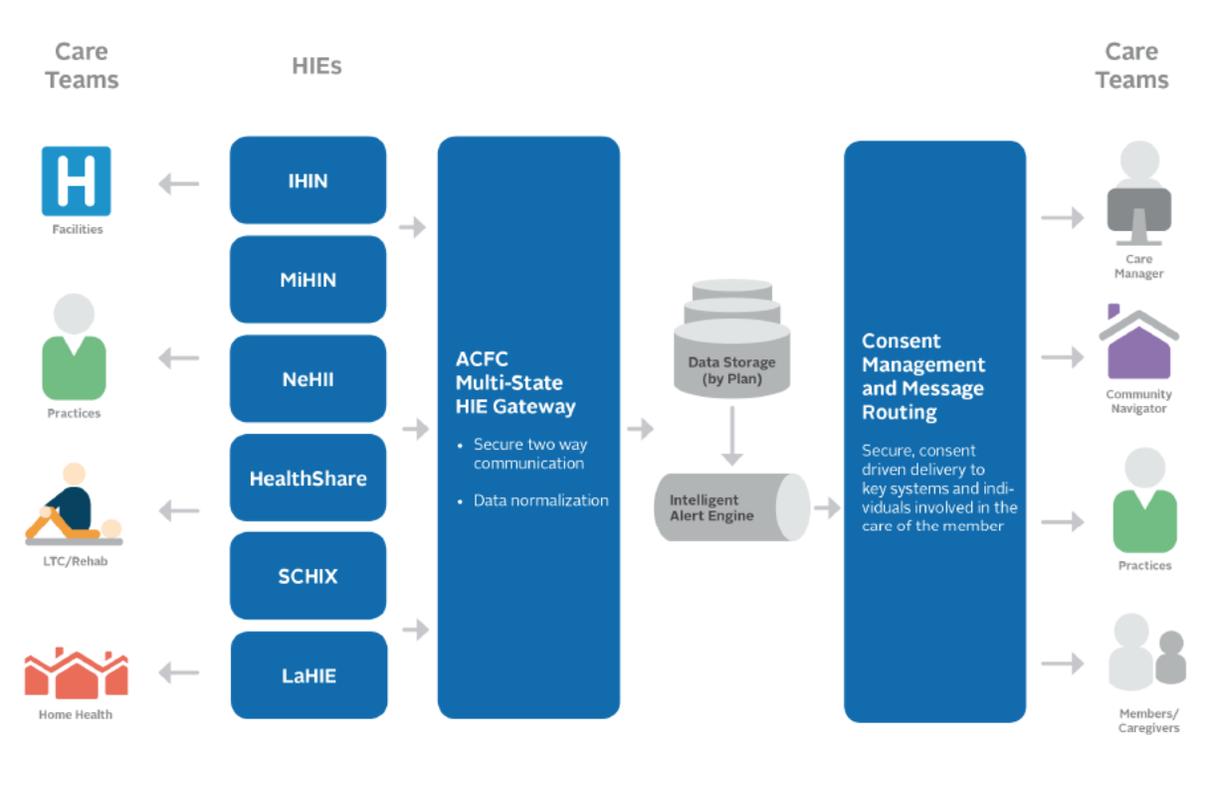


Exhibit 13.7-A: AmeriHealth Caritas HIE Gateway Overview

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.

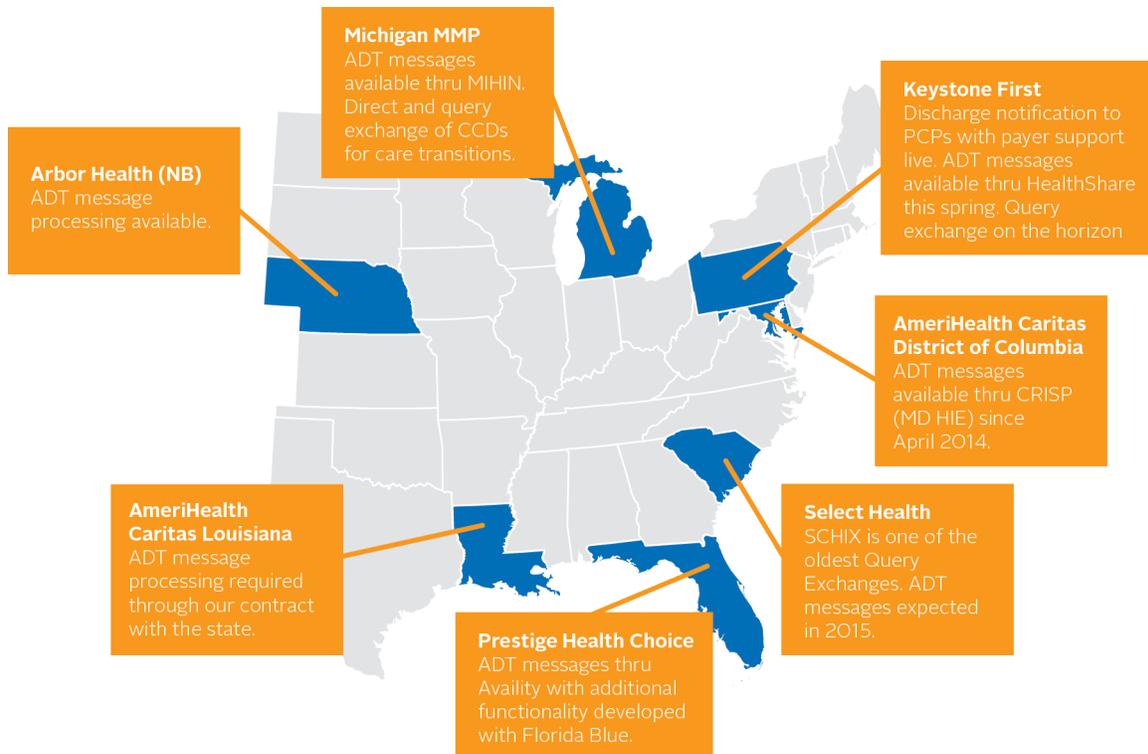


Exhibit 13.7-B: AmeriHealth Caritas HIE Collaboration

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 (NeHIE): AmeriHealth Caritas' Arbor Health Plan is a member of NeHIE 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



Business Continuity/DR Plan

Prepared by:
Corporate Business Continuity & Emergency Management Office
Original Document Release Date:
00/00/2015
Recent Document Release Date:
00/00/2015
Doc. Version:
Final 1.0 – Month Day, Year

Proprietary and Strictly Confidential:

This document is the property of AmeriHealth Caritas Family of Companies (ACFC) and AmeriHealth Caritas Iowa. It may not be duplicated, disclosed, or reproduced in whole or part without the express written authorization of AmeriHealth Caritas Family of Companies.



Business Continuity/DR Plan

Table of Contents

APPROVALS	3
1. INTRODUCTION	4
1.1 USE OF THIS DOCUMENT	4
1.2 PURPOSE OF THIS PLAN	4
1.3 DEFINITION OF A DISASTER	4
1.4 SERVICES PERFORMED	4
1.4.1 <i>Services Performed in the South Carolina Offices</i>	4
1.4.2 <i>ACIA Services Performed in Philadelphia and/or Jacksonville</i>	4
1.5 PLAN TESTING.....	5
1.6 SUPPORTING PLANS	5
1.7 ROLES AND RESPONSIBILITIES	5
1.8 NOTIFICATION/COMMUNICATION TOOLS	6
2. FIRST RESPONSE, DAMAGE ASSESSMENT AND NOTIFICATION PROCEDURES	7
2.1 EVACUATION.....	7
2.2 NOTIFICATION OF DAMAGE ASSESSMENT TEAM.....	7
2.3 PRELIMINARY DAMAGE ASSESSMENT.....	7
3. PLAN ACTIVATION AND NOTIFICATION PROCEDURES	8
3.1 PLAN ACTIVATION.....	8
3.2 NOTIFICATION OF ACIA BUSINESS CONTINUITY TEAM.....	8
3.3 EMERGENCY OPERATIONS CENTER (EOC)	8
3.4 DECLARING A DISASTER.....	9
4. PLAN ADMINISTRATION	10
4.1 BUSINESS CONTINUITY STRATEGY.....	10
4.1.1 <i>Overall Business Continuity Strategy</i>	10
4.1.2 <i>Business Function MTODs</i>	10
4.1.3 <i>Workforce Recovery</i>	10
4.1.4 <i>Crisis Management/Crisis Communication</i>	11
4.1.5 <i>Disaster (IT) Recovery</i>	11
4.2 CONTINUITY OF SERVICES	12
4.2.1 <i>Contingency Plan Strategies for [business function name]</i>	12
4.2.2 <i>Contingency Plan Strategies for [business function name]</i>	13
4.2.3 <i>Contingency Plan Strategies for [business function name]</i>	13
4.3 PROVISIONS FOR MANAGING A PANDEMIC	14
5. RESTORATION OF NORMAL OPERATIONS	15
5.1 PRELIMINARY HOME SITE TEST	15
5.2 FACILITY VERIFICATION.....	15
5.3 RESTORATION OF HOME SITE	15
5.4 RESUME NORMAL OPERATIONS.....	15
6. DEMOBILIZATION	16
6.1 DEACTIVATION	16
6.2 EVALUATION	16



Business Continuity/DR Plan

Approvals

Name	Title	Signature	Date	Version
	Market President			
	VP, Risk Management			
	Business Continuity			

Sample Plan



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

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.



Business Continuity/DR Plan

Jacksonville

- Business function name here

Philadelphia

- 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



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

Toll Free: 1-719-867-1571
of Participates Permitted: 125

Business Recovery Bridge Line

Toll Free: 1-877-860-3058
of Participates Permitted: 125

Disaster (IT) Recovery Bridge Line

Toll Free: 1-719-325-2630
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)**



Business Continuity/DR 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 and 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.



Business Continuity/DR 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

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.

Business Continuity/DR Plan

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



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	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	

4.1.3 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:



Business Continuity/DR Plan

- 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



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)



Business Continuity/DR Plan

- 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:

Business Continuity/DR 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



Business Continuity/DR 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.



Business Continuity/DR 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.

Attachment 13.1-B: AmeriHealth Caritas Problem Management High Level Process

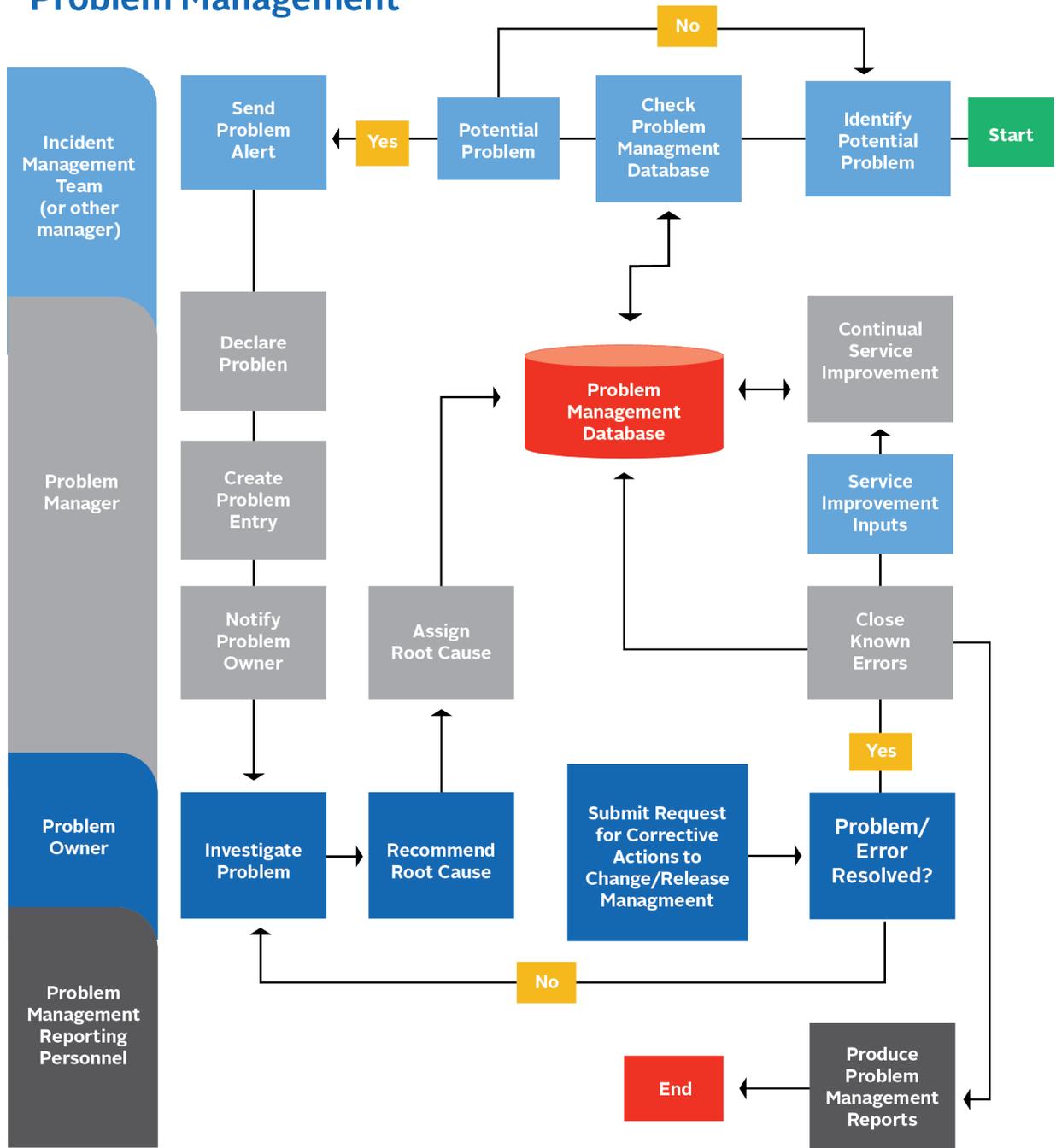
AMERIHEALTH CARITAS FAMILY OF COMPANIES (PLAN NAME) POLICY AND PROCEDURE

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

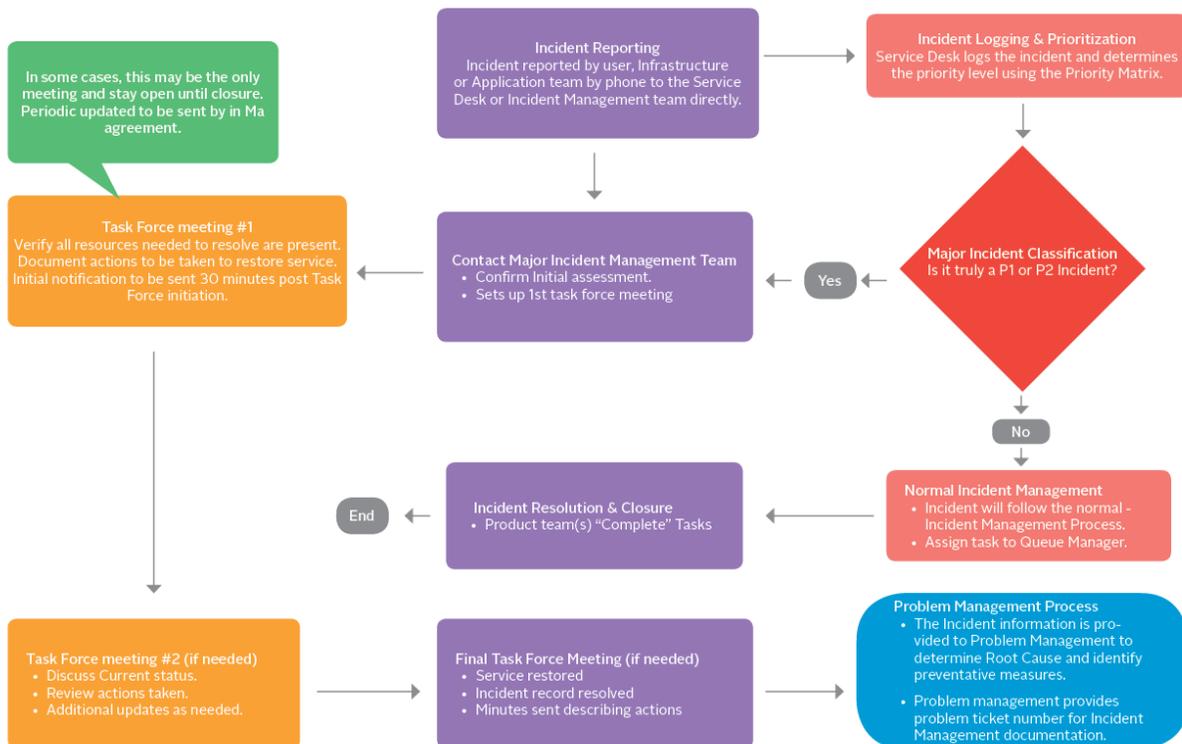
This document applies to all Incidents that impact the business of AmeriHealth and/or its partner organizations and/or its clients.

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)	<ul style="list-style-type: none"> -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)	<ul style="list-style-type: none"> -Measureable impact due to loss in functionality, 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)	<ul style="list-style-type: none"> -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)	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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 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)	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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.



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	<ul style="list-style-type: none"> • Within 15 business minutes post “validation” by Incident Management Team: <ul style="list-style-type: none"> ○ initiate “Task Force” – send “invitation” to team • Within 1 business hour post “validation” by Incident Management Team: <ul style="list-style-type: none"> ○ Send initial notification to Passport DL • Every 2 business hours after initial notification: <ul style="list-style-type: none"> ○ Send update notification to Passport DL • Work does not cease until issue resolved 	98%
P2	<ul style="list-style-type: none"> • Within 15 business minutes post “validation” by Incident Management Team: <ul style="list-style-type: none"> ○ initiate “Task Force” • Within 1 business hour post “validation” by Incident Management Team: <ul style="list-style-type: none"> ○ Send initial notification to Passport DL • Every 3 business hours after initial notification: <ul style="list-style-type: none"> ○ Send update notification to Passport DL • Work does not cease until issue resolved 	98%

Priority	Actions	SLA
P3	<ul style="list-style-type: none"> • Within 1 business day post “validation” by Incident Management Team: <ul style="list-style-type: none"> ○ Support Team(s) begin addressing issue • ITSM record updated as resolution progresses • Updates to Passport as requested 	98%
P4/5	<ul style="list-style-type: none"> • Within 5 business days post “validation” by Incident Management Team: <ul style="list-style-type: none"> ○ 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	
<p>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:</p> <ul style="list-style-type: none"> • 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 	<p>This communication level would be used as informational when a Major Incident has occurred in the environment.</p>
Level 1	
<p>I.S. Assessment Team – The list provides a Primary and Alternate contact from the following IS Teams:</p> <ul style="list-style-type: none"> • LAN/WAN • Windows Server • Unix / Linux Server • Sybase DBA • Oracle DBA • Voice Network • Service Desk • Facets Production Support • Production Control • Information Security • Desktop Engineering 	<p>This communication level would be used when a Major Incident has occurred in the environment.</p> <p>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.</p> <p>We would initially start with the I.S. Assessment Team and expand to Additional I.S. Teams as necessary.</p> <p>Notifications are sent in the form of an e-mail and SMS text message to mobile phone contacts identified.</p>

Target Audience/Recipients	Use Scenarios
Level 2	
<p>DL-ACFC: Daily Turnover - The DL is made up of everyone in Level 1 in addition to contacts from the following departments:</p> <ul style="list-style-type: none"> • 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 	<p>This communication level would be used when a Major Incident has occurred and the business impact has been determined.</p> <p>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.</p>
Level 3	
<p>Enterprise Communication – An enterprise e-mail notification would be sent to all (or some) of the DLs listed below:</p> <ul style="list-style-type: none"> • 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) 	<p>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.</p> <p>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.</p> <p>Notification to Third Party Affiliates is performed by the Business Engagement Services team.</p>

Standard Format of Incident Notifications

The format below is used by the Incident Management Team for Notification Updates and the Final Notifications (Resolved).

 Send	From	IncidentManagement
	To...	DL-ACFC: Daily Turnover
	Cc...	
	Subject:	Major Incident Notification

Description

Date/Time Reported: MM/DD/YYYY, xx.xx AM/PM

Incident #:

Steps Being Taken:

Next Update:

Incident Management
Information Systems
AmeriHealth Caritas Family of Companies
DL-ACFC: Daily Turnover: Incident Management



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
		<input type="checkbox"/> Service Desk <input type="checkbox"/> Infrastructure <input type="checkbox"/> Application <input type="checkbox"/> WFM <input type="checkbox"/> Other	<input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> 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"
 - o Type 12 (the AmeriHealth message number)
 - o 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:

- o 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	<ul style="list-style-type: none"> • IS Contact information 	2	Incident Management
10/23/2013	<ul style="list-style-type: none"> • Additional communication if needed • Incident Management conference number • Distribution Lists • IS Assessment Team contact list • Table of contents 	3	Incident Management
11/5/2013	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> CAI Contacts for escalations Front end ACD message administration Enterprise Wide Area Network 2013, 2014 	5	Incident Management
11/21/2013	<ul style="list-style-type: none"> Account Managers and IS Engagement Consultants 	6	Incident Management
1/10/2014	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Added New Incident Notifications Templates Added Operations Manager Information 	7.1	Incident Management
2/11/2014	<ul style="list-style-type: none"> Updated LAN/WAN Contact Information Updated Facility Contact Information 	7.2	Incident Management
3/4/2014	<ul style="list-style-type: none"> VIP has been removed from the Priority Matrix 	7.3	Incident Management
4/9/2014	<ul style="list-style-type: none"> 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 Section 1.2 - 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	<ul style="list-style-type: none"> Updated the Incident Handling Scorecard 	7.5	Incident Management
5/6/2014	<ul style="list-style-type: none"> Added Alternate Conference Number & Passcodes 	7.6	Incident Management

Date Updated	Description of Changes made:	Version	Name
2/26/2015	<ul style="list-style-type: none">• Added updated IT Escalation Contact List• Added revised priority matrix	7.6.1	Incident Management

This page intentionally left blank.

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.

CRG assignment occurs in four phases

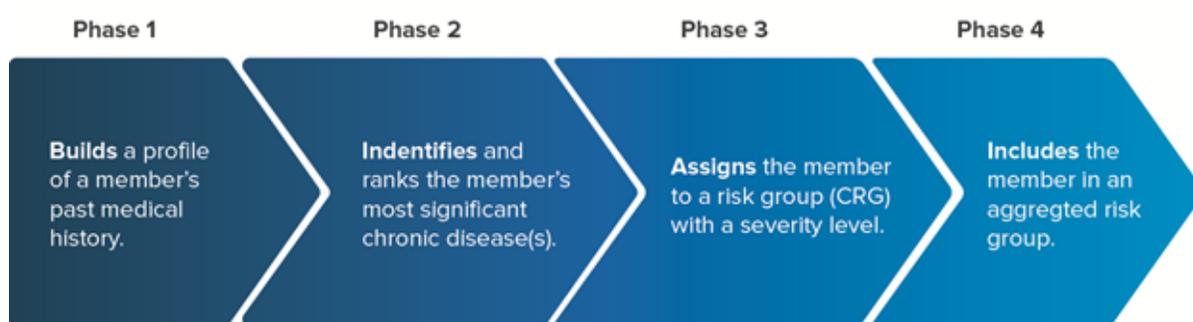


Exhibit 14.0-A: CRG Assignment Phases

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.

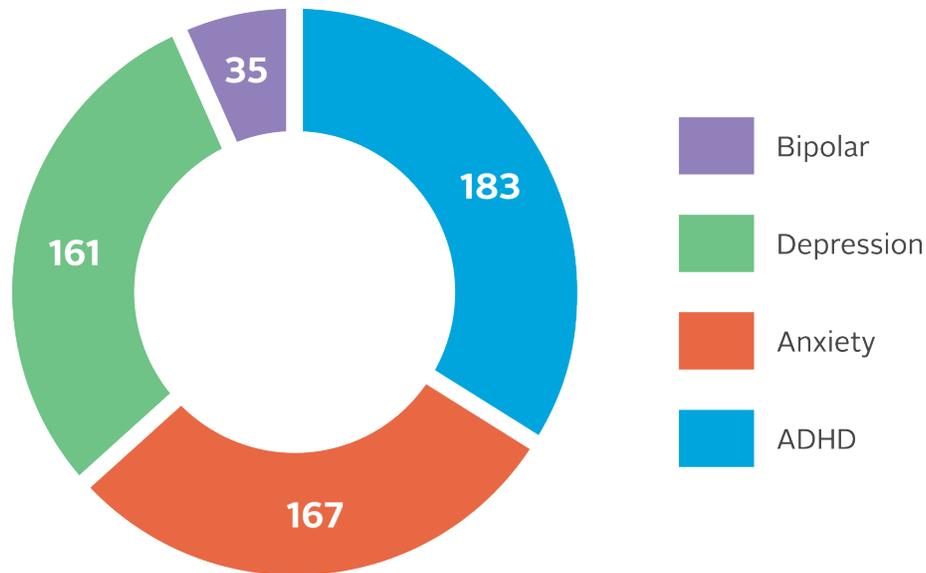


Exhibit 14.0-B: Example analysis — identification and grouping by condition

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 NCOA 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 \$^{Confidential & Not for Public} 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 \$^{Confidential & Not for Public}. 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.

This page intentionally left blank.

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. <ul style="list-style-type: none"> a. At midnight on the transition date, the Replacement Contractor (RC) will assume responsibility for all <u>new</u> requests for grievances and appeals. b. Contractor will complete all determinations for <u>existing</u> 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: <ul style="list-style-type: none">• 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.