AmeriHealth Caritas Louisiana

Redaction Log

The pages listed in the table below have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this proposer as a result of or in connection with the submission of this proposal, the state of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the state of Louisiana's right to use or disclose data obtained from any source, including the proposer, without restrictions.

Binder	Part	Section	Question	Page Number
1	I	Appendix VV	N/A	Associated Attachment
2	II	B	1	Pages 1- 4 and associated attachments
2	II	B	2	Associated attachments
3	III	E	3	Pages 19-26
3	III	E	6	Associated attachments
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3	III	E	9	Associated attachments
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5	IX	W	3	Pages 505-522
5	X	Y	1	Pages 593-608
5	X	Z and Appendix PP	1	Pages 609-624 and associated attachments
5	X	AA	1	Pages 625-632
5	X	BB	1	Pages 633-650
6	XI	BB	1	Pages 1-18

AmeriHealth Caritas Louisiana

AmeriHealth Caritas Louisiana Acronym List

17P	17 Hydroxyprogesterone
AAP	Access to Preventive/ Ambulatory Health Service
AAP	American Academy of Pediatrics
ABD	Aged, Blind, Disabled
ACA	Affordable Care Act
ACD	Automatic Call Distribution
ACFC	The AmeriHealth Caritas Family of Companies
ACG	Johns Hopkins' ACG® System for member claim data analysis
ACHP	AmeriHealth Caritas Health Plan
ACIP	Advisory Committee on Immunization Practices
ACLA	AmeriHealth Caritas Louisiana
ACLS	Advanced Cardiovascular Life Support
ACOG	American Congress of Obstetricians and Gynecologists
ACPA	AmeriHealth Caritas Pennsylvania
ACS	AmeriHealth Caritas Services, LLC
ACS	ACS Claims Service, Inc.
ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADT	Admissions, Discharges, and Transfers
AFDC	Aid to Families with Dependent Children
AHCA	Florida's Agency for Health Care Administration
AHNE	AmeriHealth Nebraska dba Arbor Health Plan
AMA	American Medical Association
ANOC/EOC	Annual Notice of Change/Evidence of Coverage
AOP	Annual Operating Plan

APM	Application Performance Monitor
ASHP	American Society of Health-System Pharmacists
ASU	Ambulatory Surgical Unit
B.E.S.T.	Breathe Easy Start Today Program
BCI	Business Continuity Institute
BCP	Business Continuity Program
BH	Behavioral Health
BH CM	Behavioral Health Care Manager
BHS	Behavioral Health Services
BHSF	Bureau of Health Services Financing
BLS	Basic Life Support
BMI	Body Mass Index
BREC	Recreation and Park Commission of East Baton Rouge Parish
C&M	Continuation and Maintenance
CAGNO	Cancer Association of Greater New Orleans
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAMP	Community Asthma Management Program
CAP	Corrective Action Plan
CAS	Claim level Adjustment Amount
CBCP	Certified Business Continuity Professional
CCC	Community Care Connector
CCD	Continuity of Care Document
C-CDA	Consolidated Clinical Document Architecture
CCM	Complex Care Management
CCME	Carolinas Center for Medical Excellence
CCMP	Chronic or Complex Care Management Program
CCMT	Community Care Management Team
CCOE	Contact Center of Excellence

CCRN	Certification for Adult, Pediatric and Neonatal Critical Care Nurses
CCS	Certified Coding Specialist
CDC	Centers for Disease Control and Prevention
CDC	Comprehensive Diabetes Care
CDJ	Cash Disbursement Journal
CDPS	Chronic Illness & Disability Payment System
CEOT	Community Education Outreach Team
CERMe	CareEnhance® Review Manager Enterprise
CFR	Code of Federal Regulations
CHCQM	Certified in Health Care Quality Management
CHCUP	Child Health Check-Up Program
CHF	Congestive Heart Failure
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CICU	Cardiac Intensive Care Unit
CLAS	Culturally and Linguistically Appropriate Services
CM/CC	Case Management/Care Coordination
CMC	Case Management Certification
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid Services
CNM	Certified Nurse Midwife
CNS	Central Nervous System
COA	Certificate of Authority
COB	Coordination of Benefits
COPD	Chronic Obstructive Pulmonary Disease
CPHQ	Certified Professional in Healthcare Quality
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement Principles
CRGs	Clinical Risk Groups

CRISP	Maryland's Chesapeake Regional Information System for our Patients
CRRU	Claim Reconciliation Recovery Unit
CSHS	Children's Special Health Service program
CSQA	Certified Software Quality Analyst
CSR	Customer Service Representative
CSV	Comma-separated Values
CWCA	Certified Wound Care Associate
DC HIE	District of Columbia Health Information Exchange
DCC	Dominant Chronic Condition
DHH	Louisiana Department of Health and Hospitals
DHHS	Department of Health and Humans Services (also HHS)
DLP	Data Loss Prevention
DM	Disease Management
DM	Diabetes Mellitus
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Certain Supplies
DMS	Durable Medical Supplies
DMZ	Demilitarized Zone (Computing)
DO	Doctor of Osteopathic Medicine
DOB	Date of Birth
DOI	Louisiana Department of Insurance
DR	Disaster Recovery
DRA	Deficit Reduction Act
DRG	Diagnosis Related Group
DTM	Drug Therapy Management
DTP	Claim/service adjudication date
DUR	Drug Utilization Review
E&M	Evaluation and Management
EB	Enrollment Broker

ECM	Episodic Care Management
ED	Emergency Department
ED	Executive Director
EDD	Estimated Due Date
EDI	Electronic Data Interchange
EFT	Electronic Fund Transfers
EHR	Electronic Health Record
EMR	Electronic Medical Record
EMSDC	Eastern Minority Supplier Development Council
EOB	Explanation of Benefits
EPLS	Excluded Parties List Serve
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	Emergency Room
ESRD	End Stage Renal Disease
ETL	Extract, Transform, and Load
EXP	SunGar EXP MACESS
FCA	False Claims Act
FCSC	First Choice by Select Health
FDA	Food and Drug Administration
FDB	First Databank
FDE	Full disk encryption
FEMA	Federal Emergency Management Agency
FERA	Fraud Enforcement and Recovery Act
FFP	Federal Financial Participation
FFS	Fee for Service
FHIMSS	Fellow, Healthcare Information Management System Society
FI	Fiscal Intermediary

FIFO	First-In-First-Out
FITAP	Family Independence Temporary Assistance Program
FLOIR	Florida Office of Insurance
FMOLHS	Franciscan Missionaries of Our Lady Health System
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent/Employee
FTH	Florida True Health
FWA	Fraud, Waste, and Abuse
FY	Fiscal Year
G&A	Grievances and Appeals
GDIT	General Dynamics Information Technology
GE	Functional Group Trailer
GEMs	General Equivalency Mappings
GINA	Global Initiative for Asthma
GS	Functional Group Header
GSA	Geographic Service Area
HCBS	Home and Community Based Services
HCFA	Health Care Financing Administration
HCPCS	Healthcare Common Procedure Coding System
HCV	Hepatitis C Virus
HDI	HealthDataInsights
HDX	Claims Clearinghouse
HEC	Health Equities Council
HEDIS	Healthcare Effectiveness Data and Information Set
HFMA	Healthcare Financial Management Association
HHA	Home Health Aide
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology

HITECH	Health Information Technology for Economic and Clinical Health Act
HIV	Human Immunodeficiency Virus
HL7	Health Level Seven
HMHB	Healthy Mothers, Healthy Babies
HMO	Health Maintenance Organization
HMS	HealthCare Management System, Inc.
HPV	Human Papilloma Virus
HRA	Health Risk Assessment
HSX	HealthShare Exchange of Southeastern Pennsylvania, Inc.
I/OCE	Integrated Outpatient Code Editor
IAD	Integrated Application Desktop
IBC	Independence Blue Cross
IBNR	Incurred But Not Reported
ICAP	Instant Capacity technology
ICC	Interconception Care
ICD-9/ICD-10	International Statistical Classification of Diseases and Related Health Problems, Version 9 or 10
ICF/DD or ICFDD	Intermediate Care Facility for Developmental Disabilities
ICM	Integrated Care Management
ICN	Internal Control Number
ICT	Interdisciplinary Care Team
ICU	Intensive Care Unit
IDEA	Individuals with Disabilities Education Act
IDS	Intrusion Detection System
IDSS	NCQA's Interactive Data Submission System
IEP	Individualized Education Plan
IHG	Independence Health Group, Inc.
iHT	iHealth Technologies
IMS	Infrastructure Monitoring System

IP/OP	Inpatient / Outpatient
IPA	Independent Practice Associations
IPC	Inter-pregnancy Care
IPNS®	Integrated Pharmacy Network System
IPS	Intrusion Prevention System
IS	Information Systems
ISTQB	International Software Testing Qualifications Board
ITIL	Information Technology Infrastructure Library
ITN	Intent to Negotiate
IVR	Interactive Voice Response
KF	Keystone First
KHPE	Keystone Health Plan East
L&OD / L&OE	Learning and Organizational Development/Effectiveness
LAALS	Louisiana Adverse Actions List Search
LaCAN	Louisiana CAREWare Access Network
LaCHIP	Louisiana Children's Health Insurance Program
LADHH	Louisiana Department of Health and Hospitals
LaHIE	Louisiana Health Information Exchange
LaHIPP	Louisiana Health Insurance Premium Payment Program
LAP	LaCHIP Affordable Plan
LARHIX	Louisiana Rural Health Information Exchange
LBHP	Louisiana Behavioral Health Partnership
LCRI	Louisiana Center for Rural Initiatives
LEERS	Louisiana Electronic Event Registration System
LEIE	Office of Inspector General List of Excluded Individuals/Entities
LEP	Limited English Proficiency
LGBT	Lesbian, Gay, Bisexual, Transgender
LGBTBE	Lesbian, Gay, Bisexual, Transgender Business Enterprise
LHCQF	Louisiana Health Care Quality Forum

LIFC	Low Income Families and Children
LINKS	Louisiana Immunization Network for Kids Statewide
LMMIS	Louisiana Medicaid Management Information System
LOC	Level of Care
LPHI	Louisiana Public Health Institute
LRS	Louisiana Relay Service
LSA	Language Service Associates
MAC	Member Advisory Council
MAID	Medical Assistance Identification Number
MBE	Minority Business Enterprise
MCC	Medical Care Coordination
MCO	Managed Care Organization
MD	Doctor of Medicine
MDC	Major Diagnostic Codes
MFCU	Medicaid Fraud Control Unit
MH/SA	Mental Health/Substance Abuse
MHPA	Medicaid Health Plans of America
MI	Motivational Interviewing
MIS	Management Information System
MLR	Medical Loss Ratio
MLTSS	Managed Long-term Services and Supports
MMIS	Medicaid Management Information System
MRP	Medication Related Problem
MRR	Medical Record Review
MSDC	Minority Supplier Development Council
MSN	Master of Science in Nursing
MSR	Member Services Representatives
MVA	Medical Vendor Administration
MWBE	Minority Women Owned Business

NAIC	National Association of Insurance Commissioners
NALS	Neonatal Advanced Life Support
NAMI LA	National Alliance on Mental Illness, Louisiana
NCCI	National Correct Coding Initiative
NCHS	National Center for Health Statistics
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NEDHHS	Nebraska Department of Health & Human Services
NEMT	Non-Emergency Medical Transportation
NHWP	National Healthy Worksite Program
NIA	National Imaging Associates
NICU	Neonatal Intensive Care Unit
NIH	National Institutes of Health
NMD	Network Medical Director
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPM	Network Performance Monitor
NTA	NetFlow Traffic Analyzer
NUBC	National Uniform Billing Code
OASIS	Outcome and Assessment Information Set
OB	Obstetric Provider
OBGYN	Obstetric and Gynecological or Obstetrician/Gynecologist
OCR	Optical Character Recognition
OLOL	Our Lady of the Lake
OMB	Office of Budget Management
OMC	Outpatient Management Checklist
OMPP	Office of Medicaid Policy and Planning

ONAF	Obstetrical Needs Assessment Form
OON	Out-of-Network Provider
OPH	Louisiana Office of Public Health
OPPS	Outpatient Professional Payment System
OT	Occupational Therapy
P&T	Pharmaceutical and Therapeutics
PA	Physician's Assistant
PA DOI	Pennsylvania Department of Insurance
PADOH	Pennsylvania Department of Health
PADPW	Pennsylvania Department of Public Welfare
PALS	Pediatric Life Support
PBM	Pharmacy Benefit Manager
PBX	Private Branch Exchange
PCCM	Primary Care Case Manager
PCMH	Patient-centered Medical Home
PCP	Primary Care Provider
PCS	Personal Care Services
PDC	Percent of Days Covered
PDCA	Plan-Do-Check-Act
PDL	Preferred Drug List
PH	Physical Health
Ph.D.	Doctor of Philosophy
PHI	Personal Health Information
PHQ-9	Patient Health Questionnaire for Depression
PHR	Personal Health Record
PIH	Pregnancy-induced Hypertension
PII	Personally Identifiable Information
PIP	Performance Improvement Project
PIR	Post-implementation Review

PIU	Payment Integrity Unit
PLC	Project Lifecycle
PMPM	Per Member Per Month
PNM	Provider Network Management
PNO	Provider Network Operations
POP	Progesterone Outreach Program
POS	Point-of-Sale
PPA	Potentially Preventable Admission
PPACA	Patient Protection and Affordable Care Act
PPC	Provider Preventable Condition
PPEs	Potentially Preventable Events
PPHC	Pediatric Preventive Health Care
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PQI	Prevention Quality Indicators
PT	Physical Therapy
QA	Quality Assurance
QACoE	Quality Assurance Center of Excellence
QAPI	Quality Assessment Performance Improvement
QAPIC	Quality Assessment and Performance Improvement Committee
QCC	Quality of Clinical Care
QCCC	Quality of Clinical Care Committee
QEP	Quality Enhancement Program
QIC	Quality Improvement Committee
QM	Quality Management
QPMs	Quality Performance Measures
QR code	Quick Response electronic code
QSC	Quality of Service Committee
R&C	Reasonable and Customary

R/E/L or REL	Race, Ethnicity, and Language
RA	Remittance Advice
RCFO	Regional Chief Financial Officer
RFC	Request for Change
RFP	Request for Proposal
RHC	Rural Health Clinic
RN	Registered Nurse
RR	Rapid Response
SAM	System of Award Management
SAS	Statistical Analysis System
SBHC	School Based Health Center/Clinic
SCD	Sickle Cell Disease
SCDHHS	South Carolina Department of Health and Hospitals
SCHIEx	South Carolina Health Information Exchange
SDLC	Systems Development Life Cycle
SDVOSB	Service Disabled Veteran Owned Small Business (not Louisiana accredited)
SECDVET	Small Entrepreneurship Service Disabled Veteran-Owned business
SEHUD	Small Entrepreneurship Hudson Initiative
SEVET	Small Entrepreneurship Veteran Owned
SFTP	Secure File Transfer Protocol
SHSC	Select Health of South Carolina, Inc.
SICU	Surgical Intensive Care Unit
SIDS	Sudden Infant Death Syndrome
SIRT	Security Incident Response Team
SIU	Special Investigation Unit
SLA	Service Level Agreement
SMO	State Management Organization
SPD	Supplemental Paid Date

SRM	Site Recovery Manager
SRMDC	Southern Regional Minority Diversity Council
SSA	Social Security Act
SSI	Supplemental Security Income
SSRS	SQL Server Reporting Services
ST	Speech Therapy
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
STP	Significant Traditional Provider
SUD	Substance Use Disorder
SVRS	Statistically Valid Random Sample
TANF	Temporary Assistance for Needy Families
TDAP	Tetanus, Diphtheria, and Acellular Pertussis
T-MSIS	Transformed Medicaid Statistical Information System
TPA	Third Party Administrator
TPL	Third Party Liability
TTY/TDD	Teletypewriter and Telecommunications Device for the Deaf
ULM	University of Louisiana at Monroe
UM	Utilization Management
UPS	Uninterrupted Power Supplies
UR	Utilization Review
URAC	Utilization Review Accreditation Committee
VBAC	Vaginal Birth After Cesarean Section
VFC	Vaccine for Children Program
VPN	Virtual Private Network
WBE	Women Business Enterprise
WCAG	Web Content Accessibility Guidelines
WCC	Weight Assessment and Counseling for Nutritional and Physical Activity for Children/Adolescents

WIC	Women, Infants, and Children
YTD	Year-to-date
ZPHA	Zero Power High Availability

Addendum # 9

Revised Appendix KK

RFP# 305PUR-DHHRFP-BH-MCO-2014-MVA

LOUISIANA BAYOU HEALTH PROGRAM MCO PROPOSAL SUBMISSION AND EVALUATION REQUIREMENTS RFP #	
PROPOSER NAME	**AmeriHealth Caritas Louisiana, Inc.**

THE PROPOSER MUST COMPLETE THIS FORM AND SUBMIT WITH THEIR PROPOSAL.

In responding to this RFP, the Proposer should adhere to the specifications outlined in Section §22 of the RFP. The proposal should address all requirements listed in this appendix and should provide, in sequence, the information and documentation as required.

The Proposer should complete only the first column of this form to provide an index referencing the location of your response to each item listed (page and section number). This completed form should be included as appendix A of your proposal. The DHH Proposal Review Team will review the proposer's response to the RFP as outlined in this evaluation tool. The review team will be comprised of state employees. DHH reserves the right, at its sole discretion, to conduct its own research and/or consult with contracted subject matter experts in order to verify and assess the information presented. **The review, including but not limited to, an assessment of the compliance with specifications and provisions of the RFP, the quality, feasibility, and reasonableness of the proposal, will be the basis for the scoring of the proposal.**

Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items as a part of said Contract (Refer to Section §22 of RFP).

NOTICE: The department reserves the right to conduct its own research and/or consult with contracted subject matter experts in order to verify and assess the information presented.

All Mandatory Requirements listed in Part I. must be included in the proposal. The DHH Division of Contracts and Procurement Support will review the proposal to determine if the Mandatory Requirement Items (below) are submitted and complete and mark each with included or not included.				
Page # of Response In Proposal	**PART I: MANDATORY REQUIREMENTS** **Any proposal submitted without all mandatory requirements will be disqualified from the evaluation process immediately.**	**Total Possible Points**	**Score**	**DHH Comments**
Binder 1 **Page 1** Appendix A	**A.1.** Provide the **Proposal Certification Statement** (**RFP Appendix # A**) completed and signed, in the space provided, by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract. The Proposer must sign the Proposal Certification Statement without exception or qualification.	Included/ Not Included	N/A	
Binder 1 **Page 3** Attachment	**A.2.** Provide a statement signed by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract guaranteeing that there will be no conflict or violation of the Ethics Code if the Proposer is awarded a contract. Ethics issues are interpreted by the Louisiana Board of Ethics. (See Section 22.4 of the RFP.)	Included/ Not Included	N/A	
Binder 1 **Page 5** Attachment	**A.3.** Provide documentation showing that the Proposer has acquired a certificate of authority (COA) from the Louisiana Department of Insurance to establish and operate a MCO as defined in RS 22:1016 and in accordance with rules and regulations as defined by the Department of Health and Hospitals. (See Section 2.1.1.2 of the RFP.)	Included/ Not Included	N/A	
Binder 1 **Page 7**	**A.4.** Provide either a statement of attestation that the Proposer has no moral or religious objections to providing any core benefits or services described in Section 6 of the RFP; **or** Submit a statement of any moral and religious objections to providing any core benefits or services described in Section 6 of the RFP. Describe, in as much detail as possible, all direct and related services that are objectionable. (continued on next page)	Included/ Not Included	N/A	

	Provide a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc. If none, so state. (See Section 2.4.3 of the RFP.)			
Page # of Response In Proposal	**PART II. FINANCIAL REQUIREMENTS** **Any proposal that does not earn 25 out of the 35 points will be disqualified from the evaluation process immediately.**	**Total possible points**	**Score**	**DHH Comments**
	Section B: Financial Stability	**30**		
Binder 2 Page 1 **Attachments**	**B.1** Provide the following as documentation of the Proposer's and parent corporation's sufficient financial strength and resources to provide the scope of services as required: • Three years of independently audited financial statements and associated enrollment figures from the Proposer. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be: o Prepared with all monetary amounts detailed in U.S. currency; o Prepared under U.S. generally accepted accounting principles; and o Audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor's opinion letter, financial statements, and the notes to the financial statements. • The Proposer's four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to-Date), with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows. (continued on next page)	15		

	• Verification of any contributions made to the Proposer to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable. • Proposer shall include the Proposer's parent organization. Provide the following information (in Excel format) based on each of the financial statements submitted: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.			
Binder 2 Page 5 Attachments	**B.2.** Provide your last three (3) statements containing your Risk Based Capital Ratio as prepared in accordance with instructions published by the National Association of Insurance Commissioners (NAIC). Include for both the proposing entity and the parent organization if applicable.	2		
Binder 2 Page 7	**B.3** As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from AM Best Company.	3		
Binder 2 Page 9	**B.4** Provide a statement of whether or not, in the last ten (10) years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation that includes relevant details, including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent organization, affiliates, and subsidiaries in this response.	5		
Binder 2 Page 11 Attachments	**B.5** Provide the following as documentation of financial responsibility and stability: • a current written bank reference, in the form of a letter, indicating that the Proposer's business relationship with the financial institution is in positive standing; • two current written, positive credit references, in the form of a letters, from vendors with which the Proposer has	5		

	done business or, documentation of a credit rating determined by an accredited credit bureau within the last 6 months; and (continued on next page) • a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate.			
	Section C: Publicly Traded Organizations **DO NOT ANSWER THIS SECTION IF YOUR ORGANIZATION IS PRIVATELY OWNED**	5 for publicly traded		
Binder 2 Page 13	**C.1** Submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report. Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. Include your organization's parent organization, affiliates, and subsidiaries in this response.	3		
Binder 2 Page 15	**C.2** Provide your organization's bond rating for the current year and each of the past three years. Include your organization's parent organization, affiliates, and subsidiaries in this response.	2		
	Section D: Privately Owned Organizations **DO NOT ANSWER THIS SECTION IF YOUR ORGANIZATION IS PUBLICLY TRADED**	5 for privately owned		
Binder 2 Page 17	**D.1** Provide your organization's credit rating for the current year and each of the past three years. Include your organization's	5		

	parent organization, affiliates, and subsidiaries in this response.			
Page # of Response In Proposal	**PART III. ORGANIZATIONAL REQUIREMENTS**	**Total possible points**	**Score**	**DHH Comments**
	Section E: Qualifications and Experience	**50**		
Binder 3 Page 1	**E.1** Provide a listing of, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years (including your parent organization, affiliates, and subsidiaries); or If your organization has not had any publicly-funded managed care contracts for Medicaid/CHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years. The listing of contracts should be provided in a table format. For each contract identified, provide each of the following items as a column in the table: the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any.	5		
Binder 3 Page 17	**E.2** Identify whether your organization currently has a Louisiana Medicaid/CHIP managed care contract.	5		

Binder 3 Page 19	**E.3** For any of your organization's contracts ~~to provide health services within the past five years~~ **listed in response to E.1**, has the other contracting party notified the Proposer that it has found your organization to be non-compliant with the terms of your contract? If yes: (1) provide a description of the events concerning the non-compliance, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? Include your organization's parent organization, affiliates, and subsidiaries in this response.	10		
Binder 3 Page 27	**E.4** Identify whether your organization has had any contract **listed in response to E.1** terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client; and If the contract was terminated/non-renewed, based on your organization's performance, describe any action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries in this response.	10		

Binder 3 Page 29	**E.5** Provide evidence of current accreditation by national entity – either URAC or NCQA for at least one state product line **listed in response to E.1**. If you have national accreditation, have you ever had your accreditation status (e.g., NCQA) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Include your organization's parent organization, affiliates, and subsidiaries in this response.	2		
Binder 3 Page 33	**E.6** Provide as an attachment a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item ~~B.1~~ **E.1** of this section that had the largest number of enrollees as of January 1, 2014. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization as a result of this review.	3		
Binder 3 Page 35	**E.7** Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries in your response to this question.	5		

Binder 3 Page 37	**E.8** State whether or not your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item ~~D.2~~ **C.1** of this part. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses.	5		
Binder 3 Page 39	**E.9** Submit three (3) client references for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix QQ. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps: a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix QQ (for your organization or for subcontractors, adding the following customized information: • Your/Subcontractor's name; • Reference organization's name; and • Reference contact's name, title, telephone number, and email address. b. Send the form to each reference contact along with a new, sealable standard envelope; (continued on next page)	5		

	c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal; d. Instruct the reference contact to: • Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission); • Sign and date it; • Seal it in the provided envelope; • Sign the back of the envelope across the seal; and • Return it directly to you. e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references. Each completed questionnaire should include: • Proposing Organization/Subcontractor's name; • Reference Organization's name; • Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work; • Date reference form was completed; and • Responses to numbered items in RFP Attachment # (as applicable). DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information. **THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.**			

	Section F: Organizational Structure	35		
Binder 3 Page 41	**F.1** Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization's parent organization, affiliates, and subsidiaries that will support this contract.	5		
Binder 3 Page 45	**F.2** Provide an organization chart for this contract (marked as Chart B) including but not limited to positions in 4.2 and 4.3 of the RFP. Indicate what is the FTE for each dedicated to this contract and whether or not the position is located in Louisiana.	10		
Binder 3 Page 49 Section 4.2	**F.3** Attach job descriptions (including education and experience qualifications) of employees in key staff positions as defined in Sec. 4.2. Job descriptions should not exceed 2 pages.	10		
Binder 3 Page 51	**F.4** Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than $100,000 annually.	5		
Binder 3 Page 53	**F.5** Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located.	5		

Page # of Response In Proposal	PART IV: Provider Network	Total Possible Points	Score	DHH Comments
	Section G: Network Development	**35**		
Binder 4 Page 1 Appendix FF	**G.1** Provide a plan to build a statewide provider network to adequate (Section 7.0) for a membership of 250,000 members that in accordance with the specifications found in Section 7.0 of the RFP and specific efforts to recruit and retain participation quality providers in the Louisiana Medicaid program. Include your process and policies for utilization of out of network providers and your plan to address any gaps in local coverage and maintain adequacy throughout the term of the contract.	20		
Binder 4 Page 17	**G.2** Describe how you will provide tertiary care providers, including trauma centers, burn centers, children's hospital, Level III maternity care; Level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. If you do not have a full range of tertiary care providers describe how the services will be provided including transfer protocols and arrangements with out of network facilities.	5		
Binder 4 Page 21	**G.3** Describe how you will keep all required provider information accurate and current, both internally and the information submitted to DHH for the provider registry.	10		
	Section H: Provider Management	**35**		
Binder 4 Page 31	**H.1** Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.	5		
Binder 4 Page 35	**H.2** Describe your provider grievance and appeal process.	10		

Binder 4 Page 41	**H.3** Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.	5		
Binder 4 Page 47 Attachments	**H.4** Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled. o Submit sample quality profile reports used by you, or proposed for future use (identify which). o Describe the rationale for selecting the performance measures presented in the sample profile reports. o Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.	10		
Binder 4 Page 57	**H.5** Describe how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers. . Identify the key requirements that will be addressed.	5		

Page # of Response In Proposal	PART V: BENEFITS AND MEMBER MANAGEMENT	Total Possible Points	Score	DHH Comments
	Section I: Member Assessment and Care Coordination	**15**		
Binder 5 Page 1	**I.1** DHH intends to provide MCOs with two years of historic claims data for members enrolled in the MCO effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your MCO effective February 1, 2015. The description should include: • How you will identify these enrollees, and how you will use this information to identify these enrollees, including enrollees who are receiving regular ongoing services; • What additional information you will request from DHH, if any, to assist you in ensuring continuation of services; • How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation; • What information, education, and training you will provide to your providers to ensure continuation of services; and • What information you will provide your members to assist with the transition of care. • Describe your approach to identifying "hot spotters" who are high utilizers and describe any innovative approaches you utilize to be able to identify the difficult to find patients.	5		
Binder 5 Page 13	**I.2** For members who need home health and/or other services upon discharge from an acute care hospital, explain how you will coordinate service planning and delivery among the hospital's discharge planner(s), your case manager(s), your disease management staff member(s), and the home health agency. Further, explain how you will monitor the post-discharge care of enrollees receiving home health services in remote areas.	5		

Binder 5 Page 21	**I.3** Aside from transportation, what specific measures will you take to ensure that members in rural parishes, or other areas where access is an issue, are able to access specialty care? Describe any plans for using telemedicine to expand services. Also address specifically how will you ensure members with disabilities have access?	5		
	Section J: Coordination of Carved Out Services	**20**		
Binder 5 Page 27	**J.1** Describe how you will coordinate with the Louisiana Behavioral Health Partnership (LBHP) State Management Organization (SMO) for the management of shared members, including processes for reciprocal referral for needed services and prescription management (including but not limited to Sections 6.4, 6.34, 6.37 of the RFP). Include how you will engage and educate primary care providers in their role in the provision of basic behavioral services and the coordination of co-existing conditions. Include a description of the role Medical Director for Behavioral Health will play in these efforts.	15		
Binder 5 Page 43	**J.2** Describe how you will coordinate with the Medicaid Dental Benefits Manager for the management of shared members, including processes for reciprocal referral for needed services.	3		
Binder 5 Page 51	**J.3** Describe your approach for coordinating other carved out services including but not limited to Person Care Services, Targeted Case Management and other waiver specific services. Please include a description of how you will identify that your members may be in need of these services and any processes you will have in place for referral to and follow up with the member and provider or payer as appropriate.	2		

	Section K: Case Management	10		
Binder 5 Page 57	**K.1** Describe your approach to MCO case management. In particular, describe the following: • Characteristics of members that you will target for case management services; • How you assess member needs; • How you identify these members; • How you encourage member participation; • What tools you will be using for patient engagement including technology or mobile aps; • How you develop and implement individualized plans of care, including coordination with providers and support services; • How you will get data feeds from hospitals when your member is admitted, discharged or transferred; • How you coordinate your disease management and case management programs; • How you will coordinate your case management services with the PCP; and • How you will incorporate provider input into strategies to influence behavior of members.	5		
Binder 5 Page 79	**K.2** Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid MCO members. Describe how you will leverage existing state and local resources to support health and wellness of your members including but not limited to: • Strategies you will use to work with the Louisiana Office of Public Health to utilize existing capacity in the state for services, outreach or education. Include models you have used in other states that are in partnership or utilize a state's public health infrastructure. (continued on next page)	5		

	• Strategies to utilized faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services			
	Section L: Member Transition	**20**		
Binder 5 Page 93	**L.1** Describe how you will coordinate transition of a member in the following scenarios to minimize member disruption and ensure continuity of care: • From one managed care entity to another (receiving and relinquishing a member); and • Between fee-or-service to/from your MCO. Your processes should address interactions with and processes for engaging existing providers in the transition	10		
Binder 5 Page 105	**L.2** Describe your approach to meeting the newborn enrollment requirements, including how you will: • Encourage Members who are expectant mothers to select an MCO and PCP for their newborns; • Ensure that newborn notification information is submitted, either by you or the hospital, to DHH or its Agent within twenty-four (24) hours of the birth of the newborn; and • Ensure that the birth is properly recorded in the Louisiana Electronic Event Registration System (LEERS).	5		
Binder 5 Page 111	**L.3** Describe the types of interventions you will use prior to seeking to disenroll a Member as described in an MCO-Initiated Member Disenrollment, Section 11 of this RFP. If applicable, provide an example of a case in which you have successfully intervened to avert requesting the disenrollment of a member.	5		

	Section M: Early Periodic Screening, Diagnosis, and Treatment	**10**		
Binder 5 Page 119	**M.1** Describe your system for tracking each member's screening, diagnosis, and treatment including, at a minimum, the components of the system, the key features of each component, the use of technology, and the data sources for populating the system.	5		
Binder 5 Page 125	**M.2** Describe your approach to member education and outreach regarding EPSDT including the use of the tracking system described in ~~E.1~~ **M.1** of this part and any innovative/non-traditional mechanisms. Include: • How you will conduct member education and outreach regarding EPSDT including any innovative/non-traditional methods that go beyond the standard methods; • How you will work with members to improve compliance with the periodicity schedule, including how you will motivate parents/members and what steps you will take to identify and reach out to members (or their parents) who have missed screening appointments (highlighting any innovative/non-traditional approaches); and • How you will design and monitor your education and outreach program to ensure compliance with the RFP.	5		

	Section N: Utilization Management	55		

Binder 5 Page 143	**N.1** Provided a detailed description of your utilization management (UM) policies and procedures including but not limited to:
	• Specific levels and qualifications required for UM staff;
	• Training you provide your UM staff;
	• Industry products (Milliman, Interqual, etc.) used and how
	• Describe any differences between your UM phone line and your member services line with respect to bullets (2) through (7) in item ~~J.1~~ **R.1** of this part;
	• If your UM phone line will handle both Louisiana MCO and non-Louisiana MCO calls,
	  o explain how you will track Louisiana MCO calls separately; and
	  o how you will ensure that applicable DHH timeframes for prior authorization decisions are met.
		10		

Binder 5 Page 159	**N.2** Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.	5		
Binder 5 Page 167	**N.3** Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider or a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.	5		

Binder 5 Page 175	**N.4** Describe your plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to DHH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions.	5		
Binder 5 Page 187	**N.5** Discuss approach you will use to address high STI prevalence by incentivizing providers to conduct screening, prevention education, and early detection, including targeted outreach to at risk populations.	5		
Binder 5 Page 195	**N.6** Describe your plan to address prematurity prevention and improved perinatal outcomes. The plan may include but not be limited to the following: • Routine cervical length assessments for pregnant women; • Provision of injectable or vaginal progesterone for every eligible pregnant woman with a history of pre-term labor or a short cervix found in the current pregnancy. • Incentives for vaginal birth after cesarean (VBAC); • Provider or patient incentives for post-partum visit provision within recommended guidelines of 21-56 days post-delivery; • Incentives for use of long acting reversible contraceptives, which are to be provided to the member without prior authorization; and • Interventions to reduce Cesarean section rates including but not limited to prior authorization for induction of labor prior to forty-one (41) weeks gestational age.	10		

Binder 5 Page 205	**N.7** Explain how you will Identify and address underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives and appropriate pain management approaches in patients with sickle cell disease.	5		
Binder 5 Page 217	**N.8** Explain how you will reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than seven years of age.	5		
Binder 5 Page 225	**N.9** Identify how you will assess the quality and appropriateness of care furnished to enrollees with special health care needs.	5		

	Section O: Chronic Care Management Program	20		
Binder 5 Page 233	**O.1** Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for Bayou Health. Include information on work you have conducted in other states, if applicable. Include how you measure success for each of the populations (i.e. 20% reduction in 30-day readmission rate for members with diabetes); any state models you plan to implement in Louisiana; and how you plan to partner with national, state, or community foundations to support this work. Your plan should include but is not limited to: • How recipients will be identified for inclusion into the Chronic Care/Disease Management program, including populations of special interest to Louisiana e.g. reproductive aged women with a history of a prior poor birth outcome and members with Diabetes, HIV, Hepatitis C and sickle cell disease. • How you identify which disease states/ recipient types will be targeted for the Chronic Care/Disease Management program. • How you identify members who require in person case management services. • Plans to integrate with existing resources/programs in Louisiana as well as your plans to have case managers “on the ground” in addition to telephonic case management • How the Chronic Care/Disease Management program will coordinate information and services with the PCP. • Methods for case management in ways other than simply telephone management. These may include the use of pre-existing community organizations, community hubs, community health workers etc. • How you engage patients (in person, mobile apps, telephonic) and explain your model of case management including what types of personnel (lay health workers, nurses, social workers) are providing case management.	20		

	Section P: Non-Emergency Medical Transportation	10		
Binder 5 Page 273	**P.1** Describe in detail your proposed approach to providing non-emergency medical transportation (NEMT) services, including, at a minimum: • What administrative functions, if any, you will subcontract to another entity (If subcontracting this function, the subcontractor information must be provided in response to item ~~**C.6.**~~ **F.4**); • How you will determine the appropriate mode of transportation (other than fixed route) for a member; • Your proposed approach to covering fixed route transportation; • How you will ensure that pick-up and delivery standards are met by NEMT providers, including training, monitoring, and sanctions; • How you will ensure that vehicles (initially and on an ongoing basis) meet vehicle standards, including inspections and other monitoring; • Your approach to initial and ongoing driver training; • How you will ensure that drivers meet initial and ongoing driver standards; • How your call center will comply with the requirements specific to NEMT calls; and • Your NEMT quality assurance program (excluding vehicle inspection).	10		

	Section Q: Pharmacy	25		
Binder 5 Page 289	**Q.1** Identify your current or proposed PBM, specifying any corporate relationship to the bidder. (If subcontracting this function, the subcontractor information must be provided in response to item ~~**C.6.**~~ **F.4**)	1		
Binder 5 Page 291	**Q.2** Describe the MCOs flexibility to customize PBM policies and procedures to meet Louisiana specific needs and program goals.	5		
Binder 5 Page 299	**Q.3** Submit a preliminary plan for MCO oversight of the PBM's performance.	5		
Binder 5 Page 305	**Q.4** The drug file for both retail and specialty drugs, including price, must be updated at a minimum every seven (7) calendar days, at the MCO's discretion they may update the file more frequently. Provide a brief summary of your policy, process and frequency for drug file updates.	2		
Binder 5 Page 309	**Q.5** Submit a summary report of three (3) pharmacy utilization management efforts which demonstrated successful outcomes for three (3) separate disease states.	6		
Binder 5 Page 313	**Q.6** Describe at least 2 and no more than 4 existing or proposed educational initiatives the PBM or MCO will take regarding the use of Behavioral Health Medications **(**including ADD/ADHD**)**, treatment of infectious diseases, **and the** treatment **and control** of diabetes ~~and/~~or asthma	6		

	Section R: Customer Service	25		
Binder 5 Page 319	**R.1** Provide a narrative with details regarding your member services line including: o Training of customer service staff (both initial and ongoing); o Process for routing calls to appropriate persons, including escalation; The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity); o Process for handling calls from members with limited English proficiency and persons who are hearing impaired; o Monitoring process for ensuring the quality and accuracy of information provided to members; o Monitoring process for ensuring adherence to performance standards; o How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and o After hours procedures.	10		
Binder 5 Page 335	**R.2** Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2014 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the **abandonment** rate. **Affiliates should be included when determining the largest contract.**	5		

Binder 5 Page 337	**R.3** Describe the procedures a Member Services representative will follow to respond to the following situations: o A member has received a bill for payment of covered services from a network provider or out-of-network provider; o A member is unable to reach her PCP after normal business hours; o A Member is having difficulty scheduling an appointment/finding a specialist. o How do you explain to a member why a particular prescription is not covered?	10		
	Section S: Member Grievances and Appeals	**10**		
Binder 5 Page 339	**S.1** Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process, including your approach for meeting the general requirements and plan to: o Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal; o Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and o Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary. Include in the description how data resulting from the grievance system will be used to improve your operational performance.	10		

Page # of Response In Proposal	PART VI: MARKETING & MEMBER MATERIALS	Total Possible Points	Score	DHH Comments
	Section T: Marketing and Member Materials	**30**		
Binder 5 Page 349	**T.1** Describe proposed content for your member educational and marketing materials and attach examples used with Medicaid or CHIP populations in other states. Describe innovative ways that you have engaged in member education. Describe how you will provide equitable marketing throughout the state. Provide examples or descriptions of how your member education and marketing materials will be used to improve service coordination including: o The coordination of carved out and behavioral health services. o Supporting MCO efforts toward EPSDT compliance, appropriate ED utilization, STI education, encouraging the use of prenatal services and prematurity prevention o The use of technological tools, including social media and mobile technology, to engage members. o Partnering with community-based organizations for education and outreach.	20		
Binder 5 Page 369	**T.2** Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated. How will this information be available to members and the public?	2		
Binder 5 Page 373	**T.3** Describe how you will fulfill Internet presence and Web site requirements, as well as any social media components.	3		
Binder 5 Page 379	**T.4** Describe how you will ensure culturally-competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each, including description how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.	5		

Page # of Response In Proposal	PART VII: QUALITY MANAGEMENT	Total Possible Points	Score	DHH Comments
	Section U: Quality Management	**75**		
Binder 5 Page 389	**U.1** Declare whether or not the proposer submitted HEDIS measures in measurement year 2013. Indicate whether the measures were reported for a State Medicaid, CHIP, and/or Commercial product line. Five points will be awarded to proposers with this experience reporting HEDIS measures.	5		
Binder 5 Page 391 Attachment, Audit Review Tables CD, IDSS Reports	**U.2** Complete appendix WW, **HEDIS Scoring Tool** by submitting the Proposer's results for the HEDIS measures specified below for measurement year 2013, for each of your State Medicaid contracts **listed in response to E.1**. • Adults' Access to Preventive/Ambulatory Health Services • Comprehensive Diabetes Care- HgbA1C component • Chlamydia Screening in Women • Well-Child Visits in the 3,4,5,6 years of life • Adolescent well-Care. • Ambulatory Care - ER utilization • Childhood Immunization status • Breast Cancer Screening • Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents • Follow-Up Care for Children Prescribed ADHD Medication Include the Proposer's legal business name, as defined by L.R.S.12:23, AND the product line name or dba. If the average of seven or more measures for state Medicaid contracts is above the 2013 NCQA HMO National 50th Percentile for Medicaid Product Lines, ten points will be awarded. (continued on next page)	10		

	If the average of all measures for state Medicaid contracts is above the 2013 NCQA HMO National 25th Percentile for Medicaid Product Lines, five points will be awarded. No points will be awarded if all measures do not meet at least the 2013 NCQA HMO National 25th Percentile for Medicaid Product Lines. DHH Reserves the right to independently verify all information provided in Appendix WW.			
Binder 5 Page 395	**U.3** Document experience in other States or previous Louisiana Medicaid managed care experience Describe experience in using results of performance measures, member satisfaction surveys, and other data will be used to drive changes and to positively impact the healthcare status of Medicaid and or CHIP populations.. Provide an example of changes implemented as a result of data collection to improve the health outcomes of your membership in Louisiana or another state Medicaid program. Examples of areas of interest include, but are not limited to the following: • Management of high risk pregnancy • Management of HIV • Sickle cell disease management • Reductions in low birth weight babies • Pediatric Obesity (children under the age of 19) • Reduction of inappropriate utilization of emergent services • Children with special health care needs • Asthma • Diabetes • Cardiovascular diseases • Reduction in racial and ethnic health care disparities to improve health status • Hospital readmissions and avoidable hospitalizations • Reduction in incidence of sexually transmitted infections	20		

Binder 5 Page 417	**U.4** Submit a preliminary description of your Quality Assessment and Performance Improvement Program (QAPI), as described in Section 14.1 of the RFP. Such description should address the following. Proposers may submit information from another state Medicaid program showing proposed adaptations to be made for the Louisiana population.
	
	• Proposed membership of the QAPI Committee including roles and responsibilities
	• Proposed QAPI Work plan including a detailed descriptions of how the QAPI Committee will work with the MCO leadership to monitor quality improvement work, specifically:
	  o performance improvement projects;
	  o medical record audits;
	  o performance measures;
	  o Plan-Do-Study-Act cycles or continuous quality improvement activities;
	  o member and/or provider surveys; and
	  o activities that address health disparities identified through data collection.
	• Work the QAPI will undergo to improve the health care status of the Louisiana Medicaid population.
	• Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.
	• How the proposer will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner.
	• How the proposed QAPIs may include, but is not necessarily, limited to the following:
	  o New innovative programs and processes.
	  o Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics or other non-traditional health care settings.
		20		

Binder 5 Page 455	**U.5** Describe the process that will be utilized to develop the performance improvement projects (PIPs) identified in Appendix DD of the RFP. Include a preliminary plan for at least one (1) required PIP including the following: • The study question; • he study population; • The quantifiable measures to be used; • Baseline methodology; • Data sources; • Data collection methodology and plan; • Data collection plan and cycle;	20		

Page # of Response In Proposal	PART VIII: PROGRAM INTEGRITY	Total Possible Points	Score	DHH Comments
	Section V: Program Integrity	**60**		
Binder 5 Page 465	**V.1** Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Include other best practices, you have utilized in other contracts that could be ~~to~~ **utilized in this contract.**	50		
Binder 5 Page 481	**V.2** Provide a description your Corporate Program Integrity Division including the Program Integrity Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart D in your response) involved in compliance along with staff levels of authority.	10		

Page # of Response In Proposal	PART IX: SYSTEMS AND TECHNICAL REQUIREMENTS	Total Possible Points	Score	DHH Comments
	Section W: Information Systems	**65**		
Binder 5 Page 487	**W.1** Describe your approach for implementing a management information system in support of this RFP by identifying all information systems (those within and outside your span of control (for claims, clinical and accounting) through which service and utilization data for the La. Medicaid population is processed. Included a Louisiana Medicaid MCO-Program-specific work plan for system readiness and operations that captures: o All Key activities and timeframes, o Projected resource requirements, o Identify the number of dedicated or corporate full-time employees (FTEs) for implementing information systems in support of this contract, and o Provide the work location of the FTE's before, during and after implementation. The work plan should cover activities from ramp up, implementation and ongoing operations.	20		
Binder 5 Page 499	**W.2** Describe results of capability and capacity assessments performed of current systems to ensure they meet or exceed contract requirements. Describe upgrades or enhancements to existing systems needed to meet or exceed contract requirements. Additionally, if no upgrades are anticipated for this project, describe what and when major system changes/enhancements were last made.	10		
Binder 5 Page 505	**W.3** Describe how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. Your description should encompass information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major systems; and continuous testing of all applicable system functions.	10		

Binder 5 Page 523	**W.4** Provide a flow-chart (marked as Chart E) detailing your process for identifying, testing and implementing system changes, to include time frames associated with each step.	5		
Binder 5 Page 529	**W.5** Provide a flow-chart (marked as Chart F) detailing your process for receiving, processing and updating member enrollment, to include time frames associated with each step.	5		
Binder 5 Page 535	**W.6** Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates.	10		
Binder 5 Page 541	**W.7** Describe your plans to utilize ICD-10.	5		
	Section X: Claims Management	**35**		
Binder 5 Page 547	**X.1** Describe system capabilities and limitations of all requirements stated in Section 17.8 Encounter Data, and identify areas where change would be necessary based on requirements stated in the Systems Companion Guide. Identify any limitations or disparities to requirements stated in Section 17.2, 17.8, and 17.10. Describe system capabilities and limitations of all requirements stated in Section 17.10 Pharmacy Claims Processing and the NCPDP Guide located in the Systems Companion Guide. If you presently unable to meet a particular requirement contained in Section 17, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.	10		
Binder 5 Page 563	**X.2** Explain in detail your process for ensuring that all claims (paid, denied, adjustments and voids) are submitted to the Fiscal Intermediary timely and accurately.	10		

Binder 5 Page 579	**X.3** Describe your ability to provide and store encounter data in accordance with the requirements of the RFP and the Louisiana Medicaid specific requirements described in the Systems Companion Guide.	5		
Binder 5 Page 587	**X.4** Describe your methodology for ensuring that claims payment accuracy standards will be achieved. At a minimum address the following in your response: • The process for auditing a sample of claims as described in Section 17.5 Sampling of Paid Claims; • Documentation of the results of these audits; and The processes for implementing any necessary corrective actions resulting from the audit.	10		

Page # of Response In Proposal	PART X: ADDED VALUE TO LOUISIANA MEMBERS,PROVIDERS & EMPLOYEES	Total Possible Points	Score	DHH Comments
	Section Y: Value Added to Members	**100**		
Binder 5 Page 593	**Y.1** Provide a listing, description and conditions under which you will offer value added benefits as described in the RFP Section 6.1.3. The proposed monetary value of these benefits will be considered a binding contract deliverable. If for some reason, including but not limited to lack of member participation, the aggregated annual per member per month PMPM proposed is not expended the department reserves the right to require the MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended. For each value-added benefit proposed: o Define and describe the expanded benefit; o Identify the category or group of Members eligible to receive the expanded service if it is a type of service that is not appropriate for all Members; o Note any limitations or restrictions that apply to the expanded benefit o Identify the types of providers responsible for providing the expanded benefit, including any limitations on Provider capacity if applicable. o Propose how and when Providers and Members will be notified about the availability of such expanded benefits; and o Describe how a Member may obtain or access the Value-added Service; • Describe how, you will identify the expanded benefit in administrative data or encounter data. Indicate the PMPM actuarial value of expanded benefits assuming enrollment of 200,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information. (continued on next page)	100		

	The department will work with its contract actuary to independently review any statements of actuarial value. • Include a statement of commitment to provide the expanded benefits for the entire thirty six (36) month term of the initial contract.			

	Section Z: Value Added to Providers	**100**		
Binder 5 Page 609, Appendix PP, Attachment 1 to PP	**Z.1** Provide a listing, description and conditions under which you will offer value added incentives or enhanced payments to providers in accordance with Section 9.8 of the RFP. The proposed monetary value of these incentives and/or enhanced payments will be considered a binding contract deliverable. If for some reason, including but not limited to lack of provider participation or performance, the aggregated annual per member per month PMPM proposed is not expended the department reserves the right to require the MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended. For each value-added incentive proposed: o Define and describe the provider incentives or expanded payments and associated measures of performance; o If not applicable to all providers; identify the category or group of providers eligible to participated in the incentive or receive enhanced payments; o Note any limitations or restrictions that apply to the incentives or enhanced payments; o Describe how and when Providers and Members will be notified about the availability of such expanded benefits; and o Describe how provider input and feedback will be used to realign incentives as appropriate. (continued on next page)	100		

	• Describe how you will identify the associated payments in administrative data or encounter data. • Indicate the PMPM actuarial value of the proposed provider incentives based on an enrollment of 250,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information. The department will work with its contract actuary to independently verify any statements of actuarial value. • Include a statement of commitment to provide the expanded benefits for the entire thirty six (36) month term of the initial contract. **Appendix PP must be submitted as part of the proposal.**			
	Section AA: Value Added to Louisiana Employees	**25**		
Binder 5 Page 625	**AA.1** Describe the workplace wellness program and employee incentives you will have in place for your Louisiana-based employees within 3 months from the effective date of the contract. Include incentives for participation. Program components, and expected results. The proposed annual monetary expenditure for this program and will be considered a binding contract deliverable. If for some reason, including but not limited to lack of employee participation, the proposed annual expenditure is not expended the department reserves the right to require the MCO to provide an alternate employee wellness benefit of equal value and/or may conduct a reconciliation for the amount unexpended. For each value-added incentive proposed: o Define and describe the wellness program/employee incentives and associated measures of performance; o If not applicable to all employees; identify the category or group of ~~providers~~ **employees** eligible **(continued on next page)**	25		

	to participate~~d~~ in the incentive or receive enhanced payments; ~~(continued on next page)~~ o Note any limitations or restrictions that apply to **the wellness benefits/**incentives ~~or enhanced payments~~; o Describe how and when employees will be notified about the availability of such programs/incentives; and o Describe how employee input and feedback will be used to realign incentives as appropriate. • Describe how you will identify the associated payments in administrative data, ~~or encounter data.~~ • Indicate the total annual expenditures proposed for each of the three (3) contract years. Include a statement of commitment to provide these expenditures for this purpose for the entire thirty six (36) month term of the initial contract.			

Page # of Response In Proposal	PART XI: VETERAN INITIATIVE AND HUDSON INITIATIVE	Total Possible Points	Score	DHH Comments
Binder 5 Page 633 **Binder 6 Page 1**	**BB.1** ~~Provide your organization's bond rating. Include your organization's parent organization, affiliates, and subsidiaries in this response.~~ If applicable, provide documentation that the proposer **(including parent organization, affiliates, and subsidiaries)** and/or its subcontractor has been certified by the Louisiana Department of Economic Development as a: • Veteran-Owned, • Service- Connected Disabled Veteran-Owned small entrepreneurship (LaVet), or • Louisiana Initiative for Small Entrepreneurships (Hudson Initiative). If a proposer is not a certified small entrepreneurship as described herein, but plans to use certified small entrepreneurship(s), proposer shall include in their proposal the names of their certified Veteran Initiative or Hudson Initiative small entrepreneurship subcontractor(s), a description of the work each will perform, and the dollar value of each subcontract.	100		

AmeriHealth Caritas Louisiana

A.1. Mandatory Requirements

A.1. Provide the Proposal Certification Statement (RFP Appendix # A) completed and signed, in the space provided, by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract. The Proposer must sign the Proposal Certification Statement without exception or qualification.

The completed and signed Proposal Certification Statement can be found in Appendix A.

This page intentionally left blank.

AmeriHealth Caritas Louisiana

A.2. Mandatory Requirements

A.2. Provide a statement signed by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract guaranteeing that there will be no conflict or violation of the Ethics Code if the Proposer is awarded a contract. Ethics issues are interpreted by the Louisiana Board of Ethics. (See Section 22.4 of the RFP.)

The Louisiana Ethics Code Guarantee can be found in Attachment A.2-A.

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AmeriHealth Caritas Louisiana

A.3. Mandatory Requirements

A.3. Provide documentation showing that the Proposer has acquired a certificate of authority (COA) from the Louisiana Department of Insurance to establish and operate a MCO as defined in RS 22:1016 and in accordance with rules and regulations as defined by the Department of Health and Hospitals. (See Section 2.1.1.2 of the RFP.)

Overview

ACLA has a certificate of authority (COA) to establish and operate a prepaid entity as defined in RS 22:1016 and in accordance with the rules and regulations as defined by the Department of Health and Hospitals. See Attachment for updated COA at the end of this section.

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AmeriHealth Caritas Louisiana

A.4. Mandatory Requirements

A.4. Provide either a statement of attestation that the Proposer has no moral or religious objections to providing any core benefits or services described in Section 6 of the RFP; or

Submit a statement of any moral and religious objections to providing any core benefits or services described in Section 6 of the RFP. Describe, in as much detail as possible, all direct and related services that are objectionable.

Provide a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc. If none, so state.

(See Section 2.4.3 of the RFP.)

ACLA has no moral or religious objections to providing any core benefits or services described in Section 6 of the RFP, as defined in the Louisiana Medicaid State Plan, administrative rules, and DHH policy and procedure manuals. No codes are objectionable or eliminated from the services we provide.

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CERTIFICATION STATEMENT

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

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

Date	September 5, 2014
Official Contact Name	Rebecca Engelman
Email Address	Rengelman@amerihealthcaritala.com
Fax Number with Area Code	225.300.9209
Telephone Number	225.300.9202
Street Address	10000 Perkins Rowe, Block G- 4th Floor
City, State, and Zip	Baton Rouge 70810

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

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

1. The information contained in its response to this RFP is accurate;
2. Proposer complies with each of the mandatory requirements listed in the RFP and will meet or exceed the functional and technical requirements specified therein;.
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer's technical and cost proposals are valid for at least 120 days from the date of proposer's signature below;
5. Proposer understands that if selected as the successful Proposer, he/she will have 10 calendar days from the date of delivery of initial contract in which to complete contract negotiations, if any, and execute the final contract document. The Department has the option to waive this deadline if actions or inactions by the Department cause the delay.
6. Proposer certifies, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the internet at https://www.sam.gov).

Authorized Signature: J Michael Jernigan

Original Signature Only: Electronic or Photocopy Signature are NOT Allowed

Print Name: J. Michael Jernigan

Title: AmeriHealth Caritas Regional President – Southern Division

AmeriHealth Caritas
Louisiana

LOUISIANA ETHICS CODE GUARANTEE

Undersigned, AmeriHealth Caritas of Louisiana, hereby guarantees that there will be no conflict or violation of the Louisiana Ethics Code if AmeriHealth Caritas of Louisiana is awarded a contract pursuant to RFP #305PUR-DHHRFP-BH-MCO-2014. AmeriHealth Caritas of Louisiana acknowledges and understands that ethics issues are interpreted by the Louisiana Board of Ethics.

Dated this 12th day of September, 2014

J Michael Jernigan

Signature Date

J Michael Jernigan

Print Name

President

Title

State of Louisiana

JAMES J. DONELON

COMMISSIONER OF INSURANCE

I, THE UNDERSIGNED COMMISSIONER OF INSURANCE OF THE STATE OF LOUISIANA,

DO HEREBY CERTIFY THAT

AmeriHealth Caritas Louisiana, Inc.

has complied with all requirements and is hereby licensed to act as a

HEALTH MAINTENACE ORGANIZATION

in the State of Louisiana
This license shall remain in effect until canceled, suspended, revoked.

Restriction: This license is issued solely for participation in Coordinated Care Network Program

Given Under my signature, authenticated with the impress of my Seal of office, at the City of Baton Rouge, this, 21st day of June A.D. 2013

James J. Donelon
Commissioner of Insurance

COPY

Appendix VV

AmeriHealth Caritas Louisiana

Reference Material for

Louisiana Medicaid Ownership Disclosure Information

For an Entity/Business

The following 173 pages have been redacted due to confidential information.

AmeriHealth Caritas Louisiana

B.1. Financial Stability

B.1 Provide the following as documentation of the Proposer's and parent corporation's sufficient financial strength and resources to provide the scope of services as required:

- *Three years of independently audited financial statements and associated enrollment figures from the Proposer. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be:*
  - *Prepared with all monetary amounts detailed in U.S. currency;*
  - *Prepared under U.S. generally accepted accounting principles; and*
  - *Audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor's opinion letter, financial statements, and the notes to the financial statements.*
- *The Proposer's four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to- Date), with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows.*
- *Verification of any contributions made to the Proposer to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable.*
- *Proposer shall include the Proposer's parent organization.*

Provide the following information (in Excel format) based on each of the financial statements submitted: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

[redacted]

CONFIDENTIAL [redacted]

[redacted]

CONFIDENTIAL

CONFIDENTIAL

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B.2. Financial Stability

B.2. Provide your last three (3) statements containing your Risk Based Capital Ratio as prepared in accordance with instructions published by the National Association of Insurance Commissioners (NAIC). Include for both the proposing entity and the parent organization if applicable.

Overview

AmeriHealth Caritas Louisiana, Inc. (ACLA) is a Louisiana for-profit business corporation licensed as a Louisiana health maintenance organization. ACLA is a wholly-owned subsidiary of AmeriHealth Caritas Health Plan (ACHP), a Pennsylvania general partnership. ACHP is owned through wholly-owned subsidiaries by BMH, LLC, which is doing business as the AmeriHealth Caritas Family of Companies (ACFC). Blue Cross Blue Shield of Michigan is a minority owner of ACFC and an indirect minority owner of ACLA. IBC MH, LLC is the majority owner of ACFC. IBC MH, LLC is owned through subsidiaries by Independence Health Group, Inc. (IHG, Inc.). IHG, Inc. is a non-profit Pennsylvania holding company and, effective July 1, 2014, an ultimate parent organization of ACLA.

As part of a restructuring of the insurance company holding system of Independence Blue Cross (IBC), ACLA's former ultimate parent organization, IBC became a controlled affiliate of IHG, Inc., effective July 1, 2014, and IHG, Inc. became the ultimate controlling party of the restructured insurance company holding system. Since IHG, Inc. is a recently organized company which did not exist prior to July 1, 2014, we are including the financial statements for Independence Blue Cross.

Risk Based Capital Ratio – ACLA

ACLA's Risk Based Capital Ratio for the last three years, 2011, 2012, and 2013, can be found at the end of this section.

Risk Based Capital Ratio – BMH, LLC.

BMH, LLC, is not a regulated entity and is not subject to the RBC requirements. Therefore, the Risk Based Capital Ratio is not applicable to BMH, LLC.

Risk Based Capital Ratio – Independence Blue Cross, Inc.

ACLA's ultimate parent organization Independence Blue Cross' Risk Based Capital Ratio for the last three years, 2011, 2012, and 2013, can be found at the end of this section.

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AmeriHealth Caritas Louisiana

B.3. Financial Stability

B.3 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from AM Best Company.

Not Applicable. As privately held company, ACLA, has not been rated by AM Best Company.

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B.4. Financial Stability

B.4 Provide a statement of whether or not, in the last ten (10) years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation that includes relevant details, including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent organization, affiliates, and subsidiaries in this response.

Overview

ACLA, and its parent organization, affiliates, and subsidiaries, have not, within the last 10 years, filed (or had filed against them) any bankruptcy or insolvency proceeding, whether voluntary or involuntary. Additionally, ACLA, and its parent organization, affiliates, and subsidiaries have not undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.

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B.5. Financial Stability

B.5 Provide the following as documentation of financial responsibility and stability:

- *a current written bank reference, in the form of a letter, indicating that the Proposer's business relationship with the financial institution is in positive standing;*
- *two current written, positive credit references, in the form of a letters, from vendors with which the Proposer has done business or, documentation of a credit rating determined by an accredited credit bureau within the last 6 months; and (continued on next page)*
- *a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate.*

Overview

ACLA has included documentation supporting the financial responsibility and stability of our organization at the end of this section.

Bank Reference

ACLA has a current bank reference from Regions Morgan Keegan Trust which states that ACLA's banking relationship is in positive standing. A copy of such bank references can be found at the end of this section.

Credit References

ACLA has provided two current, written, positive credit references from vendors with which ACLA has done business. Copies of such credit references can be found at the end of this section.

- Corp. Business Supplies
- Emprint

Valid Certificate of Insurance

ACLA has comprehensive general liability coverage in the amount of $1,000,000 per occurrence and $3,000,000 in the aggregate. A copy of such valid certificate of insurance can be found at the end of this section.

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Table of Financial Measures

The following 1 page has been redacted due to confidential information.

BMH LLC AND SUBSIDIARIES

Consolidated Financial Statements

December 31, 2011

(With Independent Auditors' Report Thereon)

40 pages have been redacted due to confidential information.

BMH LLC AND SUBSIDIARIES

Consolidated Financial Statements

December 31, 2012 and 2011

(With Independent Auditors' Report Thereon)

52 pages have been redacted due to confidential information.

BMH LLC AND SUBSIDIARIES

Consolidated Financial Statements

December 31, 2013 and 2012

(With Independent Auditors' Report Thereon)

56 pages have been redacted due to confidential information.

AMERIHEALTH CARITAS LOUISIANA, INC.

Statutory Financial Statements

December 31, 2013 and 2012

(With Independent Auditors' Report Thereon)

29 pages have been redacted due to confidential information.

Independence Blue

Cross and Subsidiaries

Consolidated Financial Statements as of and for the

Years Ended December 31, 2012 and 2011, and

Independent Auditors' Report

54 pages have been redacted due to confidential information.

Independence Blue

Cross and Subsidiaries

Consolidated Financial Statements as of and for the

Years Ended December 31, 2013 and 2012, and

Independent Auditors' Report

54 pages have been redacted due to confidential information.

AmeriHealth Caritas Louisiana, Inc.

Balance Sheet

(in thousands)

(unaudited)

Assets-September 30, 2013

5 pages have been redacted due to confidential information.

AmeriHealth Caritas Louisiana, Inc.

Balance Sheet

(in thousands)

(unaudited)

Assets-December 31, 2013

5 pages have been redacted due to confidential information.

AmeriHealth Caritas Louisiana, Inc.

Balance Sheet

(in thousands)

(unaudited)

Assets-March 31, 2014

3 pages have been redacted due to confidential information.

AmeriHealth Caritas Louisiana, Inc.

Balance Sheet

(in thousands)

(unaudited)

Assets-June 30, 2014

5 pages have been redacted due to confidential information.

ANNUAL STATEMENT

OF THE

Independence Blue Cross

Balance Sheet

of

Philadelphia

in the STATE of

Pennsylvania

TO THE

Insurance Department

OF THE

STATE OF Pennsylvania

FOR THE YEAR ENDED

SEPTEMBER 30, 2013

43 pages have been redacted due to confidential information.

ANNUAL STATEMENT

OF THE

Independence Blue Cross

Balance Sheet

of

Philadelphia

in the STATE of

Pennsylvania

TO THE

Insurance Department

OF THE

STATE OF Pennsylvania

FOR THE YEAR ENDED

DECEMBER 31, 2013

121 pages have been redacted due to confidential information.

QUARTERLY STATEMENT

OF THE

Independence Blue Cross

Balance Sheet

of

Philadelphia

in the STATE of

Pennsylvania

TO THE

INSURANCE DEPARTMENT

OF THE

STATE OF Pennsylvania

FOR THE YEAR ENDED

MARCH 31, 2014

46 pages have been redacted due to confidential information.

Quarterly Statement

OF THE

Independence Blue Cross

OF

Philadelphia

IN THE STATE OF

Pennsylvania

TO THE

INSURANCE DEPARTMENT

OF THE

STATE OF Pennsylvania

AS OF

JUNE 30, 2014

2014

The following 44 pages have been redacted due to confidential information.

BMH LLC and Subsidiaries

Consolidated Financial Statements

September 30, 2013 and 2012

The following 9 pages have been redacted due to confidential information.

BMH LLC and Subsidiaries

Consolidated Financial Statements

December 31, 2013 and 2012

The following 9 pages have been redacted due to confidential information.

BMH LLC and Subsidiaries

Consolidated Financial Statements

March 31, 2014 and 2013

The following 6 pages have been redacted due to confidential information.

BMH LLC and Subsidiaries

Consolidated Financial Statements

June 30, 2014 and 2013

The following 9 pages have been redacted due to confidential information.

ACLA RBC Ratio , 2011- 2013

Comparison of Total Adjusted Capital to Risk-Based Capital

The following 3 pages have been redacted due to confidential information.

2011 Q4 Independence Blue Cross Risk-Based Capital

For the Year Ending December 31, 2011

The following 38 pages have been redacted due to confidential information.

2012 Q4 Independence Blue Cross Risk-Based Capital

For the Year Ending December 31, 2012

The following 38 pages have been redacted due to confidential information.

2013 Q4 Independence Blue Cross Risk-Based Capital

For the Year Ending December 31, 2013

The following 37 pages have been redacted due to confidential information.

REGIONS

July 3, 2014

To Whom It May Concern:

Reference: AmeriHealth Caritas of Louisiana, Inc.

This letter will serve as acknowledgement of the safekeeping and depository relationship Regions Bank and Regions Bank Institutional Trust Division maintains with AmeriHealth Caritas of Louisiana, Inc. AmeriHealth Caritas of Louisiana, Inc. is a client of positive standing in all aspects of the relationship.

Thank you.

Sincerely,

Anita Coyle /rem

Anita Coyle
Sr. Vice President
Commercial Banking

400 Convention St., Ste. 900
Baton Rouge, LA 70802

CORPORATE BUSINESS SUPPLIES INC

June 10, 2014

To whom it may concern,

I'm writing this letter as endorsement for AmeriHealth Caritas Louisiana. They are a wonderful company to work for and to work with. Years ago, a decision was made to open an office in Louisiana. They had a goal to with work with minority vendors as much as possible for this office. My company, Corporate Business Supplies, Inc., installed all of the panel systems (cubicle), business and reception furniture, and all other items needed to complete the finished office suite. The staff was very helpful and easy to work with, and invoices were always paid promptly. Since the initial furniture installation, we've been called back many times for systems reconfigurations and additional furniture sales, and I've always had the same great experience. Additionally, AmeriHealth Caritas Louisiana is a great community partner to the state, having sponsored the building of playgrounds in New Orleans, Baton Rouge, and elsewhere without the state. The have a clear commitment to giving back in the community that is bolstered with clear action. I always enjoy working with them and look to continuing our strong business relationship. I'm happy to provide any additional information if asked. Thank you.

Sincerely,

Alfonso Gonzalez II

Alfonso Gonzalez II
President

Emprint®

A Division of Moran Printing, Inc.

July 10, 2014

To Whom it May Concern

RE: Letter of Reference for AmeriHealth Caritas Louisiana

More than one hundred and thirty years ago, the company that was to become Emprint opened its doors to its first customers. The company was founded on the principle that a business's success should be measured by its customers' success. It is that principal that has guided Emprint from a simple, 19th century print shop all the way to the modern, technically-driven, 21st century company that Emprint is today.

Over the years we have successfully expanded our business throughout the United States and vastly increased the services we offer. Known for the wide array of printing related services, Emprint currently boasts many well-known local and national clients. We most recently were awarded the Louisiana Economic Development Lantern Award for the Capital Region of Louisiana. Recipients of these awards are selected based on their contributions over a period of time to the betterment of their communities, growth in the number of employees and expansion of their facilities. The contributions of the Lantern Award winners are helping position Louisiana as the best state for business investment and job creation.

We believe that our diversity and proven track record contributed to AmeriHealth Caritas Louisiana's decision to engage in a partnership to provide print and fulfillment services in Louisiana. When they entered the market and needed a strong partner to get their materials to their new members, we put together a project team with members of both companies. It became clear early on that AmeriHealth Caritas Louisiana had a quality team, dedicated to serving their members. They are focused on on-time responses, excellent customer care, and provide excellent communication tools to help their members in the enrollment and service processes. They have demonstrated a professional, organized and knowledgeable team serving the healthcare needs of our State.

We also are keenly aware of t their commitment to the communities in which they serve. Emprint worked side by side with team members from all over the country from AmeriHealth Caritas Louisiana to build a playground at one of the inner cities schools. This experiences exemplifies both companies' commitment to the community they serve. The work day also provided an excellent opportunity to further strenghten the partnership aspect of the relationship. I am pleased to offer the highest recommendation of AmeriHealth Caritas Louisiana as a quality healthcare provider and quality corporate citizen. We continued to be honored to be their partner in Louisiana.

Sincerely,

Rebecca Vance

Rebecca Vance

President

225.923.2550 p ■ 225.923.1078 f ■ 800.211.8335 tf ■ 5425 Florida Boulevard ■ Baton Rouge, Louisiana 70806 ■ www.emprint.com

STIRLING PROPERTIES

10202 Perkins Rowe, Suite 195, Baton Rouge, LA 225-329-0285

July 11, 2014

To Whom it may Concern:

Re: Letter of Reference for AmeriHealth Caritas Louisiana

AmeriHealth Caritas Louisiana has been a tenant in good standing here at Perkins Rowe since 2011 with the commencement of their Office Lease showing their commitment to Louisiana.

During their tenure here at Perkins Rowe in Baton Rouge they have been a good partner with both the Ownership and Management entities over this complex. Since the beginning of their lease they have maintained a professional atmosphere not only within their demised office space but with a positive presence in the entire office tower. As with any Office Complex there are many challenges that occur throughout the year and they have always been helpful and cooperative no matter what the situation offering a professionalism that is contagious to other tenants.

Recently they have offered assistance in rolling out new safety / tenant co-op meetings graciously offering to host the meetings in their conference room. As the Manager of a large complex this type of support, cooperation and leadership from a tenant is a strong catalyst to helping maintain a strong business environment in any building with the entire tenant base.

I would recommend their services to anyone looking at Amerihealth as they truly understand the value of partnering with others for the true success of the local, state and Regional business community.

We are happy to have them as a tenant and partner in our success.

Sincerely,

Bill Pietri, CPM®
General Manager
Perkins Rowe – Stirling Properties

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 09/11/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Marsh USA Inc.
1717 Arch Street
Philadelphia, PA 19103-2797
Attn: healthcare.accountscss@marsh.com Fax: 212-948-1307

349741-w/pro-CAS-13-14

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Federal Insurance Company	20281
INSURER B : N/A	N/A
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
AMERIHEALTH CARITAS LOUISIANA, INC.
10000 PERKINS ROWE, SUITE 195
BATON ROUGE, LA 70810

COVERAGES **CERTIFICATE NUMBER:** CLE-004139819-02 **REVISION NUMBER:** 4

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS		
	GENERAL LIABILITY								
A	X COMMERCIAL GENERAL LIABILITY			35917631	11/30/2013	11/30/2014	EACH OCCURRENCE	$	1,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$	1,000,000
							MED EXP (Any one person)	$	10,000
							PERSONAL & ADV INJURY	$	1,000,000
							GENERAL AGGREGATE	$	2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$	INCLUDED
	POLICY PRO-JECT X LOC							$	
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$	
	ANY AUTO						BODILY INJURY (Per person)	$	
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$	
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$	
								$	
A	X UMBRELLA LIAB X OCCUR			71727744	11/30/2013	11/30/2014	EACH OCCURRENCE	$	3,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$	3,000,000
	DED RETENTION $							$	
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						WC STATU-TORY LIMITS / OTH-ER		
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$	
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$	
							E.L. DISEASE - POLICY LIMIT	$	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER

LOUISIANA DEPARTMENT
OF HEALTH AND HOSPITALS
628 NORTH 4TH STREET
BATON ROUGE, LA 70802

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Manashi Mukherjee Manashi Mukherjee

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AmeriHealth Caritas Louisiana

C.1. Publicly Traded Organizations

C.1 Submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report. Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. Include your organization's parent organization, affiliates, and subsidiaries in this response.

Overview

AmeriHealth Caritas Louisiana (ACLA) and its parent organization, affiliates, and subsidiaries are not publicly traded; therefore, this question is not applicable.

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AmeriHealth Caritas Louisiana

C.2. Publicly Traded Organizations

C.2 Provide your organization's bond rating for the current year and each of the past three years. Include your organization's parent organization, affiliates, and subsidiaries in this response.

Overview

ACLA and its parent organization, affiliates, and subsidiaries are not publicly traded; therefore, this question is not applicable.

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AmeriHealth Caritas Louisiana

D.1. Privately Owned Organizations

D.1 Provide your organization's credit rating for the current year and each of the past three years. Include your organization's parent organization, affiliates, and subsidiaries in this response.

ACLA has never had a credit rating process completed.

Independence Blue Cross credit rating is not available.

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AmeriHealth Caritas Louisiana

E.1. Qualifications and Experience

E.1 Provide a listing of, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years (including your parent organization, affiliates, and subsidiaries); or

If your organization has not had any publicly-funded managed care contracts for Medicaid/CHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years.

The listing of contracts should be provided in a table format. For each contract identified, provide each of the following items as a column in the table: the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any.

Overview

The AmeriHealth Caritas Family of Companies (ACFC) comprises one of the largest organizations of government-funded managed care and administrative services entities in the United States, serving more than 6 million lives throughout 16 states and the District of Columbia (D.C.). These programs include Medicaid risk and non-risk programs, non-risk Medicaid Behavioral Health contracts, Children's Health Insurance Programs (CHIP), and pharmacy benefit management services.

Publicly Funded Managed Care Contracts

The tables below list affiliated publicly funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five years. Contracts that did not meet these criteria have not been included.

Unless otherwise indicated, the following assumptions were used:

- Membership numbers are from July 2014
- Annual contract amounts are from January through December 2013.

Parent

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
Independence Blue Cross (IBC) – Keystone Health Plan East (KHPE)						**Pennsylvania**
More than 25,000	Children's Health Insurance Program (CHIP)-No cost, low cost and full cost plans	2013 to present	CHIP (Ages 0-18 years)	Capitated	John Mancano Director Special Programs 215-241-3023	Behavioral health Pharmacy Vision Dental

AmeriHealth Caritas Louisiana

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
AmeriHealth Caritas Louisiana						**Louisiana**
More than 140,000	Primary care, specialists, FQHC, and nurse practitioner services; emergency, ambulatory, and ASU services; inpatient and outpatient services; labs & x-rays; pharmacy; DME, prosthetics, and orthotics; dental & vision services; home health services; rehab & therapy services; pregnancy & EPSDT services; ESRD support; transportation; family planning	2012 to Present	Medicaid Managed Care SSI FITAP (TANF) HCBS Waiver population Foster children Breast & Cervical Cancer LaCHIP (LAP)	Capitated $461.6M	Rebecca Engelman Executive Director 225-300-9202	Pharmacy Non-emergency medical transportation (NEMT) Dental Vision Over the counter Radiology 24 hour nurse line

Medicaid and CHIP Affiliates

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
Keystone First						**Pennsylvania**
More than 290,000	Primary care and specialist visits; emergency care; DME and medical supplies; EPSDT services; nursing facility services; home health care; inpatient services; labs and x-rays; ob/gyn services; pharmacy; occupational, speech, and physical therapy; rehab services; renal dialysis; dental and vision care; translation and interpretive services; smoking cessation; fitness incentives	1996 to Present	Medicaid Managed Care (Health Choices Program) SSI with & without Medicare TANF State and Fed GA & Medically Needy	Capitated $2,025M	Russ Gianforcaro, Executive Director 215-863-5612	Vision Pharmacy Radiology Dental 24/7 nurse hotline
First Choice by Select Health						**South Carolina**
More than 345,000	Adult well visits and primary care visits; well-child/EPSDT visits; chiropractic care; communicable disease services; DME; home health care; inpatient services; labs and x-rays; emergency services; maternity services; pharmacy; mental health, emotional health, psychiatric, and SUD services; occupational, speech, and physical therapy; outpatient services; specialist visits; vision care; translation & interpretive services; Pulmonary Rehab; Cardiac Rehab; IP/OP hospital services; skilled nursing facility; initial long term care placement; pain management; family planning; ambulance	1996 to Present	Medicaid Managed Care SSI without Medicare TANF OCWI CHIP Foster children	Capitated $1,100M	Cindy Helling, Executive Director 843-569-4620	Pharmacy Radiology Dental

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
AmeriHealth Caritas Pennsylvania						**Pennsylvania**
More than 129,000	Primary care visits; chiropractic services; durable medical equipment; emergency services; EPSDT services; family planning; home health care; inpatient services; labs and x-rays; nursing facility services; ob/gyn services; pharmacy; physical, speech, and occupational therapy; specialist visits; dental and vision care; translation and interpretive services; smoking cessation assistance	1997 to Present	Medicaid Managed Care (Health Choices Program) SSI with & without Medicare TANF State and Fed GA & Medically Needy	Capitated $611M	Margaret C. Angello, RN Executive Director 717-651-3551	24/7Nurse Call Line Vision Dental Radiology Pharmacy
AmeriHealth District of Columbia						**District of Columbia**
More than 110,000	Primary care, preventive, and specialist services; labs & x-rays; hospital services; nursing home & hospice care; pharmacy; emergency services; family planning services; rehab & therapy services; podiatry; DME/DMS & prosthetics; vision, dental, and hearing services; mental health services; home health services; personal care services; transportation	2013 to Present	Medicaid Managed Care TANF CHIP Previously uninsured adults	Capitated $255M (8-month period ending 12/31/2013)	Karen Dale, Executive Director 202- 326-8741	Pharmacy Non-emergent transportation 24/7 nurse line Vision Dental Prescription benefit program Radiology TPL and recovery services.

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
AmeriHealth Northeast						**Pennsylvania**
More than 57,000	Primary care visits; chiropractic services; durable medical equipment; emergency services; EPSDT services; family planning; home health care; inpatient services; labs and x-rays; nursing facility services; ob/gyn services; pharmacy; physical, speech, and occupational therapy; specialist visits; dental and vision care; translation and interpretive services; transportation; smoking cessation assistance	1997 to Present	Medicaid Managed Care (Health Choices Program) SSI with & without Medicare TANF State and Fed GA & Medically Needy	Capitated $250M	Margaret C. Angello, RN Executive Director 717-651-3551	Pharmacy 24/7 nurse line Vision Dental Radiology
MDwise Hoosier Alliance						**Indiana**
More than 127,000	Primary, preventive, and specialty care; inpatient & outpatient services; prenatal care; labs and x-rays; pharmacy; DME; home health care; renal dialysis; hearing aids & prosthetic devices; immunizations; physical, speech, and occupational therapy; smoking cessation; transportation	2014 to Present	Medicaid Managed Care & Healthy Indiana Uninsured Program TANF CHIP State and Fed GA & Medically Needy Previously uninsured adults	Capitated $243.9M	Greg Yust Executive Director 317-238-8909	Behavioral Health

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
Arbor Health Plan						**Nebraska**
More than 22,000	Primary care, specialist, FQHC & RHC services; hospital services; labs & x-rays; pregnancy & EPSDT services; home health and private duty nursing services; physical, occupational, and speech therapy; DME & medical supplies; podiatry services; chiropractic services; vision care; emergency transportation	2012 to Present	Medicaid Managed Care SSI TANF CHIP State and Fed GA & Medically Needy	Capitated $65M	Tom Smith Executive Director 402-507-5995	Vision 24/7 nurse hotline Radiology
Florida True Health						**Florida**
More than 7,000	Adult well visits; primary care & specialist visits; behavioral health services; EPSDT; DME; labs & x-rays; dental, hearing, and eye care; family planning, well-woman, and maternity services; home health care; hospital services; chiropractic services; pharmacy; physical & respiratory therapy; emergency services & transportation	2012 to Present	Medicaid Managed Care SSI TANF	Capitated $10.5M	Dwight D. Chenette Regional President 561-282-4330	PBM/ Pharmacy Behavioral Health DME/ Home Health Nurse Line Dental

Behavioral Health Contracts

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
Capital Area Behavioral Health Collaborative						**Pennsylvania**
More than 149,000	Psychiatric outpatient services; psychiatric partial hospitalization programs; psychiatric hospitalization; targeted case management; crisis intervention services; clozapine (clozaril) support services; outpatient drug and alcohol services; methadone; drug and alcohol detoxification, rehabilitation, and halfway house services; behavioral health rehabilitation services for children and adolescents; family based mental health services; residential treatment facilities	2001 to Present	Medicaid Managed Care (Health Choices Program) SSI with & without Medicare TANF State and Fed GA & Medically Needy	Capitated $15M	Jim Laughman Executive Director 717-909-2171	Appeals

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
Behavioral Health Services of Somerset and Bedford Counties, Inc.						**Pennsylvania**
More than 17,000	Psychiatric outpatient services; psychiatric partial hospitalization programs; psychiatric hospitalization; targeted case management; crisis intervention services; clozapine (clozaril) support services; outpatient drug and alcohol services; methadone; drug and alcohol detoxification, rehabilitation, and halfway house services; behavioral health rehabilitation services for children and adolescents; family based mental health services; residential treatment facilities	2007 to Present	Medicaid Managed Care (Health Choices Program) SSI with & without Medicare TANF State and Fed GA & Medically Needy	Capitated $21.6M	Jim Laughman Executive Director 717-909-2171	Appeals

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
Central PA Behavioral Health Collaborative, Inc.						**Pennsylvania**
More than 22,000 (at 6/2013)	Psychiatric outpatient services; psychiatric partial hospitalization programs; psychiatric hospitalization; targeted case management; crisis intervention services; clozapine (clozaril) support services; outpatient drug and alcohol services; methadone; drug and alcohol detoxification, rehabilitation, and halfway house services; behavioral health rehabilitation services for children and adolescents; family based mental health services; residential treatment facilities	2007 to 2013	Medicaid Managed Care (Health Choices Program) SSI with & without Medicare TANF State and Fed GA & Medically Needy	Capitated $14.3M (1/2013 to 6/2013)	Jim Laughman Executive Director 717-909-2171	Appeals

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
Lycoming Clinton Joinder Board						**Pennsylvania**
More than 22,000 (at 6/2013)	Psychiatric outpatient services; psychiatric partial hospitalization programs; psychiatric hospitalization; targeted case management; crisis intervention services; clozapine (clozaril) support services; outpatient drug and alcohol services; methadone; drug and alcohol detoxification, rehabilitation, and halfway house services; behavioral health rehabilitation services for children and adolescents; family based mental health services; residential treatment facilities	2007 to 2013	Medicaid Managed Care (Health Choices Program) SSI with & without Medicare TANF State and Fed GA & Medically Needy	Capitated $12.3M (1/2013 to 6/2013)	Jim Laughman Executive Director 717-909-2171	Appeals

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
Tuscarora Managed Care Alliance						**Pennsylvania**
More than 20,000	Psychiatric outpatient services; psychiatric partial hospitalization programs; psychiatric hospitalization; targeted case management; crisis intervention services; clozapine (clozaril) support services; outpatient drug and alcohol services; methadone; drug and alcohol detoxification, rehabilitation, and halfway house services; behavioral health rehabilitation services for children and adolescents; family based mental health services; residential treatment facilities	2007 to present	Medicaid Managed Care (Health Choices Program) SSI with & without Medicare TANF State and Fed GA & Medically Needy	Capitated $2M	Jim Laughman Executive Director 717-909-2171	Appeals
Gateway						**Pennsylvania**
More than 30,000 (at 12/2012)	Initial member inquiries regarding covered behavioral health services or providers; crisis intervention services on a 24 hr/7 day a week basis; provider network management; credentialing and re-credentialing; utilization management; quality improvement; reporting	2005 to 2012	Dually Eligible for Medicaid and Medicare Benefits	Sub-capitated Behavioral Health Administrative Services Agreement $1.2M (1/2012 to 12/2012)	Jim Laughman Executive Director 717-909-2171	Appeals

Medicare Advantage D-SNP

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
Keystone VIP Choice						Pennsylvania
More than 1,700	Ambulance, Chiropractic Care, Dental Services, Diabetes Supplies and Services, Diagnostic Tests, Lab and Radiology Services, and X-Rays, Doctor's Office Visits, Durable Medical Equipment, Emergency Care, Foot Care, Hearing Services, Home Health Care, Mental Health Care, Outpatient Rehabilitation, Outpatient Substance Abuse, Outpatient Surgery, Over-the-Counter Items, Prosthetic Devices, Renal Dialysis, Transportation, Urgent Care, Vision Services, Preventive Care, Preventive Care, Hospice, Inpatient Hospital Care, Inpatient Mental Health Care, Skilled Nursing Facility, Part D drugs	2013 to Present	Enrollees must be eligible for Medicare and Medicaid	Capitated $5.45M (2013) $16.73M (YTD 2014)	Nathan Hui VP Medicare Advantage 215-937-7237	Over the Counter Non-Emergent Medical Transportation Dental Nurse Call Line Vision Hearing Laboratory

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
AmeriHealth VIP Care						**Pennsylvania**
More than 80	Ambulance, Chiropractic Care, Dental Services, Diabetes Supplies and Services, Diagnostic Tests, Lab and Radiology Services, and X-Rays, Doctor's Office Visits, Durable Medical Equipment, Emergency Care, Foot Care, Hearing Services, Home Health Care, Mental Health Care, Outpatient Rehabilitation, Outpatient Substance Abuse, Outpatient Surgery, Over-the-Counter Items, Prosthetic Devices, Renal Dialysis, Transportation, Urgent Care, Vision Services, Preventive Care, Preventive Care, Hospice, Inpatient Hospital Care, Inpatient Mental Health Care, Skilled Nursing Facility, Part D drugs	2013 to Present	Enrollees must be eligible for Medicare and Medicaid	Capitated $391k (2013) $738k (YTD 2014)	Nathan Hui VP Medicare Advantage 215-937-7237	Over the Counter Non-Emergent Medical Transportation Dental Nurse Call Line Vision Hearing Laboratory

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
First Choice VIP Care						**South Carolina**
More than 500	Ambulance, Chiropractic Care, Dental Services, Diabetes Supplies and Services, Diagnostic Tests, Lab and Radiology Services, and X-Rays, Doctor's Office Visits, Durable Medical Equipment, Emergency Care, Foot Care, Hearing Services, Home Health Care, Mental Health Care, Outpatient Rehabilitation, Outpatient Substance Abuse, Outpatient Surgery, Over-the-Counter Items, Prosthetic Devices, Renal Dialysis, Transportation, Urgent Care, Vision Services, Preventive Care, Preventive Care, Hospice, Inpatient Hospital Care, Inpatient Mental Health Care, Skilled Nursing Facility, Part D drugs	1/2013 to 12/2014	Enrollees must be eligible for Medicare and Medicaid	Capitated $1.75M (2013) $6.66M (YTD 2014)	Nathan Hui VP Medicare Advantage 215-937-7237	Over the Counter Non-Emergent Medical Transportation Dental Nurse Call Line Hearing Laboratory

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
AmeriHeatlh VIP Care						**Louisiana**
More than 10	Ambulance, Chiropractic Care, Dental Services, Diabetes Supplies and Services, Diagnostic Tests, Lab and Radiology Services, and X-Rays, Doctor's Office Visits, Durable Medical Equipment, Emergency Care, Foot Care, Hearing Services, Home Health Care, Mental Health Care, Outpatient Rehabilitation, Outpatient Substance Abuse, Outpatient Surgery, Over-the-Counter Items, Prosthetic Devices, Renal Dialysis, Transportation, Urgent Care, Vision Services, Preventive Care, Preventive Care, Hospice, Inpatient Hospital Care, Inpatient Mental Health Care, Skilled Nursing Facility, Part D drugs	1/2013 to 12/2014	Enrollees must be eligible for Medicare and Medicaid	Capitated $340k (YTD 2014)	Nathan Hui VP Medicare Advantage 215-937-7237	Over the Counter Non-Emergent Medical Transportation Dental Nurse Call Line Vision Hearing Laboratory

Trade Name & Number of Members	Scope of Work	Duration of Contract	Population Types	Payment Type & Annual Contract Payments	Contact Name & Number	Role of Subcontractors (if any)
AmeriHealth VIP Care						**District of Columbia**
More than 100	Ambulance, Chiropractic Care, Dental Services, Diabetes Supplies and Services, Diagnostic Tests, Lab and Radiology Services, and X-Rays, Doctor's Office Visits, Durable Medical Equipment, Emergency Care, Foot Care, Hearing Services, Home Health Care, Mental Health Care, Outpatient Rehabilitation, Outpatient Substance Abuse, Outpatient Surgery, Over-the-Counter Items, Prosthetic Devices, Renal Dialysis, Transportation, Urgent Care, Vision Services, Preventive Care, Preventive Care, Hospice, Inpatient Hospital Care, Inpatient Mental Health Care, Skilled Nursing Facility, Part D drugs	1/2013 to 12/2014	Enrollees must be eligible for Medicare and Medicaid	Capitated $1.26M (YTD 2014)	Nathan Hui VP Medicare Advantage 215-937-7237	Over the Counter Non-Emergent Medical Transportation Dental Nurse Call Line Vision Hearing

AmeriHealth Caritas Louisiana

E.2. Qualifications and Experience

E.2 Identify whether your organization currently has a Louisiana Medicaid/CHIP managed care contract.

AmeriHealth Caritas Louisiana currently has a Louisiana Medicaid/CHIP managed care contract.

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E.3. Qualifications and Experience

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

Overview

The following describes instances where ACLA, its parent organization, affiliates, or subsidiaries were notified of being non-compliant with a publicly funded managed care contract described in Section E.1.

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E.4. Qualifications and Experience

E.4 Identify whether your organization has had any contract listed in response to E.1 terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client; and

If the contract was terminated/non-renewed, based on your organization's performance, describe any action taken to prevent any future occurrence of the problem leading to the termination/non-renewal.

Include your organization's parent organization, affiliates, and subsidiaries in this response.

ACLA, AmeriHealth Caritas Health Plan, and their parent organization, Independence Health Group have not had any contract terminated or non-renewed within the past five years.

The chart below details the contract non-renewals experienced by ACLA's affiliates.

Affiliate	Contract Party (Client)	Reason for Non-renewal or Termination	Termination Date	Client Address & Phone Number
PerformCare	Lycoming Clinton Joinder Board	Competitive reprocurement upon expiration of contract.	June 2013	Sharwell Building 200 East Street Williamsport, PA 17701 570-323-6467
PerformCare	Central PA Behavioral Health Collaborative Inc.	Competitive reprocurement upon expiration of contract.	June 2013	1906 N. Juniata Street Hollidaysburg, PA 16648 814-696-5680
PerformCare	Gateway	Decision by contract holder not to renew contract and to bring work in house.	December 2012	444 Liberty Ave #2100 Pittsburgh, PA 412-255-4640
Florida True Health	State of Florida Agency for Health Care Administration (ACHA)	Competitive reprocurement.	No membership as of 8/1/14. Contract term runs through 8/31/15 and AHCA has not given any indicated that they are going to terminate it early.	2727 Mahan Drive, Tallahassee, FL 32308 888-419-3456

Exhibit E.4-1: Nonrenewed PerformCare Contracts

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E.5. Qualifications and Experience

E.5 Provide evidence of current accreditation by national entity— either URAC or NCQA for at least one state product line listed in response to E.1.

If you have national accreditation, have you ever had your accreditation status (e.g., NCQA) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation.

Include your organization's parent organization, affiliates, and subsidiaries in this response.

Overview

As a nationwide leader in Medicaid managed care, ACFC has maintained its mission to help the underserved for 30 years. Our health plans, wellness programs, and executive leadership have been consistently recognized for their excellence.

NCQA Accreditation

We have included a summary of the current NCQA accreditations for ACLA, parent organization, affiliates, and subsidiaries. NCQA Report Cards for ACLA, parent organization, affiliates, and subsidiaries can be found immediately following this section.

Health Plan	Effective Date	Current Accreditation Status (based on last rescore)
Parent		
AmeriHealth Caritas Pennsylvania	August 2013 to August 2016, earned Excellent Accreditation	Commendable
ACLA		
AmeriHealth Caritas Louisiana	April 2013 to June 2015	Interim
Affiliate		
Keystone First Health Plan	August 2013 to August 2016, earned Excellent Accreditation	Commendable
Select Health of South Carolina	October 2013 to October 2016, earned Excellent Accreditation	Commendable
MDwise, Inc. * Parent company, MDWise, holds the accreditation and completes single admission on behalf of all subsidiaries (Hoosier Alliance).	December 2012 to December 2015, earned Accreditation	Commendable
Arbor Health Plan	March 2014	Interim
AmeriHealth District of Columbia, Inc.	July 2014	Interim
Keystone Health Plan East, Inc.	November 2011	Commendable

* MDwise Hoosier Alliance is accredited through MDwise, Inc. as one of several MDwise, Inc. Delivery Systems.

Exhibit E.5-1: Current NCQA Accreditation Status

As a new health plan, ACLA was awarded a status of "Interim" from NCQA in 2013. Accordingly, ACLA has never had its accreditation status adjusted down, suspended, or revoked. NCQA will conduct a 'First Review' in June 2015, after 18 months of demonstrating that we meet expectations for consumer protection and quality improvement, and ACLA will have the opportunity to advance from "Interim" status.

ACLA is actively engaged in preparation for the NCQA First Review. ACLA has established a solid foundation to meet expectations and requirements for consumer protection and quality improvement to achieve NCQA Accreditation.

Changes in Accreditation

Changes to NCQA's accreditation scoring methodologies adversely impacted the results of three of our Medicaid plans—Keystone First, AmeriHealth Caritas Pennsylvania, and Select Health of South Carolina—whose accreditation dropped one level from Excellent to Commendable. Overall, accreditation results for each ACFC affiliated plan range from 0.4 to 3.6 points away from the minimum required score of 90 for "Excellent" accreditation.

Specifically, NCQA has lowered the weighing of standards contribution and eliminated the practice of adding points to adjust for regional differences to the HEDIS and CAHPS results before results are scored. HEDIS and CAHPS results now make up approximately 50 percent of the total score. This scoring change reinforces the critical importance HEDIS and CAHPS plays in the organization. Keystone First, AmeriHealth Caritas Pennsylvania, and Select Health of South Carolina are currently in the process of developing strategies and interventions to regain "Excellent" accreditation next year.

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

NCQA Multicultural Health Care Distinction

Select Health, Keystone First, and AmeriHealth Caritas Pennsylvania also renewed their Multicultural Health Care Distinction statuses from NCQA. Each of the three plans was recognized by NCQA as "early adopters" of Multicultural Health Care Distinction standards in 2010. In 2011, the three plans were among the first seven health plans in the country to receive this prestigious accolade. With renewal, the plans are three of only eight Medicaid plans in the country to hold this distinction, which is valid through May 2015. Select Health is the only plan in South Carolina that has earned the recognition.

The NCQA distinction recognizes Select Health, Keystone First, and AmeriHealth Caritas Pennsylvania as leaders in the delivery of culturally appropriate care and services to diverse populations. AmeriHealth Caritas Pennsylvania and Keystone First both use 55 different languages to communicate with their membership and offer health education programs designed to meet the unique needs of the ethnic groups they serve. Select Health's efforts include accessible language services, specialized training for its associates and providers, and innovative programs aimed at reducing health care disparities.

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

- Collection of race/ethnicity and language data.
- Provision of language assistance.
- Cultural responsiveness.
- Quality improvement of culturally and linguistically appropriate services.
- Reduction of health care disparities.

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E.6. Qualifications and Experience

E.6 Provide as an attachment a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item E.1 of this section that had the largest number of enrollees as of January 1, 2014. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization as a result of this review.

Overview

A wholly owned subsidiary of ACFC, Select Health of South Carolina (Select Health) had the largest number of members as of January 1, 2014, managing the delivery of health care to more than 345,000 enrollees statewide through the First Choice health plan. As the state's first and largest Medicaid managed care organization, Select Health of South Carolina continues to provide the top-ranked Medicaid health plan in the state, according to rankings released from the NCQA.

External Quality Review Report

The most recent full external quality review (EQR) report for Select Health of South Carolina is provided in at the end of this section. 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.

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AmeriHealth Caritas Louisiana

E.7. Qualifications and Experience

E.7 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts.

Include your organization's parent organization, affiliates, and subsidiaries in your response to this question.

Overview

Regulatory actions or sanctions imposed by a federal or state regulatory agency with the five-year timeframe against ACLA, it parent organization, affiliates, and subsidiaries are described below.

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AmeriHealth Caritas Louisiana

E.8. Qualifications and Experience

E.8 State whether or not your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item C.1 of this part. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses.

ACLA is not currently nor has it recently (within the past five years) been the subject of a criminal or civil investigation by a state or federal agency.

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AmeriHealth Caritas Louisiana

E.9. Qualifications and Experience

E.9 Submit three (3) client references for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency.

Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix QQ. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:

a. *Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix QQ (for your organization or for subcontractors, adding the following customized information:*
   - *Your/Subcontractor's name;*
   - *Reference organization's name; and*
   - *Reference contact's name, title, telephone number, and email address.*

b. *Send the form to each reference contact along with a new, sealable standard envelope;*

c. *Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;*

d. *Instruct the reference contact to:*
   - *Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);*
   - *Sign and date it;*
   - *Seal it in the provided envelope;*
   - *Sign the back of the envelope across the seal; and*
   - *Return it directly to you.*

e. *Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.*

   Each completed questionnaire should include:
   - *Proposing Organization/Subcontractor's name;*
   - *Reference Organization's name;*
   - *Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;*
   - *Date reference form was completed; and*
   - *Responses to numbered items in RFP Attachment # (as applicable).*

DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.

THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.

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AmeriHealth Caritas Pennsylvania

General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	200 Stevens Drive, Suite 500, Philadelphia, PA, 17112
Number of members enrolled:	126,060
Website:	www.amerihealthcaritaspa.com

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

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Expiration Date:	08/09/2016
Date of Next Review:	05/10/2016
HEDIS measures included in results:	Yes
CAHPS measures included in results:	Yes

Performance Results

Accreditation Status:	Commendable

Accreditation Star Ratings

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

Other

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

AmeriHealth Caritas Health Plan NCQA Report Card

Keystone First

General Information	
Plan Type:	Medicaid
Accredited Product:	HMO
Address:	200 Stevens Drive, 210, Philadelphia, PA, 19113
Number of members enrolled:	288,578
Website:	www.keystonefirstpa.com

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

For specific areas covered, please contact the plan directly.

Accreditation Details	
Accreditation Type:	Health Plan Accreditation
Expiration Date:	08/09/2016
Date of Next Review:	05/10/2016
HEDIS measures included in results:	Yes
CAHPS measures included in results:	Yes

Performance Results	
Accreditation Status:	Commendable
Accreditation Star Ratings	
Access and Service:	★★★★
Qualified Providers:	★★★★
Staying Healthy:	★★☆☆
Getting Better:	★★☆☆
Living with Illness:	★★☆☆

Other

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

Keystone First Health Plan NCQA Report Card

MDwise, Inc.

Print Close this window

General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	Madison Plaza, 1200 Madison Avenue, Suite 400, Indianapolis, IN, 46225
Number of members enrolled:	282,322
Website:	www.mdwise.org
Other Names:	Healthy Indiana Plan, Hoosier Healthwise, MDwise Community Munster, MDwise Healthy Indiana Plan, MDwise Hoosier Alliance, MDwise Hoosier Healthwise, MDwise Methodist, MDwise Select Health, MDwise St. Anthony's, MDwise St. Catherine, MDwise St. Margaret Mercy, MDwise St. Mary's, MDwise St. Vincent, MDwise Wishard

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

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Expiration Date:	12/05/2015
Date of Next Review:	09/08/2015
HEDIS measures included in results:	Yes
CAHPS measures included in results:	Yes

Performance Results

Accreditation Status: Commendable

Accreditation Star Ratings

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

Other

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

MDwise, Inc. Health Plan NCQA Report Card

Select Health Of South Carolina, Inc.

General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	4390 Belle Oaks Drive, Suite 400, N. Charleston, SC, 29405
Number of members enrolled:	280,858
Website:	www.selecthealthofsc.com
Other Names:	First Choice

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

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Expiration Date:	12/31/2016
Date of Next Review:	10/04/2016
HEDIS measures included in results:	Yes
CAHPS measures included in results:	Yes

Performance Results

Accreditation Status: Commendable

Accreditation Star Ratings

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

Other

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

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

AmeriHealth Caritas Louisiana

General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	10000 Perkins Rowe, 4th Floor, Block G 4th, Baton Rouge, LA, 70810
Number of members enrolled:	145,157
Website:	www.amerihealthcaritasla.com
Other Names:	ACLA

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

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Expiration Date:	06/19/2015
Date of Next Review:	03/24/2015
HEDIS measures included in results:	No
CAHPS measures included in results:	No

Performance Results

Accreditation Status: Interim

Accreditation Star Ratings

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

Other

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

AmeriHealth Caritas Louisiana, Health Plan NCQA Report Card

AmeriHealth District Of Columbia, Inc.

General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	1120 Vermont Ave NW, 200, Washington, DC, 20005
Number of members enrolled:	96,464
Website:	www.amerihealthdc.com
Other Names:	AmeriHealth District of Columbia

This health plan serves members in the following state(s):
District of Columbia

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Expiration Date:	01/10/2016
Date of Next Review:	10/06/2015
HEDIS measures included in results:	No
CAHPS measures included in results:	No

Performance Results

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

Other

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

AmeriHealth District Of Columbia, Inc.

Arbor Health Plan

General Information

Plan Type:	Medicaid
Accredited Product:	HMO
Address:	2120 South 72nd Street, Suite 1000, Omaha, NE, 68124
Number of members enrolled:	21,295
Website:	www.arborhealthplan.com

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

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Expiration Date:	09/14/2015
Date of Next Review:	06/23/2015
HEDIS measures included in results:	No
CAHPS measures included in results:	No

Performance Results

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

Other

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

Arbor Health Plan

Keystone Health Plan East, Inc.

General Information

Plan Type:	Commercial
Accredited Product:	HMO/POS Combined
Address:	1901 Market Street, 29th Floor, Philadelphia, PA, 19103
Number of members enrolled:	411,564
Website:	www.ibx.com
Other Names:	Keystone Health Plan East

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

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Expiration Date:	11/22/2014
Date of Next Review:	09/03/2014
HEDIS measures included in results:	Yes
CAHPS measures included in results:	Yes

Performance Results

Accreditation Status: Commendable

Accreditation Star Ratings

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

Other

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

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Keystone Health Plan East, Inc.

Select Health of South Carolina

2013 External Quality Review Report

February 28, 2014

The following 116 pages have been redacted due to confidential information.

Select Health of South Carolina 2013 EQR Quality Improvement Plan

The following 1 page has been redacted due to confidential information.

AmeriHealth Caritas Louisiana

F.1. Organizational Structure

F.1 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization's parent organization, affiliates, and subsidiaries that will support this contract.

Overview

AmeriHealth Caritas Family of Companies (ACFC) is a national leader in health care solutions for those most in need, touching more than 6 million lives through our product lines nationwide. We are one of the nation's experts and industry leaders in the delivery of quality health care to low-income populations covered by publicly-funded programs, with a special focus on the Medicaid population. Our mission and values are constructed from our history of connecting the most vulnerable citizens to primary care while providing health care through our network providers and our own health management programs.

ACFC has provided managed care to Medicaid recipients and other low-income populations throughout the country. This longstanding experience includes managing health care service delivery for TANF, dual eligible, and ABD populations. These programs include Medicaid risk and non-risk, Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs), Prescription Drug Plans (PDPs), Medicaid risk and non-risk Behavioral Health Organizations (BHOs), Medicaid/Medicare Dual Eligible demonstrations, and State Children's Health Insurance Programs (SCHIP).

Description of Organization

AmeriHealth Caritas Louisiana (ACLA) is a Louisiana for-profit business corporation licensed as a Louisiana health maintenance organization. ACLA is a wholly-owned subsidiary of AmeriHealth Caritas Health Plan (ACHP), a Pennsylvania general partnership. ACHP is owned through wholly-owned subsidiaries by BMH, LLC, which is doing business as the AmeriHealth Caritas Family of Companies (ACFC). Blue Cross Blue Shield of Michigan is a minority owner of ACFC and an indirect minority owner of ACLA. IBC MH, LLC is the majority owner of ACFC. IBC MH, LLC is owned through subsidiaries by Independence Health Group, Inc. (IHG, Inc.). IHG, Inc. is a non-profit Pennsylvania holding company and, effective July 1, 2014, an ultimate parent organization of ACLA.

Chart A

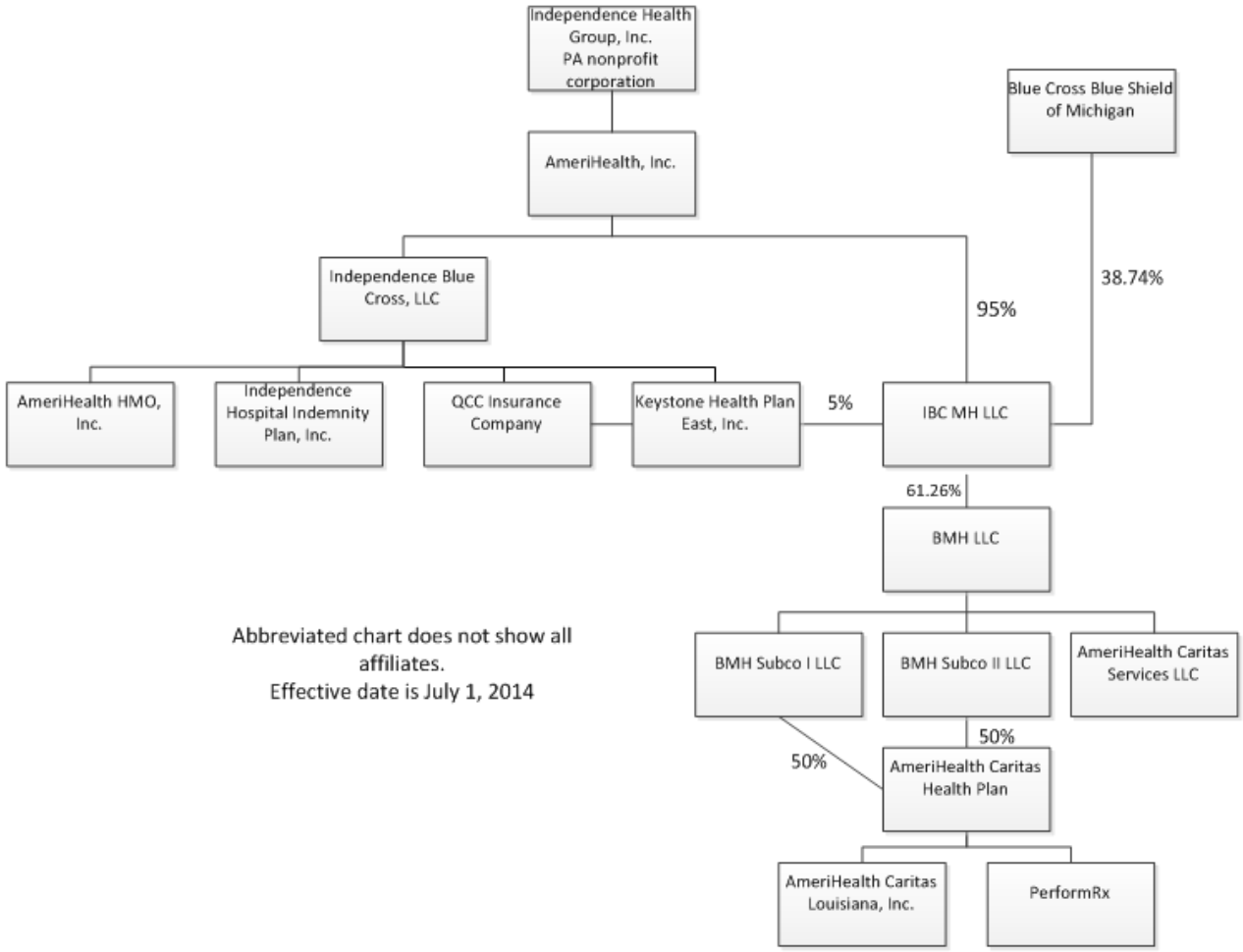

Chart A: Organizational Chart

The following affiliate entities will be used to support the services provided by ACLA under the contract with DHH: AmeriHealth Caritas Health Plan (ACHP), AmeriHealth Caritas Services LLC (ACS), and PerformRx LLC.

- AmeriHealth Caritas Health Plan (ACHP). ACLA has the advantage of having ACHP, one of the nation's experts and industry leaders in the delivery of Medicaid managed care, as its direct parent organization. ACLA leverages ACHP's experience, expertise and systems through operational and corporate support from ACHP. ACHP is headquartered in Philadelphia, PA. ACHP has a total of 2500 corporate and southern regional employees that provide support to plans across ACFC including ACLA.
- AmeriHealth Caritas Services, LLC (ACS). ACS, is a wholly-owned subsidiary of BMH, LLC, and is responsible for furnishing to ACLA the employees necessary to carry out the operations of ACLA. ACS is headquartered in Philadelphia, PA. ACS has a total of

approximately 160 full time employees that are dedicated to ACLA. The southern regional office is located in Charleston, South Carolina.

- PerformRx LLC (PerformRx). Perform Rx is a wholly-owned subsidiary of ACHP and is responsible for providing pharmacy benefit management services to ACLA. ACLA utilizes PerformRx's clinician-led pharmacy benefit management services and breakthrough technology to improve clinical outcomes and better coordinate care of ACLA members. Services provided by PerformRx to ACLA. PerformRx is headquartered in Philadelphia, PA. Approximately 21 employees from PerformRx are allocated to provide pharmacy services for ACLA.

ACLA has a continued focus on local communities and their individual needs. We place great importance on participating in local events, supporting local organizations and building relationships with community leaders and groups in the areas we serve. The plan, located in Baton Rouge, LA, has approximately 119 employees based in Louisiana. In addition to our local employees, ACLA is supported by regional and corporate staff.

Client Base

ACLA was formed to serve the specific needs of those who live in Louisiana and who enroll in the Bayou Health program. We have built and customized our approach in serving multiple populations in the state since 2012, under the existing CCN-P contract. Working with DHH and the Bayou Health program, we have provided a robust array of health services designed to improve health outcomes and access; prevent disease and manage chronic conditions; promote personal responsibility, healthy behaviors, and self-management; and improve the coordination of care for our members.

Our Medicaid Managed Care client base in Louisiana includes, but is not limited to, those children and caretakers who are enrolled in Family Independence Temporary Assistance Program (FITAP)/TANF program; the Supplemental Security Income (SSI) population; Foster Care/Former Foster Care Children; children enrolled in Louisiana Children's Health Insurance Program (LaCHIP); Extended Medicaid Program recipients; Pregnant Women; and Women enrolled in the Breast and Cervical Cancer (BCC) Program.

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AmeriHealth Caritas Louisiana

F.2. Organizational Structure

F.2 Provide an organization chart for this contract (marked as Chart B) including but not limited to positions in 4.2 and 4.3 of the RFP. Indicate what is the FTE for each dedicated to this contract and whether or not the position is located in Louisiana.

Overview

Our organizational chart includes local, regional, and corporate positions that will be responsible for successful ongoing operations of ACLA. Functions managed at the local level will include administration, integrated care management, provider network management, medical network management, community outreach, human resources, finance, service operations, quality improvement, regulatory affairs, program integrity, and compliance. The organizational chart below depicts the assignment of resources at the local level for these functions.

Chart B

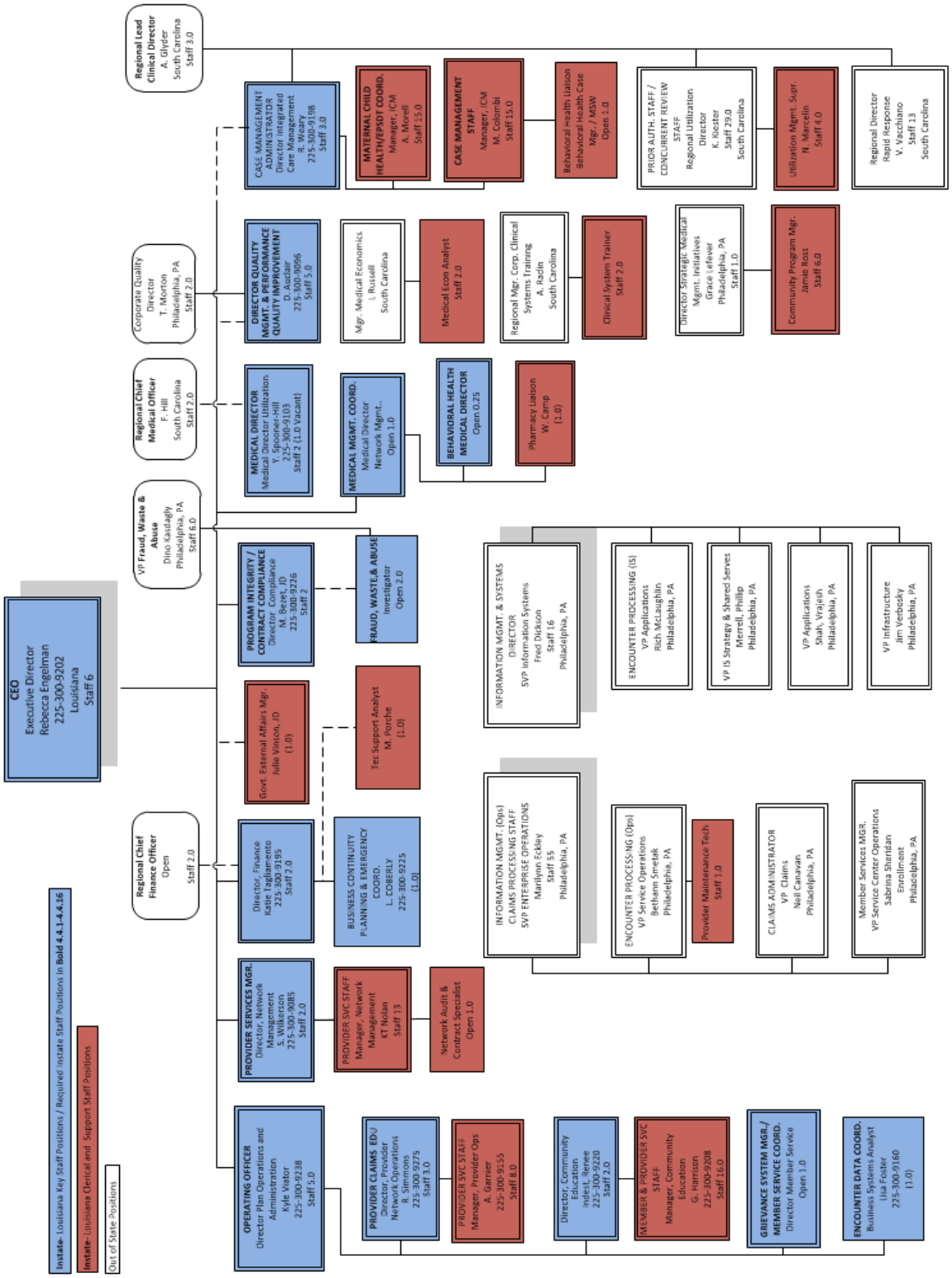

Chart B: Local, Regional, and Corporate Key Positions that Support ACLA

Regional Allocation of FTE's Supporting ACLA

All regional positions are located in the AmeriHealth Caritas Southern Division office in Charleston, South Carolina. The time and responsibilities of senior leadership and management positions are allocated equally among their lines of business in the region. There are over 65 positions in the ACFC Regional Office that are fully allocated to serving the members enrolled in ACLA.

Regional Allocation of FTE's supporting Louisiana Medicaid	FTE
Appeals	8
Medical Management	3
Pharmacy Management	3
Informatics	2
Rapid Response	14
Regional Finance	2
Utilization	33
Total	**65**

Corporate Allocation of FTE's supporting ACLA

All corporate positions are located in the AmeriHealth Caritas Corporate office in Philadelphia, PA or in the AmeriHealth Caritas Contact Center in Jacksonville, FL. There are 94 positions in the Corporate Office that are fully allocated to serving the members enrolled in ACLA.

Corporate Allocation of FTE's supporting Louisiana Medicaid	FTE
Claims Processing & Research	28
Member / Provider Services	13
Provider Claim Services (Call Center)	10
Enrollment	4
IS Applications, System Configuration & Testing, Helpdesk	16
Credentialing	5
Provider Network Management	1
Provider Partnership Innovations, Medical Economics	2

Corporate Medical Management Support	2
Fraud, Waste, and Abuse Investigations	4
Publics Affairs, Marketing & Communications	2
Finance	3
Support from other Corporate Areas	4
Total	**94**

AmeriHealth Caritas Louisiana

F.3. Organizational Structure

F.3 Attach job descriptions (including education and experience qualifications) of employees in key staff positions as defined in Sec. 4.2. Job descriptions should not exceed 2 pages.

In alignment with the organizational charts presented in section F.2, please find job descriptions of employees in key staff positions as defined in Section 4.2 at the end of this section.

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F.4. Organizational Structure

F.4 Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than $100,000 annually.

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

Subcontractor Name	Mailing Address	Description of Work
SironaHealth, Inc.	500 Southborough Drive, Ste. 105 South Portland, ME 04106	SironaHealth manages a 24/7 nurse call line that triages and appropriately routes calls to registered nurses (when identified as a potential emergency) or to a registered nurse callback queue. Based on clinical criteria, the member is advised to do one of the following: • Proceed to an emergency facility • Immediately contact his or her physician • Contact physician to schedule an appointment • Provide general health information.
LogistiCare Solutions LLC	1275 Peachtree Street NE, 6th Floor Atlanta, GA 30309	LogistiCare is delegated for credentialing and recredentialing, financial services and claims payment processes necessary for administration of the non-emergency transportation benefit. These responsibilities include developing, managing, and maintaining a state-wide Non-Emergency Transportation provider network.
Vision Service Plan (VSP)	**Corporate Headquarters:** 3333 Quality Drive Rancho Cordova, CA 95670. **Eastern Operations Center:** 3400 Morse Crossing Columbus, OH 43219	VSP is delegated for credentialing and recredentialing financial services and claims payment processes necessary for administration of the vision benefit.
DentaQuest	465 Medford Street Boston, MA 02129	DentaQuest is delegated for credentialing and recredentialing financial services and claims payment processes necessary for administration of the enhanced adult dental benefit.
National Imaging Associates (NIA)	6950 Columbia Gateway Drive Columbia, MD 21046	NIA provides radiology benefits management. It is delegated for utilization management and related

Subcontractor Name	Mailing Address	Description of Work
		communication services for members and practitioners. NIA supports radiology claims processing by conducting a paid claims audit review, participating in overpayment recovery, and assisting in addressing any questions related to edits and authorization match.
PerformRx	200 Stevens Drive Philadelphia, PA 19113	PerformRx is delegated to assign, develop, and manage the pharmacy network and provide Pharmacy Benefits Management (PBM) services to members. Some services provided are: • Prior Authorization • Drug Utilization Review • Formulary Management • Participating Pharmacy/Provider/Member Information Services • Account Management • Analysis and Reporting • Rebate Contracting Management • Pharmacy Network Management • Provider Claims Disputes • Pharmacy Mail Service • Member Complaints and Grievances and Appeals • Provider Claims Disputes • Reporting

Exhibit F.4-1: Subcontractor Information

F.5. Organizational Structure

F.5 Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located.

Overview

ACLA understands that accountability for the completion of a function or responsibility, even when performed by a subcontractor, remains with ACLA. Our subcontractor oversight program is designed to ensure that all subcontractors are qualified to perform the delegated services, that they remain qualified throughout the term of the contract, and that they perform their responsibilities in accordance with the terms of their agreement and the requirements of the Bayou Health program.

Subcontractor Name	Subcontractor Location	Description of Work	Currently Providing Services in Louisiana?	Currently Providing Services in Other States?
SironaHealth, Inc.	500 Southborough Drive, Ste. 105 South Portland, ME 04106	24/7 Nurse Line	Yes	Yes
LogistiCare Solutions LLC	1275 Peachtree Street NE, 6th Floor Atlanta, GA 30309	Non-Emergency Medical Transportation	Yes	Yes
Vision Service Plan (VSP)	**Corporate Headquarters:** 3333 Quality Drive Rancho Cordova, CA 95670. **Eastern Operations Center:** 3400 Morse Crossing Columbus, OH 43219	Vision	Yes	No
DentaQuest	465 Medford Street Boston, MA 02129	Dental	Yes	Yes
National Imaging Associates (NIA)	6950 Columbia Gateway Drive Columbia, MD 21046	Radiology Benefits Management	Yes	Yes
PerformRx	200 Stevens Drive Philadelphia, PA 19113	Pharmacy	Yes	Yes

ACLA currently uses six subcontractors to provide portions of the comprehensive scope of services that constitute the Bayou Health Program. See Exhibit F.5-1, below.

Exhibit F.5-1: Subcontractor Information

Selection and Contracting

During the process of subcontractor selection, ACLA reviews the scope of services needed and the ability of the subcontractor to perform those services and to meet the specific requirements outlined in the scope of work outlined in the RFP. We make a concerted effort to utilize vendors that are commonly used by our affiliates to facilitate provider simplification. Using common subcontractors increases ACLA's leverage and ability to hold the subcontractor to strict standards. As part of the contract finalization process, we conduct an onsite audit of the subcontractor's records using comprehensive assessment tools that combine NCQA health plan accreditation standards, industry performance levels, and Louisiana-specific requirements, including those outlined in the Subcontractor Requirements Checklist. The scope of the audit is determined by the functions we are delegating, but typically includes a review of credentialing files, policies and procedures, relevant workflows, and claim payment and encounter processing, as applicable. The results of the audit are compiled and presented to ACLA management and the relevant quality committees. If a subcontractor does not meet our requirements, we will either select a different subcontractor, or educate the subcontractor and implement an action plan.

If a subcontractor is able to meet our requirements, ACLA submits the proposed agreement, which includes the requirements defined in 42 CFR Part 438, to DHH for review and approval. ACLA will not execute a contract until we have received approval from DHH. The contract describes the specific functions that are being delegated to the subcontractor (credentialing, utilization management, claims processing), as well as key functions that are not being delegated (member complaints and grievances, quality management). Our contracts require subcontractors to obtain and maintain any certificate(s) of insurance required by the RFP or applicable state and federal requirements. We reserve the right to investigate or audit a subcontractor at any time. Additionally, we do not allow a subcontractor to delegate any delegated functions without obtaining prior written approval from ACLA and the state.

The contract also specifies the standards against which we will measure the subcontractor's performance, and the frequencies at which the metrics must be provided. These standards include timely claims payment, encounters processing, and call center performance. At a minimum, we require performance consistent with industry standards. Below are examples of the performance standards included in ACLA subcontractor agreements.

Functions	Standards
Claims Processing	
Claims financial accuracy	≥ 99%
Claims procedural accuracy	≥ 99%
Clean claims paid within thirty (30) business days of receipt	≥ 90%
Clean claims processed within 30 calendar days of receipt	≥ 99%

Rejected claims returned to provider with reason code within 15 calendar days of receipt of claim	≥ 99%
Interest paid at 12% per annum, calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30 day claims processing deadline.	
Call Center Management	
Abandoned call rate	≤ 5%
Average speed of answer	95 % of calls within ≤ 30 seconds
Average call blockage rate	≤ 1%
Average Hold Time	≤ 3 minutes
Service Level	≥ 85%
Quality Score	≥ 95%
Account Administration	
Electronic eligibility online within 2 business days[1]	98%
Electronic report delivery by 25th of month for prior month for monthly reports, and 30th of month for previous quarter for quarterly reports	100%
Web-portal availability using Member ID	99%
Credentialing	
Compliance with 36 month Re-credentialing cycle	100%
Annual Delegation Review Aggregate score	95%
Appeals	
Submission of information necessary to adjudicate a non-urgent member appeal is sent to the plan within 3 business days	100%
Submission of information necessary to adjudicate expedited Member Appeal within 24 hours	100%
Complaints and Grievance	
Submission of information necessary to resolve a member complaint and/or a member grievance is sent to the plan within 5 business days	100%
Utilization Management	

Standard service authorization determination within two business days of obtaining appropriate medical information.	80%
Concurrent service authorization determination within one business day of obtaining the appropriate medical information that may be required.	95%
Expedited service authorization determination within 72 hours after receipt of the request for service.	100%
Post service authorization determination within 72 hours after receipt of the request for service.	95%
Retrospective authorization determination within 30 days after receipt of the request for service.	95%
Notice of Action – Notification of service authorizations decision to provider, one business day of making the initial determination.	95%
Notice of Action - Notification documented confirmation to the provider within two business days of making the initial certification.	95%
Notice of Action - Notification of approval for extended stay or additional services to the provider or member within one business day of the service authorization approval.	95%
Notice of Action – Notification of decision for expedited service authorization as expeditiously as condition requires – no later than 72 hours	100%
Inter Rater Reliability – Semi-Annually	90%
Encounter file submission	100% by the 10th of the month
Encounter submission timeliness	100% by the 10th of the month
Encounter submission accuracy	100%
Encounter error correction timeliness addressed within 30 calendar days	99%
Encounter system changes - 120 days upon request or as otherwise required by CMS or DHH	100%

Exhibit F.5-2: ACLA Performance Standards

Performance Monitoring and Evaluation

We have staff dedicated to subcontractor oversight who monitor performance on a monthly basis against documented performance standards, which include standards for encounter data. In addition, the subcontractor oversight team serves as the point of contact for the subcontractor to ensure that subcontractor goals and procedures continue to be aligned with ACLA and DHH requirements and to communicate and validate the implementation of any changes in requirements or guidelines. Initial reporting around paid claims did not include the reporting requirement for a Cash Disbursement Journal. Subcontractor oversight was able to provide the subcontractor with the reporting template, reviewed the template data content requirements, and provided the submission requirement. This change in action supported the DHH

requirement for the subcontractors to provide their financials on claims paid. As with the changes noted previously, ACLA will continue to devote appropriate resources to monitor subcontractor performance on an ongoing basis.

In one instance, the subcontractor was not able to meet the level of performance needed to support ACLA's delivery of the Bayou Health Program. A new subcontractor was identified and vetted, and the low-performing subcontractor was terminated.

In 2014, through monthly performance monitoring, the Delegation Oversight team identified three service metric deficiencies in one subcontractor performance measurement. Our transportation vendor reported Contact Center Service Levels of 89.5%, 83.2%, and 79.1% in February, April, and May 2014. None of the measures were out of compliance in a continuous three-month period; therefore, a corrective action plan was not warranted. However, ACLA takes all deficiencies very seriously and acts proactively at the first report of a metric performance declining or falling below standards, in order to work with the subcontractor to restore performance to the expected contracted level. The subcontractor was contacted and counseled, and the subcontractor developed an internal plan to address the deficit. In this case, planned actions by the vendor were deemed appropriate by ACLA's transportation services manager. Frequent monitoring during June revealed a dramatic reversal (92%) of the negative trend. From June thru August 2014, service level performance averaged 97%.

The Delegation Oversight team holds monthly Vendor Partnership meetings with each subcontractor. These meetings provide an open forum for both ACLA and the subcontractor to discuss any issues, trends, or updates, as well as the opportunity to discuss performance over the previous period.

Most subcontractor performance metrics are tracked on a monthly basis, and are compiled into a report that is presented to the ACLA Quality of Service Committee. We review month-over-month results to identify performance trends and quickly address any deficiencies. When a subcontractor has a significant or persistent failure to meet agreed performance standards, we seek out the root cause and implement a corrective action plan. We require a subcontractor to meet the performance standard for three consecutive months before closing the corrective action plan. A subcontractor who continues to miss performance standards may be terminated for cause, and may be subject to financial penalties.

On an annual basis, we audit all subcontractors to ensure that their credentialing, utilization management, and other business processes and procedures are continuing to meet our requirements. The results of these audits are compiled and submitted to the ACLA Quality of Service Committee, along with any recommendations.

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4.2.2 Administrator/Chief Executive Officer (CEO)

Executive Director

Position Summary

Responsible for the strategic direction, growth, and leadership of AmeriHealth Caritas Louisiana (ACLA), including the daily operations of Medical Affairs, Operations, Information Services, Quality, Marketing, Regulatory and Legislative Affairs, and Human Resources. Responsible for the management of employees, and the achievement of all profitability and membership goals, as well as subsidiary operating costs. Must be available during DHH working hours, 40 hours per week.

Principal Accountabilities

- Provides leadership direction, and an overall vision to the organization, in an effort to maintain and improve the performance of the business revenues, membership, external relationships, and profits. Holds planning sessions with executive staff to develop, establish, and maintain visions and goals, ensures clear communication to all employees and provides resources to promote achievement of goals.
- Provides clear, concise, and logical direction to team members in line with strategic vision and goals.
- Swiftly resolves crisis and conflicts in the organization in a fair, equitable, and calm manner, without being deterred from the strategic plan.
- Supports the continued growth and development of all employees to promote competence and develop/maintain skills necessary to enhance continued business growth.
- Creates an atmosphere where creativity and achievement are appreciated and rewarded.
- Demonstrates ethical decision making when making decisions which balance the needs of customers with ACLA's fiscal responsibility.
- Identifies and develops new business opportunities that fall within the context of managed care, and are consonant with government health care programs.
- Directs the operations of ACLA, including Operations, Information Systems, Quality, Marketing, Human Resources, Medical Affairs, Provider Contracting, and Regulatory and Legislative Affairs.
- Directs quality assurance activities and reports results to governing board.
- Responsible for regulatory activities/legislative affairs for ACLA.
- Demonstrates ACLA philosophy and values and ensures that philosophy and mission drive the day-to-day operating environment.
- Develops and maintains appropriate external relationships in support of the Plan.
- Develops strategic plans, budgets, and management action plans as a basis for management decision making.
- Fosters constructive positive relationships between the Plan and its providers.
- Leads in fostering clear and constructive communication in the organization.
- Participates in the activities of the ACLA governing bodies.
- Performs other related duties and projects as assigned.

- Ensures that key stakeholders are involved in the continuous process of policy formulation and implementation. Responsible for approval and endorsement of ACLA policies.
- Adheres to ACFC policies and procedures.
- Supports and carries out the ACLA Mission & Values.
- Attends required training on an annual basis.

Position Qualifications/Requirements

Education and Training

- BA/BS Business /Health care Industry
- Five to ten years progressive responsibility in Business or Government; health care management required

4.2.3 Medical Director/Chief Medical Officer

Medical Director, Network Management

Position Summary

The Medical Director, Network Management reports directly to the Executive Director of ACLA and has a dotted line reporting relationship to the Regional Chief Medical Officer in a Region. The Network Medical Director (NMD) works directly with the Plan's Provider Network Management and Clinical Services teams to promote the strategy and goals as defined in the work/strategic business plans for the Region, Corporate Provider Network Management and Corporate Quality Management. The NMD provides other Medical Director support to other Plan and cross-enterprise business initiatives as identified. The Network Medical Director also provides support as needed to the Regional Utilization Management organization through review of appeals and utilization management and as a consultant to the UM team. As required, the NMD provides his/her unique medical specialty expertise throughout the enterprise as required. The NMD is a seasoned professional who faces outward to and interacts with the Plan's membership and physician community, physician and health system networks, medical/physician professional associations, government representatives, and advocacy groups to advance medical education, quality measures, and Plan service and organizational effectiveness.

Principal Accountabilities

- Assists in the development and implementation of medical policy, including recommendations for modifications to enhance efficiency and effectiveness.
- Assures compliance with medical policy.
- Maintains compliance with the DHH and CMS guidelines.
- Directs the efforts of the utilization review, case management, and pre-certification functions to accomplish objectives within policy and budget.
- Devotes a full time minimum of 40 hours per week to ACLA, and after hours consultation as needed.
- Performs daily medical reviews.
- Serves as a member of, and participates in, every quarterly and phone meeting of the Medicaid Quality Committee, either in person or by phone. The Medical Director may designate a representative with a working understanding of the clinical and quality issues impacting Medicaid.
- Serves as the director of the Utilization Management committee and chairman or co-chairman of the QAPI Committee.
- Oversees the quality management function in the identification and analysis of medical information to develop interventions to improve quality of care and outcomes and to ensure proper provision of CCMP services for participants.
- Collaborates with Medicaid Medical Director to implement programs, including chronic care management, medical case management, and pharmacy and other issues identified by DHH.
- Assists in implementation, administration, and improvement of DHH's goals for health care reform.

- Meets with key provider representatives in order to develop and facilitate positive working relationships.
- Adheres to AmeriHealth Caritas confidentiality codes at all times, respecting the dignity and privacy of all members, providers, and associates.
- Responsible for oversight of the Quality Improvement and Care Management programs, including chronic care management and quality measurement reporting.
- Obtains necessary educational requirements to maintain professional licensure and certifications.
- Serves on various committees as assigned by AmeriHealth Caritas or DHH.
- Complies with ACLA and HIPAA confidentiality requirements to protect members' personal, identifiable health information.
- Maintains confidentiality of all company, provider, and participant information.
- Adheres to ACFC policies and procedures.
- Supports and carries out the ACFC Mission & Values.

Position Qualifications/Requirements

Education and Training

- Must have five to ten years practice experience
- Minimum three years of training in a medical specialty
- Minimum five years practice experience in his/her area of specialty
- A minimum of five years of medical management and general management experience in a managed care environment is preferred
- Primary care discipline, and prior experience as an Associate Medical Director (or equivalent) or a physician reviewer in a Managed Care Plan are preferred
- Utilization management experience is preferred
- Proven ability to function in large, complex matrix organization
- Ability and willingness to travel extensively
- Proven effectiveness as an ambassador with practitioners, medical facilities, state representatives, professional societies, advocacy groups, and other external partners; History of activity and leadership positions with these organizations throughout his/her career
- Board Certified Physician
- An unrestricted license to practice medicine in the Plan's state and any other state in which he/she works

4.2.4 Behavioral Health Medical Director

Behavioral Health Medical Director

Position Summary

The Behavioral Health Medical Director is responsible for guiding development of all Behavioral Health programs and guidelines, and for providing administrative and clinical guidance and expertise to senior management and staff to enhance and improve the quality of care and services provided to ACLA's members. The Behavioral Health Medical Director reports to the Medical Director, Network Management, and must be either located in Louisiana, or available to Louisiana for consultation. The Behavioral Health Medical Director liaison is responsible for providing clinical behavioral health supervision to ACLA. This is a one quarter time position (minimum 10 hours/week).

Principal Accountabilities

- Supports the provision of quality and clinically sound system of care services to all individuals in the system of care.
- Serves as a medical advisor for clinically related activities in Integrated Care Mgmt.
- Serves as a liaison to state agencies and partners, community and network Providers.
- Assures that organization medical policies and procedures adhere to contractual obligations.
- Establishes prior authorization of clinically appropriate use of psychopharmacology monitors/assists and has oversight for pharmacy benefit manager (PBM) activities. including step therapy requirements for the use of antipsychotics and stimulants for members under age 18;
- Consults with contracted PCPs treating behavioral health concerns that do not require referral to specialists. Works with medical management staff to create comprehensive care programs for youth and adult concerns, such as depression and ADHD.
- Performs clinical case reviews in conjunction with Clinical Department.
- Develops and implements education and training programs for ACLA PCPs focused on commonly-encountered behavioral health issues frequently treated by PCPs.
- Adheres to all ACFC policies and procedures, including, but not limited to: Corporate Code of Conduct, Confidentiality, and Corporate Compliance.
- Attends training to ensure a working knowledge of the System of Care internal policies and procedures, including the appeal and reconsideration process.
- Demonstrates knowledge of prescribed and established medical procedures and practices.
- Maintains familiarity with federal, state, and local regulations that may pertain to the medical and clinical operations.
- Adheres to ACFC policies and procedures.
- Supports and carries out the ACFC Mission & Values.
- Serves as a consultant to ACLA as indicated.

Position Qualifications/Requirements

Education and Training

- Physician with a current unencumbered license through the State Board of Medical Examiners
- Board Certified Psychiatrist with an unrestricted license to practice in Louisiana and any other applicable states, with five years clinical psychiatric experience. Over five years' experience in behavioral health, mental health, and substance abuse managed care
- Public-sector program management experience
- Experience in crisis intervention, utilization management, and benefit plans
- Membership in a national professional organization

4.2.5 Chief Operating Officer (COO)

Director of Plan Operations and Administration

Position Summary

Responsible for the strategic development and management of the overall ACLA operations. The Director of Plan Operations and Administration reports to the Executive Director while providing coaching and guidance to support staff in the development of skills enhancement and career development. Accountable to the ED/CEO for all operational results. She/he manages key performance indicators to achieve or exceed organization goals. In addition, the Director of Plan Operations and Administration ensures effective service delivery by local team and service providers.

Principal Accountabilities

- Understands state program contractual and regulatory requirements (benefit and payment rules, data and information submission specifications, performance and service level requirements, etc.) and ensures requirements are met for the plan.
- Acts as a liaison between the state, health plan and enterprise functions.
- Is accountable for all contractual obligations and ensures that both local and corporate resources deliver on all commitments.
- Acts as a second in command to the Executive Director.
- May serve as primary point of contact for all ACLA operational issues.
- Ensures that all problems, complaints and grievances, presented by ACLA providers, members, or their representatives are resolved in accordance with established policy and procedures, NCQA, and federal/state guidelines.
- Ensures that all service levels are met for all functional areas supporting the plan, including corporate, regional, and local functions. Addresses the need for corrective action when any service levels are not met.
- Oversees the submission of specific information to corporate, based on the plan's provider contracts, for configuration of the system to support the payment of claims. Responsible for ensuring that claim payments, once configuration has been completed, are consistent with the terms of the contract.
- Takes responsibility for internal operational functions and oversight of corporate functions that support key plan requirements, such as claims processing and encounter data submissions and corrections.
- Maintains up-to-date Policies and Procedures for all local functions, conforming to regulatory requirements.
- Tracks State Bulletins to identify changes and operational impacts, communicates them, and marshals local, regional and corporate resources to make necessary system and process changes to meet the requirements.
- Convenes regular operational meetings at the plan to include peers, e.g., provider network management, compliance, and community outreach, to facilitate the coordination of plan activities.

- Supports the execution, in collaboration with the Regional CFO and CMO, of cost containment initiatives. Responsible for developing action plans and tracking results for operational cost containment initiatives.
- Proactively identifies risks that would impact ACLA's ability to meet enterprise and local strategic and financial goals and develops strategies to mitigate the risks.
- Adheres to ACFC policies and procedures.
- Supports and carries out the ACFC Mission & Values.

Position Qualifications/Requirements

Education and Training

- Bachelor's Degree
- 3-5 years, with preference for 5-10 years

4.2.6 Chief Financial Officer (CFO)

Regional Chief Financial Officer

Position Summary

The Regional Chief Financial Officer (CFO) provides strategic financial support to the Regional President and ACFC CFO. The RCFO, in coordination with the Corporate Finance office, also provides support for all associates in Louisiana performing financial functions in both the local markets and regional office. Priorities for the RCFO include financial planning, reporting, audit activities, and budgeting and identifying opportunities for financial performance improvements in the state, in collaboration with business leaders and the Regional President. The Louisiana RCFO Position is 50% of full time employment, at a minimum.

Principal Accountabilities

- Is responsible for the strategic financial planning, direction, budget oversight, and coordination of the financial function for all business units within Louisiana, as well as the regional component providing financial expertise, input, and support to all departments.
- Provides regional financial leadership and guidance for the expansion into other states and/or other products as developed.
- Participates in ongoing strategic planning and oversight with the regional leadership and corporate functions.
- Participates in the operational management of each business unit in the state as well as the regional structure providing financial input and support.
- Communicates operational results for each business unit as well as regional results in a timely manner.
- Provides financial support and guidance to each business unit's Network Development and Provider Contracting functions to ensure provider contract reimbursements fall within budgeted targets.
- Participates in financial meetings with regulatory officials for each business unit in the State.
- Is responsible for managing and maintaining a positive and cohesive relationship with the Department of Insurance in each market in Louisiana.
- Provides oversight of all financial operations, including training and implementation of new systems.
- Hires, evaluates, develops, and supervises financial personnel.
- Leads all budget activity for each business unit in Louisiana, as well as the regional structure, and coordinates with corporate finance to ensure timeliness and completeness.
- Acts as a primary contact for the state with the ACLA's independent auditors.
- Coordinates with each business unit in the state as well as corporate finance staff to manage audit activity both internally and externally.
- Oversees day-to-day facility activities for each business unit's office and coordinates with Corporate Facilities on a routine basis.
- Administers general accounting, cost accounting, property accounting, office equipment control, and records retirement programs.

- Assumes responsibility for the correct and accurate accounting classifications of all expenditures and documents including capital and others.
- In coordination with the Corporate Finance team, directs the preparation of each business unit's monthly, quarterly, and annual financial statements for both GAAP and statutory purposes.
- In coordination with the Corporate Finance team, submits to each business unit's Department of Insurance financial reports and other information on a timely basis.
- Implements internal control procedures and systems to be consistent with all ACFC entities.
- Communicates monthly with all departments for operating results compared to budget.
- Performs other duties as assigned by the Regional President.
- Adheres to ACFC policies and procedures.
- Supports and carries out the ACFC Mission & Values.

Position Qualifications/Requirements

Education and Training

- BS/BA in Accounting or financial management, CPA or MBA preferred
- Minimum of 12 years of progressively responsible financial managerial experience; five years healthcare management experience; minimum of six years senior management experience in finance are required
- CPA preferred, HFM membership

4.2.7 Program Integrity Officer

Director of Compliance and Regulatory Affairs

Position Summary

Under the general direction of the Executive Director, the Directorof Compliance and Regulatory Affairs provides strategic advice and guidance for achieving ACFC goals and objectives while complying with ACLA contract requirements and Medicaid regulations for both physical health and behavioral health managed care business. He/she is responsible for the development and implementation of a robust Compliance Program to ensure compliance with key business requirements and to minimize risk issues. He/she also provides strategic guidance to the implementation of policy and initiatives in response to emerging federal health care policy.

The Director of Compliance and Regulatory Affairs manages the annual DHH contract amendment process, facilitating timely review and comments and maintaining appropriate change control procedures.

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

Principal Accountabilities

- Directs the planning and management of the Compliance Program for Louisiana, including, but not limited to the following: the development of policies and procedures; the development of an annual compliance plan; conducting internal investigations of compliance issues; directing and leading the Louisiana Compliance Committee; and conducting contract compliance audits on identified risk areas.
- Develops implements and maintains a contract compliance monitoring tool which includes all contract requirements, the assignment of responsible internal stakeholders, and documentation of compliance.
- Directs the implementation and execution of initiatives designed to resolve identified DHH contract compliance issues and to implement new DHH contract requirements and operational initiatives.
- Oversees, monitors, and enforces all FWA activities for ACLA. Recommends controls to address FWA within scope of responsibilities. Conducts confidential internal investigations at the direction of Executive management, Corporate Legal, the Corporate Compliance office, and/or Human Resources. Works closely with internal and external auditors, financial investigators, and claims processing areas.
- Works effectively with federal, state and local investigative agencies on FWA cases to ensure best outcomes, while adhering to regulatory protocols on case records. Resolves fraud and abuse program questions, problems, and concerns from members, providers, and DHH. Monitors reports to regulatory agencies monthly, quarterly and annually.
- Provides strategic advice and guidance on contract and regulatory policy matters to enable ACLA to achieve AOP goals and objectives and maintain compliance with

contract requirements and Louisiana Medicaid regulations. Negotiates issue resolution between ACLA and DHH.

- Conducts oversight of monitoring process for state regulations and provides strategic direction and guidance to ensure timely and accurate implementation of all mandated changes.
- Analyzes and summarizes Medicaid policy emerging in response to federal health care policy. Provides guidance and recommendation and directs the implementation of initiatives to come into compliance with emerging policy.
- Manages the annual DHH contract language negotiation and amendment process.
- Facilitates timely review and comment on proposed changes.
- Oversees the development and implementation of procedures for contract management and administration, including maintenance of contractual records and documentation, such as receipt and control of all contract correspondence.
- Ensures that all signed contracts are communicated to all relevant parties to provide contract visibility and awareness, and to provide interpretation to support implementation.
- Directs and oversees the implementation of initiatives to come into compliance with new contractual requirements resulting from the annual amendment process.
- Adheres to ACFC policies and procedures.
- Supports and carries out the ACFC Mission and Values.

Position Qualifications/Requirements

Education and Training

- BA/BS Business /HealthCare Industry
- Five to ten years progressive responsibility in Business or Government, health care management required

4.2.8 Grievance System Manager

Director of Member Services

Position Summary

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

Principal Accountabilities

- Plans, organizes, and directs the identification, prioritization, and implementation for improvement of strategic initiatives that improve member satisfaction with the Plan.
- Is responsible for Member Services' contribution to ACLA's accreditation certifications.
- Chairs the Member Grievance and Appeals Committee; oversees member complaints and grievances and keeps documentation of same.
- Advises Director of Plan Operations of recurring or ongoing problems and concerns.
- Coordinates problem resolution efforts with the Medical Affairs and Provider Services departments regarding complaints and grievances pertaining to quality of care or providers.
- Oversees ACLA's disenrollment program; develops strategies to improve the disenrollment rates; advises Director of Plan Operations of trends and specific problems regarding voluntary and involuntary disenrollment.
- Coordinates with ACLA's disability conversion program, ensuring that members have access to the best program for their health status.
- Develops and implements strategies for member education that increase member compliance and satisfaction with plan rules.
- Participates in quality committees.
- Ensures the availability of ongoing customer service training for Member Services staff and other employees as needed.
- Represents the Plan in a professional manner at community and governmental functions.
- Develops and directs quality improvement activities structured to achieve outcomes success.
- Maintains updated department policies and procedures.responsible for the development and distribution of culturally and linguistically appropriate print and web-based communication with members designed to meet regulatory and accreditation requirements, and member health education needs.
- Communicates with state regulatory representatives as necessary regarding member complaints and other member service issues.

- Develops and implements strategies for member education that increase member compliance and satisfaction with plan rules.
- Ensures the department's compliance with applicable regulatory requirements and company policies.
- Provides supervision and mentoring to direct reports completing performance reviews on an annual basis.
- Adheres to ACLA policies and procedures.
- Supports and carries out ACFC Mission & Values.

Position Qualifications/Requirements

Education and Training

- BA/BS degree in business, healthcare or relevant field
- Minimum of ten years of customer service experience, preferably in a healthcare setting
- Must possess at least five years of supervisory experience

4.2.9 Business Continuity Planning and Emergency Coordinator

Facilities & Emergency Management Specialist

Position Summary

Under the direction of the Director of Finance, the Facilities & Emergency Management Specialist is responsible for project building needs, including safety, security, and facility operations. This specialist manages lease agreements and security contracts. This specialist also coordinates the development, implementation, and maintenance of emergency management plans for ACLA in the event of a local or statewide emergency, including any disruption to normal business operations. The Facilities & Emergency Management Specialist ensures continuity of core services and benefits for members who are evacuated out of state or to other locations within Louisiana during disasters. This person also provides backup support to local finance for ACLA, including vendor management, sourcing oversight, and resource purchase and allocation.

Principal Accountabilities

- Manages multiple projects, including facilities service and repairs and maintenance via external vendors and the landlord, ensuring timely, high-quality completion of project tasks.
- Manages internal/external dependencies and tracks progress ensuring stated financial, operational, and timeline goals are satisfied throughout the project.
- Develops plans, document requirements, timelines, and structures for successful implementation of facilities projects.
- Provides a high degree of customer interaction, direction, coordination, and oversight of internal entities and external contractors.
- Establishes and maintains an atmosphere of urgency and optimism with regard to overcoming obstacles and achieving project goals in a timely manner.
- Provides Security/Safety Oversight.
- Provides Facility Management.
- Negotiates with vendors to acquire quotes, drawings and installation of cubes and office furniture.
- Provides Administration.
- Provides Emergency Management.
- Performs other duties as assigned.
- Adheres to ACFC policies and procedures.
- Supports and carries out the ACFC Mission & Values.

Position Qualifications/Requirements

Education and Training

- Bachelor's Degree in Business or Information Technology or equivalent business experience
- Business Continuity/Disaster Recovery (CBCP) certification or equivalent experience
- Minimum of 8 years of facilities management/business experience
- 5-7 years of progressive work experience in Emergency Management

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4.2.10 Contract Compliance Coordinator

Director of Compliance and Regulatory Affairs

Position Summary

Under the general direction of the Executive Director, the Director of Compliance and Regulatory Affairs provides strategic advice and guidance for achieving ACFC goals and objectives while complying with ACLA contract requirements and Medicaid regulations for both physical health and behavioral health managed care business. He/she is responsible for the development and implementation of a robust Compliance Program to ensure compliance with key business requirements and to minimize risk issues. He/she also provides strategic guidance to the implementation of policy and initiatives in response to emerging federal health care policy.

The Director of Compliance and Regulatory Affairs, manages the annual DHH contract amendment process, facilitating timely review and comments and maintaining appropriate change control procedures.

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

Principal Accountabilities

- Directs the planning and management of the Compliance Program for Louisiana, including, but not limited to the following: the development of policies and procedures; the development of an annual compliance plan; conducting internal investigations of compliance issues; coordinating ad hoc compliance visits; directing and leading the Louisiana Compliance Committee; and conducting contract compliance audits on identified risk areas.
- Develops, implements, and maintains a contract compliance monitoring tool which includes all contract requirements, the assignment of responsible internal stakeholders, and documentation of compliance.
- Directs the implementation and execution of initiatives designed to resolve identified DHH contract compliance issues and to implement new DHH contract requirements and operational initiatives.
- Oversees, monitors, and enforces all Fraud, Waste, and Abuse (FWA) activities for the ACLA. Recommends controls to address FWA within scope of responsibilities. Conducts confidential internal investigations at the direction of Executive management, Corporate Legal, the Corporate Compliance Office, and/or Human Resources. Works closely with internal and external auditors, financial investigators, and claims processing areas.
- Provides strategic advice and guidance on contract and regulatory policy matters to enable ACLA to achieve AOP goals and objectives and maintain compliance with

contract requirements and Louisiana Medicaid regulations. Negotiates issue resolution between ACLA and DHH.

- Conducts oversight of the monitoring process for state regulations and provides strategic direction and guidance to ensure timely and accurate implementation of all mandated changes.
- Analyzes and summarizes Medicaid policy emerging in response to federal health care policy. Provides guidance and recommendation and directs the implementation of initiatives to come into compliance with emerging policy.
- Manages the annual DHH contract language negotiation and amendment process.
- Facilitates timely review and comments on proposed changes.
- Oversees the development and implementation of procedures for contract management and administration, including maintenance of contractual records and documentation, such as receipt and control of all contract correspondence.
- Ensures that all signed contracts are communicated to all relevant parties to provide contract visibility and awareness, and interpretation to support implementation.
- Directs and oversees the implementation of initiatives to come into compliance with new contractual requirements resulting from the annual amendment process.
- Adheres to ACFC policies and procedures.
- Supports and carries out the ACFC Mission and Values.

Position Qualifications/Requirements

Education and Training

- BA/BS Business /Health care Industry
- Five to ten years progressive responsibility in Business or Government, health care management required

4.2.11 Quality Management Coordinator

Director Quality Management

Position Summary

Under the general direction of the Corporate Clinical Quality Lead and ACLA Network Medical Director, the Director of Quality Management is responsible and accountable for the successful, ongoing development, refinement, implementation, measurement, ongoing quality improvement, and effectiveness of ACLA's Quality Management (QM) and Quality Improvement (QI) Programs. This Director works directly with senior executives to plan, organize, and direct the identification, prioritization, and implementation of strategic projects that improve financial, service, and clinical outcomes for ACLA. Additionally, the position is responsible and accountable for ongoing maintenance of ACLA's compliance with state regulations and NCQA/URAC standards for activities related to Quality, Care Coordination, and Utilization Management. This includes quality of care investigations, as well as the corresponding inter- and intra-departmental coordination, communication, and education. The Director of Quality Management provides primary oversight and responsibility for ACLA's Quality and Medical Management Committee structure and support.

In addition, the Director of Quality Management provides functional support to the Network Management, Informatics, Information Solutions, Care Coordination, Utilization Management, and Public Affairs departments to integrate Quality Management initiatives and goals with organizational programs. The Director of Quality Management plays an active role in the dissemination of the Quality Management best practices throughout ACFC and assists with new business opportunities and implementation.

Principal Accountabilities (QM)

- Works directly with senior executives to plan, organize, and direct the identification, prioritization, and implementation of strategic projects that improve financial, service, and clinical outcomes for ACLA.
- Maintains current knowledge of all NCQA/URAC accreditation standards and other regulations that effect ACLA's compliance.
- Ensures systemic and individual quality of care and resolving, tracking, and trending quality of care grievances.
- Develops and oversees a process for ongoing monitoring and updating of ACLA accreditation and Clinical Services aspects of ACLA's compliance infrastructure.
- Provides direct oversight for the process and staff associated with Quality of Care Review to ensure compliance with documented process, regulatory, and accreditation requirements.
- Provides direct oversight for the processes and staff associated with delegation oversight to ensure compliance with documented process, regulatory, and accreditation requirements. Ensures Plan requirements are appropriately communicated to the delegate; evaluates the delegate's routine and ad hoc response and takes appropriate action. Ensures required approvals for new and ongoing delegation arrangements are obtained.

- Champions the use of and acts as a resource for the dissemination of the Quality Management best practices throughout ACFC. Participates in the development and response for new business opportunities.
- Develops and implements systems to support the Quality Improvement Committee (QIC) and subcommittee structure, including minutes, QI activities, and other reports as required.
- Provides guidance and structure for development and implementation of structured quality and service Quality Improvement Activities.
- Directs the gathering and management of statistical and quantitative data supporting patient outcomes, quality management performance, and overall program effectiveness in accordance with Plan Quality Management standards.
- Provides clinical support to QM staff, including interpretation of regulations, and clinical and administrative data analysis to support outcome decisions.
- Coordinates the development of the QM program description, QM evaluation and QM workplan for the Medical Affairs division.
- Participates in coordination of internal ACLA and external Provider directed communication regarding issues impacting Quality Management and Accreditation.
- Develops and recommends a consolidated operating budget and submits to senior management for approval. Reviews and authorizes disbursement of funds in accordance with operating procedures.
- Adheres to ACFC policies and procedures.
- Supports and carries out the ACFC Mission & Values.
- Complies with HIPAA and ACFC confidentiality requirements.

Position Qualifications/Requirements

Education and Training

- Bachelor's Degree and 5 to 10 years in clinical areas with 5 or more years in managed care
- Training in Quality Management, such as Six Sigma
- Experience in quality management and quality improvement
- Prior URAC or NCQA Accreditation experience
- Current Louisiana RN license required; Registered Nurse

4.2.12 Performance/Quality Improvement Coordinator

Director Quality Management

Position Summary

Under the general direction of the Corporate Clinical Quality Lead and ACLA Network Medical Director, the Director of Quality Management is responsible and accountable for the successful, ongoing development, refinement, implementation, measurement, ongoing quality improvement, and effectiveness of ACLA's Quality Management (QM) and Quality Improvement (QI) Programs. Works directly with senior executives to plan, organize, and direct the identification, prioritization, and implementation of strategic projects that improve financial, service, and clinical outcomes for ACLA. Additionally, the position is responsible and accountable for ongoing maintenance of ACLA's compliance with state regulations and NCQA/URAC standards for activities related to Quality, Care Coordination, and Utilization Management. This includes quality of care investigations, as well as the corresponding inter- and intra-departmental coordination, communication, and education. The Director of Quality Management provides primary oversight and responsibility for ACLA's Quality and Medical Management Committee structure and support.

In addition, the Director of Quality Management provides functional support to the Network Management, Informatics, Information Solutions, Care Coordination, Utilization Management, and Public Affairs departments to integrate Quality Management initiatives and goals with organizational programs. The Director of Quality Management plays an active role in the dissemination of the Quality Management best practices throughout ACFC and assists with new business opportunities and implementation.

Principal Accountabilities (QI)

- Works directly with senior executives to plan, organize, and direct the identification, prioritization, and implementation of strategic projects that improve financial, service, and clinical outcomes for the Plan.
- Develops and monitors goals and milestones designed to further the success of the Quality Management Program within the framework of the organization's annual operating goals and strategic plan. Works collaboratively with the Network Management, Informatics, Information Solutions, Utilization Management, Care Coordination, and Public Affairs departments to integrate Quality Management initiatives and goals with organizational programs.
- Works collaboratively with clinical analysts, statisticians and various ACFC functional departments to develop baseline quantitative analysis (clinical and service outcomes) of members and providers.
- Formulates measurable Quality Management goals based on quantitative analysis, ACFC corporate goals, and regulatory expectations and requirements. Develops specific and quantifiable methods for measuring outcomes.
- Develops trended reports with appropriate action plans for submission to Quality Committees, as appropriate.
- Adheres to ACFC policies and procedures.

- Supports and carries out the ACFC Mission & Values.
- Complies with HIPAA and ACFC confidentiality requirements.

Position Qualifications/Requirements

Education and Training

- Bachelor's Degree and 5 to 10 years in clinical areas with 5 or more years in managed care
- Prior URAC or NCQA Accreditation experience
- Current Louisiana RN license required; Registered Nurse
- Professional certification in CPHQ and CHCQM

4.2.13 Maternal Child Health/EPSDT Coordinator

Manager Integrated Care Management

Position Summary

Under the general direction of the Director of Integrated Care Management, the Maternal Child Health/EPSDT Coordinator is responsible for the successful and ongoing development, refinement, implementation, measurement, quality improvement, and effectiveness of ACLA's Care Coordination department and the Case Management/Care Coordination (CM/CC) Program. The CM/CC program is a blended model that provides comprehensive case management and disease management services to the highest risk health plan members.

Principal Accountabilities

- Plans, organizes, and directs the development and implementation of CM/CC program. Ensures staff is properly trained, oriented, and provided with regular professional development. Identifies opportunities for improvement, both clinical and administrative, and assists the Director in the strategic planning processes for these functions. Is responsible for working with cross functional teams that direct and plan preventive health care strategies for preventive services, including EPSDT. Works collaboratively with these teams to ensure that initiatives developed are sufficient in scope to impact performance measure goals and are timely executed.
- Coordinates and implements the development of recommended policies and programs. Coordinates, establishes, and monitors achievement of departmental goals and objectives. Responsible for achievement of assigned NCQA standard compliance and compliance with all applicable state and federal laws, as well as achievement of assigned incented health outcomes.
- Directs effectiveness of existing programs and services, and identifies and evaluates new programs and services to address cost effectiveness, proposed process improvements, and the achievement of compliance with NCQA and state incented health outcomes.
- Ensures the receipt of maternal and postpartum care services, promotes family planning, coordinates assistance for maternal/child health and EPSDT, and works with community partners.
- Participates in and supports the corporate Medical Management Strategy.
- Directs the CM/CC activities to be in compliance with the PerforMED Model for CM/CC.
- Develops and recommends a consolidated operating budget and submits to Director for approval. Reviews and authorizes disbursement of funds in accordance with operating procedures. Monitors monthly financial statements for areas of responsibility to determine and recommend adjustments.
- Directs the coordination of positive inter- and intra-communication to share information regarding quality of care, member issues, and cost effective services. Works across departmental lines to achieve objectives.
- Creates and supports an environment that fosters teamwork, cooperation, respect, and diversity. Establishes and maintains positive communication and professional demeanor with ACFC employees and providers, and acts as a liaison with outside entities as required. Demonstrates and supports commitment to corporate goals and mission.

- Adheres to ACFC policies and procedures.
- Supports and carries out the ACFC Mission & Values.
- Attends required training on an annual basis.
- Performs other related duties and projects as assigned.

Position Qualifications/Requirements

Education and Training

- Bachelor's Degree with Louisiana Nurse/Physician/Physician Assistant License
- Master's Degree in absence of Louisiana Nurse/Physician/Physician Assistant License; CPHQ or CHCQM is an alternative or added qualification
- 3 to 5 years of CM/CC experience preferred and at least 3 years' experience as a case manager; Certification (CCM) as a Case Manager required within 2 years of accepting position
- Current unrestricted Registered Nurse License in the state of Louisiana required
- Professional certification in a clinical specialty

4.2.14 Medical Management Coordinator

Medical Director of Utilization

Position Summary

The Medical Director is the key leader providing organizational leadership in the operational areas of utilization review, case management, and related policy and practice initiatives. This Director will serve as the lead utilization or medical management coordination for the ACLA plan working closely with regional medical management team members. The Medical Director of Utilization's primary responsibility lies in leading the development and implementation of medical policy as it relates to health services utilization.

Principal Accountabilities

- Assists in the development and implementation of medical policy, including recommendations for modifications to enhance efficiency and effectiveness.
- Assures compliance with medical policy.
- Maintains compliance and Medicaid management requirements with the DHH and CMS guidelines.
- Directs the efforts of the utilization review, case management, and pre-certification functions to accomplish objectives within policy and budget, including implementing and analyzing appropriate interventions based on utilization data.
- Performs daily medical reviews ensuring consistent application of appropriate medical necessity criteria, including ensuring that appropriate concurrent review and discharge planning of inpatient stays is conducted.
- Oversees the quality management function in the identification and analysis of medical information, to develop interventions to improve quality of care and outcomes, and to ensure proper provision of CCMP services for participants.
- Collaborates with Medicaid Medical Director to implement programs, including chronic care management, medical case management, and pharmacy and other issues identified by DHH.
- Assists in implementation, administration, and improvement of DHH's goals for health care reform.
- Meets with key provider representatives in order to develop and facilitate positive working relationships.
- Adheres to AmeriHealth Caritas confidentiality codes at all times, respecting the dignity and privacy of all members, providers, and associates.
- Obtains necessary educational requirements to maintain professional licensure and certifications.
- Serves on various committees as assigned by ACLA or DHH.
- Complies with ACLA and HIPAA confidentiality requirements to protect members' personal, identifiable health information.
- Maintains confidentiality of all company, provider, and participant information.
- Adheres to ACLA policies and procedures.
- Supports and carries out the ACFC Mission & Values.

Position Qualifications/Requirements

Education and Training

- MD (M.D. or D.O)
- Must be licensed to practice in Louisiana as a Medical Director
- Minimum of two years' full-time experience practicing medicine and a minimum three (years' experience in one or a combination of the following:
- Full-time experience as an administrator in a Medicare or state-level Medicaid program, Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), large Health Care Organization, health plan or any combination thereof, or
- Full-time medical facility administration or medical facility management experience
- Must be Board-certified in his/her medical specialty
- Must be clear of any sanctions by the State of Louisiana or Office of the Inspector General
- Must not be prohibited from participating in any federally or state funded healthcare programs

4.2.15 Provider Services Manager

Director Provider Network Management

Position Summary

This position is responsible for all hospital, physician, and physician extender network development and management. This position is also responsible for implementing strategies to improve provider satisfaction. This Director coordinates communications between subcontracted providers and ACLA. This position will interact with Hospital and Physician Practice Chief Executive Officers, Chief Financial Officers, Directors of Managed Care, and other high level executives. This Director ensures that this department achieves annual goals and objectives.

Principal Accountabilities

- Is responsible for understanding new information technology from a strategic perspective and leading the corporate effort to employ new technologies applicable to Provider Network Management (PNM). Works with external customers/providers, other business areas, and IT staff to reengineer existing processes through the use of technology.
- Maintains a comprehensive understanding of the capacities and limitations of systems affecting service to providers, and achieve maximum productivity from these systems, e.g., Facets, I-Exchange, MedDecision, and NaviMedix.
- Is responsible for leading system implementations, upgrades, and ongoing management of on-line communication systems linking providers to ACLA. This includes ongoing management of the relationship with the IT vendor.
- Is responsible for physician and facility provider profiling to allow relevant interventions to correct provider inefficiencies.
- Is responsible for establishing medical policy, in conjunction with Patient Care Management and Finance, and for informing Service Operations of all necessary code, fee, and clinical edit changes. Is responsible for medical policy control provider payments of nearly $1 billion.
- Is responsible for evaluation of all system upgrades, system configuration changes, and installations for PNM.
- Is responsible for all relevant code and fee schedule analysis and updates.
- Is responsible for leading system upgrades and configuration changes related to national billing standards and correct coding initiatives to ensure ACLA remains compliant with industry guidelines.
- Is responsible for accurate, effective PCP compensation, including management of conversion of PCPs to and from capitation.
- Is responsible for effective participation in and technical support of the Data Integrity Project, which is charged with correcting and avoiding disconnects between Finance, Patient Care Management, and Provider Network Management databases and data analysis processes.
- Negotiates all PCP and ancillary service contracts; identifies and corrects all performance deficiencies.
- Manages the ACFC relationships with the ancillary providers.

- Meets with key ancillary provider representatives in order to develop and facilitate positive working relationships.
- Oversees rate negotiations and adjustments, with appropriate input from all relevant ACLA associates.
- Continually analyzes ancillary providers' utilization trends to identify critical issues, analyzes these issues, proposes issue resolutions for senior management review, and implements approved interventions.
- Works with Provider Support Services to ensure the ancillary providers are set-up accurately in the system, and in a timely manner.
- Manages all service visits and educational efforts to ancillary providers. Works in conjunction with Director of Provider Communications to ensure production of current educational materials for providers.
- Works with Manager and Business Analyst Specialist II to ensure that Provider Contracting meets ACFC standards around Provider Availability and Provider Accessibility.
- Supports the Medical Provider and Network/Membership strategies.
- Manages staff effectively in pursuit of the following goals: complete "employment engagement," sustained productivity, and efficiency.
- Demonstrates ability to keep staff motivated and performing effectively, and displays willingness to help staff develop to full potential.
- Makes optimal use of available human resources and structures operations in a fashion which maximizes quality and production.
- Coordinates the personnel requisition, interview, and hiring processes for all approved positions.
- Assists staff with diplomatic problem resolution.
- Demonstrates working knowledge of ACFC Policies and Procedures by relaying accurate information.
- Renders technical advice and assistance to staff on a prompt and ongoing basis relative to policies, procedures, and specific operational aspects of Cost Containment and Claims Processing, Finance, General Administration, Member Services/Marketing, Special Projects, Information Systems and the Utilization Review Department; such advice and assistance is consistent with established policies, methodologies, and goals.
- Acts as a liaison for interface with other departments and intercedes as necessary to assure timely responses to Provider issues.

Position Qualifications/Requirements

Education and Training

- Bachelor's Degree (or higher) degree preferred in a health related field and licensure as a health professional (where such licensure is available); or certification as a case manager (as documented and accepted on URAC's website @ www.urac.org)
- 3 to 5 years of Case Management experience preferred and at least 3 years' experience as a case manager; Certification as a Case Manager is required within 1 year of accepting position & Professional certification in a clinical speciality
- Current unrestricted Registered Nurse License required

4.2.16 Member Services Manager

Director Member Services

Position Summary

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

Principal Accountabilities

- Plans, organizes, and and directs the identification, prioritization, and implementation for improvement of strategic initiatives that improve member satisfaction with ACLA.
- Is responsible for Member Services' contribution ACLA's accreditation certifications.
- Oversees ACLA's disenrollment program; develops strategies to improve the disenrollment rates; advises the Director of Plan Operations of trends and specific problems regarding voluntary and involuntary disenrollment.
- Coordinates with ACLA's disability conversion program, ensuring that members have access to the best program for their health status.
- Develops and implements strategies for member education that increase member compliance and satisfaction with plan rules.
- Participates in quality committees.
- Ensures the availability of ongoing customer service training for Member Services staff and other employees as needed.
- Represents ACLA in a professional manner at community and governmental functions.
- Develops and directs quality improvement activities structured to achieve outcomes success.
- Maintains updated department policies and procedures.
- Chairs Member Grievance and Appeals Committee; oversees member complaints and grievances and keeps documentation of same.
- Advises the Director of Plan Operations of recurring or ongoing problems and concerns.
- Coordinates problem resolution efforts with the Medical Affairs and Provider Services departments regarding complaints and grievances pertaining to quality of care or providers.
- Is responsible for the development and distribution of culturally and linguistically appropriate print and web-based communication with members designed to meet regulatory and accreditation requirements, and member health education needs.
- Communicates with state regulatory representatives as necessary regarding member complaints and other member service issues.
- Develops and implements strategies for member education that increase member compliance and satisfaction with plan rules.

- Directs the development, design, internal and DHH approval process, production, and distribution of all print and web-based member communications for the Louisiana lines of business including, but not limited to, the Member Handbook, the member newsletter, the Welcome Kit, member website content, member web portals, Enrollment Broker materials, and ad-hoc member mailings. Ensures that materials are delivered on-time and within budget. Identifies opportunities for achieving efficiencies in the production of member materials, and directs the implementation of process changes to achieve efficiencies and cost savings.
- Directs the development and implementation of an annual review process for all member materials to ensure materials are up-to-date with current contractual requirements and regulations and to ensure that materials meet the needs of members with limited English proficiency and low health literacy.
- Ensures the department's compliance with applicable regulatory requirements and company policies.
- Provides supervision and mentoring to direct reports completing performance reviews on an annual basis.
- Adheres to ACLA policies and procedures.
- Supports and carries out ACFC Mission & Values.

Position Qualifications/Requirements

Education and Training

- BA/BS degree in business, healthcare or relevant field
- Minimum of ten years of customer service experience, preferably in a healthcare setting
- Must possess at least five years of supervisory experience

4.2.17 Claims Administrator

VP Claims

Position Summary

The Vice President, Claims is responsible for the enterprise direction and organization of all operational activities related to the claims function, including claims system processes, claims business rules, and timely, accurate claims payment in accordance with established SLAs, stringent quality standards, and state and federal regulatory requirements. Oversight includes claims systems utilization, capacity analysis/planning and reporting. The scope of this role is to support the enterprise's portfolio of product lines, health plans, TPAs, and other potential projects and product types.

Principal Accountabilities

- Provides direction and accountability for the front-end claims processing, claims projects, and research and analysis; accountable for root cause analyses of claims issues and implementation of enterprise-wide solutions.
- Is accountable for meeting established regulatory, contractual, and operational standards and goals as it relates to the performance and services of the enterprise claims function. This includes achievement of time to pay requirements and all internal and external quality levels for both claims processing and claims payment.
- Ensures timely processing of claims and compliance with industry fair claims practices and applicable state regulations concerning the processing of claims and cost avoidance.
- Identifies systems enhancements to improve quality in claim processing to ensure minimization of claims recoupments.
- Ensures coordination to collect and report reliable encounter data to meet the DHH reporting requirements.
- Interfaces with external stakeholders (e.g. high-profile providers) and internal and external clients (e.g. TPA clients, health plans, product lines, etc.) to assist with and resolve claims issues.
- Engages external partners and provides oversight of the intake of claims through electronic and paper clearinghouses to ensure completeness of claim submissions and diagnose any potential issues.
- Acts as the business owner of all automation of claims processing to optimize the claims system's capability to auto-adjudicate claims; owns all related decisions and changes.
- Works with Workforce Management to ensure appropriate capacity and staffing levels for ongoing and future operations.

Position Qualifications/Requirements

Education and Training

- BA/BS degree in business, healthcare or relevant field
- 10 – 15 yrs. experience in Health Care;
- 10 - 12 yrs. claims center management experience, with experience managing a large claims staff preferably in multiple locations.

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4.2.18 Provider Claims Educator

Director Provider Network Operations

Position Summary

Under the general supervision of the Director of Plan Operations and Administration, the Director Provider Network Operations is responsible for managing/overseeing the efficient and effective local operational functions. This Director ensures that plan policies and procedures meet all applicable regulatory standards and have gained approval from all stakeholders, and he/she ensures that the downstream impact of all policy and procedure changes are communicated to Providers and ACLA systems. This Director must be available during DHH working hours, 40 hours per week.

Principal Accountabilities

- Supports Director of Plan Operations as contact support for local management team, state, and providers as it relates to operational functions.
- Oversees Network Operations function on behalf of health plan and manages ACLA's Provider Communications in consultation with subject matter experts. Manages indexing, archiving and retrieval, posting to Provider Portal, and exchange of information between these systems and providers.
- Is responsible for the day to day management and accuracy of provider data and information as the entry point for such data into ACFC systems. Coordinates provider data information between network management, credentialing, and provider maintenance teams. Manages education for providers regarding claims submission requirements, coding updates and electronic claims transactions. Integrates claims processing, grievances, provider relations systems, and facilitates the exchange of information between these systems and providers.
- Identifies trends and guides the development and implementation of strategies to improve the provider satisfaction.
- Monitors daily staff activities of the operational areas through appropriate direction of management team and interfaces with ACFC's call center to compile, analyze, and disseminate information from provider calls.
- Is responsible for development and promotion of provider and claims education, including all provider materials. This includes, but is not limited to the provider handbook, provider website, provider newsletter, and provider directory.
- Is responsible for the day to day management and auditing of provider reimbursement methodologies and for updating codes and fee schedules for correct reimbursement to providers.
- Is responsible for supporting the enterprise encounter reconciliation process and implementing corrective actions as needed to ensure compliance with state requirements. Works in collaboration with Enterprise Operations team to streamline processes, and to identify and resolve issues related to reimbursement, provider demographics, and service codes.

- Is responsible for auditing and coordinating with the Enterprise Recovery team and internal and vendor recovery projects to ensure correct local state processing rules are applied.
- Ensures compliance with departmental policies and procedures, service standards, corporate mission, and goals.
- Monitors and maintains appropriate staffing levels to assure delivery of quality product.
- Acts as a liaison between the local office and Enterprise Network Operations.
- Performs other job related duties and projects as assigned.
- Is required to multi-task and crisis manage as necessary to assure client requirements are met and maintained.
- Ensures adherence to budgetary objectives. Manages and monitors budgeted staff ratios and dollars.
- Exhibits leadership behavior with people and relationships, with processes, and with personal accountability, and consistently coaches and finds creative ways to develop team members.
- Demonstrates CQI principles by presenting new ideas and opportunities while motivating others to apply CQI principles to daily work.
- Displays strong communication skills including listening, providing effective feedback, and the ability to work effectively with a wide range of constituencies in a diverse community.
- Works well with a team.
- Builds on the ideas of others to help solve problems.
- Seeks and shares information freely.
- Makes administrative and procedural decisions and judgments on sensitive, confidential issues
- Adheres to ACFC policies and procedures.
- Supports and carries out the ACFC Mission & Values.

Position Qualifications/Requirements

Education and Training

- Bachelor's Degree
- Previous experience in developing and delivering presentations
- Working knowledge and strategic understanding of medical billing principles, procedures, ICD-9, ICD-10, and/or CPT medical billing codes and documentation
- Minimum of eight years progressive business management experience, preferably in Healthcare
- Minimum three years managed care provider reimbursement/contracting/claims experience
- Previous experience in a role managing relationships with clients

4.2.19 Case Management Administrator

Director Integrated Care Management

Position Summary

Under the general direction of the Medical Director, the Director of Integrated Care Management (ICM) is responsible for the successful, ongoing development, refinement, implementation, measurement, ongoing quality improvement, and effectiveness of the Plan's Care Coordination department and the Case Management/Care Coordination Program (CM/CC). The CM/CC program is a blended model that provides comprehensive case management and disease management services to the highest risk health plan members. In addition, the Director ICM will provide functional support to the Network Management, Informatics, Information Solutions, Quality Management, Utilization Management, and Public Affairs departments to integrate Care Coordination initiatives and goals with organizational programs. The Director ICM plays an active role in the dissemination of the Care Coordination model (PerforMED) throughout ACLA and assists with new business opportunities and implementation. The Director ICM is responsible to ensure consistency and conformance to all applicable standards and regulations.

Principal Accountabilities

- Plans, organizes, and directs the development and implementation of Case Management. Ensures staff is properly trained, oriented, and provided with regular professional development. Identifies opportunities for improvement, both clinical and administrative, and assists the Director in the strategic planning processes for these functions.
- Coordinates and implements the development of recommended policies and programs. Coordinates, establishes, and monitors achievement of departmental goals and objectives. Responsible for achievement of assigned NCQA standard compliance and compliance with all applicable state and federal laws, as well as achievement of assigned incented health outcomes.
- Directs effectiveness of existing programs and services, identifies and evaluates new programs and services to address cost effectiveness, and proposes process improvements and to achieve compliance with NCQA and state incented health outcomes.
- Participates in and supports the corporate Medical Management Strategy.
- Directs the case management activities to be in compliance with the PerforMED Model for case management.
- Develops and recommends a consolidated operating budget and submits to Director for approval. Reviews and authorizes disbursement of funds in accordance with operating procedures. Monitors monthly financial statements for areas of responsibility to determine and recommend adjustments.
- Directs the coordination of positive inter- and intra-communication to share information regarding quality of care, member issues, and cost effective services. Works across departmental lines to achieve objectives.
- Creates and supports an environment that fosters teamwork, cooperation, respect, and diversity. Establishes and maintains positive communication and professional demeanor with ACFC employees and providers, and acts as a liaison with outside entities as required. Demonstrates and supports commitment to corporate goals and mission.

- Adheres to ACFC policies and procedures.
- Supports and carries out the ACFC Mission & Values.
- Performs other related duties and projects as assigned.

Position Qualifications/Requirements

Education and Training

- Case Management certification required (CCM)
- Two years' experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities
- Two years' managed Medicaid experience preferred
- Minimum five years' management/supervisory experience required.
- Minimum two years' project management experience preferred, preferably at management level
- NCQA accreditation
- Active Louisiana RN license

4.2.20 Information Management & Systems Director

Senior Vice President Information Systems

Position Summary

Reporting to the Chief Operating Officer, the Senior Vice President Information Systems (SVP-IS) has overall responsibility and accountability for the design, development, release, and maintenance of technology systems and services for all ACFC business functions. The SVP-IS acts as the highest technical interface with technical and non-technical users in determining the overall Information Systems (IS) approach within the organization. This officer works closely with customers, colleagues, and other stakeholders to identify and maximize opportunities to utilize technology, improve business data processes, and promote the strategic use of information technology for the nation's largest multi-state Medical Assistance (Medicaid) managed care organization with over 5,000 employees and over two million members.

Principal Accountabilities

- Develops organizational technology strategies by investigating and understanding informational, clinical, business, and operational requirements. Identifies, prioritizes, and implements IT initiatives that align with the long-term organizational strategy. Executes those strategies through consultation with the Executive Team and the Chief Operating Officer.
- Establishes and maintains connectivity with DHH information systems, and providing necessary and timely reports to the DHH.
- Develops the necessary supporting strategies, including systems development, hardware acquisition, and integration of all information systems.
- Provides leadership, vision, and direction for technology systems and ensures support of business objectives and requirements behind those systems.
- Demonstrates a thorough understanding of competing architectures and industry trends. Effectively communicates highly technical aspects of architecture and integration to management and clients, including the short-term and long-term impact on internal and external customers.
- Ensures the consistency and maintainability of existing applications by creating, maintaining, and enforcing standards and procedures for technical solutions throughout the business. Has overall responsibility for ensuring that the integration of components and data is both flexible and progressive.
- Prepares enterprise objectives and budgets to facilitate the orderly and efficient capture, storage, processing, and dissemination of information. Identifies opportunities to reduce redundancy, streamline processes, improve quality, and reduce costs.
- Identifies emerging information technologies to be assimilated, integrated, and introduced within the company. Creates and implements an IT infrastructure that supports the organizational strategic objectives.
- Assesses and improves the infrastructure and resources (both human and technical) for the technology production environment, with the result being improved reliability and resulting business unit confidence in critical technology infrastructure.

Position Qualifications/Requirements

Education and Training

- Master's degree or equivalent work experience required
- Ten years of experience in information systems, with at least five years of project management and/or major development project experience within a large-scale systems environment.
- Previous experience in business process re-engineering or process improvement involving broad-based information systems utilizing tools and techniques to affect business change is desired.
- Demonstrated track record of working collaboratively with business partners in the application of technology to solve problems, reduce costs and expand business.
- Must possess the ability to change direction when necessary, welcome new ideas, and respond effectively to change in demands and priorities.
- Experience with e-commerce and web-based technologies and products are necessary as is the exposure to multiple hardware and software platforms within a client / server context.
- Experience with systems such as FACETS and MedDecision will be a distinct plus. In addition, experience that includes working closely with I/T in the development and implementation of large-scale systems is preferred.
- Experience with data processing and data reporting.

4.2.21 Encounter Data Quality Coordinator

Business Analyst Data Systems

Position Summary

This position requires analyzing the business requirements related to application and data systems, and directing the testing and implementation of new systems, or changes to the current system, as required, to meet the contractual needs of the business and improve processes. This Analyst will be responsible for business and application analysis, quality assurance and testing, project management, and other duties as assigned. This position will maintain expert knowledge of business processes in regards to direction, structure and requirements, the identification of deficiencies, and the recommendation of system improvements. This Analyst must have expert functional knowledge of organizational systems deployed by the business, and must also maintain expert knowledge of national health industry standards for levels of care, procedural coding, care coordination, provider networks, and claim processing. This position requires that the Analyst maintain expert knowledge of all specific contractual obligations and requirements, research and troubleshoot system and application defects, and work with vendors or developers for resolution. This position requires research and identification of data integrity errors and working with database administrators and/or data entry clerks for resolution.

This Analyst defines test conditions and develops accurate and complete testing scenarios prior to implementation of new processes or application changes. He/she also defines the scope of projects and develops implementation strategies and plans for release of new functionality, systems, and processes. This Analyst coordinates activities with all departments and technical personnel as required for roll out of new systems, and creates and maintains project plans and schedules for testing, preparation, and implementation. He/she assesses operational impacts related to projects in regards to data integrity, workflow, and training and addresses these impacts accordingly as required for successful implementation. This Analyst also completes duties and assignments as directed.

Principal Accountabilities

- Performs EDI 837 (claim) analysis: reconfigures format of files to verify presence of state required data in “loops”, “segments” and “data elements.”
- Audits reported data for HIPAA compliance in both content and format. Utilizes external HIPAA regulation website to perform audit.
- Verifies and prepares for transmission information in EDI 837 file, cross-checking between State Companion Guide and Federal Implementation Compliance Guide. Ensures information is mapped according to both state and federal regulations.
- Resolves EDI 837 cross-check discrepancies.
- Resolve EDI 837 data content issues in response to business partners’ audit of information received.
- Communicates as necessary with business partners to resolve issues.
- Acts as liaison between our subcontractors (e.g., Oral Dental, Davis/IBC Vision) and the state to assist in resolving data submission errors by subcontractors.
- Retains knowledge of state’s EDI formats.

- Adheres to ACFC policies and procedures.
- Supports and carries out the ACFC Mission & Values.

Position Qualifications/Requirements

Education and Training

- Bachelor's Degree in Computer Science or a related field and 3-4 years' experience in a similar role, or an equivalent combination of education and work experience
- 3 to 5 years of progressively more responsible related work experience, necessary in order to gain understanding of application data systems, operations, quality assurance processes, and business analysis skills
- Experience with client/server architectures and the basic function and process of computers, software applications, networking and computer technology
- 1 to 3 years' technical experience in creation and use of SQL queries

G.1. Network Development

G.1 Provide a plan to build a statewide provider network to adequate (Section 7.0) for a membership of 250,000 members that in accordance with the specifications found in Section 7.0 of the RFP and specific efforts to recruit and retain participation quality providers in the Louisiana Medicaid program.

Include your process and policies for utilization of out of network providers and your plan to address any gaps in local coverage and maintain adequacy throughout the term of the contract.

Overview

Leveraging our years of relationship building in Louisiana, AmeriHealth Caritas Louisiana (ACLA) implemented an initial resource-intensive campaign to contract our current network. For more than 17 years, senior leadership had been working with various providers, administrations, and associations as Louisiana considered Medicaid managed care programs. While the challenges of creating a statewide network were significant, ACLA was uniquely positioned to develop a comprehensive network for our members; we did so and began providing access to health care for our members in 2012.

In accordance with the Bayou Health MCO RFP, Appendix FF is included in our submission. We also include GeoAccess mapping of our network at the end of Section G as Attachment G.1-A. Additionally, we include our provider network listing in digital format on CD.

Network Development Plan

The ACLA Provider Network Management (PNM) department has developed and maintains an annual development plan that ensures the provision of core benefits and services. To meet our mission of helping families get care, stay well, and build healthy communities, our network development plan involves the following steps.

- **Recruiting providers**: ACLA recruits providers with consideration of the number of Medicaid members, the number and types of providers needed to serve them, and the geographic location of providers and members. We recruit providers through multiple avenues to maintain a complete network.
- **Contracting providers**: ACLA contracts providers in accordance with GeoAccess standards and develops action plans to overcome network challenges in any areas, including increased outreach, focused recruitment efforts, and the execution of single-case agreements as needed.
- **Assisting providers**: ACLA's PNM team is a local presence that actively supports providers and members through close relationships, education, and frequent on-site visits. The team bridges gaps between the provider and member, ensuring clear communication and effective service delivery.

In addition to promoting a sound and consistent contracting and credentialing experience, we promote a network development process that:

- Maintains a compliant statewide network to support a capacity of 250,000 members in the network
- Identifies and builds upon the strengths of our provider community
- Develops, maintains, and monitors an appropriate provider network supported by written agreements
- Monitors network compliance with DHH and ACLA policies, including the grievance and appeal process, to ensure continuity of member care.
- Assesses the quality of network services
- Provides adequate access to all required services included in the contract and identifies capacity to meet the unmet needs of members, families, and community
- Actively recruits among providers who are significant traditional Medicaid providers to support continuity of care
- Works within our network to clarify capacity and ensure timeliness of access according to contract requirements

ACLA will not enter into a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another Bayou Health Plan, or in which ACLA represents or agrees it will not contract with another provider. ACLA will not advertise or otherwise present itself as having an exclusive relationship with any service provider.

Network Development

The provider network is designed to reflect the needs and service requirements of ACLA's member population. In accordance with 42 CFR 438.206(b) (1), ACLA considers the following elements when developing and maintaining its provider network:

- Anticipated maximum number of Medicaid members
- Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the plan
- Number and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core benefits and services
- Number of contracted providers who are not accepting new plan members
- Geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid members with disabilities

Provider Recruitment

Initial contracting outreach efforts focused on the recruitment of Louisiana Office of Public Health (OPH), all OPH-Certified School-Based Health Clinics, all small rural hospitals that meet the definition of the Rural Hospital Preservation Act of 1997, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act.

Additional network development focused contracting efforts on Louisiana Medicaid significant traditional providers (STPs) currently caring for our target member population. The contracting of these providers allowed minimum disruption in care and presented a network with established practices to members.

Steps taken to identify and recruit external providers include:

- Ongoing outreach to increase participation of Louisiana Medicaid STPs in our network, to include three documented attempts
- Face-to-face provider meetings to engage key providers
- Provider Association outreach and collaboration
- Community recommendations through ACLA Member Advisory Council (MAC)
- Physician recommendations through ACLA Quality of Clinical Care Committee
- Potential/interested provider contacts:
    - Through the ACLA website, a provider can submit an inquiry to register interest in contracting with ACLA; Provider Network account executive then contacts provider to initiate contracting.
    - Through the ACLA Provider Services Call Unit, a provider can initiate account executive contracting outreach.

Provider Network Capacity Highlights

Highlights of ACLA's provider network capacity are shown in the table below. This information is based upon network adequacy requirements found in Addendum 6 Appendix UU of the Bayou Health MCO RFP and with a projected membership of 250,000.

Provider Type	Required Ratio Provider: Patients	ACLA Ratio	Percentage of membership with coverage
Primary Care	1:2500 1:1000		Physicians 99.8 % Physician Extenders 99.7%
Specialists			
Allergy	1:100,000	39:100,000	99.9%
Cardiology	1:20,000	343:20,000	100%
Gastroenterology	1:30,000	141:30,000	99.9%
Hematology/Oncology	1:80,000	86:80,000	100%
Nephrology	1:50,000	145:50,000	100%
Neurology	1:35,000	188:35,000	100%
OB/GYN			100%

Ophthalmology	1:20,000	234	100%
Orthopedics	1:15,000	255:15,000	99.9%
Otorhinolaryngology	1:30,000	223:30,000	99.9%
Podiatry			100%
Pulmonary Medicine			99.9%
Rheumatology			99.9%
Surgery-Cardiovascular			100%
Urology	1:30,000	149:30,000	100%

Exhibit G.1- 1: Provider Network Capacity

Major Population Centers and Overview of Current Network Access

The information below provides an overview of key contracted providers in the nine regions of Louisiana, along with an indication of network challenges and mitigation activity.

Region	Name of City	Key Contracted Providers
Northwest Louisiana	Shreveport	Christus Health System, Willis Knighton Health System BRFF Shreveport, Desoto Regional Health System, Homer Memorial Hospital, David Raines Community Clinics,

Although a Chiropractic gap exists in Caddo/Bossier parishes, it has not risen to an access issue. Contracting is in process with significant traditional providers (STPs) to fill this gap and prevent access issues.

Northeast Louisiana	Monroe	St. Francis Medical Center, Affinity Health Group, Family Care Clinic, Healthy Moms, Morehouse General, East Carroll Parish Hospital

Pediatric Endocrinology and Gastroenterology are current gaps in region 8, as there are limited pediatric sub-specialists available in this area of the state. ACLA partners with a transportation vendor to provide non-emergency transportation and mileage reimbursement for members to travel from this region to medical hubs, such as Shreveport, to obtain services. The use of telemedicine is another consideration to mitigate the need for specialized care in this region.

Central Louisiana	Alexandria	St. Francis Cabrini, Rapides Regional Medical Center, Bunkie General, Byrd Regional, Hardtner Medical Center

Through relationship development, a contract has been finalized with Imperial Calcasieu to close the current Endocrinology – Adult and Pediatric - gaps in this area.

Southwest Louisiana	Lake Charles	Lake Charles Memorial System, SWLA, Imperial Calcasieu Medical, Imperial Health, Lake Area Physicians, Apogee Medical Clinic, Chadha Medical Clinic

Through relationship development, a contract has been finalized with Imperial Calcasieu to close the current Endocrinology – Adult and Pediatric - gaps in this area.

Acadiana	Lafayette	Lafayette General, Opelousas General, Lourdes Physician Group, Iberia Medical Center, Pediatric Group of Acadiana, Women's & Children's Hospital
Capitol Area	Baton Rouge	FMOLHS, Baton Rouge General, Lane Regional Ochsner Health System, Woman's Hospital

Although access to care in the capitol area has not proven to be a barrier, specialty providers restricting their practices or limiting patient load is a concern. ACLA continues work to develop relationships and support practices with member non-compliance concerns. ACLA is finalizing a contract with the Baton Rouge General Health System that will increase specialty care access and availability in the capitol area.

Florida Parishes	Hammond	North Oaks Healthy System, North Oaks OB/GYN
	Covington/Slidell	Ochsner Health System, Access Health, Total Family Clinic

Access to adult primary care is a concern within this region. However, we have seen an increase in contracting with new graduates establishing practices in the area.

An additional barrier is the acquisition of independent traditional Medicaid providers by large integrated delivery systems (IDS) and the reluctance of the IDSs to expand Medicaid payer base, or panel restrictions placed by the IDS.

Greater New Orleans		Ochsner Health System, Daughters of Charity Tulane University Medical Center & Clinic, Excelth, LSU HealthCare Network, Children's Hospital and Children's Hospital HealthCare Network.

Although access to care in the greater New Orleans area has not proven to be a barrier, acute care discharge needs, such as home health, DME, and lower levels of inpatient care have been a consideration.

State-wide Considerations and Action Steps

ACLA works diligently to develop relationships with providers who have not historically accepted Medicaid, as the willingness to accept Medicaid as a payer has proven to be a barrier in many areas of the state. Our local Provider Network account executives are an integral resource in encouraging provider participation in Medicaid. Account executives establish a presence with potential network providers through frequent in-office visits and attendance at

trade and association events. Through these encounters, they educate providers who are unfamiliar with the program and answer questions about serving the population. They are able to address many of the underlying reasons for reluctance to participation. Account executives explain the resources ACLA offers to support providers in effectively serving our members. Our supportive strategies include efforts to educate members on the importance of preventive care and regular well-exams—but they reach beyond education and include practical steps, such as assisting members in scheduling appointments and removing barriers to keeping appointments by coordinating appointment reminders, transportation, and child care.

To increase network participation, ACLA also reaches out to new graduates seeking to build their practice. We also participate in residency programs to reach these providers. For example, ACLA's Medical Director, Dr. Spooner, is on the staff of Baton Rouge General Medical Center's residency program and educates potential new Medicaid providers through this avenue.

Despite these efforts, there are occasions when out-of-network services are needed. ACLA follows an expeditious process to negotiate single case-agreements to provide access to services in these cases.

In building our network, initial barriers existed that significantly impacted ACLA's ability to discharge members appropriately from an acute care hospital. Of note are:

Pediatric Apnea Monitors

- ACLA successfully renegotiated a contract with a Louisiana-owned and operated participating provider as single-source vendor.

Short-term Transitional Care

- ACLA is in contract negotiations with two Louisiana-owned skilled nursing organizations to provide state-wide coverage for acute care step-down needs.

Telemedicine Utilization Plan

ACLA supports the use of telemedicine to improve access to care for rural populations.

Through our contracted relationship with BRFHH Shreveport (formerly LSU Health Science Center), rural members can be connected from 24 rural hospitals throughout Louisiana to the medical center in Shreveport. The availability of specialty types such as Hematology/Oncology, Endocrinology, Cardiology, Infectious Disease, Hepatology, Pulmonology, Gastroenterology, Nephrology, and Rheumatology via telemedicine will allow rural patients to receive specialized health care, and in many cases continue to be cared for in their own communities. ACLA commits to developing a contractual relationship with the Louisiana Rural Health Information Exchange (LARHIX),

The objectives of ACLA's use of telemedicine are to:

- Increase access to care in rural areas
- Improve timeliness to diagnosis and treatment planning
- Improve quality of care

- Support the continued education and retention of rural providers

A comprehensive Telemedicine Utilization Plan will be submitted to DHH based upon schedule of events, quarterly statutory reporting, upon material change, or upon DHH request.

Utilization of Out-of-Network Providers

To ensure that members have access to care, ACLA accommodates services rendered by out-of-network providers through a single-case agreement process. If services are unavailable or cannot be performed by an in-network provider, or if transition to another provider would be disruptive to a member's treatment plan, the PNM team makes same-day contact with out-of-network providers to begin the negotiation process, which is completed in three to seven days. During this time, the ACLA UM department is engaged to ensure that a prior authorization is in place and claims related to services will be processed and reimbursed accordingly.

Mirroring our practice of personal interaction with in-network providers, ACLA keeps in close contact with out-of-network providers during this process to ensure smooth delivery and payment of services. The relationship our account executive develops with the provider through this engagement often forms the foundation for a successful contractual relationship, thus mitigating gaps and strengthening our provider network. In fact, ACLA's streamlined methodology for ensuring continuity of care for members and payment for providers through the single-case agreement process resulted in the successful re-entry of Ochsner Health System into the ACLA provider network, as described below.

Case Study in Retaining Provider Systems: Ochsner Health System

Building great relationships with providers often takes time and requires meeting challenges along the way. This was the case with ACLA's relationship with Ochsner Health System (Ochsner), a large provider system in the southeastern region.

"Ochsner leaders said they would like to keep the door open for future participation but did not feel that the partnership was working at the time," said Rebecca Engelman, Executive Director of ACLA. Engelman, along with Sherry Wilkerson, Director of PNM, went to work with their ACLA teams to ensure a smooth and precise termination process.

Using single-case agreements, the team proposed a plan that would allow several hundred members to remain in the Ochsner system for OB/GYN, transplants, and other services.

"If possible, we wanted impacted members to continue in established treatment plans at Ochsner and remain with the doctors who were currently treating them," Wilkerson said. "Continuity of care was important, as well as our ongoing quest to avoid gaps in care that may occur when member care is transferred."

The Ochsner providers agreed to the plan and were impressed with this approach. ACLA worked with its managed care team to provide the best care for our members still engaged with Ochsner over the past year. In this way, the partnership continued.

At a meeting earlier this year, Ochsner leaders indicated that they were ready to contract again with ACLA.

Credentialing oversight began, and the provider relationship resumed. Through this relationship, ACLA members have access to Southeast Louisiana's largest non-profit, academic, multi-specialty, health care delivery system: 9 hospitals, 40 multispecialty health centers, and more than 900 physicians in over 90 medical specialties.

Network Monitoring

ACLA ensures access to health care services (distance traveled, length of time to obtain an appointment, availability of after-hours care) in accordance with the Provider Manual and provider contract. ACLA works to ensure that there are accessible and adequate numbers of institutional facilities; service locations; service sites; and professional, allied, and mid-level medical personnel for the provision of core benefits and services to include emergency services as needed. ACLA monitors our network according to the standards and requirements below.

Geographic Access

GeoAccess mapping and coding of all network providers, in each service area, is prepared for each required provider type to demonstrate network capacity. Direct access to Women's Health, special conditions for prenatal providers, and second opinions are also monitored to ensure availability. ACLA reviews GeoAccess on a quarterly basis to ensure that any network improvement opportunities are addressed and our members have access to all required providers. ACLA provides updated GeoAccess coding and maps to DHH based upon schedule of events, quarterly statutory reporting, and upon material change, or DHH request.

ACLA takes corrective action if there is a network gap found, to include active recruitment and contracting outreach and use of out-of-network providers through single-case agreements as needed to provide the necessary services to a member in an adequate and timely manner. PNM ensures coordination across all internal functional areas with respect to authorization and proper claims processing and reimbursement.

In accordance with 42 CFR 438.208 (C)(4), for members determined to need a course of treatment or regular monitoring, ACLA has a mechanism in place to allow members to directly access a specialist as appropriate for member's condition, identified needs, and continuity of care.

Appointment Availability Standards

Timely access to care is of high importance; therefore, ACLA requires providers:

- To meet state standards for timely access to care and services, taking into account the urgency of the need for services

- To offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid fee for service if the provider serves only Medicaid members
- To be available 24 hours a day, 7 days a week, when medically necessary

Appointment availability and access standards are expressed to providers via the Provider Manual, during new provider orientation, and through regular site visits. Compliance with these standards is monitored regularly for primary care providers, specialists, hospitals, and ancillary providers through an annual survey conducted by a third-party entity. Gaps are identified through provider site visits, member grievances, interdepartmental communication, and regular "Mystery Shopper" surveys. Appointment availability issues are handled in an expedient manner with direct communication with respective providers, related to findings and contractual requirements. Appointment no-shows and late arrivals can result in providers having limited appointment availability. ACLA helps to reduce these occurrences by assisting provider offices with in-office scheduling and reminder calls to our members.

"Bradford (ACLA Care Connector) has been very helpful at the Goodwood location. He has always had a very welcoming demeanor. Bradford has personally assisted my clinic with two families with a history of repeat missed appointments. He called them to see what the issues were on their end in an attempt to fix the problem. He has also educated me on AmeriHealth Caritas and what the plan offers."

Manager, Pediatric Academic Clinic
Our Lady of the Lake Physician Group

The results of our 2013 annual audit of appointment availability showed an overall primary care provider (PCP) appointment availability compliance rate of 81.3%. Additionally, we audited 10% of the highest-volume specialty practices in the network. The compliance rate for specialists was found to be higher, at 91%. In an effort to mitigate the PCP compliance rate of 81.3%, account executives initiated a campaign to provide education to primary care offices that encourages providers to take advantage of ACLA member outreach staff. The outreach staff provides education to members on no-shows and missed appointments and provides assistance with appointment-setting, as these areas contribute to delayed appointments and accessibility issues.

Provider-to-Member Ratio Standards

GeoAccess mapping and coding of all network providers, in each service area, is prepared for each required provider type to demonstrate network capacity; this includes an analysis of provider-to-member ratios in each geographical area as required by contract. Member to primary care provider linkages are also reported to DHH based upon schedule of events, quarterly statutory reporting, and upon material change, or DHH request.

Since we began serving the Louisiana Medicaid population in 2012, ACLA has maintained a broad provider network that meets DHH standards and upholds adequacy standards in our provider network.

Cultural Needs and Preference Standards

ACLA is committed to identifying and removing barriers to care for our members and will not execute a contract with a provider with the intent of allowing or permitting them to implement barriers to care. If ACLA becomes aware of the failure of any of its existing providers to allow full access to care, we will take action to correct this within 30 calendar days. ACLA understands that failure to do so is considered by DHH a breach of contract provisions and requirements.

All internal staff and network providers are educated in culturally and linguistically appropriate services. Training and education is offered via the Provider Manual, Provider Portal accessible through our website, regular provider visits, and ad-hoc webinars and presentations. ACLA strives to ensure that members have access to practitioners who can meet their cultural and linguistic needs. Specific language skills are captured in the initial provider enrollment process and monitored collaboratively on a regular basis relative to membership needs by the Quality Management and PNM departments.

Additionally, all providers are surveyed for compliance with the American Disabilities Act requirements to ensure that they provide physician access for members with disabilities. This survey is conducted upon contracting for all primary care and OB/GYN providers and is monitored by regular provider office visits and member complaints/grievances.

Ongoing Network Maintenance and Monitoring

Network maintenance and ongoing monitoring activities include:

- Regularly scheduled provider office visits
- An annual provider/practitioner after hours and availability survey
- An annual appointment availability survey
- Quarterly scheduled after hours and appointment availability "Mystery Shopper" surveys
- Member grievance and/or provider complaint investigation and resolution
- Corrective Action Plan requirements and follow-up

The Network Management Plan includes provisions for member grievances and/or provider complaints regarding network access and availability requirements or non-compliance with ACLA policies and procedures.

Member complaints/grievances against a provider are investigated and followed up by the PNM department. The area account executive makes contact with the respective provider's office and obtains the history of the event(s) expressed by the member. The account executive then logs the provider's statement into an electronic service form that is routed to the Member Services Department. The Member Service Department follows up with the member to discuss

the outcome of the provider outreach and finalizes the member complaint/grievance by formal letter of response.

Network Resources and Provider Support

Relationship building is paramount to network management, and ACLA works diligently to establish collaborative relationships with providers, ensuring that our members have access to care and choice in practitioners. These relationships are established and cultivated by our high-touch PNM and Provider Network Operations staff, and supplemented by our member outreach staff.

PNM Team

PNM consists of two functional areas: Intake and account executives (field staff).

The intake coordinator is responsible for the initial intake, review, and validation of contracts and credentialing documentation. Once a complete packet is received, the intake coordinator loads provider demographic information into our credentialing system to initiate the credentialing process. This position also ensures that expedited and temporary credentials are processed accordingly, and that providers are credentialed per the requirements of LA Act 311 and within the established contract requirement.

ACLA's field staff live and work in the nine regions of Louisiana. This local presence comprises 12 account executives: 10 dedicated to primary care providers, specialists, and ancillary providers; and two dedicated to the needs of our network hospitals and skilled nursing facilities. The team's extensive experience with providers, combined with their thorough, first-hand knowledge of the communities in which they serve, gives them a distinct advantage in identifying and mitigating concerns on a pre-emptive basis, before they become access issues. Our hospital account executives bring more than 30 years of hospital-specific experience to their roles, which proves a valuable asset in facilitating—and often continuing already-existing—relationships with the hospital community, especially in rural areas.

This background exhibits itself in a meaningful way for our members. For example, a member who is having difficulty scheduling an appointment to see a specialist may reach out to our Member Services or Rapid Response team for assistance. Our representative immediately engages the account executive who works in the member's geographical area and knows the local providers personally. The account executive can then reach out to providers in the area to expedite appointment scheduling, remedy any issues the provider office may be having in accommodating the member, and educate the member in effectively navigating the health care system. The account executive supports both the provider and the member and facilitates clear communication between the parties.

"(ACLA account executive) consistently visits each of the five family practice clinics I supervise in New Roads, LA representing AmeriHealth Caritas. She's available to the staff for questions and issues they may have, and I have had the opportunity to observe her professional skills & interpersonal style. She's very pleasant, and her ability to communicate processes and information has fostered a professional relationship with the clinic staff and AmeriHealth Caritas."

Practice Manager II
Our Lady of the Lake Physician Group

The PNM department staff meets with providers through regularly scheduled visits to discuss and review key network indicators. These include, but are not limited to:

- Access and Availability Standards and requirements
- Continuity and coordination of care across delivery settings to include Head Start, Health Start, Nurse/Family Partnership, Early Intervention Programs, and school system services
- Quality, costs, and outcomes of health services
- Use of preventive services and health education resources
- ACLA programs and campaigns
- Assistance in the practice transformation to Patient-Centered Medical Home (PCMH) by offering
    - Technical support
    - Specialty network coordination
    - Facilitation for the attainment of accreditation or recognition by recognized body

All provider contact, site visits, and communication are recorded electronically to ensure that provider calls and issues are acknowledged within three business days of receipt and issue resolution communicated within 30 business days of receipt. This enables an electronic record of provider trainings, the tracking and trending of provider inquiries/complaints/requests for information, and the systemic action taken to resolve them.

Provider Network Operations Team

The Provider Network Operations team provides assistance in the resolution of provider complaints/issues. The account executives submit provider issues into an internal database; Network Operations enters these issues for centralized tracking and resolution into MACESS EXP (EXP). EXP has the functionality to route issues between departments as needed, track issues to ensure adherence to established turnaround times, and report call activity and trends.

Once the complaint or inquiry is researched and the course of action required for resolution is determined, the assigned department coordinates and tracks all activity related to resolution of the submitted issue. Activities required for resolution vary but may include a request to modify existing processes or rules utilized by operational areas, or education of internal staff or providers regarding a plan policy, process, or contractual arrangement.

ACLA sets high goals for accuracy and timeliness of resolution of provider inquiries. Many provider inquiries can be resolved at the time of the call. We are tracking a year-to-date 30-day resolution rate of 99.5% for calls in which providers are expressing dissatisfaction.

All documentation associated with provider issues, including those received outside of ACLA's formal dispute process, is managed through the Provider Network Operations team and the EXP database. Maintaining all of this information in a central location enables accessibility as needed by various internal departments involved in resolving a provider issue. The tracking database is also utilized to generate internal reports that assist in monitoring activity to ensure that issues are resolved within established timeframes, as well as spot any issue trends. Identified trends are reviewed to determine what improvements can be made to address any underlying problems.

Member Outreach Team

A supplemental source of support to our provider network is our Member Outreach Team. A valuable resource to provider office staff, the Member Outreach Team is available to assist provider office staff with outbound appointment setting, either on site at the provider office or off site. This value added service ensures that the member has an appointment that is conducive to their schedule and that the member is aware of the date/time of the appointment. The Member Outreach staff is also able to ensure that transportation to and from the appointment is not a barrier, and if needed, can provide transportation assistance as well. This benefit allows the provider office staff to devote time and energies to patient care rather than to administrative functions.

The Member Outreach team also is available to provide member education directly to members through the use of an education booth. Through direct contact with the member, the Member Outreach team can assist members in remedying any issues they may be experiencing and educate the member in effectively navigating the health care system. The Member Outreach team supports both the provider and the member and facilitates clear communication between the parties.

Like our account executive staff, the Member Outreach team live and work in the 9 regions of Louisiana. The team's extensive experience within the community, combined with their affiliation with and first-hand knowledge of the communities in which they serve, gives them a distinct advantage in identifying and mitigating concerns on a pre-emptive basis, before they become access issues.

This background exhibits itself in a meaningful way for both providers and members. The Member Outreach team acts as the feet on the street and engages the account executive when they become aware of access-related issues. The Member Outreach team is another mechanism to ensure that clear lines of communication exist between member and providers.

ACLA's Unique Approach to Provider Collaboration: The Quality of Clinical Care Committee (QCCC)

ACLA engages STPs as an integral part of the management of the provider network through our QCCC. The QCCC is formally organized to solicit input from key stakeholders regarding the structure and implementation of new and existing clinical policies and strategies. It is important that these stakeholder groups are geographically representative of Louisiana and reflect the communities that serve Medicaid recipients. The QCCC has become a strong recruiting tool for STPs to engage in the delivery of care in a true partnership with ACLA.

To convene the QCCC, we have conducted outreach to different constituencies. These include:

- Significant traditional providers, including FQHCs, RHCs, clinics, and safety net hospitals
- Providers of all types who serve the Louisiana Medicaid population, including physicians, hospitals, health departments, and school-based Health Centers

We have asked each constituent to identify suitable delegates to participate in the Clinical Care Committee. Participation is limited to a certain number of delegates from each major constituency, to ensure that each group is equally and fairly represented. We have asked that delegates serve for at least one year.

QCCC Functions

The primary goals of the QCCC are to improve the health status of members and build relationships with key Medicaid providers. The QCCC also contributes to the future direction of our program through collaboration around policy, training, provider education, and research. The QCCC meets to:

- Exchange clinical information and materials
- Discuss approaches to service delivery and models of care
- Select priority areas on which to focus collaborative efforts and communication
- Jointly design consensus clinical guidelines, protocols, and health promotion materials when appropriate
- Discuss issues or concerns and facilitate problem-solving

The QCCC plays an integral role in providing input to, and collaborating with ACLA regarding:

- Improving access to comprehensive and coordinated care for our members, including behavioral health, condition management, and member outreach programs
- Creating better systems for identification, screening, and evaluating health outcomes for members with special health care needs
- Decreasing use of emergency room for primary and specialty care services
- Developing new approaches to preventive, primary, and specialty care
- Identifying methods to reduce the administrative burden on physicians
- Responding to cultural, racial, and linguistic needs of our members

- Supporting dissemination and replication of "best practices"
- Strengthening data sharing capabilities, use of health information technologies, outcome evaluation, and measures for collaborative activities
- Evaluating the results of quality activities, instituting actions, and overseeing follow up as appropriate
- Decreasing or eliminating non-clinical barriers for members

The QCCC has been instrumental in the development of metrics used for the Quality Enhancement Program (QEP), our pay-for-performance program for primary care providers, and committee members are serving as pilot sites during the development of the QEP dashboard tool.

ACLA also uses the QCCC as a forum to provide technical assistance, share data, and offer program development support. The QCCC helps to focus the collective efforts of members on high-priority health problems that affect low-income populations in the region and ensure that our constituents have a voice in determining the policies and procedures of ACLA's program. The QCCC fosters open communication, creates an atmosphere where lessons learned from successes as well as failures can be shared, and provides opportunities to apply new learning.

Delegates to the QCCC include representatives of the following constituencies:

- Hospitals
- Physicians
- Specialty providers
- ACLA staff

Current members of our QCCC include:

- Medical Director – Chairperson
- Regional Medical Director, Medical Affairs
- Regional Clinical Director, Medical Affairs
- Manager, Appeals
- Director, Utilization Management
- Director, Integrated Case Management
- Director, Quality Management
- Director, PNM
- Director, Operations Services

Practitioners:

- Mary Beth Alvarez, MD
- Jada Armstrong, MD
- Brooke Bock, MD
- Naseem Jaffrani, MD
- Arthur Mauterer, MD
- Paul Rachal, MD
- Lynda Roberts, MD
- Monir Shalaby, MD

- Bryan Sibley, MD
- Ulla Ule, MD
- Craig Vitrano, MD
- Martha Wafer, MD
- Cassandra Youmans, MD

The QCCC reports findings and recommendations to the Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC, which comprises ACLA executive staff and participating providers, is responsible for the overall effectiveness of the quality improvement program.

Our successful network delivers high quality care to our members in Louisiana through these strong relationships with STPs, our targeted and personalized outreach to STPs, and our formulation of the Clinical Care Committee.

Through our multi-faceted strategy for provider and member engagement, the ACLA PNM team strives to provide our members a network of providers that ensures the provision of core benefits and services and member choice. In an effort for continued improvement, our department and network are reviewed regularly to ensure access, provider availability, and depth of choice for our membership.

G.2. Network Development

G.2 Describe how you will provide tertiary care providers, including trauma centers, burn centers, children's hospital, Level III maternity care; Level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. If you do not have a full range of tertiary care providers describe how the services will be provided including transfer protocols and arrangements with out of network facilities.

Overview

Severe injuries and complex medical conditions may require more specialized services. To facilitate effective access to higher levels of specialty care, including for trauma, burns, high-risk pregnancies, or severe childhood illnesses, ACLA contracts with tertiary care providers throughout Louisiana. Additionally, emergency care is always covered whether the service is provided by a participating or non-participating provider.

In-network Tertiary Care Providers

ACLA maintains a network of tertiary care providers by leveraging statewide systems as well as regional and local providers. ACLA is contracted with the only two Level 1 trauma centers in Louisiana. Level 2 trauma care is available at network hospitals, Our Lady of the Lake Regional Medical Center, and Rapides Regional Medical Center.

Relationships with Woman's Hospital, Ochsner Health System, Willis Knighton, CHRISTUS, Rapides Regional, Lake Area Medical Center (formerly Women's and Children's Hospital of Lake Charles), and Women's and Children's Hospital–Lafayette provide a foundation for maternity and neonatal services.

Highly specialized pediatric care is provided by key Children's Hospital partners. Children's Hospital New Orleans, Ochsner Medical Center for Children, Tulane Hospital for Children, Lake Area Medical Center (formerly Women's and Children's Hospital of Lake Charles),Women's and Children's Hospital–Lafayette, and Our Lady of the Lake Regional Children's Hospital, have strong pediatric services available to members as well.

Transplant services are available to members through our relationships with Children's Hospital, New Orleans and Medicare recognized Transplant Centers of Excellence, Ochsner Foundation Hospital, and Tulane Hospital and Clinics.

Specialty	In-network Providers
Trauma	Level 1–Interim LSU Hospital, New Orleans Level 1-BRFHH Shreveport Level 2–Rapides Regional Medical Center Level 2–Our Lady of the Lake Regional Medical Center
Burn Centers	BRFHH Shreveport Our Lady of Lourdes Medical Center Baton Rouge General (contract pending)
Children's Hospitals	Children's Hospital-New Orleans Our Lady of the Lake Children's Hospital Shriners Children's Hospital Women's and Children's Hospital–Lafayette Lake Area Medical Center (formerly Women's and Children's-Lake Charles) Tulane Hospital for Children
Rehabilitation Hospitals	Bastrop Rehabilitation Hospital Bethesda Rehabilitation Hospital Lafayette Rehabilitation Hospital Neuromedical Center Rehabilitation Hospital North Oaks Rehabilitation Hospital Specialty Rehabilitation Hospital of Coushatta Sterlington Rehabilitation Hospital United Rehabilitation Hospital
NICU Level 2	Beauregard Memorial Glenwood Regional Lane Regional Medical Center Northern Louisiana Medical Center Ochsner Medical Center-North Shore Ochsner Medical Center–Kenner Rivers Parishes Hospital

NICU Level 3	Baton Rouge General Medical Center (contract pending) BRFHH Shreveport Children's Hospital-New Orleans Christus Health Shreveport Christus St. Frances Cabrini Hospital Lake Area Medical Center (formerly Women's and Children's Lake Charles) Lake Charles Memorial Lakeview Regional Medical Center North Oaks Medical Center Ochsner Foundation Hospital Ochsner Medical Center Baton Rouge Rapides Regional Medical Center Women's and Children's Hospital–Lafayette Slidell Memorial Hospital St. Francis Medical Center St. Tammany Parish Hospital Terrebonne General Medical Center Touro Infirmary Tulane University Medical Center West Jefferson Medical Center Willis Knighton Medical Center Woman's Hospital

Exhibit G.2-1: In-network Tertiary Care Providers by Specialty

Out-of-Network Tertiary Care

ACLA endeavors to provide in-network access to specialized services, state-of-the-art facilities, and technology, as well as access to follow-up treatment, such as rehabilitation. However, occasions do arise when members need tertiary care services not available within our network, or even within the state of Louisiana. In those cases, we swiftly evaluate needs and obtain the service from an appropriate out-of-network provider. Our transfer protocols require prior authorization for medical necessity for the use of non-participating practitioners or providers.

Members and providers can always access tertiary care services in an emergency from any available provider without prior authorization. Prior authorization is also not required for pregnant women and newborns who require immediate transfer and care from a Level III maternity facility or Level III nursery.

Requests for urgent or routine services from a non-participating provider are reviewed by a physician reviewer based upon the availability of the service or expertise within the ACLA

network, the physician reviewer's clinical expertise, the needs of the member, and the definition of medical necessity. Upon approval of services from an out-of-network provider, the authorization and contact information of the provider is sent to PNM Department for the negotiation of a single case agreement. A care manager works with the member and family to facilitate transportation and make any other necessary arrangements.

When a request for services from a non-participating provider is not approved, this decision is communicated to both the provider and the member via fax or phone. A written notification of action is also issued. The member, and the provider on behalf of the member, can appeal the decision. In these situations, a care manager works with the member to facilitate access to available in-network tertiary care.

PNM has built strong relationships with many Mississippi, Arkansas, and Texas trade-area significant traditional providers, including Natchez Regional Medical Center, Natchez Community Hospitals, Ashley Memorial Hospital, and Medical Center of South Arkansas. Additionally, we have relationships with a significant number of specialists that provide services to members who live in the Louisiana parishes that border Mississippi, Arkansas, and Texas. ACLA provider relationships are far-reaching, with Georgetown University Medical Center, Texas Children's Hospital, and Arkansas Children's Hospital proving to be supportive partners to our most vulnerable members.

24-Hour Availability

To ensure 24-hour availability to necessary services, ACLA has UM nursing staff and a physician reviewer on call 24-hours a day, seven days a week. Members or providers needing to arrange medically necessary tertiary care can call the toll-free Contact Center number or the toll-free UM number to reach the on-call nurse after business hours, on weekends, and on holidays. The UM nurse will facilitate the authorization process, as needed, and arrange for a care manager to continue to work with the member.

G.3. Network Development

G.3 Describe how you will keep all required provider information accurate and current, both internally and the information submitted to DHH for the provider registry.

Overview

ACLA recognizes the importance of maintaining accurate and current provider information. We follow a defined process for adding and updating information on participating and non-participating providers. This process includes established guidelines for ensuring that the most current provider information is captured in our claims processing system, which serves as the official source for all provider data. Information is entered and updated in this system and provided for inclusion in the Bayou Health provider registry.

Provider data change requests are submitted and tracked using our Enterprise Workflow Management Solution, MACESS EXP. This application allows for centralized storage of information and action items, while allowing access for coordination across multiple departments.

In addition to the verification of change requests, provider information is reviewed and audited weekly based upon a provider maintenance report of updates made in Facets, which is a system used to record and maintain member and provider data, as well as process claims and perform other operational functions. The following methods are used to facilitate the ongoing accuracy of the ACLA provider network on the Bayou Health provider registry.

- Provider information is validated through credentialing and other national registry files prior to uploading into Facets.
- The PNM account executives verify provider demographic information during quarterly site visits and submit updates as needed.
- ACLA also conducts annual provider validation to confirm provider information which is currently listed in Facets.

Provider Information Maintenance

Required Data Elements

The following data elements (as applicable) are required for all providers, including PCPs, specialists, ancillary and hospital providers, and practitioners, and are stored in the Facets provider database.

Group Practice Name	Office Address (including City and Zip Code)
Provider's/Practitioner's Name	Additional Office locations (if applicable)
Specialty(s)	Office Phone Number
Type of Medical Degree	Languages spoken by the provider
Board Certification(s) (if any)	Wheelchair Accessibility
Hospital Affiliation(s)	Age Limitations
Use of Physician Extenders (if applicable)	Gender
Accepting New Patients	Physical address, telephone, county, day/hours of operation
Medical Group Affiliations	Patient Centered Medical Home (NCQA Designation) (PCP
Group Practice Name	Office Address (including City and Zip Code)
NPI	Tax ID

Exhibit G.3-1: Required Data Elements for Providers

New Providers

To facilitate accurate and complete entry of new providers into the system, PNM reviews the provider's application for completeness and forwards it to the Credentialing Department. In compliance with Act 358, once a completed credentialing packet is received, new providers are loaded into Facets under an existing participating group to allow payment until credentialed. The Credentialing department reviews and verifies provider information which is stored in Visual CACTUS, which is a flexible application with the ability to handle all user credentialing needs efficiently. The standard credentialing timeframe is between 30-60 days depending on the extent of the review. Providers who fall under a delegated credentialing agreement are processed by the provider roster provided by the delegate entity.

Upon notification of the Credentialing Committee's approval, the local Provider Network Operations (PNO) staff validates the data using the weekly Provider File from DHH, and the information submitted on the provider's application or roster. If there is a discrepancy, the information is relayed back to PNM and Credentialing for confirmation prior to sending it to Provider Maintenance. Once information has been validated, PNO communicates data elements of the confirmed provider to the Provider Maintenance department through EXP, so that all information for the provider can be entered into the Facets system. The Provider Maintenance department also has a staff representative based in our ACLA office to facilitate high priority projects that need to be coordinated more closely with local plan representatives.

New information for participating providers is loaded into the Facets within 30 days. The PNO department conducts a review to ensure the accuracy of the information by comparing the submitted data with the weekly provider maintenance report listing updates made in Facets. Participating providers are sent a welcome letter listing their provider ID and demographic information with instructions for them to contact ACLA with corrections if any of the information is not accurate.

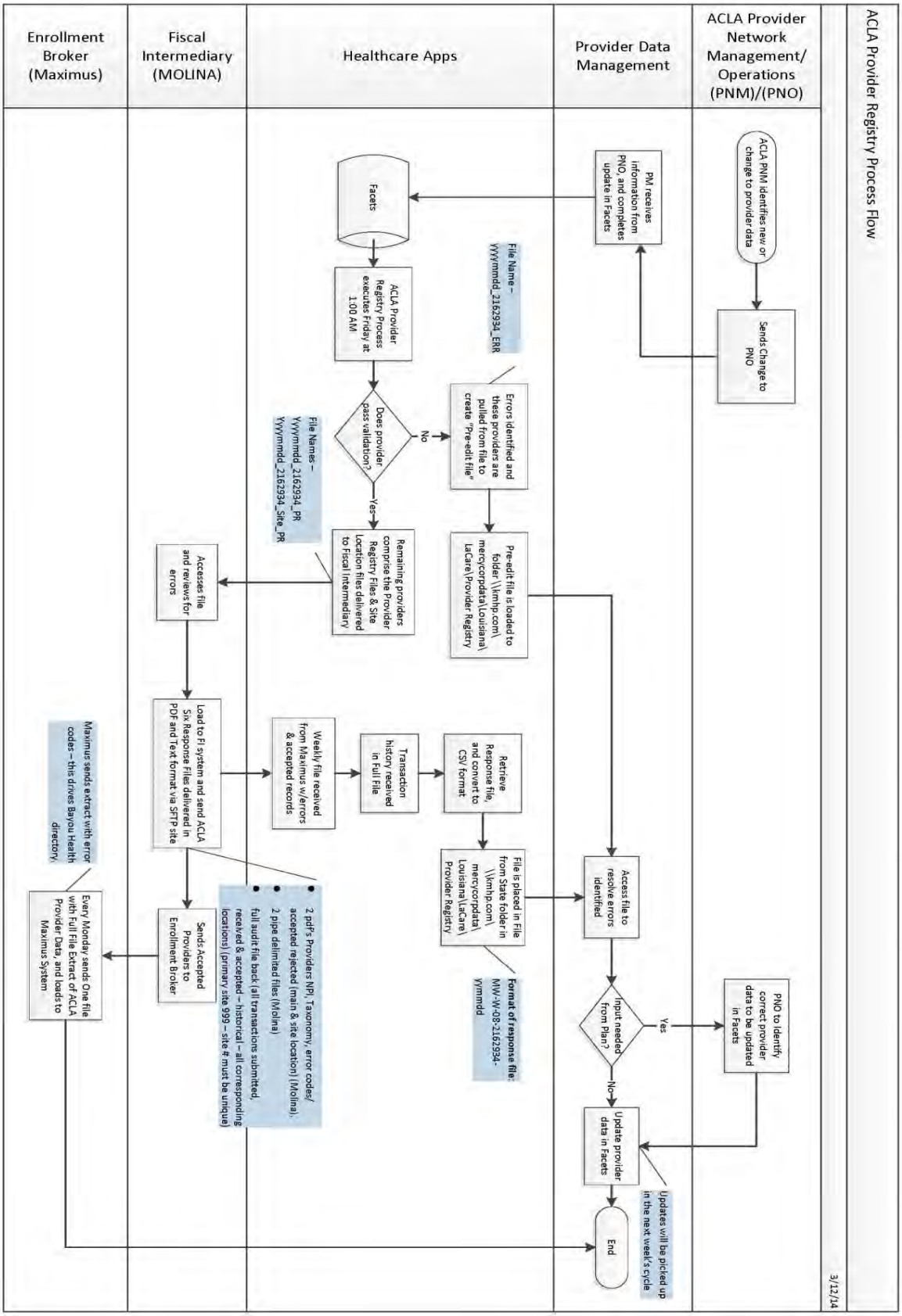

Exhibit G.3-2: ACLA Provider Registry Process Flow

Provider Updates

The local PNO department is responsible for validating all provider data submitted through various entry points. This locally based team has experience in working directly with the provider community and ensures that this crucial plan function is fully coordinated with the ACLA network providers. Updates to provider information are communicated to the PNO department through various means, including:

- PNM account executives can receive updated information from providers during site visits and other regular interactions with network providers.
- ACLA contact center may receive notification from a provider that their information has been updated.
- Delegated credentialing files are received on a routine basis from providers with those agreements.
- Mail that is returned to ACLA is scanned and routed to a specific queue where it is researched by reviewing the documentation returned against what we have in Facets. If there is not a corrected address in Facets, PNM account executives reach out to the provider to identify the correct address.

Requests by providers to change information currently captured in the Facets system must be made in writing and have a signature by the individual authorized by provider location to make changes, or by submitting a Provider Enrollment or Provider Change form (see exhibit below), which can be obtained on the ACLA Provider Portal. Upon receipt, the account executive loads the form into a database tracking tool that allows our PNO department to document, track, and forward change requests. The PNO department gathers any attachments or supporting documentation and submits them to Provider Maintenance through MACESS EXP.

AmeriHealth Caritas Louisiana

APPENDIX 20

PROVIDER CHANGE FORM

CURRENT PRACTICE INFORMATION

Group Practice Name/Individual Name: _____
(Please Circle One ✎)

Group Practice ID/Individual ID: AmeriHealth Caritas ID: _____ NPI # _____ PPID# _____
(Please Circle One ✎)

Contact Person Name (please print clearly) Telephone Fax E-mail address

Authorizing Signature (physician/office manager) Today's Date Effective Date of Change
Change will not be completed without signature

PROVIDER CHANGE INFORMATION

Provide Complete Information – This Request will be processed for AmeriHealth Caritas Louisiana. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 with this change form. PLEASE NOTE: Practitioners must complete AmeriHealt Caritas Louisiana Credentialing before they will be added to your practice as a participating provider. Refer to the LaCare website for Credentialing Requirements www.amerihealthcaritasla.com

Type of Change: (Please check all that apply)
- ☐ Adding a Practice
- ☐ Joining a Practice
- ☐ Telephone change
- ☐ Adding an office location
- ☐ Changing an office location
- ☐ Other (attach documentation)
- ☐ Fax change
- ☐ Name change only

PREVIOUS OFFICE INFORMATION

AmeriHealth Caritas Provider ID NPI
Name
Street Address
City State Zip
Telephone Fax Email address

NEW OFFICE INFORMATION

AmeriHealth Caritas Provider ID NPI
Name
Street Address
City State Zip
Telephone Fax Email address

ADD Practitioners (New Practitioners must complete AmeriHealth Caritas Louisiana Credentialing before they are added as a participating provider)

1. Last First M.I. Degree NPI PPID
2. Last First M.I. Degree NPI PPID

TERMINATE Practitioners (Please give LaCare 60 days advance notice when a practitioner is leaving the group)

1. Last First M.I. Degree NPI PPID
2. Last First M.I. Degree NPI PPID

BILLING LOCATION CHANGE ☐

Street Address 1
Street Address 2
City State Zip
Telephone Fax e-mail address
Federal Tax ID (change in Federal ID requires new W-9)

CHANGE OF OWNERSHIP ☐ _____ _____
Legal Business Name of New Owner and Federal Tax ID (Requires new W-9) Effective Date of Ownership

Please mail or fax this change form and supporting documents to:
AmeriHealth Caritas Louisiana, Provider Network Management, 10000 Perkins Rowe, Block G, 4th Floor
- Fax: 225-300-9126-

Exhibit G.3-3: Provider Change Form

Requests to change data that does not require prime source verification through credentialing are forwarded daily to Provider Maintenance through EXP. Requests to change or correct information that requires credential verification (e.g. board certification, specialty, or accreditation) are forwarded to the credentialing department for prime source verification. Upon confirmation from the credentialing department, updates are forwarded to Provider Maintenance through EXP. Provider Maintenance reviews the change request to verify that all information is valid. If missing or invalid information is present, the request is returned to PNO for correction and completion.

Practitioner updates will be submitted within 10 calendar days. PNO submits provider updates for hospitals, ancillary facilities, etc., as soon as the information is available from the provider. Provider Maintenance will complete change requests within five business days of receipt. Change requests for multiple practitioners of 100 or more within a group will take up to 10 days to load into the system. All changes made to the Facets provider database during the business day are uploaded nightly to the online directory. PNO will conduct an audit review of the directory once the providers are loaded by Provider Maintenance. This audit will include review of all provider updates to groups with less than 50 practitioners/providers and a minimum of 10% of groups that include greater than 50 providers, to ensure accuracy of provider load and updates.

Additionally, the annual Provider Roster Validation Process is another measure for confirming the accuracy of provider practice and practitioner demographic data as it appears in our Facets systems. A provider data validation form and guidelines for reviewing and submitting changes to demographic and other data elements is mailed to the provider along with a roster that includes information on each PCP, specialist, and ancillary practice not affiliated with a Large Complex Group. Included in the request to validate demographic data, and to better service our members, we also request language services offered. To comply with NCQA's Multi-cultural Health Care Program Standards, the collection of accurate race and ethnicity is also requested in the validation process. The data elements to be attested are listed below and additional space is provided, as well as request of attachments to add, delete, or correct individual provider information.

- Practice address, including, office location (primary address)
- Payment address
- Phone number, fax number, and email
- Office hours
- Laboratory in system

A designated fax number is provided to return the data verification forms and other attachments, or they can be received by mail sent to the local P.O. Box and distributed to PNO for review and processing. The designated fax number is connected to a fax server and systematically routes the forms to a queue in EXP. PNO accesses the queue to validate the information and create SF within EXP to have the Provider's information updated in Facets by Provider Maintenance.

Provider Data Verification Forms that are returned due to invalid address or updated address by the U.S. Postal service are received by local PNO. The returned mail is researched and direct contact is made to the provider's office. The correction to the address is submitted via a service form to Provider Maintenance. Another attempt is made by fax or mail to send a request to the Provider(s) to validate information. The account executives participate in the process through site visits to request validated roster information or to confirm changes received through return mail.

Ensuring Accuracy of Provider Information

The ACLA Provider Maintenance Department ensures that information on our providers is accurate through regular review and audit of the provider information on file. Our quality auditing process evaluates activity associated with updating the provider database, including daily work audits to assess the accuracy of updates made by the Provider Maintenance team. The ACFC Quality Audit department reviews a percentage of the daily work completed by the ACLA Provider Maintenance Team to ensure that the change or addition completely matches what was submitted by the local PNO team. The Provider Maintenance Management team accesses real-time results and uses inaccuracies as opportunities to coach employees. Data queries from Facets are run on a regular basis to identify and correct any errors or discrepancies.

Provider data is updated through several input points and quality checked using a variety of methods to ensure that provider information is both current and accurate. The principal input sources are updates from the provider facilitated by ACLA, claim submissions, and any provider registry file discrepancies ascertained in the normal course of business auditing. ACLA utilizes the weekly Pre-Edit Registry File to help in identifying any discrepancies with the provider registry information on file with the state. The quality audit process occurs at various stages within ACLA's business process. We have a Quality Audit team that performs assessments of manual data updates made in our credentialing and claims payment platforms. Moreover, we have a set of automated reports, called the Provider Data Quality Initiative, designed to identify the most common data errors or discrepancies that impact claims payment, provider directories, encounter submissions, and/or provider file registry synchronization. These reports are run on a recurring basis, and any errors are remediated between cycles using part manual and part automated processing. Additionally, ACLA has provider disconnect reports that ascertain data anomalies between our credentialing and claims payment platforms. These reports are also recurring—and utilized to remediate provider data periodically.

Submitting Provider Information

On a weekly basis, ACLA executes the ACLA Provider Registry Process to submit information to DHH. Providers whose information passes validation comprise the Provider Registry and Site Location files that are delivered to the state's Fiscal Intermediary. These files include provider name, address, licensing information, Tax ID, National Provider Identifier (NPI), taxonomy, and contract information. Changes in the weekly registry process, when required by

DHH, are executed timely in conjunction with our PNO team and our IS Department to ensure compliance. A full audit is completed weekly with the returned results of the Registry File from DHH to ensure that any provider who was not appropriately registered is corrected and resubmitted on the next weekly file. A full audit is also completed on the weekly file received from the Enrollment Broker to ensure that all providers are accurately represented for member enrollment purposes. The ACLA provider registry acceptance rate through summer 2014 averaged 99.96%.

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Network Development

Total Number of Providers in State

Primary Care	
Physicians	4,116
Physician Extenders	2,417
Hospitals	
Acute Inpatient Hospitals	147
Ancillary	
Lab	76
Dialysis Centers	148
Personal Care Services [(1)]	-
Radiology	29
Specialists	
Allergy/Immunology	55
Anesthesiology	1,912
Audiology	86
Cardiology	506
Chiropractic	20
Dermatology	91
Emergency Medical	653
Endocrinology and Metab	46
Gastroenterology	147
Hematology/Oncology	156
Hospice [(2)]	-
Infectious Diseases	142
Neonatology	49
Nephrology	145
Neurology	188
Nuclear Medicine	9
OB/GYN	618
Occupational Therapy	42
Ophthalmology	396
Optician/Optometry	257
Orthopedics	255
Otorhinolaryngology/Otolaryngology	223
Pathology	239
Pediatric Allergy	55
Pediatric Cardiology	43
Pediatric Critical Care Medicine	26
Pediatric Emergency Medicine	63
Pediatric Endocrinology	15
Pediatric Gastroenterology	19

Pediatric Hematology - Oncology	22
Pediatric Infectious Disease	10
Pediatric Nephrology	10
Pediatric Pulmonology	21
Pediatric Rheumatology	3
Pediatric Sports Medicine	1
Pediatric Surgery	24
Physical Therapy	83
Podiatry	97
Pulmonary Medicine	152
Radiology - Diagnostic	847
Radiology -Therapeutic (3)	-
Rheumatology	47
Speech Therapy	81
Surgery - Cardiovascular	506
Surgery - Colon and Rectal	9
Surgery - General	429
Surgery - Neurological	61
Surgery - Plastic	38
Surgery - Thoracic	59
Urology	149

NOTES

(1) Invitations to contract have been send to 158 PCS agencies identified on the significant traditional LA Medicaid providers listing.

(2) Invitations to contract have been send to 158 Hospice providers identified on the significant traditional LA Medicaid providers listing. Six agencies have returned contracts and are being reviewed through the Credentialing process.

(3) All contracted Radiology providers offer both Diagnostic & Therapeutic services. To avoid an inflated count, providers are only identified once under the "Radiology-Diagnositic" entry.

H.1. Provider Management

H.1 Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.

Overview

A foundational component of delivering high-quality care to members is ensuring that they can make and keep appointments for needed services within reasonable timeframes. AmeriHealth Caritas Louisiana (ACLA) requires its network providers to conform to the DHH-established Appointment Availability Access Standards outlined in Section 7.2 and Appendix SS of the Bayou Health MCO RFP

We communicate these standards to providers through multiple methods, including the notable support of our Provider Network Management (PNM) account executives, who are dedicated to educating and interfacing with providers. ACLA monitors providers for compliance with appointment and wait-time standards and analyzes results. When non-compliance issues arise, ACLA develops action plans to achieve compliance. Our account executives are especially effective in working closely with providers on strategies to remedy issues of non-compliance with these standards.

Education and Communication of Standards

ACLA has a written policy and procedure that outlines our requirements and defines the process to monitor providers for compliance with accessibility standards. These standards meet or exceed minimum standards required by the Bayou Health program and NCQA for emergent care or emergency visits; urgent care; non-urgent sick care; routine, non-urgent, or preventive care; specialty care consultation; laboratory and X-ray services; maternity care including high-risk pregnancies; follow-up visits after emergency care; and after-hour availability; as well as the in-office waiting time for scheduled appointments.

ACLA is committed to keeping providers informed of requirements and standards, and we use several methods to educate and communicate accessibility standards to our providers. Our process includes communicating through documents such as the Provider Manual, provider contracts, and the provider newsletter, complemented by frequent and routine site visits, as well as initial and ongoing in-person training sessions. The goal is to ensure that providers have a clear understanding of expectations placed on them as an ACLA network provider.

Additionally, our Provider Network Management (PNM) staff is dedicated to developing and maintaining strong relationships with providers thorough regularly scheduled site visits. Providers receive individual attention from their PNM account executive, who reaches out to providers to answer questions and resolve issues that may arise. Through these proactive methods, we encourage adherence to standards.

Monitoring Standards

Once after-hours and accessibility standards have been communicated to providers, following up to ensure that the member's experience is consistent with those standards is a critical component of assessing access to care. The Member Grievance process is monitored through a tracking and reporting vehicle maintained by our Member Services department. We track calls from members related to dissatisfaction with after-hours availability, appointment and wait times, access, and other issues.

Member grievances against a provider are forwarded from the Member Services department to the PNM department for investigation and follow-up. The service form is routed to the area account executive, who makes contact with the respective provider's office and obtains their history of the event(s) expressed by the member. The area account executive then logs the provider's statement into an electronic service form that is then rerouted back to the Member Services department. The grievance coordinator follows up with the member to discuss the outcome of the provider outreach and finalizes the member grievance by formal letter of response.

ACLA also conducts an annual After Hours Access and Appointment Availability Survey of all primary care practices using a third-party entity. The vendor records how well each call is answered (e.g., live party, answering machine, automated message, no answer).

- Reaching a live party directly was immediately marked as compliant. If a recording or automated message was reached, the vendor assessed whether the recording included emergency instructions and a way to reach a live party.
- If connected with a live party(either directly or through a recorded/automated message), the interviewer identified themselves as the health plan and asked whether they had reached an answering service, office staff, 24-hour facility/hospital, physician, or a nurse triage line. This information was recorded for reference; however, the specific role of the staff member did not affect compliance. (Any of the aforementioned live parties are acceptable).
- If connected with an automated message that pages a physician or health professional, or a number, the interviewer provided a call-back number. If the call was returned within 30 minutes, the site was scored compliant.

The results of the 2013 after-hours survey found the requirement for on-call staff to call back within 30 minutes greatly affected the compliance of the network; providers were reluctant to return a phone call to the health plan vendor for survey purposes. This requirement was new to the Access to Care audit in 2013.

The results of our 2013 annual audit of appointment availability showed an overall PCP appointment availability compliance rate of 81.3 percent. The PNM department re-educated provider offices that had non-compliant results following the initial survey. The non-compliant provider offices were resurveyed, and overall PCP appointment availability was recalculated with a compliance rate of 92 percent.

ACLA aims to ensure that network providers have an appointment system for medically necessary covered benefits and services and/or expanded benefits that is in accordance with prevailing medical community standards as specified below.

- Routine Care: within 6 weeks of member request.
- Non-Urgent sick care: within 72 hours or sooner of member request.
- Urgent Care: within 24 hours.
- Emergent Care: Immediately upon presentation at the service delivery site.
- Maternity Care:
    - First trimester: within 14 days of request.
    - Second trimester: within 7 days of request.
    - Third trimester: within 3 days.
    - High risk: within 3 days of identification of high risk or immediately for an emergent situation.

The results of our 2013 annual audit of Appointment Availability for specialty providers demonstrated a compliance rate of 91 percent. ACLA audited 10 percent of the highest-volume specialty practices in the network, including Cardiology, OB/GYN, Allergy/Immunology, Endocrinology, Pulmonology, and Orthopedics.

"Mystery Shopper" surveys are conducted by PNM staff on a bi-annual basis, and help to identify the gap between the experience we seek to deliver and the actual experience the member receives. Mystery Shopper surveys not only provide strategic information about patient concerns and needs, but also help influence provider office staff behaviors and focus. PNM staff is able to gather detailed and critical information and present it in an engaging format to help drive success and adherence to after-hours and appointment availability standards and guidelines.

Mystery Shopper surveys are conducted using the same rationale and reporting standards used during the annual vendor managed surveys, but evaluate provider offices using direct feedback from the mystery shopper "patient/customer" perspective.

Additional assessments may be initiated through provider audits, adhoc reporting following a member grievance trend, or upon ACLA staff request.

Ensuring Adherence to Standards

Once we have identified that a provider is non-compliant with availability and wait-time standards, we work aggressively and collaboratively to bring the provider back into compliance. Providers who are found to be non-compliant are reported on the QM Report with a tracking number, summary description of the issue, and any follow-up or actions planned or taken by ACLA. The non-compliant providers are carried over on subsequent quarterly reports until final resolution of the issue has been accomplished; these provider offices are automatically included in the sample pool for the next monitoring session.

Providers who are non-compliant with any of the standards are notified of our findings and educated regarding the standards. The assigned PNM account executive is actively involved in

helping the provider initiate solutions for meeting compliance. The account executives schedule another monitoring event, either an on-site visit to monitor office wait times, a "Secret Shopper" call to check appointment availability, or an after-hours call to verify ability to reach a physician. Offices found to be non-compliant in the follow-up monitoring are required to create and implement a corrective action plan. The PNM account executive monitors the implementation of any corrective action. Results of all monitoring activities are combined with phone access performance to create a global picture of Access and Availability. The Access and Availability findings are reported to the Quality of Service Committee (QSC), a subcommittee of the Quality Assessment Performance Improvement Committee (QAPIC), for review, identification of opportunities, prioritization, and planning. Final results and recommendations are reviewed by the QAPIC.

Our PNM account executives work with provider offices to help them find creative solutions and alter their processes to become compliant. We have worked with some PCPs to offer "open hours" and to correctly identify urgent care and walk-in clinics, providing urgent/walk-in care site information to our nurse helpline, Member Services, and Rapid Response departments. ACLA more than doubled our network of urgent care centers over the previous contact period.

We also work closely with our primary care provider network to identify those that offer several "unscheduled" appointments throughout the day. This process has provided our Rapid Response team an easy way to resolve immediate member appointment needs. One group is offering our members urgent care appointments by leaving each physician unscheduled slots of time available for these appointments each hour.

Case Study: Resolving Non-adherence to After-hours Performance Standards

We have found providers to be willing in most cases to become compliant once they are notified they are not meeting a contractual requirement. The example below demonstrates how we worked with a provider office to resolve non-adherence and to support their care of our members. This example demonstrates our desire to collaborate with our providers to resolve contractual issues with the appropriate information and provider assistance.

Resolving Non-compliance: Practitioner After-hours Performance

During the course of our annual after-hours availability audit, we identified a rural provider's office with a member panel size of 400, primarily devoted to pediatric care, that did not offer an option for patients to contact them after regular business hours. This provider was not in compliance with access to care standards, specifically Practitioner After-hours Performance.

A site visit was held with the office and the required compliance standards were discussed. Office staff verbalized understanding of their contractual requirements and requested assistance with back-up coverage. The Provider Network Management account executive shared with the provider office existing processes and suggested recording a message that would meet the contractual requirements. The provider office updated the recording to improve access to care and support their patients. A follow-up after-hours call verified that the office had become compliant with the access standards.

H.2. Provider Management

H.2 Describe your provider grievance and appeal process.

Overview

ACLA invests in developing supportive relationships with our providers. Through orientation and training sessions, communication and website materials, and—often most compellingly—personal contact with a designated Provider Network Management account executive, we strive to present information that reinforces them in their vital role of caring for our members. Our goal is to understand their concerns and work with them to address potential issues before they escalate to formal disputes or complaints.

Nonetheless, ACLA has clearly defined processes, policies, and procedures to guide providers through filing a complaint (grievance) or claim dispute (appeal). Providers also have access to file a grievance or appeal on behalf of a member, as outlined in Section S: Member Grievances and Appeals of this response. All complaints, disputes, and their supporting documentation and final resolution are captured in EXP MACESS (EXP), our enterprise workflow management solution. This tool enables the tracking, trending, and reporting of complaints and disputes.

Providers may request an on-site meeting to address any complaints or disputes in person. If requested, the provider's account executive will contact the provider to arrange a convenient date within five business days of receipt of the request.

Providers are educated on their rights to file a complaint or dispute via several communications, including the Provider Handbook, Provider Orientation, ACLA website, or their account executive. Providers may access the complaint and/or dispute process via phone, in writing or in person. Upon hire, ACLA's account executives and Provider Customer Service Unit (PCSU) representatives receive extensive training on the intake and routing of provider complaints and disputes for resolution.

In addition, ACLA has developed an electronic spreadsheet for submission of large claim projects consisting of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients and payment claims included in the bundled dispute. Providers can access this spreadsheet online in the Provider Center section of the ACLA website.

Provider Complaint Process

A Provider Complaint is defined as any contact (by phone, in writing, or in person), originating from a provider and delivered to any member of health plan staff, voicing dissatisfaction with a policy, procedure, or any other communication or action by the health plan. Provider Complaints encompass a variety of issues, including but not limited to:

- Claim processing errors, such as failure to pay timely.
- Insufficient reimbursement rates.

- Prior authorization issues, such as failure to timely process.
- Enrollment or credentialing processing.
- Provider data.

Providers have up to 30 calendar days from the date of the incident in question to file a complaint with ACLA. Providers may file a complaint by calling the PCSU, writing to ACLA, or speaking to their account executive. The receiving department records the provider complaint in EXP for tracking and reporting purposes, and forwards it to the appropriate department via an electronic service form for resolution. All action steps are recorded in the provider's record in EXP, with the receiving department tracking the complaint to ensure resolution within 30 days. When the intake department receives final resolution from the appropriate stakeholder(s), the complaint determination is communicated to the provider by the same method of communication in which the compliant was registered. For example, complaints received in writing are followed up with written resolution.

Formal Dispute Process

A Formal Dispute is defined as a written request from a provider for post-service review of claims that have been denied, underpaid, or otherwise limited by ACLA, or as a written request for reconsideration of a complaint. In addition to reconsideration of a complaint resolution, examples of provider disputes include:

- Inaccurate payment due to wrong agreement type or updated Medicaid fee schedule.
- Claims denied for missing or invalid information.
- Claims denied administratively for untimely filing or failure to include a prior authorization number when required.
- Payment limitations, including NCCI edits and TPL misinformation.

Providers may request a Formal Dispute by submitting the request in writing within the timeframes outlined below.

Providers may use the Member Grievance and Appeal Processes, outlined in Section S of this response, for pre-service denials, including administrative and medical necessity prior authorization denials or reductions. ACLA's Provider Relations staff is trained to distinguish between a provider complaint or dispute and a member grievance or appeal in which the provider is acting on the member's behalf. This training is received upon hire and throughout employment via departmental in-services and ACLA's Online Help feature. Online Help is an internal reference guide, accessible by all associates, that walks the user through completion of various tasks or processes.

Each dispute is investigated with deference to the provider's contract with ACLA, ACLA's administrative policies, ACLA's contract with DHH, and relevant Medicaid laws, regulations, and rules. A determination is then issued to uphold, overturn, or modify the initial determination.

In-network providers are informed of Formal Dispute policies and procedures at the time of contract. Out-of-network providers receive this information with the remittance advice of a

processed claim, along with instructions on accessing the ACLA website for claim dispute filing instructions. Additionally, any provider may contact Provider Services through our toll-free telephone number for instructions on how to file a claims dispute. The toll-free number is included on the remittance advice.

First-level Dispute Review Process

The request for a Formal Dispute review must be received in writing within 90 calendar days of the date of the disputed decision of ACLA. The provider is encouraged to include all relevant documentation to be considered during the First-level Dispute review.

Upon receipt of the First-level Dispute, the ACLA Claims Research department reviews the documentation, prepares the First-level Dispute file, acknowledges the dispute within three business days, and initiates the investigation necessary to resolve the matter. The resolution of the First-level Dispute is communicated to the provider within 30 calendar days of ACLA's receipt of the First-level Dispute.

If supporting documentation necessary to make a determination was not received, ACLA sends a letter to request additional information from the provider. If all relevant documentation was received, the ACLA Claims Research department will either address the First-level Dispute or forward the First-level Dispute File to the appropriate department for resolution.

If the resolution requires claim reprocessing without system modification, the ACLA Claims Research department is able to re-adjudicate the claim immediately. If the resolution requires the modification of any system, or has the potential to impact more than one provider, efforts are coordinated with the locally based Provider Network Operations to fix the issue. Once fixed, Provider Network Operations orders claims analysis and reprocessing of all impacted claims. ACLA senior management is informed of identified trends during weekly meetings.

After submission of the work request, Provider Network Operations returns the First-level Dispute service form and resolution to the Claims Research department via EXP. Within three business days of receipt of the service form, the Claims Research department records the disposition in EXP, reprocesses any claims recommended for adjustment or payment, and forwards a written response to the provider advising them of the First-level Dispute determination and the provider's Second-level Dispute rights. Copies of all correspondence are maintained in EXP.

Second-level Dispute Review Process

If the provider remains unsatisfied with the first-level claim dispute resolution, he/she may file a Second-level Claim Dispute within 30 calendar days of the date on the First-level Dispute determination letter. Upon receipt of the Second-level Dispute, ACLA's Claims Management department prepares the Second-level Dispute file, acknowledges the dispute within three business days, and forwards the Second-level Dispute to the Director of Provider Network Operations or his/her designee. The director of Provider Network Operations coordinates

resolution of the Second-level Dispute and communicates the resolution to the provider within 30 calendar days of ACLA's receipt of the Second-level Dispute.

The Director of Provider Network Operations or his/her designee forwards the First-level Dispute documentation, as well as any additional documentation received from the provider with the Second-level Dispute, to the Second-level Dispute Committee within five business days of receipt.

Second-level Disputes will be reviewed and decided upon by a Second-Level Dispute Committee comprised of at least three of the following ACLA leadership staff or their designees:

- Director of Network Operations.
- Director of Network Management.
- Director of Compliance.
- Manager of Network Operations.
- Manager of Appeals, UM.
- Manager of Claims.

Within three business days of the Second-level Dispute Committee meeting, the director of Provider Network Operations or his/her designee documents the determination in EXP, forwards any required claim adjustments to the Research Analyst for reprocessing, and mails a resolution letter to the provider.

Binding Arbitration

Providers who have exhausted ACLA's internal dispute process related to denied or underpaid claims have the option to request binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. The arbitrator will have experience and expertise in the health care field and will be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this section will be binding on all parties. The arbitrator will conduct a hearing and issue a final ruling within 90 days of being selected, unless the ACLA and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, will be shared equally by the parties.

Complaints Regarding Non-ACLA Covered Services

There may be times when a provider has a dispute regarding non-ACLA services. Our Provider Claim Services Unit representatives and account executives are trained upon hire and via online help to distinguish between core benefits and services provided by ACLA and those maintained by DHH or its vendors. In cases involving complaints about non-ACLA covered services, our provider representatives assist in directing the provider to the appropriate DHH or State vendor contact.

Tracking, Monitoring, and Process Improvement

ACLA captures, tracks, and reports the status of Formal Disputes through EXP. With specific standards for managed care organizations, EXP delivers automated data flow management across functional areas and locations. EXP stores and indexes electronic images of documents to facilitate processes that cross multiple functional areas. All stored information is easy to retrieve through advanced search functions.

EXP can generate internal reports to monitor complaints and disputes by various data elements such as category, status, and time until resolution. This serves as a further safeguard for timely processing. It also provides insight into the issues of concern to providers, affording the opportunity to investigate systemic issues and initiate improvements as necessary. All summary reports are distributed to ACLA management, who are equipped to take corrective action when necessary. For instance, ACLA identified a provider complaint trend related to lack of access to infant sleep apnea monitors. Identification of this trend prompted further analysis to determine the root cause of the gap, which was an absence of providers in a specific geographic area. ACLA used this information to contract with a statewide provider of infant sleep apnea monitors with provisions for coverage in this specific geographical area.

In response to provider feedback received by ACLA's account executives, ACLA also improved its provider complaint and dispute processes by streamlining the number of P.O. Boxes required for provider communications. Upon implementation, ACLA utilized multiple P.O. Boxes for provider communications, with different P.O. Boxes for First-level Disputes, Second-level Disputes, and Provider Complaints. We have now implemented a system utilizing one P.O. Box for all Provider Complaints and Disputes, easing the administrative burden on providers.

ACLA reports the status of all provider complaints and disputes and their resolution to DHH on a monthly basis in the format required by DHH. The majority of ACLA's Formal Provider Disputes are resolved in First-level Dispute review. In 2013, ACLA resolved over 99 percent of complaints and 95 percent of disputes in less than 30 days.

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H.3. Provider Management

H.3 Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.

Overview

One of ACLA's goals is to assure smooth transactions and interactions with our provider network community. Quickly addressing providers' inquiries, complaints, and requests is key to enabling providers to better serve our members. ACLA has implemented several processes to respond timely and effectively.

Although providers may file a formal claims dispute in writing, they may also access information, ask questions, and request investigation of a problem or potential issue through a variety of other venues. Our goal is to answer questions immediately and accurately to resolve problems before they become formal disputes or complaints. Once these inquiries and requests for information are submitted by providers, we monitor progress and final resolution through our Enterprise Workflow Management Solution, EXP.

Provider Access to Information

Our proactive approach to communication facilitates provider access to information through multiple entry points. This allows providers to choose the most convenience mechanism to find the information they need.

Provider Center

The ACLA website contains a Provider Center, which allows providers to submit questions through a secure contact form. Information posted in the Provider Center is consistently updated and includes topics such as:

- Services.
- Provider Credentialing.
- Resources.
- Clinical Practice Guidelines.
- EPSDT.
- Member Rights and Responsibilities.
- Patient Centered Medical Home.
- Provider Portal.
- Provider Directory.
- Provider Forms.
- Provider Manual.
- Provider Orientation.
- Provider Reference Guide.
- Billing Information.
- Electronic Fund Transfers.
- Electronic Data Interchange (EDI) Questions and Answers.
- Communications.
- Contact Account Executive.
- Provider Newsletters.
- Cultural Competency and Language Services.

NaviNet Provider Portal

ACLA makes information available through our Provider Portal, NaviNet. As a multi-payer portal, NaviNet allows providers to log in once and access information from multiple plans. NaviNet also grants providers secure reporting capabilities to develop and customize reports that can be used to help them manage the health of their patient population. Providers can build customized reports on key metrics, patient data, or outcomes related to pay-for-performance programs through filters and sorting. ACLA offers access to all the standard transactions through NaviNet, including eligibility and benefits and claim status, as well as links to important administrative information. This resource allows providers access to information at their convenience.

Additional Information Channels

Information is also readily available through the following means:

- 24/7 Provider Contact Center with a specially-trained Provider Claim Services Unit.
- Provider Claims Educator.
- Provider Network Management Staff.

Receiving Provider Inquiries, Complaints, and Requests

A provider complaint is any expression by a provider indicating dissatisfaction with an ACLA policy, procedure, or any other aspect of administrative functions or actions, excluding request for reconsideration or appeal for specific individual claims, filed by phone, in writing, or in person with ACLA. Inquiries and requests refer generally to contacts from providers who are seeking information.

Contact Center

Although we ensure that information is easily available through multiple modes, providers may prefer to voice their inquiries, complaints, or requests, or may need more specific information. Our toll-free, 24/7 Provider Claim Services Unit (PCSU) is available for telephonic inquiries regarding eligibility, enrollment verification, routine billing questions, prior authorization requests, and requests for documents. PCSU staff are specially trained to resolve provider complaints such as dissatisfaction with a plan policy and claims payment issues or questions. They have the ability to research and resolve certain claims payment issues over the phone.

PCSU staff are supported internally by the locally based Provider Network Operations (PNO) unit. The Provider Network Operations Unit is responsible for assuring that provisions of the provider contract are accurately transmitted to the configuration department, assuring that all contracts are tested and paying as expected prior to going “live” in the system, and researching and resolving provider issues or claims disputes brought to the organization through the Provider Network Account Executives or other departments.

All provider calls are documented via EXP, including provider data and issue identification and resolution, related to the call. This application has the functionality to route issues between departments as needed, track issues to ensure adherence to established turnaround times based on service level agreements, and report call activity and trends.

All provider calls are acknowledged immediately by our 24/7 Provider Claim Services Unit, with resolution of the call communicated back to the provider as soon as possible but no later than 30 business days of receipt. PCSU representatives are trained to escalate complaints or issues that are of a significant nature to ensure expeditious resolution. If the call is not resolved within 30 business days of receipt, ACLA documents why the call has not yet been resolved. ACLA ensures that all provider calls will be resolved within 90 days.

Provider Network Management

In addition to the Provider Claim Services Unit, providers have the opportunity to interact with ACLA's Provider Network Management (PNM) staff. Each provider is assigned a PNM account executive, who serves as a resource for questions and concerns. The PNM account executive visits providers through regularly scheduled site visits and is trained to appropriately route provider concerns and assist in resolution. Account executives are committed to developing and maintaining a relationship with their providers and being a resource for them when they have concerns.

Because of this high-touch relationship, providers frequently bring inquiries and complaints to the attention of their account executive. The account executives submit provider issues into an internal database; Network Operations enters these issues for centralized tracking and resolution into EXP. As described above, EXP routes issues between departments as needed, tracks issues to ensure adherence to established turnaround times, and reports call activity and trends.

Some providers testify to the support and responsiveness of ACLA's Provider Network Management staff.

I have enjoyed your responsiveness and ability to resolve a few issues. I was extremely frustrated when you came on the scene and you have been a breath of fresh air. I know that we still have a few mountains to climb, but I know that I can reach out to you and I will get a response, an update or an "I'll find out."

Julia J. Lively
Chief Financial Officer
Health Centers in School

You are the only rep who has actually come to our facility and asked if there are any problems or concerns. You are also the only one who has sent any emails to me and asked how your company was doing and what could be done to improve. As the site administrator I appreciate the little extra you give us trying to make our partnership in providing health care a successful one. Thanks again,

Brad
Open Air MRI

I have been doing credentialing here at Highland Clinic for 15 years. There are some MCO contacts/ representatives in which I have experienced a "working relationship" that DOES NOT work. My working relationship with Lorie Emmons has always been a positive experience for me. Before Lorie I was challenged to get answers that I needed from Bayou Health. Since my working relationship with Lorie began I can attest that I rest easy when it comes to relying on her for any issues or concerns that may come up.

Becky Smith
Credentialing Specialist
Highland Clinic, APMC

Monitoring Provider Inquiries, Complaints, and Requests

Once the complaint or inquiry is researched and the course of action required for resolution is determined, the assigned department coordinates and tracks all activity related to resolution of the submitted issue. Activities required for resolution vary but may include a request to modify existing processes or rules utilized by operational areas, or education of internal staff or providers regarding a plan policy, process, or contractual arrangement.

ACLA sets high goals for accuracy and timeliness of resolution of provider inquiries. Many provider inquiries can be resolved at the time of the call. We are tracking a year-to-date 30-day resolution rate of 99.5 percent for calls in which providers are expressing dissatisfaction.

All communication, research, subsequent action, and documentation associated with provider issues, including those received outside of ACLA's formal dispute process, are managed through the EXP database. Maintaining all of this information in a central location enables accessibility as needed by various internal departments involved in resolving a provider issue. The tracking database is also utilized to generate internal reports that assist in monitoring activity to ensure that issues are resolved within established timeframes, as well as identifying any issue trends. Trends are reviewed to determine what improvements can be made to address any underlying problems.

If the provider is not satisfied with the resolution presented, the provider may proceed through ACLA's formal process as described in Section H.2. Provider Grievance Process of this response.

DHH-Escalated Provider Inquiries and Complaints

Providers sometimes file questions and complaints with Louisiana DHH. Due to the sensitive nature of these requests, they are monitored by ACLA's Compliance & Regulatory Affairs staff.

Provider complaints received from DHH are immediately forwarded to the Director of Compliance and/or the Regulatory Affairs Analyst, who act as intermediaries for these matters. Complaints received through this channel are recorded in the DHH Complaint Tracking Log and forwarded to the department responsible for investigation and resolution. The responsible department stakeholder acknowledges receipt of the complaint in writing within 24 hours.

Throughout the process, the Compliance & Regulatory Affairs department monitors the investigation progress daily to ensure timeframes are met. The responsible party provides

written communication of the complaint resolution to Compliance & Regulatory Affairs, who then reviews the response, provides confirmation of complaint closure, and forwards the resolution in writing to the state. ACLA's goal is to complete this process within three business days of receipt of complaint. For cases in which resolution is not attainable within this timeframe, the DHH Complaint Tracking Log is updated continually, and status updates are communicated to the state weekly until resolution. To ensure privacy and maintain compliance with HIPAA, resolution is communicated to the state via secure e-mail server.

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H.4. Provider Management

H.4 Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled.

- *Submit sample quality profile reports used by you, or proposed for future use (identify which).*
- *Describe the rationale for selecting the performance measures presented in the sample profile reports.*
- *Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.*

Overview

ACLA values supporting our providers in caring for our members. We develop close relationships with providers and deliver resources that help them to be effective in offering the care members need to achieve and maintain their health goals. An important part of this support is information on the quality of care providers deliver. ACLA uses data and metrics to assess the quality and performance of our network providers in various measures, including HEDIS, as well as areas of focus identified by DHH or targeted for enterprise-wide improvement by the AmeriHealth Caritas Family of Companies (ACFC). Additionally, ACLA monitors providers for compliance with Medical Records Standards, and our Quality of Clinical Care Committee profiles provider quality of care through reviews of cases that present potential quality of care concerns. To increase budget predictability, we are also developing reporting that specifically identifies provider cost outliers.

Quality Enhancement Program

Our Quality Enhancement Program (QEP) profiles participating primary care providers (PCPs) in quality measures This program not only gives participants a thorough understanding of their performance, but also the opportunity to earn incentives for achieving quality measures.

QEP enhances primary care reimbursement through a performance incentive payment, which is calculated based upon how well a primary care provider office scores on each bonus component relative to their peers of the same specialty type. The program focuses on PCPs with greater than 500 members on their panels. To be eligible for the maximum amount of the pool, the practice must have an open panel and be accepting new patients.

The five performance components of the QEP program are:

- Quality Performance.
- Severity of Illness.
- Cost Efficiency Management.
- Non-Emergent Emergency Room Utilization.
- Improvement Incentive.

Performance Measures Selected

Through the QEP program, PCP offices are scored relative to their peer providers of the same specialty type on key quality measures. Selected with extensive input from our Clinical Care Committee, which comprises network physicians from across the state, these measures are intended to address locally prevalent conditions and health issues. They reflect areas of concern as identified by DHH, as well as areas ACLA has committed to improving through Annual Operating Plan goals. ACLA has included outcome measures identified by DHH and created targets based on DHH expectations and baselines. Ultimately, improved performance in the selected measures can be expected to positively impact member health and present cost-effective care.

To that end, ACLA's QEP program measures and rewards provider success in the following areas:

- Well Child Visits for ages 3–6.
- Reduction in low-level emergency room (ER) utilization.
- Adolescent well-child care.
- Comprehensive diabetes care – HbA1c testing.
- Adults' access to preventive Ambulatory Health Services (AAP).

In consideration of health issues that are increasing in prevalence in Louisiana, ACLA has expanded the QEP to include the additional quality measures listed below.

- ADHD follow-up care.
- STI Screenings for HIV, syphilis, chlamydia, and gonorrhea.
- Patient-centered Medical Home recognition.

QEP Reporting

PCP profiles in Key Performance Measures compare each practice to its peers and include a risk-adjusted analysis of actual versus expected utilization for the assigned members. These performance indicators provide tangible results and opportunities for intervention and education. The comparison against peers encourages the providers to work to improve their scores.

Results for each Key Performance Measure are calculated for each practice and then aggregated for a total score of all measures. Overall practice scores are calculated as the ratio of members who received the above services as evidenced by claim and/or encounter information (numerator) to those members in the practice's panel who were eligible to receive these services based upon the above definitions (denominator). This score is then compared to the score for all practices of the same specialty type to determine the practice percentile ranking.

We also score the ER Utilization patterns of panel members in the practice. ER utilization is compared from two perspectives: Total ER utilization and Non-Emergent ER utilization. These measures are ranked against peer performance for a percentile ranking.

Providers can quickly retrieve profile reporting at their convenience through the QEP dashboard. This online dashboard gives providers self-service access 24/7 to population- and patient-level analytics in a secure, easy to use format. The dashboard is refreshed once a month with up-to-date, actionable data.

The Key Performance Measures in the dashboard are designed to provide easy access to the critical measures and associated reporting options. Key Performance Measures are sorted into groups that have been defined to support the analytical needs of the program. Various levels of data are available to ensure that the dashboard provides consistent information with an appropriate level of detail. The dashboard allows providers to run reports that identify members and their care gaps, so that they can discuss the needed services with the member when they come in for an appointment. The data in the detail dashboard can be exported into an Excel spreadsheet for providers to use in contacting members or executing a mailing to address a particular issue. A sample Care Gap Worksheet appears below.

AmeriHealth Caritas Louisiana

September 09, 2014

Important Clinical Information

Print this document and place it at the front of the member's medical record for review by a healthcare professional

Care Gap Worksheet

Member :

Name: [redacted]

ID#: [redacted]

Age/DOB: [redacted]

SSN(Last 4): [redacted]

Phone: [redacted]

PCP Assigned :

Name: [redacted]

Address: [redacted]

Phone: [redacted]

***** Claims Processed Through End of Month July 2014 *****

Alert Service(s) - Due Soon/Over Due/Missing - Response Required

Condition	*Service Due*	*Last Service*	*Last Value*	*Status*	*Frequency*	*Date Done*	*Result*	*Date Referred*
EPSDT	Annual Vision Screen	06/13/2013		Overdue	At least once per year			
EPSDT	Annual Hearing Test	06/13/2013		Overdue	At least once per year			
EPSDT	Adolescent Well Care	06/13/2013		Overdue	At least once per year			
EPSDT	Annual Dental Visit 2 to 21 Years	03/07/2013		Overdue	At least once per year			

At Risk/Risk Service(s) - Information Only

Condition	*Service Due*	*Last Value*	*Status*	*Frequency*
Diabetes	Blood Glucose Monitoring		At Risk	At Risk indicates underutilization/absence of blood glucose testing supplies

Care Gap Worksheet

Member Name [redacted] **Member ID** [redacted] **Age/DOB** [redacted]

*The above services may be part of the Quality EnhancementProgram(QEP). To update the member data, complete the columns in the "Response Required "section above. Sign below and fax a copy of the updated worksheet to 1-866-928-5136 .

Physician Signature

Date

Data source: The data in the Care Gap Worksheet is derived from claims information submitted to and processed by the Health Plan . The information may lag behind the actual delivery of services depending on when the claim was submitted and processed.

Exhibit H.4-1: Care Gap Worksheet

Sample Quality Profile Report

A printed QEP profile report is included after Section H as Attachment H.4-A. Screenshots of the QEP dashboard appear below.

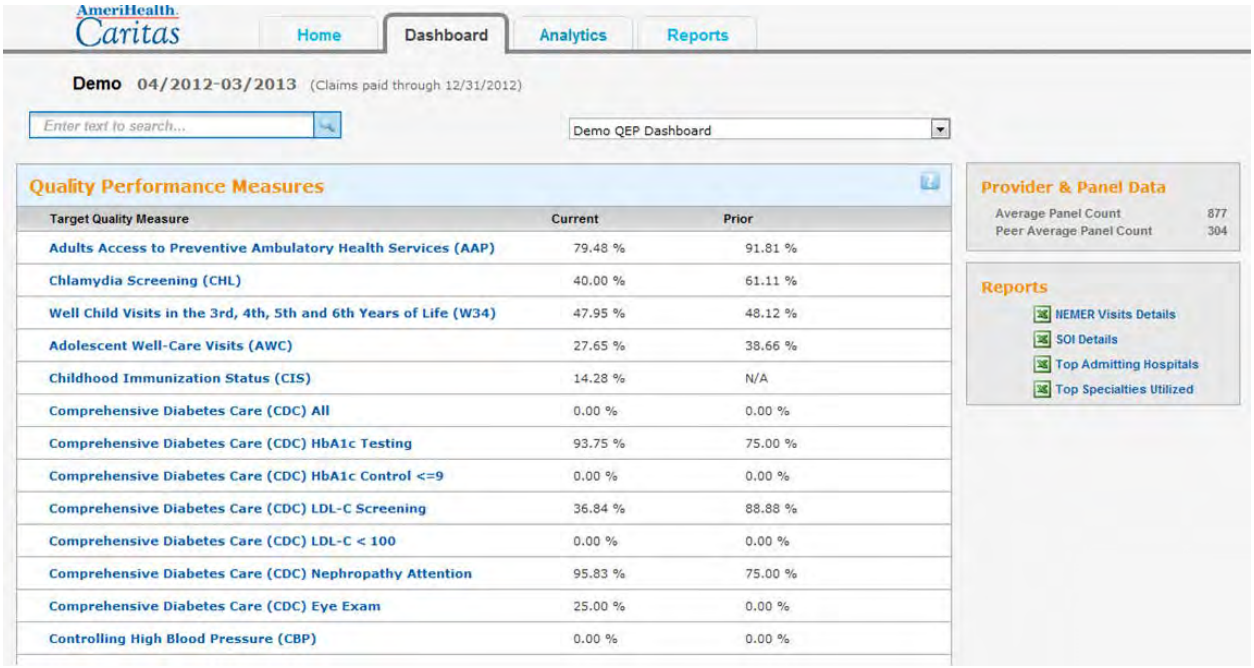

Exhibit H.4-2: QEP Dashboard

ACLA is also developing a Perinatal Program, modeled after the QEP program, that will be available to providers who offer perinatal care. The QEP dashboard will be available for this program as well, enabling providers to access actionable profiling data. The Perinatal Program will measure and reward providers for achieving Quality Performance Measures in:

- Frequency of prenatal care.
- Timeliness of prenatal care.
- Postpartum care.
- Antenatal progesterone administration.
- STI Screenings for HIV, syphilis, chlamydia, and gonorrhea for pregnant women.
- Completion of the Obstetrical Needs Assessment Form.
- Network Cesarean Section Performance.

Provider Performance Report Cards

ACLA is currently developing an overall HEDIS Performance Report Card to be provided to all PCPs. This report card will provide PCPs with their overall annual HEDIS results for members attributed to their practice. The results in this report are compared to health plan averages and national baselines in order to make providers aware of their personal performance. This profile report is expected to be in place and available to providers in 2015.

Performance Measures Selected

ACLA has selected performance measures that include quality outcome measures important to Louisiana health conditions. Quality measures are selected based on Louisiana health statistics, DHH key areas of focus, plan health outcomes, and input from our Quality of Clinical Care

(QCC) Committee. The QCC Committee comprises local PCPs and specialists, as well as ACLA leadership in Medical Affairs, Appeals, Utilization Management, Integrated Care Management, Quality Management, Provider Network Management, and Operations Services. The QCC considers measures that improve health care for the local community, and that support enterprise-wide Annual Operating Plan goals. Preliminary performance measures selected are:

- Prevention & Screening.
- Utilization.
- Respiratory Conditions.
- Comprehensive Diabetes Care.
- Access and Availability of Care.
- Behavioral Health Services.
- Use of ED Services.

Quality Profile Reporting

The selected outcome measures and rankings are combined in a comprehensive Performance Report Card that compares provider measurement period measures with their measures for the previous year. This allows providers a clear view of the areas that have improved, as well as those that need attention. A component of the report is the non-compliant member list, which gives patient names, Medicaid ID numbers, and contact information for members lacking a required health service. The report would be sent monthly to provider sites, accompanied by a letter that explains areas to target and information on corresponding procedure and diagnosis codes.

PCP practices shown to be utilization outliers receive education regarding potential process changes that should be considered to address issues. ACLA's Provider Network Management account executives and Network Medical Director are trained on measures and methodology to help PCPs use the data to improve their performance.

Sample Quality Profile Report

A sample of the draft Performance Report Card is included after Section H as Attachment H.4-B.

PerformPlus®

The PerformPlus® profiling and reporting model supports ACLA's efforts in providing health care systems in the network with actionable benchmark data to improve the quality of care delivered to our members. PerformPlus® is available to physicians, hospitals, and integrated delivery systems including primary care physicians and specialists. ACLA approaches high-quality providers for participation in the program based on their interest in meeting quality measures and sharing in the resulting savings. Ideal candidates for the program include integrated health systems whose PCPs admit to the same major hospitals. ACLA may also develop custom incentive programs with strong provider partners based on mutually acceptable quality metrics, as we have done with Franciscan Missionaries of Our Lady Health System.

The PerformPlus® model gives ACLA the ability to monitor and discuss utilization performance with our provider partners. PerformPlus® provides a balanced scorecard of accountable care quality and cost concepts characterized by key performance metrics on which physician incentives are based. Peer- and trend-based performance metrics are aligned to promote efficient use of resources and to mitigate unnecessary or redundant care.

Performance Measures Selected

Based on 3M's "Potentially Preventable Readmission" logic, Potentially Preventable Admissions, and HEDIS-based quality standards, PerformPlus® quality metrics include:

- Potentially preventable hospital admissions.
- Potentially preventable hospital re-admissions.
- Low-acuity emergency department visits.
- Neonatal intensive care unit length of stays.
- Obstetric and primary care HEDIS measures.
- Appropriate care measures: the percent of patients who received all recommended treatments based on their clinical condition.

Reporting

Partners participating in the PerformPlus® model can access ACLA's web-based dashboard to track their progress for each metric and produce self-service reports and drill-down data mining. The dashboard also allows identification of frequent emergency department utilizers, readmissions, HEDIS results, care gaps, clinical risk, and other member-centric data to foster collaboration and meaningful member outreach.

Sample Quality Profile Report

A sample of the reporting available through the web-based dashboard is shown in the exhibit below.

Home | Dashboard

Demo 2010/10-2011/09

Demo Shared Savings

KPI Measures

Key Performance Measure	Rolling 12 months	Baseline
ACSC Rate	22.43 %	23.25 %
PPR Rate Actual vs Expected	0.00 %	(1.40) %
ER Rate	65,508	65,260
NICU Admissions Rate	17.15 %	15.63 %
C-Section Rate	29.00 %	30.25 %

Obstetrics & Primary Care Measures

Key Performance Measure	Rolling 12 months	Baseline
Chlamydia Screening in Women (CHL)	36.10 %	51.05 %
Postpartum Care (PPC)	50.20 %	62.36 %
Prenatal Care (PPC)	70.40 %	71.75 %

Exhibit H.4-3: Reporting Capabilities through the Dashboard

Additional Quality Profiling

Reporting Available through NaviNet

Information on HEDIS measures and care gaps is available on a self-serve basis at any time to all of our network providers through NaviNet, our online Provider Portal. Our account executives present introductory training in NaviNet during provider orientation sessions and retrain providers on its functions during face-to-face site visits. NaviNet offers secure reporting capabilities, allowing providers to access patient-level information on care gaps, such as missed EPSDT visits or HbA1c tests. All HEDIS measures are present to allow providers to filter by area of focus and address members in need of services. For example, providers can filter by EPSDT and obtain a report of their members in need of a well exam. This information facilitates outreach to members to improve provider performance and ensure optimal care for members.

Educational Opportunities to Network Providers

ACLA has a well-defined quality program that serves as a framework to evaluate the delivery of health care and services provided to members. The program identifies educational opportunities with plan providers through the analysis of Incentive Base Measure, HEDIS metrics, clinical outcomes, and other metrics as defined by DHH. Reviewing these results allows the Quality department to identify members who have gaps in care.

Reports are further drilled down to identify the providers that have the highest number of members with gaps in care. In collaboration with Provider Network Management and the Medical Director, the Quality department formulates the best strategy for addressing the deficiencies with the provider and their office staff as necessary. Provider Network Management account executives and/or the Medical Director schedule one-on-one meetings with providers to communicate the information and formulate plans for improvement. Ongoing monitoring is important as many provider offices may have staff turnover requiring additional training.

Review of Potential Quality of Care Cases

An important mechanism for profiling the quality of care our members receive is our review process for investigating, monitoring, reporting, and trending potential quality of care concerns. Quality of care concerns represent a substantiated deviation from expected provider performance, clinical care, or outcome of care, as determined by a clinical review of medical records. Quality of care concerns are related to the care that is delivered to members in an inpatient or outpatient setting. The goals for reviewing these issues are to:

- Have a positive impact on improving patient care, treatment, and services and prevent sentinel/adverse events.
- Focus the attention of the organization on understanding the causes that underlie the event, and on changing systems and processes to reduce the probability of such an event in the future.
- Increase general knowledge about adverse and sentinel events and hospital-acquired conditions, their causes, and strategies for prevention.

Potential quality of care concerns are identified by various sources, including internal departments such as Appeals, Credentialing, Integrated Care Management, Legal, Member Services, Provider Services, Network Management, Special Investigations, Utilization Management, and Claims Data; and external sources including the regulatory agencies with authority over ACLA. All quality of care concerns are referred for investigation, analysis, and reporting of clinical quality issues to the Quality of Clinical Care Committee, a subcommittee of the QAPI Committee. Nurses in the QCC Committee review the details of the referred cases to determine whether they should be escalated to ACLA's Medical Director, who chairs the QCC Committee. The QCC Committee comprises specialists and primary care practitioners, as well as ACLA leadership in Medical Affairs, Appeals, Utilization Management, Integrated Care Management, Quality Management, Provider Network Management, and Operations Services.

Based on the details of the quality of care concern, the Medical Director may consult with other physicians, leadership within ACLA, or an independent review organization. The Medical Director issues an outcome determination within 30 days.

Data supporting the quality of care concerns is collected and stored in the Quality of Care database. The data elements include event type, case summary, outcome determination, severity level code, action steps, and Corrective Action Plan. This careful categorization of data enables thorough tracking, trending, and reporting. Should trending reveal the need, the QCC Committee can investigate further and make recommendations. Review and analysis focuses on

factors that underlie variations in expected performance, including the possible occurrence of an adverse event. This analysis focuses on systems and processes to isolate root causes in processes and systems. If system or process issues are identified, the QCC Committee develops strategies for corrective action to reduce the risk of similar events occurring in the future.

Medical Records Review

Well-documented medical records facilitate communication, coordination, continuity of care, and efficient and effective treatment. To ensure that PCPs provide high-quality care and document it according to established standards, ACLA's QCC Committee reviews all PCP practice sites with 50 or more members once every 2 years for compliance with ACLA's Medical Records Documentation Standards. These standards include guidelines pertaining to medical record content, confidentiality, consistency, organization, completeness, and ease of retrieving medical records. The standards are included in the provider contract and distributed to providers and their staff, as well as being available in the Provider Manual and on ACLA's website. The Provider Network Management team works with sites that fall below the expected performance benchmark to improve documentation processes prior to a follow-up review in six months.

As with other profiling processes, the Medical Records audit presents an opportunity to identify issues of concern and opportunities for improvement. Audit results are aggregated to identify trends and network opportunities. The Provider Network Management department, in collaboration with the Quality department, designs network-level education and initiatives to improve documentation compliance. A summary of performance is presented to the QAPI Committee for their review and recommendations. The Medical Records Review results are reported quarterly to DHH with an annual summary.

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H.5. Provider Management

H.5 Describe how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers. Identify the key requirements that will be addressed.

Overview

ACLA provides a full orientation for all new providers. Components of our routine initial education and training program are on-site orientations for newly contracted providers, routine site visits, provider workshops, welcome letters, provider handbook, newsletters, and the provider website.

In addition to initial education and training, ACLA supports providers continually by keeping them abreast of new information. Provider Network Management (PNM) account executives develop and maintain high-touch relationships with provider offices to ensure that their informational needs are heard, addressed, and resolved. We offer ongoing provider training in multiple formats. To ensure effectiveness, we request provider feedback on educational offerings and make adjustments accordingly.

Initial Education and Training

Providers who are new to Medicaid managed care are frequently unsure of what to expect. ACLA's specific experience serving the Medicaid population in Louisiana, strengthened by our parent organization's history of serving this population throughout the country, informs and shapes the training we offer providers.

Key Requirements Addressed in Provider Training

ACLA schedules provider orientation visits within 30 days of placing a newly contracted provider or provider group, and continuously upon request. Key educational components in the initial new provider orientation include:

- ACLA overview.
- Bayou Health program basics.
- Physician requirements and programs.
- Member eligibility.
- Confidentiality requirements.
- Marketing requirements, including acceptable and prohibited practices.
- Benefit coverage.
- Referrals and authorizations.
- Claims.
- Provider Contact Center (24/7 access) services.
- NaviNet Provider Portal use and instructions.
- Quality.

- Credentialing.
- Utilization management.
- Integrated Care Management (ICM).
- Provider rights and responsibilities.
- Member rights and responsibilities.
- Provider complaint system and claims dispute process.
- Grievances and appeals.
- Regulatory provisions.

Provider Network Management Account Executives

In addition, each provider is assigned a PNM account executive as a resource for ongoing support. The PNM account executive performance goals require that account executives complete eight visits per week in addition to any special project that they may be working on. These visits are based upon the following provider visit policies:

Provider Type	Frequency of Visits
Primary Care Providers with Panels > 500	Monthly
Primary Care Providers with Panels < 500	Quarterly
Specialists and Ancillary Providers	Quarterly
Hospitals and Facilities	Quarterly

Exhibit H.5-1: Provider Visit Policies

PNM account executives educate providers on our quality programs, administrative or program changes, and other topics as requested by the provider. This enhanced provider support increases overall satisfaction and promotes an opportunity for us to engage with the provider on initiatives that improve quality outcomes. Provider visits serve as an effective communication vehicle for both parties because we use their feedback to continuously improve our services.

I want to thank (my account executive) for all of her help. She is always available to visit our clinic. Sometimes, there are issues that need to be taken care of face to face! As the account executive for Marksville Family Care Center, we are thankful for her hard work. Thanks,

Practice Manager III
Marksville Family Care Center
Christus Health System
Marksville, Louisiana

Claims Payment Processes

At the root of their concerns, providers most often seek confirmation that they will be paid timely and without hurdles for the work they do to keep members healthy. Therefore,

education about claims submission and payment processes is always a top priority among the many topics we discuss in provider orientation sessions.

As an extra measure, ACLA trains account executives on claims processing. This training allows our account executives to provide front-line claims resolution. This ensures that providers receive the maximum support from someone whom they see regularly and with whom they are comfortable. The early concern providers feel may be alleviated upon experience with our unique claims payment processes that ensure prompt payment. In fact, ACLA pays claims within an average of six calendar days—a rate that ranks us as one of the top two among Bayou Health Plans.

Ongoing Education and Training

Billing and claims training information is available on-demand to providers via the Provider Portal of our website as well as through the Provider Manual, which also covers referral and prior authorization requirements (both of which can impact claims payment). A "Detailed Claims Filing Instructions" booklet is available online that includes sample claim forms, field requirements, and common reasons for claims rejection. Hard copies can also be made available to the provider.

Other topics included in the online provider reference include:

- Timely filing
- EDI questions and answers.
- Eligibility verification guide.
- Electronic fund transfer instructions.
- Billing guidance notifications or coding requirements (for example, NCCI edits).

This information is reviewed in depth with new providers, and all information available for providers through the website is reviewed and updated on a regular basis.

Providers are directed to our website to allow them to become familiar at their convenience with the broad range of educational topics we cover. Providers are always able to contact their assigned Provider Network Management account executive for education, follow-up questions, and concerns.

Our provider manual is available electronically within the provider portion of our website and can be downloaded for those who prefer a hard copy version. Our provider manual and all provider-related materials, including the provider portion of our website, are reviewed regularly to ensure information is current and concise.

Providers are often concerned about prior authorization requirements. ACLA details the prior authorization requirements during all new provider orientations and continues to reinforce the prior authorization processes during regularly scheduled and provider-requested visits.

Additionally, we provide education related to billing requirements during routine site visits and Provider Workshops held by the Provider Claims Educator within provider communities for their convenience. The Provider Claims Educator conducts Regional Provider Trainings

across the state to target billing questions and issues. We offer assistance with establishment of electronic claim submission and/or electronic funds transfer as needed. We also review the claims edits performed by the claims administration platform and how to easily review claims status and correct claims when necessary. Changes and updates are also included in our regular provider fax communications.

In addition, we host seminars in the local community for additional provider education. We structure the seminars in a variety of ways to address the needs of different provider community audiences. We host practitioner seminars focused on concerns of physicians and health care service providers; office manager seminars, which typically focus on administrative and claims issues; and hospital system orientation sessions where we invite employees at health system practices to attend sessions covering orientation subjects.

Responding to Provider Education Needs

ACLA designs supplemental provider training sessions as needed to achieve plan initiatives as well as those identified by DHH. For example, in an effort to collaborate toward common HEDIS goals, ACLA partnered with the Louisiana Primary Care Association in presenting a HEDIS Coding Boot camp to Federally Qualified Health Center (FQHC) practice managers in August 2014. This day-long event provided practice managers with an overview of the HEDIS principles, how the data is used, and how it affects providers, as well as a basic overview of the HEDIS measures for the Bayou Health program. HEDIS coding guidelines were reviewed in an effort to assist FQHCs properly capture information via the claim submission process. The agenda for the program follows:

- AmeriHealth Caritas Louisiana History and Background.
- HEDIS 101.
- HEDIS Measure Overview.
- 5 HEDIS Measures for Louisiana.
- HEDIS Coding Guidelines.
- ACLA Quality Enhancement Program Overview.
- Open discussion and questions.

Evaluating the Effectiveness of Provider Training

We evaluate the effectiveness of these training sessions by requesting feedback from the provider. We are committed to constantly improving our training sessions and making the sessions a worthwhile endeavor for the provider and the provider staff. We have a form that we request the provider to complete at the end of each session. The responses are reviewed by the Director of Provider Network Management for determining the topic of the training sessions. We also conduct provider surveys in order to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, and claims reimbursement.

The 2013 Provider/Practitioner Satisfaction Survey found that 80% of providers would recommend ACLA to other practices/providers and their patients; a similar proportion agree that ACLA takes their input and recommendations seriously.

A compelling measure of the success of our ongoing outreach to providers is the informal feedback we receive from them. We have found providers to be appreciative of the relationships established by our Provider Network Management and Operations departments; their hands-on, proactive approach to supporting providers, hearing their concerns, and resolving their issues ensures an effective partnership in care delivery.

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AmeriHealth Caritas Louisiana

Quality Enhancement Program Profile

Payment Cycle: February 2012 through June 2013

Claims Cycle: July 2012 through June 2013

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Provider Performance Report

Tax ID: 000000000
Group: PROVIDER MD
Provider: PROVIDER, JOHN 22222222
1070 ANYWHERE DR STE 102 * ANYTOWN * LA * 70000

AmeriHealth Caritas Louisiana

P.O. Box 83580
Baton Rouge, LA 70884

[redacted]

1 Current Year performance rates based on claims submitted through 07/31/2014. Performance rates for previous years are based on claims paid through the end of specified calendar year. Final report results may vary. HEDIS is a registered trademark of the National Committee of Quality Assurance.

Provider Performance Report

Tax ID: 000000000
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1 Current Year performance rates based on claims submitted through 07/31/2014. Performance rates for previous years are based on claims paid through the end of specified calendar year. Final report results may vary. HEDIS is a registered trademark of the National Committee of Quality Assurance.

I.1. Member Assessment & Care Coordination

I.1 DHH intends to provide MCOs with two years of historic claims data for members enrolled in the MCO effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your MCO effective February 1, 2015. The description should include:

- *How you will identify these enrollees, and how you will use this information to identify these enrollees, including enrollees who are receiving regular ongoing services;*
- *What additional information you will request from DHH, if any, to assist you in ensuring continuation of services;*
- *How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation;*
- *What information, education, and training you will provide to your providers to ensure continuation of services; and*
- *What information you will provide your members to assist with the transition of care.*
- *Describe your approach to identifying "hot spotters" who are high utilizers and describe any innovative approaches you utilize to be able to identify the difficult to find patients.*

Overview

ACLA is dedicated to identifying and fully understanding our members' initial, ongoing, and/or unmet health needs. When members enroll in our plan, our first step is to welcome them and identify their health and coordination needs. This is accomplished through several methods, including claims analysis, member interaction, notification by previous plans, analysis of DHH's prior authorization file, and our health risk assessment.

After identifying needs, our Care Management, Utilization Management (UM), and Rapid Response teams assist in coordinating access to the medically necessary covered services that the transitioning member will need. The UM department plays a critical role in ensuring that open and new authorizations for medically necessary covered services are provided to members in a timely fashion, with minimal hassle.

ACLA recognizes that members with special health needs can particularly benefit from a high degree of care coordination during the initial post-enrollment period. For these members, ACLA's process often includes establishing an individualized plan of care. ACLA also connects members to internal resources—such as intensive case management, maternity management, or condition/disease management (e.g., asthma, obesity, pregnancy, sickle cell disease)—that can support continuity and ongoing management of care.

Identifying Members with Special Health Needs

Members with special health care needs comprise individuals of any age with a mental or physical disability or other circumstances that put their health and their ability to fully function in society at risk, requiring individualized health care services. Because these members often have multiple chronic, comorbid illnesses that impact both physical and behavioral health, it is especially

important that they receive high-quality, targeted care to ensure the best possible outcomes.

ACLA uses several methods to identify members with special health care needs within 90 days of receiving the member's historical claims data, if available. These methods include claims analysis, receipt of ongoing prior authorizations, provider referral, and member identification through our new member assessment. After identification, ACLA's Integrated Care Management (ICM), UM, and Rapid Response associates work to ensure that appropriate, medically necessary services are delivered at the appropriate levels of care.

Claims Analysis and Predictive Modeling

ACLA analyzes available medical, behavioral, and pharmacy claims data, such as the DHH-provided historic claims, to identify members who have targeted chronic conditions. Data mining algorithms are designed to avoid false-positives and only flag members with active diagnoses.

In addition to basic data mining, ACLA uses 3M-licensed tools to assign members to Clinical Risk Groups (CRGs), which classify members into clinically based populations. Using standard claims data, the algorithms assign members into a single risk group based on their burden of illness. The CRG tool uses historic clinical and demographic characteristics to predict the amount and type of services and treatments the member will access in the future. Members identified as having complex and/or special health care needs through these data analytics are referred for complex care management.

Ongoing Care Needs and Authorizations

Members with special health needs often have open authorizations for medically necessary covered services when they enroll in our plan. These open authorizations are typically shared with ACLA through DHH or the relinquishing health insurer. If they are not, ACLA actively requests the authorization information in order to support continuity of care.

During the transition period, ACLA honors open authorizations and previous treatment plans for up to 90 days unless revised by the member and his or her primary care provider (PCP).

Once the data is received, the UM team reviews the open authorizations and contacts the member's PCP, or other providers as appropriate, to verify the member's health status and the need for continuation of services. Arrangements to continue the care will be made as appropriate.

UM associates also ensure that received authorization data—including services approved, authorized date span or visit quantity, and facility/provider names, addresses, phone and fax numbers—is entered in our core clinical care management platform, ZeOmega Jiva. The data is then automatically loaded into our core claims administration platform, TriZetto Facets, on a daily basis so that submitted claims do not deny due to missing service authorization data.

New authorizations will be requested as the new members visit their providers. The UM department reviews all authorization requests to identify members who may have special health needs and then refer them to complex care management.

Welcome Process and New Member Assessment

New ACLA members are welcomed into the plan with welcome packets, welcome calls, and a copy of the Member Handbook, which are designed to inform members about our plan and the services that are available to them. Continuity of care provisions are detailed in these materials, and ACLA encourages members to let us know—either on the call or through our New Member Assessment—if they have special health needs or are receiving ongoing care. These members are referred to ACLA's Rapid Response team to ensure appropriate care coordination and care management services are offered to the member.

Our welcome packets include a New Member Assessment for members to fill out, which enables ACLA to identify members' current, ongoing, and future health needs and triage them into appropriate components of our ICM program. The assessment asks members to identify the services—both medical and non-medical—that they are receiving, as well as their current providers.

Due to the critical role it plays in care coordination during the transition period, ACLA uses a number of outreach methods to connect with members and complete the New Member Assessment. In addition to its inclusion in the welcome packet, our Member Services representatives will offer to walk through the assessment with the member during the welcome call. Members may also fill out the assessment electronically through ACLA's secure Member Portal.

If the preliminary screening indicates that the member has special health needs or that further clinical review is necessary, the member is referred to a nurse care manager, who completes an additional assessment. If the assessment results indicate that the member would benefit from case management, the member is invited to participate in ACLA's ICM program.

Individualized Care Plan

After the comprehensive clinical assessment, the nurse care manager collaborates with the member, the PCP, and specialists who are treating the member to develop an individualized care plan. ACLA care managers develop holistic treatment plans that address the member's medical, behavioral and social/support needs. This may include regular monitoring, member education, coordination of needed services, focused care management support, and/or enrollment in an ACLA disease management program. Care plans for members with special or complex health needs members also include assessments and interventions that focus on caregiver support.

Care plans that are in place when the member enrolls in ACLA are honored until a new care plan is developed and approved by the member and his or her providers.

Additional Information to Assist in Continuity of Care

Analyzing the historic claims data is a critical first step in assessing member needs. In addition to the claims data, ACLA would find it invaluable if DHH could provide any of the following information for new members transitioning into the plan on the contract start date:

- Provide Prior Authorization information from transferring MCO.
- Historical claims data for members transferring from one MCO to another.
- Receipt of the 124 In/Out Transfer by Health Plan Report within 3 to 5 days of initial member enrollment.

Additionally, ACLA has already begun participating in DHH's prior authorization information exchange. If members entering the plan effective February 1, 2015 have open authorizations on file from other MCOs, this information would be valuable in identifying their health needs and ensuring continuity of care.

Ensuring Continuity of Medically Necessary Services

ACLA is dedicated to preserving continuity of care by providing a high degree of care coordination, especially for members with complex health conditions or comorbidities. This includes:

- Helping members schedule specialty health care, transportation, or other service supports.
- Monitoring and resolving gaps in care and evaluating treatment adherence/progress.
- Collaborating with members, facility staff, and providers to plan transitions in care so that appropriate steps are taken to safeguard members' health and quality of life.

Medically necessary services indicated in the member's care plan are continued throughout the transition period, and do not require prior authorization, and existing providers are allowed to continue service delivery throughout the transition period, regardless of whether they are contracted in ACLA's network. ACLA's Transition Coordinator works with DHH and representatives from other health insurers to better assist members through the transition process and ensure continuity of care.

Authorizing Continuation of Medically Necessary Covered Services

ACLA abides by the DHH-specified timeframes when authorizing the continuation of ongoing medically necessary covered services for members who are new to our plan. Notably, ACLA honors existing authorizations 30 - 90 days, or until the member is assessed and a new care plan is developed and approved by the member and his or her provider(s). Prior authorizations are not required for previously authorized services during the transition period.

Cases that require ongoing approval after 90 days are reviewed by ACLA's medical director in accordance with ACLA's general prior authorization requirements.

Collaborating with Non-Contract Providers

If a new member has an existing treatment plan that is managed by an out-of-network provider, ACLA may attempt to contract with the provider so that continuity may be preserved once the course of treatment is completed. If that is not possible for whatever reason, an ACLA care manager will work with the member and the existing provider to identify a point in time when the member's care can be transitioned to a network provider.

If this is not possible or in cases where the provider recently left ACLA's network, continuity of care is provided for members with open active treatment plans. The member authorized to continue receiving care from that provider, if the provider agrees, until such time as treatment is completed or 90 days, whichever comes first. During that transition period, ACLA works actively with members to identify an acceptable participating provider.

Rapid Response coordinates with providers to facilitate the transfer of medical records between the existing out-of-network and the newly selected in-network provider to further support continuity of care.

ACLA may authorize ongoing care from non-participating providers, beyond the end date of the previous authorization or the continuity of care period, if there is not sufficient expertise or access within the regional network to provide appropriate care to the member. In those situations, a single case contract may be negotiated, which documents the approved services, duration, and payment in writing.

Identifying and Addressing Transportation Needs

Many Medicaid members experience difficulty arranging for reliable transportation between their homes and provider offices. This is especially true for members with special health needs, who may need specialized vehicles to safely and comfortably commute to their appointments. ACLA provides non-emergency medical transportation (NEMT) services for these members.

ACLA generally identifies current and ongoing transportation needs through the welcome process, routine member outreach and customer service, and provider referrals. After these needs are identified, an ACLA care manager or Rapid Response associate coordinates with our NEMT vendor to schedule transportation services to prevent disruption in care.

ACLA coordinates with members and the NEMT vendor to identify and address member-specific transportation needs. This includes specialized vehicles or ongoing transportation to and from regularly scheduled medical appointments with PCPs, specialists, or outpatient facilities.

Our members and providers can call the NEMT vendor's toll-free, ACLA-dedicated line to schedule transportation, or they can contact Member Services or Rapid Response at any time for assistance with their transportation needs.

Engaging Providers to Support Continuity of Care

Ensuring providers have a complete understanding of the requirements and policies around member transitions is a key strategy in supporting continuity of care. ACLA shares this information with our network in a variety of ways, including provider materials, provider training, and direct contact between ACLA associates and providers.

Provider Materials

In the Provider Handbook, ACLA clearly outlines the plan's expectations for providers to assist in member transitions to the best of their ability; this includes coordinating with other health plans and providers. The Provider Handbook also details how providers who no longer participate in ACLA's network may continue to support their members.

Through the provider materials, ACLA also encourages providers to notify the plan when they identify new members who have special health needs or when an existing member experiences an abrupt change in their health or social conditions. This enables ACLA to reach out to the member and assess whether additional services or supports are needed, such as disease management, care management, or care coordination.

The Provider website is accessible to participating and non-participating providers. For non-participating providers who are providing treatment or services to ACLA members, the site includes instructions on alerting ACLA so that continuity of coverage can be evaluated and arranged.

Provider Training

The Provider Network Management department staff meets with providers through regularly scheduled visits. ACLA has more than 10 Louisiana-dedicated Provider Network account executives who provide initial orientation and ongoing education and training to ACLA's provider network. Continuity and coordination of care are key components of ACLA's provider training and communication plan.

Direct Contact with Providers

In addition to the in-person training provided by ACLA's Provider Network account executives, ACLA's transition and care management staff are also available to providers to discuss the continuity of care processes for individual members who are transitioning between health insurers or care settings.

Our Medical Director also makes herself available to network providers via telephone and office visits to discuss issues regarding service authorization, referrals, or continuity of care issues.

ACLA's Member Clinical Summary

ACLA provides a Member Clinical Summary to network providers through our secure NaviNet Provider Portal to further support continuity of care. This report enables providers to quickly and easily review a member's history, including chronic conditions, recent prescription history, inpatient admissions, emergency room visits, and office visits. The Member Clinical Summary also includes the member's demographic information, open authorizations, and identified gaps in care.

Data populated on the summary is pulled directly from ACLA's core information platforms, which includes the historic claims data provided by DHH, to ensure providers have access to up-to-date member information.

The Member Clinical Summary can be printed from the portal for inclusion in the member's chart, and it can be downloaded as a Continuity of Care Document (CCD) for integration into an electronic health record. The portal also has reporting tools that allow providers to build customized reports using ACLA member information.

AmeriHealth Caritas Louisiana

Member Clinical Summary

Date of Report: 09/09/2014

Member Information

Name :
Address1 :
Address2 :
City/St/Zip :
Phone :
Gender : F
DOB :
Member ID :

PCP Information

Provider Name :
Address1 :
Address2 :
City/St/Zip :
Phone :

Medications (within past 06 months)

Fill Date	Name & Strength	Days Supply	Prescriber Name	Pharmacy Name
8/20/2014				

Chronic Conditions

There are no data records available for this section

Gaps in Care

Condition	Service	Status	Last Service	Next Service	Rule
EPSDT	Annual Hearing Test	Overdue	12/07/2012		At least once per year

ER Visits (within past 06 months)

Date	Facility	Reason

There are no data records available for this section

Inpatient Admissions (within past 06 months)

From Date	To Date	Facility	Reason

There are no data records available for this section

Office Visits (within past 06 months)

Date	Provider Name	Speciality	Reason
08/22/2014			

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

EPSDT Screening Services within the past 24 months

Date	Service	Age (Yrs)
7/31/2014		12Y
3/9/2012 1		12Y
3/9/2012 1		12Y
12/7/2012		12Y

Additional Vaccinations

Date	Service	Age (Yrs)
7/31/2014		12Y
2/4/2014 1		12Y
2/4/2014 1		12Y

Exhibit I.1-1: Supporting Continuity of Care through the Member Clinical Summary

Informing Members of Continuity of Care Provisions

ACLA recognizes that the Bayou Health population comprises many individuals who have diverse cultural identities, linguistic needs, social values, and work schedules. We communicate with our members through multiple methods to ensure our messages are effectively communicated. This is especially important as members transition into the plan, as continuity of care can easily be disrupted if the member does not have easy access to targeted information. To address this, our welcome materials are mailed and available electronically through our member website and portal. ACLA also reaches out telephonically to welcome members to the plan.

Welcome Packets

Our welcome packets include a welcome letter, a Notice of Privacy Practices, the Member Handbook, and a copy of the New Member Assessment. The Member Handbook details key information about ACLA, the Bayou Health program, covered services, and member rights and responsibilities. This includes instructions on how to access care, continuity of care provisions, and prior authorization requirements. ACLA's care management programs are also discussed, and encourage members to call the appropriate department for more information.

Welcome packets are available in English, Spanish, and Vietnamese to ensure the majority of members can access the information. Additional languages will be provided upon request.

Welcome Calls

On the welcome call, Member Services representatives welcome the member to the plan and briefly explain the Bayou Health program. Covered services, including the availability of interpretation and translation services, are discussed in a friendly and engaging manner, and information about continuation of services through the transition period is discussed.

Even if the New Member Assessment is not being completed on the welcome call, the Member Services representative asks questions to identify any current or ongoing health needs the member may have—including chronic conditions, special health needs, and/or pregnancy. These needs are communicated to ACLA's Rapid Response, ICM, and/or Bright Start maternity management teams (as appropriate) for further assessment and care coordination.

Through the welcome calls, the Member Services representative will also explain the purpose of having a PCP, if necessary, and help members make appointments with that provider or select a new PCP if they want one other than currently listed in the system. Representatives highlight that all information discussed on the call is also detailed in the Member Handbook.

Connecting Members to Medically Necessary, Appropriate Care

ACLA recognizes that overutilization and underutilization are critical to our members' quality of care and quality of life, as well as controlling costs from adverse health events and

inappropriate utilization emergency services. A small number of members in the general population can often be responsible for a disproportionate percentage of health care costs due to uncoordinated, haphazard, and/or unmet use of the traditional health care system. Because of this, they often have overall poor health quality and outcomes. These members tend to:

- Experience numerous potentially preventable events and inpatient admissions.
- Often do not see their PCP or medical home.
- Overutilize emergency rooms instead of accessing primary care.
- Have multiple complex chronic medical problems and/or behavioral health conditions.

These members often need help managing their medical, behavioral, and social needs. ACLA identifies these "high need" members by analyzing data from claims, authorizations, utilization, and health outcomes, and reaches out to help coordinate their care and connect them to the services and supports they need to improve their health and reduce service costs.

ACLA has developed several in-person care management methods to address the needs of high-need, complex, and difficult to find members. Our community teams help members access appropriate care, provide face-to-face care management, and build trust. Members are stratified into low-risk and high-risk groups based on their predictive modeling results and their utilization of medications, emergency rooms, and inpatient stays. Each group receives risk-appropriate levels of in-person outreach and intervention.

Members in low-risk categories who exhibit an abrupt change in their circumstances or sudden deterioration in their condition will be moved to high-risk case management to ensure appropriate, medically necessary services are provided in a timely manner to support continuity of care and prevent unnecessary or inappropriate usage of plan services.

Community Care Management for Super-Utilizers

ACLA implemented the Community Care Management Team (CCMT) to provide in-person care management for our super-utilizer members with complex chronic conditions who receive the majority of their care in the emergency room and inpatient settings. The program was designed to connect with these chronically ill members in their own environment, using community care connectors to build the relationships necessary to change member behaviors.

The community-based teams are staffed by a registered nurse, a community care connector, and a social worker to coordinate care under the overall direction of a supervising physician. The teams consult with pharmacy, behavioral health, and medication management specialists as needed. The community care connectors engage members through frequent, in-person interaction and follow-up to address physical, behavioral, and socio-environmental needs.

Community Care Connectors (CCCs) are hired from within the community and share language and life experiences of members served. They cultivate relationships with our members to help connect them to the medical delivery system in their communities.

ACLA has 15 super-utilizer members currently enrolled in the CCMT program in Baton Rouge, LA. Another 29 members have been identified as potential participants.

Community Education and Outreach for "Difficult to Find" Members

High-risk members who are non-responsive to traditional telephonic outreach are referred to our Community Education and Outreach Team (CEOT). The team goes door to door to connect with members who were recently discharged from an inpatient setting, have started a new medication, have a high-risk pregnancy, or are in need of provider-recommended follow-up.

Our Informatics Department runs a monthly report that identifies members who have not seen their assigned PCP within certain timeframes. ACLA's Medical Director reviews the reports to help direct outreach efforts.

Where possible, we hire our field-based community workers directly from the communities they serve, as they know the resources and communication patterns of their assigned neighborhoods. When they are in the field, the community workers wear ACLA-branded clothing and carry photo identification to identify them as health plan workers to our members and other individuals in the community.

Sometimes knocking on the door still isn't enough to make contact. If the member isn't home or doesn't answer the door, the ACLA community worker will leave a DHH-approved postcard at the door. The postcard contains the community worker's contact information. In many cases, the member will call and agree to a visit after receiving the card.

Exhibit I.1-2: ACLA Member Missed Contact Card

If repeated outreach attempts are unsuccessful, the ACLA community workers also talk with neighbors and individuals at local businesses, churches, and other community gathering places to locate these members. Community workers will also contact providers and pharmacies that the member frequents to identify additional phone numbers or addresses that the member may use. If the provider agrees, the community worker may leave a contact card for the provider to give to the member the next time the member visits.

Pharmacy Lock-In Program

ACLA is implementing a Pharmacy Lock-In Program to encourage appropriate use of prescription drugs when evidence indicates the member may be abusing or misusing prescription medications. Potential program enrollees will be identified through analyzing pharmacy utilization data for inappropriate, abnormal, and/or harmful patterns of use. Members may also be referred to the program by DHH, their providers, or their pharmacists.

Members who are enrolled in the program are restricted to a single pharmacy for approximately one year, with exceptions for emergencies and reasonable change requests. The member is allowed to choose their pharmacy; however, ACLA will assign one after 30 days if the member has not made a selection.

While members are locked-in, care coordination and case management services will be offered to them, as indicated by their medical, behavioral, and social health needs, to help members address the underlying or overt causes of the medication misuse (e.g., depression, chronic pain). Pharmacy utilization data is continually monitored, and may result in either early disenrollment from the program or an enrollment extension.

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I.2. Member Assessment & Care Coordination

I.2 For members who need home health and/or other services upon discharge from an acute care hospital, explain how you will coordinate service planning and delivery among the hospital's discharge planner(s), your case manager(s), your disease management staff member(s), and the home health agency. Further, explain how you will monitor the post-discharge care of enrollees receiving home health services in remote areas.

Overview

ACLA recognizes that effective discharge planning and follow-up plays an important role in helping members avert potentially preventable events and avoidable readmissions. We have developed a formal discharge program that engages key stakeholders while the member is still in the hospital to identify and coordinate the member's post-discharge care needs. ACLA coordinates with facility discharge planners, the member's primary care provider (PCP), and needed post-discharge care providers to develop a discharge plan. Participation in the Louisiana Health Insurance Exchange (LaHIE) will be an important element in coordinating care for these members.

The discharge plan details all planned medical, behavioral, and home health care services, including transportation and other community supports, that the member will need after leaving the hospital. Follow-up appointments are also outlined so that the member's PCP can continue to monitor the member's health during the transition period. ACLA communicates with the member's providers throughout this transition to coordinate prior authorization requests, referrals, and medication regimens.

ACLA uses a variety of monitoring and outreach methods to follow members post-discharge. Recently discharged members are a priority population for our Rapid Response team. We also use in-person outreach and care management teams to follow-up with recently discharged members in their communities.

Establishing Discharge Plan and Coordinating Service Delivery

Discharge Planning is an integral component of the Utilization Management (UM) process that is initiated at admission. Hospital discharge planners, PCPs, and specialists are encouraged to contact ACLA's UM department for assistance with member discharge. Phone numbers are identified in the Provider Handbook specifically for discharge notification and discharge planning. In addition to notices of admission, ACLA monitors prior authorization and claims data to identify when one of our members has been admitted to an acute-care setting. Our UM nurses perform ongoing, concurrent reviews of the care admitted members receive, as well as outreach to admitted members. Using the diagnosis, length of stay, and reported social supports, ACLA identifies the member's potential discharge care needs, and therefore what level of follow-up and care coordination is needed from ACLA.

Our Discharge Coordinator provides assistance to the members who have the highest risk of readmission. The Discharge Coordinator actively works with the hospital and other stakeholders to transition the member between care settings.

ACLA's Rapid Response team also plays a critical role in supporting members and providers before, during, and after members discharge from acute-care settings. Hospital staff are encouraged to contact the Rapid Response team for assistance in arranging additional services, including home health follow-up, PCP appointment scheduling, or transportation to outpatient care. The Rapid Response team also assists in connecting members to community resources to address needs identified during an emergency room visit.

Discharge Planning Process

ACLA's UM associates work with PCPs, specialists, and hospital discharge planners to begin the discharge planning process and take proactive steps to plan the discharge. The process begins with a review of the member's health background, including prior health care concerns, services received in the past, and providers involved in the member's care prior to hospital admission. We also identify the presence (or absence) of family/friend or community supports that would be available to help as the member recovers.

ACLA has ongoing operational meetings with high-volume facilities to monitor our discharge processes and ensure ongoing, effective communication through admission and discharge.

UM associates then coordinate with the hospital discharge planners, attending physician, hospitalists, and appropriate ancillary service providers, to assist in coordinating necessary arrangements for post-discharge care needs. This may include working with the member's support network to ensure that needed home equipment and post-hospitalization services are in place when the member arrives home. This includes coverage and authorizations for any needed home health care services, prescription or over-the-counter medications, durable medical equipment, medical supplies, and/or community supports.

- **Discharge Planning**: AmeriHealth Caritas Louisiana nurses/social workers work collaboratively with staff from the Integrated Care Management programs to provide appropriate access to non-hospital based health care. Utilization Management staff work with the facility discharge planners to review and update the discharge plan, and take proactive actions to plan for discharge.

Exhibit I.2-1: Promoting Discharge Planning in the Provider Handbook

Home Health Services

ACLA encourages home health care as an important support for members who are discharging from the hospital. The UM department helps coordinate medically necessary home health and home infusion needs with the member's PCP, attending specialist, and the selected home health provider. The member's first six home health visits do not have to be authorized; however, additional visits would require prior authorization.

Home health agencies are required to submit ongoing visit notes and updates so that ACLA's UM nurses can ensure the plan of care is being followed.

Case Study: Coordinating Post-Discharge Care to Transition a Member Home

At 55 years old, "Peggy" was hospitalized due to a joint-replacement infection of her right hip prosthesis. The hospital was concerned about discharging her to a home setting, as the member was not mobile and was not capable of performing self-care activities, including wound care. Additionally, the member had very limited caregiver support, as she lived with her elderly parents who had their own health and functionality limitations. With these factors combined, "Peggy" was at high risk for poor health maintenance and, consequently, readmission. The hospital was leaning toward transitioning the member to long-term acute care, but she normally provided assistance for her elderly parents, and her absence would jeopardize their health and safety.

ACLA's utilization review nurse referred "Peggy's" case to our Discharge Coordinator due to the complexity and risks associated with "Peggy's" discharge and her need to transition home. The Discharge Coordinator stepped in to identify all of "Peggy's" care needs and develop a discharge plan that would effectively address them.

After consulting with key stakeholders, the Discharge Coordinator established a plan for "Peggy" to transfer home with home health services and receive in-home antibiotic therapy for six weeks. The Discharge Planner coordinated with an infusion company to access the needed medications and supplies, and a home health agency that "Peggy" had previously used was engaged to provide the needed skilled nursing care. As a result, "Peggy" successfully received the care she needed to address her health needs after transitioning home, while also continuing to support her elderly parents.

Participation in LaHIE

Health information exchanges (HIE) enable real-time alerts about admissions, discharges, and transfers (ADT), increasing the ability to coordinate and manage member care. ACLA currently exchanges health information with providers through a variety of other means, but we recognize that participation in Louisiana's HIE will further improve our ability to serve our members, especially those who have been admitted to an acute-care setting.

ACLA affiliates already participate in HIEs in Pennsylvania, South Carolina, the District of Columbia, Nebraska, Indiana, Florida, Michigan, and Kentucky. The enterprise's HIE platform, Mirth, is capable of receiving ADT data. Based on our AmeriHealth District of Columbia affiliate's experience, ACLA anticipates that fully connecting our platform to LaHIE can be accomplished in approximately 60 days. ACLA will work with LaHIE, the Louisiana Health Care Quality Forum (LHCQF), and our providers to support the information exchange and our members.

Post-Discharge Monitoring

After the member transitions out of the acute-care setting, ACLA care managers or Rapid Response associates call the member to survey the member's understanding of their discharge plan and determine whether appropriate services are being received. This includes medication reconciliation and understanding of the medication regimen, as well as assistance scheduling any needed non-emergency medical transportation. If home health was not ordered upon discharge, but the post-discharge outreach indicates it may be beneficial, ACLA will work with the member to identify a local home health provider and then contact the member's provider to initiate a referral.

Members with complex discharge needs or previous readmissions are followed weekly by a nurse care manager to ensure that key transition steps are completed. Weekly follow-up is continued until the nurse care manager determines that the member is stable in the new care setting.

Encouraging Member Engagement

Ensuring that members are engaged in the discharge process is critical to the success of transitions between care environments, especially when members are transitioning back into their homes. ACLA encourages members to follow through on four critical activities after they leave the hospital; this includes:

- Following up with their PCP within seven days of discharge.
- Understanding and managing their medication regimens.
- Understanding the signs/symptoms that need to be reported to their provider.
- Understanding and adhering to the discharge instructions.

AmeriHealth Caritas
Louisiana

PO Box 83550
Baton Rouge, LA 70884

www.amerihealthcaritasla.com

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

Quý vị có thể có thông tin này bằng các ngôn ngữ và định dạng khác miễn phí. Quý vị cũng có thể có thông tin này thông dịch ra bất kỳ ngôn ngữ nào qua điện thoại. Xin gọi Dịch vụ Thành viên số **1-888-756-0004**.

Puede obtener esta información en otros idiomas y formatos sin costo. También se le puede interpretar esto por teléfono en cualquier idioma. Llame a Servicios al Miembro al **1-888-756-0004**.

Date
Member Name
Address

Dear (name of member):

Our records show you were in the hospital. We care about you staying well and out of the hospital. Every day matters during recovery.

Now that you are home, what do you do next?

- ✓ Call your doctor to make a follow-up appointment within 7 days of when you left the hospital (or follow-up as your discharge papers say to).
- ✓ Fill your prescriptions.
- ✓ Take your medicine as the doctor has said to.
- ✓ Take a list of your medicines and your discharge papers with you to the doctor.
- ✓ For help with rides to the doctor or pharmacy, call the Transportation Line at 1-888-913-0364.

If you need help, please call our Discharge Hotline **at 1-888-643-0005**.

Exhibit I.2-2: Post-Discharge Transition Letter

After a member discharges from an acute-care setting, ACLA outreaches telephonically to recently discharged members to follow up and provide assistance. The calls focus on medication reconciliation, checking the status of ordered home services, confirming the post-discharge physician appointment, and determining how well the member understands the discharge instructions.

If the member does not understand their discharge instructions or how to comply with them, our care management and Rapid Response associates can provide additional guidance. ACLA also works with the member to remove any barriers to care, including transportation.

If Rapid Response identifies that a recently discharged member may benefit from intensive care management, they will refer the member to our ICM team, who will assess the member's needs and connect them to the ICM program that can meet those needs.

If contact with a high-risk, recently discharged member cannot be achieved telephonically, ACLA's CEOT will go out to the member's home to confirm that the member understands their discharge plan. During the home visit, the Community Health Educator discusses the member's

discharge instructions, medication regimen and adherence, and necessary follow-up care. If new or unmet care needs are identified during the visit, the Community Health Educator coordinates with Rapid Response to initiate in-depth assessment and care coordination support.

Monitoring Outcomes

ACLA tracks readmissions for a 30-day period. If a member has had to be readmitted to the hospital during the 30-day period, the ACLA staff works with the member's PCP and the hospital to develop and implement more intensive preventive measures to eliminate the need for readmission.

ACLA has decreased our 30-day readmisision rate by 2.8% through June 2014, compared to the 2013 rate.

Readmissions are analyzed to identify any trends or patterns that may exist in diagnosis, physician, procedure, or facility. Results are shared with the facility or provider in order to begin the process of improvement.

NICU Graduate Program

Infants who have had a Neonatal Intensive Care Unit (NICU) hospital stay are 'enrolled' in ACLA's NICU Graduate Program to help control and possibly reduce their chances of readmission due to medical and developmental complications. Through this program, our NICU Graduate care manager performs an inpatient concurrent review and assists with the discharge planning needs of the newborn and family.

ACLA hires NICU Level III trained nurses as NICU care managers to perform the reviews and help the parent(s) during the inpatient stay and the transition home. Weekly NICU rounds are held with an ACLA-hired neonatologist to present complex cases and discuss any required interventions with the plan medical directors during the NICU stay. This helps proactively identify and resolve barriers to a timely and appropriate discharge.

The NICU care manager follows each newborn post discharge, and provides up to six months of follow-up case management. Extremely complex members that require case management beyond six months are referred over to ACLA’s pediatric Complex Care Manager for continued coordination and follow up.

Post-Discharge Care of Enrollees in Remote Areas

Members residing in remote or rural areas face additional challenges after discharge. ACLA conducts outreach calls to ensure that these members receive all necessary care, including home health care, transportation to doctor visits, durable medical equipment, and other health care needs. ACLA's Rapid Response Team works with these members to overcome barriers to health, such as a lack of transportation or difficulty in securing medication.

Telemonitoring Pilot Program

ACLA has partnered with a vendor to begin in-home monitoring services in October 2014. In addition to targeting specific diagnoses, the program will target members will have had multiple emergency room visits and/or admissions. The services include a combination of daily monitoring, provider coordination, and clinical assessment, as well as objective measures such as blood pressure monitoring, glucose monitoring, and daily weight. ACLA care managers will refer members to this program as an intervention within the disease management programs. ACLA's Provider Network Management (PNM) account executives will inform network providers of the program, as well as the benefits for member participation.

ACLA-affiliate, Select Health of South Carolina, has used this telemonitoring program for over four years, and recent outcome reports assessing high-risk members who had received service over the 10 months from January 2013 through May 2014 demonstrated significant decreases in inpatient and Emergency Department (ED) utilization, as well as the total cost of their care.

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I.3. Member Assessment & Care Coordination

I.3 Aside from transportation, what specific measures will you take to ensure that members in rural parishes, or other areas where access is an issue, are able to access specialty care? Describe any plans for using telemedicine to expand services. Also address specifically how will you ensure members with disabilities have access?

Overview

ACLA recognizes that members in rural parishes and other remote areas have additional challenges. Our PNM department has built partnerships across Louisiana to ensure that our members have access to medically necessary covered services in the appropriate care settings. Our network currently meets statewide network adequacy requirements, and our Provider Network Management team continues to strengthen our network in rural parishes to ensure access to specialists and subspecialists.

PNM makes special effort to build and supplement access to providers and specialists in rural and remote areas. This includes recruiting a number of non-Louisiana providers to serve members who live near the borders between Louisiana and surrounding states. Additionally, ACLA partners with all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) in Louisiana, including those in rural parishes, and helps members coordinate with their visiting specialist programs. ACLA also partners with school-based health clinics (SBHCs) to care for children and adolescents in the school environment. Our PNM team also coordinates with non-participating providers when a member needs care that cannot be supplied by the local or regional network.

ACLA is currently working with BRFHH Shreveport (formerly LSU Health Science Center) to provide access to telemedicine services throughout the state. Through this program, members travel to their local hospital to "see" or consult with specialists from other parts of the state. This includes cardiologists, pulmonary specialists, oncologists, and nephrologists, among others.

All ACLA providers are expected to adhere to the requirements outlined in the Americans with Disabilities Act (ADA) for access to medical care. Our PNM account executives survey offices during site visits to verify that accessibility requirements are met. ACLA also encourages providers to actively use the translation services offered through the plan to ensure that members with sensory impairments or limited English proficiency can access the care they need.

Rural Access to Providers

Easy and timely access to appropriate health providers can be a challenge in rural parishes and other remote areas of the state, due to provider shortages and transportation concerns. To offset these complications, ACLA's PNM department is dedicated to increasing network capacity through network development activities, as well as through non-traditional/supplemental access to providers and specialists.

Network Development

ACLA focused network development activities on contracting providers that were already serving the Medicaid population. This minimized the disruption to continuity of care that could have potentially occurred during members' transition into the plan. Substantial effort was dedicated to recruiting:

- Small rural hospitals
- FQHCs, critical access hospitals, and RHCs
- Louisiana Offices of Public Health (OPH) and OPH-certified school-based health clinics
- Significant traditional providers (STP)

ACLA's PNM account executives are the primary force behind our recruitment efforts. These associates live in Louisiana, and establish relationships with our network providers through in-office visits and attendance at local health association events. The PNM account executives work closely with providers in their communities and territories to identify and build opportunities for ACLA to contract with providers. ACLA has 12 PNM account executives, two of whom are dedicated to acute-care facilities; the other 10 PNM account executives focus efforts on primary care providers (PCP), specialists, and ancillary providers.

The network adequacy is reviewed on a quarterly basis to identify opportunities to improve access to network providers. This is done through GeoAccess reports, which are provided to DHH on a regular and ad-hoc basis. Any gap in the network is actively addressed through additional recruitment activities.

Out-of-State Network

In addition to Louisiana-based STPs, PNM has also built strong relationships with STPs and specialists in the Mississippi, Arkansas, and Texas trade areas to ensure members near the state border have access to medically necessary covered services.

FQHCs, RHCs, and Rotating Specialty Care

ACLA contracts with all of the FQHCs and RHCs in Louisiana to support the Bayou Health population. FQHCs and RHCs provide care to a large percentage of Medicaid members, and are critical components of local care networks. These providers are uniquely positioned to preserve continuity of care by providing routine care as members 'churn' between programs and social circumstances.

As pivotal community providers, FQHCs and RHCs often invite specialists to rotate through their facilities. ACLA collaborates with the facility to support these initiatives, and our Care Management and Rapid Response teams help coordinate transportation and scheduling so our members can access these specialists.

School-based Health Clinics

With more than half of Louisiana's parishes classified as rural, SBHCs are a significant statewide resource for children in rural or remote access. ACLA has partnered with the Louisiana School-Based Health Alliance and the Louisiana Office of Public Health to promote the delivery of high-quality care to Bayou Health members at their school sites. We currently contract with 65 SBHCs across Louisiana.

This alternative health care model makes it easy for members to access comprehensive health care while reducing student absenteeism and preventing parents from needing to take time off from work. The SBHCs provide preventive, diagnostic, and immunization services. Many SBHCs are also able to provide care for other children in the household, further increasing the convenience for parents.

Utilization of Out-of-Network Providers

While ACLA's provider network meets network adequacy requirements across the state, there are occasions when members need services that are not available within the member's local or regional network. ACLA's Utilization Management (UM) department reviews requests for routine services from non-participating providers. Determination is based upon the availability of the service or expertise within our existing network, the needs of the member, and the medical necessity of the services requested.

If services are unavailable or cannot be performed by an in-network provider, or the request is approved for other reasons, a PNM account executive will attempt to negotiate a single-case contract with a local, non-participating provider. This negotiation process is typically completed within seven days of first contact. In addition to processing authorizations, ACLA's UM department is engaged to ensure claims related to the required services will be processed and reimbursed accordingly.

Relationships that our account executives develop with providers through single-case contracts often serve as a foundation for a successful contractual relationship, enabling ACLA to recruit the provider and strengthen our provider network.

Mirroring our practice of personal interaction with in-network providers, ACLA keeps in close contact with out-of-network providers during this process to ensure smooth delivery and payment of services. When a request for services from a non-participating provider is not approved, this decision is communicated to both the provider and the member via fax or phone. A written notification of action is also issued. In an emergency, members can always access services from any available provider regardless of network status without prior authorization.

24-Hour Utilization Management Support

To ensure timely availability to necessary services, ACLA has UM nursing staff and a physician reviewer on call 24 hours a day, seven days a week. Members or providers needing to arrange medically necessary tertiary care can call the toll-free Member Services number or the toll-free

UM number to reach the on-call nurse after business hours, on weekends, and on holidays. The UM nurse will facilitate the authorization process, as needed, and if necessary arrange for a care manager to continue to work with the member.

Plans for Telemedicine

ACLA has contracted with BRFHH Shreveport to improve access to specialty care, as well as timeliness to diagnosis and treatment planning, for members in rural and remote parts of Louisiana. This telemedicine program enables rural members to connect to the medical center in Shreveport from 24 rural hospitals throughout Louisiana.

The program provides access to specialists in the following fields:

- Cardiology
- Endocrinology
- Gastroenterology
- Hematology/Oncology
- Infectious Disease
- Nephrology and hepatology
- Pulmonology
- Rheumatology

Our PNM account executives promote the program to our network providers and hospitals in rural areas as a replacement for referring and transporting members to facilities in other regions of the state. ACLA and our network providers currently coordinate with the Louisiana Rural Health Information Exchange (LARHIX) to schedule appointments for members.

Ensuring Access for All Members

ACLA is committed to identifying and removing barriers to care for all members. This includes ensuring that providers comply with appointment accessibility standards and ADA requirements, and provide care in culturally competent ways.

After-Hours Accessibility

For rural and low-income members, after-hours access can mean the difference between a PCP appointment and a visit to the emergency room. ACLA conducts an annual After Hours Access and Appointment Availability Survey of all PCPs using a third-party entity to ensure that our accessibility standards are being met and that members can access appropriate preventive care in a timely fashion. Our PNM account executives work with providers to improve accessibility as necessary.

Compliance with Americans with Disabilities Act Requirements

ACLA PNM account executives survey all PCP and OB/GYN providers for compliance with the American Disabilities Act requirements to ensure that they provide physical access for members

with disabilities. This survey is conducted upon contracting and is monitored through regular provider office visits, as well as member complaints and grievances.

Cultural Needs and Preference Standards

ACLA is committed to upholding the standards that that have made ACFC a national leader in the delivery of Culturally and Linguistically Appropriate Services (CLAS). ACFC plans represent three of the eight plans nationwide that have received NCQA's Multicultural Health Care Distinction.

Medicaid members often face many challenges in accessing needed services, communicating with providers and medical staff, and getting the care they need due to cultural barriers such as Limited English Proficiency (LEP), illiteracy, or different social norms. All network providers are provided with education related to CLAS. Training materials and education are offered in the Provider Manual, through our website, during regular provider visits, and via ad-hoc webinars and presentations.

Membership Demographics and Language Access Services

At LaCare, we strive to maintain a high level of cultural competency, so that all of our members receive high quality medical care, regardless of their background or language. To help you provide culturally competent care to your patients, we offer LaCare membership demographic information and information on our Language Access Services for patients with Limited English Proficiency *(LEP)*.

Race, Ethnicity	Percentage
African American	57.00%
Caucasian	34.60%
Hispanic or Latino	2.40%
Other/Unknown/Declined to State	6%

**As of March 31, 2013*

Language	Percentage of Membership*
English	98.00%
Spanish	1.60%
Vietnamese	0.20%
Unknown	0.10%

**As of March 31, 2013*

If you discover that you have an LEP patient, it is mandated by law that you offer interpretation services to them, free of charge. At LaCare, we offer these services free to you and the member. To connect to an interpreter, call Member Services at **1-888-756-0004**.

Exhibit I.3-1: Informing Providers about Interpretation Services in July 2013 Provider Newsletter

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J.1. Coordination of Carved Out Services

J.1 Describe how you will coordinate with the Louisiana Behavioral Health Partnership (LBHP) State Management Organization (SMO) for the management of shared members, including processes for reciprocal referral for needed services and prescription management (including but not limited to Sections 6.4, 6.34, 6.37 of the RFP).

Include how you will engage and educate primary care providers in their role in the provision of basic behavioral services and the coordination of co-existing conditions.

Include a description of the role Medical Director for Behavioral Health will play in these efforts.

Overview

Individuals with serious physical health problems often have comorbid mental health problems, and nearly half of those with any mental disorder meet the criteria for two or more disorders, with severity strongly linked to co-morbidity. As many as 70 percent of primary care visits stem from psychosocial issues. While patients typically present with a physical health complaint, data suggest that underlying mental health or substance abuse issues are often triggering these visits. The integration of resources and services to meet the individual needs of our members is a central component of ACLA's person-centered care management model.

ACLA works collaboratively with service providers across the continuum of care to facilitate holistic care for members. We provide information about covered services in member materials including the Member Handbook and website, and through contact with our Member Services, Integrated Care Management (ICM), and Rapid Response teams. For members who need carved-out services, the ICM team serves as a resource to access these services and coordinate the scheduling of needed care.

Our ICM model ensures that members are treated in a holistic manner, meeting the behavioral health needs of people with physical disorders, as well as the physical health needs of people with behavioral health disorders. Through the expertise of our corporate affiliates, including our dedicated behavioral health line of business, PerformCare, ACFC has successfully coordinated behavioral health services in multiple markets, including in Louisiana, for the past two years. We use our in-depth integrated care experience to inform our treatment of our members with mental illness.

ACLA stresses the importance of behavioral health (BH)-physical health (PH) integration and of building collaboration with the Louisiana Behavioral Health Partnership (LBHP) State Management Organization (SMO). We currently work with Magellan on bi-directional, reciprocal referrals, coordinated care plans, and pharmacy collaboration. We provide specialized training on behavioral health comorbidities for our staff. In addition, we recognize the important part that providers play in the identification and treatment of basic behavioral health needs. We have a focused program to educate primary care providers (PCPs) on screening, diagnosis, treatment protocols, and how to connect with more specialized services for members with greater behavioral health needs.

For those members who need basic BH services that can be provided in the primary care setting, ACLA continues to work to increase early detection and treatment of low BH needs in order to empower members and providers with the long-term goal of reducing utilization of higher level services and increasing compliance with outpatient services, including pharmacy.

Coordination with the LBHP SMO

ACLA has processes in place to seamlessly interface with Magellan Health Services, DHH's current behavioral health vendor, for services not covered by ACLA's basic behavioral health services. We are committed to working in partnership with the behavioral health community to provide holistic care for the member. We have significant experience coordinating behavioral health services for members in our affiliate plans, working directly with behavioral health providers or with a separately contracted vendor. Our experience has allowed us to develop a firm understanding of the requirements and procedures for ensuring that members have access to these services.

To address the complex issues surrounding care of members with behavioral health issues, ACLA's model draws on the following elements:

- Expertise of a multidisciplinary team with clinical experience in caring for the special needs of this population;
- Strong relationships with local providers and organizations that care for these members; and
- Integrated care management processes and software support to facilitate an active Integrated Care Management (ICM) program.

Care management interventions vary based on the unique needs of the member, but the goal is to address all conditions and issues, and to coordinate with the member/family/guardian and a multidisciplinary team of providers to set priorities, goals, and tasks. This multidisciplinary team, combined with community partnerships and strong primary and ancillary provider relationships, strengthens the comprehensive approach to care.

For the past three years in Louisiana, we have been successfully coordinating with Magellan Health Services. In addition to our experience in Louisiana, ACFC has also successfully coordinated with behavioral health care vendors in Pennsylvania and Nebraska, where most behavioral health services are provided by separately contracted entities.

An Integrated Staffing Structure

Currently, we have designated, experienced care managers who also act as the primary contact for the SMO in the coordination of care for shared members. ACLA care managers assess for behavioral health needs as part of our comprehensive assessment process, including review of medications, clinical history, prior utilization, and the administration of the PHQ-9 depression screen. Upon identification of a member in need of behavioral health care, the ACLA Care Manager engages the member for enrollment in the Care Management program and coordinates a referral to the SMO.

As described more fully below, ACLA will also hire a dedicated Behavioral Health Care Manager who will act as the liaison for ACLA with network PCPs as well as the SMO to facilitate the following activities:

1) Assist in ensuring that relevant clinical information is accessible to both the PCP and BH providers;
2) Assist the PCP in making referrals to the SMO with follow-up documented in the member's record within the clinical management system;
3) Ensure that outreach follow up occurs for BH ED visits within 48 hours if initiated by the nurse call line or health plan;
4) Provide leadership to care management team to facilitate engaging the member's cooperation and permission to work with the BH provider;
5) Work with the SMO to arrange training for providers and CM staff on identification and screening of BH conditions and referral procedures;
6) Facilitate integrated SMO/ACLA monthly rounds and sharing of identified members;
7) Attend ongoing meetings with the SMO, other Bayou Plans, and LBHP to continue to identify areas to improve integration of BH and physical health in the PCP environment; and
8) Work with PCPs to provide technical assistance to facilitate the integration of BH services into their practice setting.

Training

All care managers are trained to manage both behavioral health and physical health conditions, including screening, identification, and referral process procedures. The team is supported by behavioral health clinicians. We also use the expertise of our behavioral health affiliate, PerformCare, as a resource for consultation with psychiatrists and psychologists. Throughout 2014, Integrated Care Managers across ACFC were trained in Motivational Interviewing. This evidenced-based behavioral intervention enhances our care managers' ability to engage members in making healthier behavior choices that will positively impact their overall health and outcomes. The newly hired BH Medical Director and BH Care Manager will bring additional behavioral health expertise to the ACLA care management team.

Reciprocal Referral Process

ACLA is continually looking for innovative ways to partner with the state and behavioral health providers to provide continuity of care for the member and cost effective care. ACLA and the SMO currently use a referral workflow process, as outlined below:

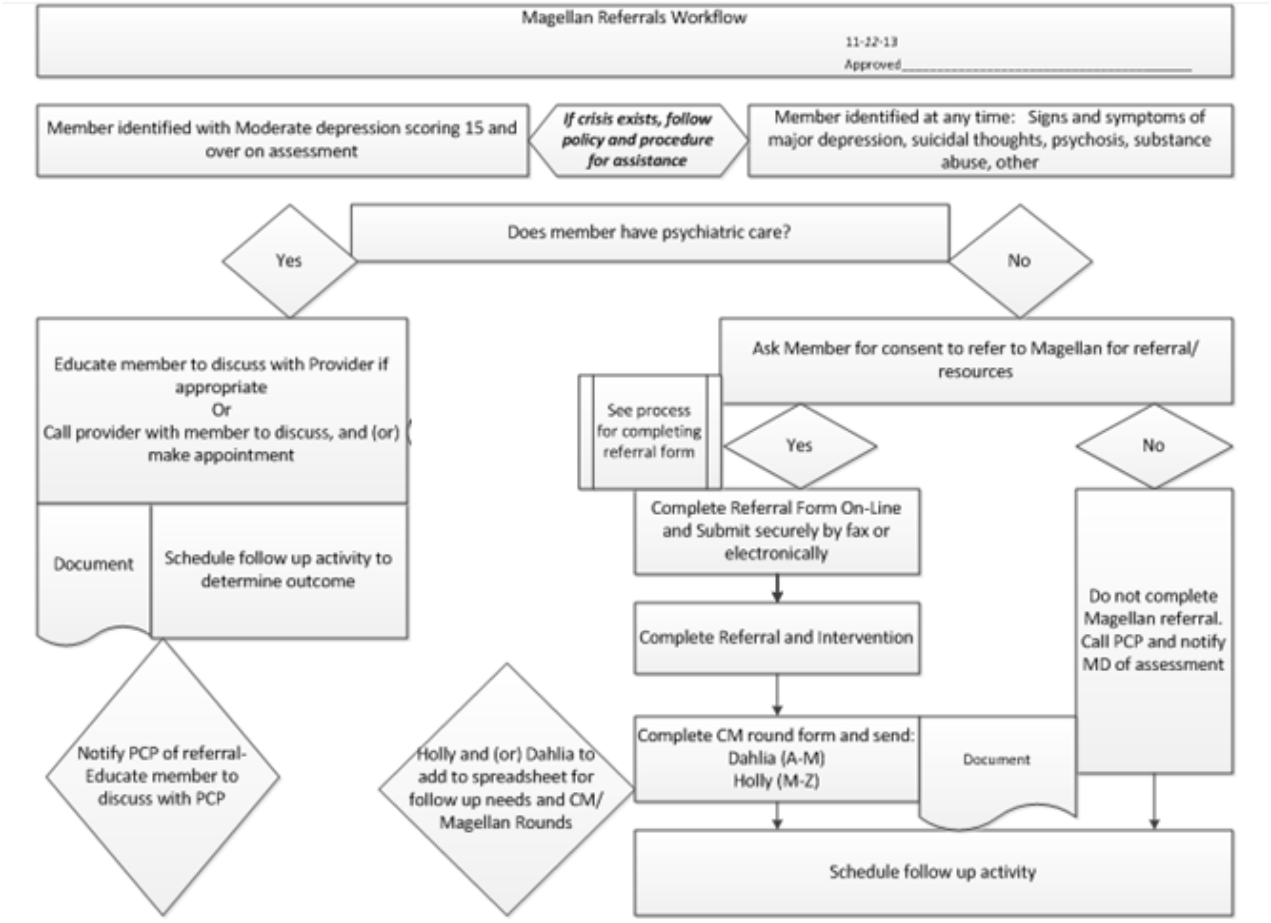

Exhibit J.1-1: ACLA-Magellan Referral Workflow Process

Because there was no formal referral process at the start of the Bayou Health contract period, ACLA identified areas that needed improvement in the referral process and created a streamlined program. All Bayou Health participating health plans now use this DHH-approved referral process. In collaboration with the SMO, the referral form below was developed by our ICM BH staff to assist with referrals to the SMO, and referrals back to the physical health plan. The form provides an avenue for collaboration and a formal avenue for tracking member referrals.

LOUISIANA BEHAVIORAL HEALTH PARTNERSHIP COORDINATION OF CARE
Magellan and Bayou Health Care plans

MAGELLAN

Email: LBHPCoordinationofCare@MagellanHealth.com
Fax: (888) 656-5727
Voicemail: (800) 424-4469

Submit By Email

For use with secure email, otherwise for printed Magellan use only

Referral Source Name:		Referral Date:	

Referral From	Referral To
Magellan Health Services	Magellan Health Services
Amerigroup Keil Solutions	Amerigroup Keil Solutions
AmeriHealth Caritas Louisiana	AmeriHealth Caritas Louisiana
Community Health Solutions	Community Health Solutions
LA HealthCare Connections	LA HealthCare Connections
United Healthcare	United Healthcare

To be Co Managed (BHC and Magellan)	Adult	Adult age 65+	Child
Resources needed (i.e. PCP, BH outpatient provider, ...)			
Notification Only	Consultation Needed (e.g. higher level of care, medication questions, etc.)		
Pregnant	Postpartum (depression, psychosis)		

Note: If member is in crisis and does not require Emergency Response/911, call Magellan Health Services at 1-800-424-4350 or 225-367-1000.

Purpose of Referral:

List specific reasons for the Referral, include medical conditions and current medications:

If referral is to Magellan, has the BHC plan acquired verbal consent for the referral? Yes No or Not from BHC plan

Member Information:

Member's Name:		DOB:	
Guardian's Name: (if youth under age 18):			
Address:			
City:	State:	Zip:	Homeless:
Phone:	None:	Alternate Phone:	
Cultural/Linguistic Needs:			Unknown:
Ambulatory:			Unknown:
Current PCP Name:	Unknown:	Phone:	

Exhibit J.1-2: Referral Form created by ACLA to streamline the referral process between PH and BH providers and the MCO/SMO

This Referral Coordination of Care form also allows the SMO to refer members to ACLA, should they be identified as needing focused physical health care management. Because of the collaborative relationship between ACLA and the current SMO, referrals from the SMO are made directly to ACLA care managers.

ACLA also ensures that timely follow-up occurs after submission of the referral form. ACLA performs follow-up within three business days of receipt of the referral for routine referrals and within one business day if the referral is marked "urgent."

Integrated Rounds

The ICM team also conducts bi-weekly integrated rounds with Magellan to discuss the referrals from both the SMO and the PH plan. Participants include the ACLA care managers, social workers from the SMO, consulting psychiatrist from ACLA, and maternity supervisors, as appropriate. This facilitates the follow-up required for the outreach that is performed to our members and assists the team in discussing any continued gaps or barriers. ACLA participates in these meetings with the SMO to review joint cases and to review cases that have been identified by ACLA staff for potential referral.

The ACLA care managers track the members that are co-managed with the SMO to follow-up with service requests and update progress with the members' PCPs. The co-managed members are discussed in bi-weekly BH-PH integration rounds that include the SMO's psychiatrist, who reviews available clinical information and provides recommendations as appropriate.

The screening process also aids in the referral process and sharing of information between ACLA and the SMO. Because it is pertinent that all relevant information is accessible to the physical and behavioral health entities, our care managers screen members for select behavioral health conditions, including depression. We then set up referral pathways for members who screen positive for a BH condition to connect them with clinical and BH resources for further assessment and intervention, and through the referral and face-to-face meeting process with the SMO, ensure continuity of care for our members.

"Gerard" was an inpatient for self-inflicted 2nd and 3rd degree burns over 30% of his body. He was discharged home in the care of his mother, but due to a significant mental health history including post traumatic stress disorder (PTSD), major depressive disorder, suicide attempts, and a traumatic amputation of his left hand at age 15 while trying to build a bomb, maintaining care was a challenge. "Gerard" was practically homebound due to his wounds and could not participate in outpatient therapy. His mother stated that he was often angry, frustrated, anxious, and depressed, and she was concerned that he wasn't receiving any mental health treatment except for medication prescribed for him while he was an inpatient.

Using the Referral Form and the reciprocal referral process in place, ACLA's ICM team worked with the SMO to secure follow-up care, including a therapy appointment and group therapy for "Gerard" to attend. The ACLA care manager also helped to facilitate home visits from a psychiatrist, social worker, and therapist. "Gerard" was in great need of psychiatric services and at a high risk of self-harm. As a result of this collaboration, he is now receiving the services he needs.

Coordinating for Members with Special and Co-occurring Needs

For those members who require services from multiple providers and a more complex coordination of benefits and services, ACLA has developed customized programs to meet their needs. These programs are described below.

Drug Therapy Management for Children in Foster Care

Children in foster care are 4.5 times more likely to receive psychotropic drugs, and often multiple drugs, than children who remain with their families. These drugs may be prescribed by practitioners who do not specialize in the care of children, depression, or anxiety — and the children may have no one with the time and knowledge to watch for adverse side effects. Beginning in September 2014, and in partnership with our PBM, PerformRx, ACLA will launch a Drug Therapy Management (DTM) program that focuses its efforts on optimizing medication regimens for members enrolled in foster care.

Foster care children who meet one of the following two scenarios will be enrolled in this focused DTM program:

- A unique drug count of 4 or more in the previous 90 days
- Any behavioral health medication filled in the previous 90 days

The expansion of the DTM program to other populations at risk for co-occurring behavioral health conditions will be mutually determined by ACLA and PerformRx, guided by experience of this DTM program.

DTM interventions are determined through pharmacist review of the member's clinical history and medication profile. The path that an intervention follows from identification to completion is dependent on whether the intervention is directed to the member or the provider, as recommended by the reviewing pharmacist. Prescriber interventions are addressed directly with the prescriber by the pharmacist, while patient interventions are forwarded to care management. The member's legal representatives are counseled by their respective care managers, thereby leveraging existing care manager-patient relationships, streamlining patient contact efforts, and resulting in a seamless managed care experience from the member perspective. At any time, a pharmacist is available to assist in the patient counseling and communication. This can be conducted via a conversation between the pharmacist and care manager prior to outreach; a three-way conference call with the patient's legal representative, pharmacist, and care manager; or a conversation between the pharmacist and the patient's legal representative.

After no more than 20 days from the date that the member intervention was identified, the pharmacist reviews the care manager's notes about the member outreach. If additional outreach is needed to the provider, pharmacy, or member, the pharmacist triages those recommendations according to the established workflow. After no more than 90 days from the date the provider intervention was identified, the technician or pharmacist, depending on the nature of the outreach, performs a follow-up on the identified intervention using claims data to determine outcomes. For jointly managed cases, information from the DTM review and subsequent interactions is included in the care coordination information shared with the SMO care management team.

Decreasing Emergency Department (ED) Utilization

ACLA also works with PCPs on programs that aim to reduce ED utilization, common amongst those with co-occurring physical and mental health conditions. ACLA tracks ED usage for jointly-mandated members and shares the information with the SMO through the referral and collaboration processes outlined above. The SMO also provides a monthly ED report listing members seen in the ED for BH reasons. The report details dates of service and number of ED events in the timeframe. ACLA has a robust ED outreach initiative. Members found on the SMO list are contacted by the ACLA Rapid Response team or the member's assigned care manager to assess for unmet needs and facilitate reconnection with primary care.

The Rapid Response team or assigned Care Manager also contacts members who were referred to emergency BH services after contacting any of ACLA's call centers. Callers who contact Member Services are transferred directly to Rapid Response or to the Nurse call line for assistance. The ACLA Rapid Response team receives a daily report of members who contacted the ACLA nurse call line, including the reason for the call and the advice given to the member. The Rapid Response team contacts the member to ensure that needed services are in place and to facilitate coordination of any follow-up care.

In addition, the ICM department reviews reports of ED Utilization on a monthly basis. Members are identified based on usage and stratified into three tiers (High, Medium, and Low) depending the on frequency and timeframe of the visits. Campaigns are designed to address each level of utilization, and include communication with the assigned PCP and the SMO for members with comorbid BH conditions.

Care Transition Planning

If a member is in need of behavioral health care, ACLA will arrange services upon inpatient discharge to ensure that follow-up appointments are made and referrals to the appropriate care occur, as outlined in our reciprocal referral process above. In the event a member is discharged from an inpatient stay and needs follow-up BH services, ACLA:

1) Coordinates with the UM department upon receipt of discharge notice and starts an Outpatient Management Checklist (OMC) that validates the member's contact information and the reason for admission.
2) Alerts the existing care manager or assigns the member to the Rapid Response team, if there is not an existing care management relationship.
3) Assists in the scheduling and documentation of follow-up appointments according to the available discharge instructions.

Prescription Management

ACLA actively coordinates with the SMO to ensure that there are no gaps in member pharmacy needs. We have processes in place to ensure that there is continuity of prescriptions for members new to ACLA.

ACLA recognizes that adjudication of pharmacy claims will be driven by prescriber. The health plan covered pharmacy benefits will no longer include pharmacy prescribed by a specialized behavioral health provider. ACLA will work closely with Magellan or the designated SMO to ensure that systems recognize these provider specialty types and Louisiana pharmacies receive appropriate training.

This separation of payers for administration of pharmacy benefits will present more opportunity for coordination between ACLA and Magellan to ensure that members receive optimum coordination of services.

In addition, ACLA will coordinate the exchange of pharmacy utilization data to facilitate the coordination of services and enhance predictive modeling capabilities to identify those members requiring intensive care management services.

The ACLA BH Medical Director will be responsible for reviewing pharmacy utilization and working with the SMO clinical leadership to coordinate physical and behavioral health services for at-risk members with medical and behavioral comorbidities.

Primary Care Provider Education and Engagement

PCPs are often the front line provider of behavioral health screening and low-level behavioral health treatment.

Our network providers receive initial orientation and ongoing training in helping members navigate the health care system. This training includes information about BH services available through the Bayou Health and companion SMO program. We have also developed a PCP toolkit and a series of educational materials about depression for PCPs to share with members:

- What is Depression?
- Help Yourself (to target adolescent depression)
- Managing Depression
- Recovering from Depression
- Antidepressants and Their Side Effects

Our Care Managers educate members on behavioral health resources within our ICM program. Care Managers provide this education through one-on-one interaction as well as by sharing information on topics such as Post-traumatic Stress Disorder, anger management, and bipolar disorder.

We empower PCPs through a robust educational program along with additional supports provided by ACFC/ACLA.

- ACFC is hiring a clinical trainer to work with PCPs on screening for comorbid conditions.
- Additional primary care toolkits are planned for anxiety and attention deficit hyperactivity disorder (ADHD).

- The Rapid Response team assists PCPs with follow-up if a member screens positive for a behavioral health condition or needs additional monitoring for medication adherence or follow-through in obtaining new psychotropic prescriptions.
- A sample of what is included in our provider education materials in the toolkit for depression is shown below:

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This toolkit is intended to provide educational guidance for clinicians on the subject of depression and should not be relied upon other than for informational purposes. The document is not intended to provide medical advice to either individuals or members. The information provided in the document is not member-specific and clinicians should verify both the accuracy of any statement in the document and the applicability before relying upon such statement. Any steps in the management of depression should include the discussion of risks and benefits as well as member preferences.

AmeriHealth Caritas Louisiana does not warrant, either expressly or implied, the accuracy, timeliness, or appropriateness of the information contained in this toolkit and disclaims any responsibility for content errors or omissions as well as for any direct, indirect, consequential, special, exemplary or other damages that arise from the use of this toolkit by any party.

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Exhibit J.1-3: Provider Education Materials

Adolescent Patient Health Questionnaire (PHQ-9)

Name:_____ Date:_____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom, put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
Feeling down, depressed, irritable or hopeless?				
Little interest or pleasure in doing things?				
Trouble falling or staying asleep, or sleeping too much?				
Poor appetite, weight loss or overeating?				
Feeling tired or having little energy?				
Feeling bad about yourself — feeling that you are a failure, or that you have let yourself or your family down?				
Trouble concentrating on things like school, work, reading or TV?				
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual?				
Thoughts that you would be better off dead or thoughts of hurting yourself in some way?				

In the past year have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?
☐ Not difficult at all
☐ Somewhat difficult
☐ Very difficult
☐ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

Have you ever in your whole life tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

(Office use only) Severity score: _____

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Exhibit J.1-4: PHQ-9 Depression Screening Questionnaire in Adolescents

Member Education Materials

ACLA also produces member materials that are distributed to providers, with the goal of educating members upon distribution, on behavioral health conditions including depression in adults and adolescents as shown in Exhibit J.1-5.

Managing Your Depression

How can I help myself if I am depressed?

If you have depression, you may feel tired, helpless and hopeless. It may be very hard to take any action to help yourself. But as you begin to understand your depression and begin treatment, you will start to feel better.

To help yourself:

- Do not wait too long to get evaluated or treated. Try to see a professional as soon as possible.
- Try to be active and exercise. Go to a movie, a ballgame, or another event or activity you once enjoyed.
- Set goals for yourself you can make and keep.
- Break up large tasks into small ones, and start on the important ones first. Do what you can as you can.
- Try to spend time with other people and confide in a trusted friend or relative. Try not to close yourself off from others who are trying to help you.
- Your mood will improve slowly; it will not be overnight. Do not think you will "snap out of" your depression.
- Don't make big decisions, such as getting married or divorced or changing jobs, until you feel better. Talk about your decisions with others who know you well and have a clear view of your issues.
- Remember that positive thinking will replace negative thoughts as your depression reacts to treatment.
- Continue to educate yourself about depression.

This material was adapted from What Is Depression? This source is in the public domain and may be reproduced or copied without permission from National Institute of Mental Health.
http://www.nimh.nih.gov/index.shtml

You can have this information in other languages and formats at no charge to you. You can also have this information posted over the phone in any language. Call Member Services at 1-888-756-0004. For TTY, call 1-866-625-7588.

Quý vị có thể có thông tin này bằng các ngôn ngữ và định dạng khác miễn phí. Quý vị cũng có thể có thông tin này thông dịch trên bất kỳ ngôn ngữ nào qua điện thoại. Xin gọi Dịch vụ Thành viên số 1-888-756-0004.

Puede obtener esta información en otros idiomas y formatos sin costo. También se la puede transmitir oral por teléfono en cualquier idioma. Llame a Servicios al Miembro al 1-888-756-0004

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Managing Your Depression

Depression, even the most difficult cases, can be treated.

The sooner that treatment can begin, the better treatment will work.

The first step is to visit your doctor. Certain medicines and some medical problems can cause the same signs as depression. A doctor will do an exam, talk to you and sometimes do blood work. If the doctor can find no medical reason that may be causing the depression, the next step is to complete a depression test.

The doctor may feel he or she can treat the depression by just talking with you or by ordering an antidepressant. Sometimes, the doctor will suggest you see a mental health professional, who would discuss with you any family history of depression or other mental disorder, and get a complete history of your symptoms. You should talk about when your symptoms started, how long they have lasted, how severe they are and if you have had depression before. If you had depression before, they will ask how you were treated for the depression. The mental health professional may also ask if you are using alcohol or drugs, and if you are thinking about death or suicide.

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Exhibit J.1-5: Depression Fact Sheet

Antidepressants and Their Side Effects

Antidepressants are medications that help balance the chemicals in your brain that affect your mood. People taking antidepressants need to follow their doctors' directions. This medicine should be taken in the right dose for the right amount of time. It can take 3 or 4 weeks for the medicine to work. Some people take them for a short time. People with long-term or severe depression may need to take this type of medicine for a long time.

Once a person is taking antidepressants, it is important not to stop taking them without the help of a doctor. Sometimes people taking antidepressants feel better and stop taking the medication too soon. This means the depression may return. When it is time to stop the medication, the doctor will help the person slowly and safely decrease the dose. It's important to give the body time to adjust to the change. People don't get addicted, or "hooked," on the medications. But stopping them quickly can cause problems.

If a medicine does not work, it may help to try another one. A study funded by the National Institute of Mental Health found that if the first medication does not help, chances of getting better improved with a new one. Sometimes adding a second medicine helped.

Do not take a double dose if you forget your medication. Take your next dose at the regular time.

Antidepressants may cause mild side effects that usually do not last long. Any unusual reactions or side effects should be reported to a doctor right away.

The most common side effects associated with newer antidepressants include:

- Headache, which usually goes away within a few days.
- Nausea (feeling sick to your stomach), which usually goes away within a few days.
- Sleeplessness or feeling tired. This may happen during the first few weeks, but then the feeling goes away. Sometimes the medication dose needs to be reduced or the time of day it is taken needs to be changed to help lessen these side effects.
- Agitation (feeling jittery).
- Sexual problems, which can affect both men and women. It may include a lower sex drive, and problems having and enjoying sex.

Older antidepressants can cause other side effects, including:

- Dry mouth.
- Constipation.
- Bladder problems. It may be hard to empty the bladder, or the urine stream may not be as strong as usual. Older men with enlarged prostate conditions may be more affected.
- Sexual problems, which can affect both men and women. It may include a lower sex drive, and problems having and enjoying sex.
- Blurred vision, which usually goes away quickly.
- Feeling tired. Usually, antidepressants that make you drowsy are taken at bedtime.

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Exhibit J.1-6: Medication Fact Sheet

Supporting Integration of BH Providers in PCP Offices

ACLA will encourage and help to facilitate the placement of behavioral health practitioners/licensed social workers in the PCP setting. Since the implementation of Bayou Health, ACLA has shown our commitment to supporting the expansion of patient-centered medical homes (PCMH) adopting PCMH best practices. Aligned with this model is a best practice to provide our members with increased ability to integrate all of their care in one location, including their behavioral health needs. ACLA is dedicated to structuring a program in which PCPs will be supported for integrated behavioral health services delivered via an in-office social worker/behavioral health consult or through the use of telemedicine. This is crucial to supporting the PCP in being able to take a more direct role in providing management of the

behavioral health needs of their patients and avoid preventable worsening of medical conditions.

Providers will receive education and technical assistance from the ACLA BH Medical Director and Social Worker, as well as the Network Medical Director and the provider network management team, which is dedicated to improved access to basic behavioral health. Training and education will be provided relative to a reimbursement structure similar to what is available for the services provided by physician extenders in the PCP's office for master's level social workers who are able to obtain reimbursement through the SMO for providing LBHP-authorized services in an outpatient setting. ACLA will also support practices that are unable to identify a provider in their own community to deliver these services at their clinic by helping to facilitate resources that would allow for needed behavioral health counseling to be provided via telemedicine. ACFC has an enterprise-wide strategic plan goal to facilitate tele-psychiatry, psychiatric consulting, and online therapy in the primary care setting. As part of this initiative, ACLA will develop a pilot program to offer financial support to targeted practices up to and including the award of computer-based video equipment. Such award would be based on need and operational support being documented by network providers to connect members with access to this care.

Targeted efforts will be made by ACLA to assist providers with higher rates of prescribing of ADHD medications with technical assistance to facilitate the availability of social workers in this setting. During the summer of 2014, the top 25 ADHD providers in the ACLA network initiated prescriptions for an average of 26 members each. These prescribers were located in every geographic area of the state, from both rural and urban communities.

ACLA will entertain recognition and rewards benefits within contractual arrangements for PCPs who facilitate an integrated behavioral health visit on the same day as the initial medical assessment associated with ADHD-related diagnosis. Ensuring that PCPs have assistance with initial evaluation and that families have support of ongoing consultation along with drug therapy is important to ensuring that the rate of ADHD prescribing is aligned with national norms.

Medical Director for Behavioral Health

Integral to carrying out our ICM model and overseeing our experienced staff is our BH-dedicated leadership. ACLA will employ a Louisiana-based board-certified psychiatrist to work with our care management staff and the behavioral health provider in the coordination of care.

Role Description

The BH Medical Director is responsible for guiding development of all BH programs and guidelines, and for providing administrative and clinical guidance and expertise to senior management and staff to enhance and improve the quality of care and services provided to ACLA's members. The BH Medical Director liaison is responsible for providing clinical behavioral health supervision to ACLA.

Principal Accountabilities

- Support the provision of quality and clinically sound system of care services to all individuals in the system of care
- Serve as medical advisor for clinically related activities in ICM
- Serve as a liaison to state agencies and partners, community, and network providers
- Assure that organization medical policies and procedures adhere to contractual obligations
- Perform clinical case reviews in conjunction with Clinical department
- Adhere to all ACFC policies and procedures, including, but not limited to: Corporate Code of Conduct, Confidentiality, and Corporate Compliance
- Attend training to ensure a working knowledge of the System of Care internal policies and procedures, including the appeal and reconsideration process
- Demonstrate knowledge of prescribed and established medical procedures and practices
- Maintain familiarity with federal, state, and local regulations that may pertain to the medical and clinical operations
- Adhere to ACFC policies and procedures, and support and carry out the ACFC Mission &Values

Position Qualifications/Requirements

- Board Certified Child and Adolescent Psychiatrist with unrestricted license to practice medicine in Louisiana and any other applicable states.
- At least five years of experience in behavioral health managed care
- Five years of clinical experience as a Board Certified Child/Adolescent Psychiatrist
- Public-sector program management experience
- Experience in crisis intervention, utilization management, and benefit plans
- Membership in a national professional organization

Behavioral Health Care Manager II/MSW

ACLA will also employ a full-time Behavioral Health Care Manager (BH CM), either a licensed social worker with a BA or MS in social work or a counselor, who will coordinate services with the Medical Director. This role will serve as a liaison with the SMO and act as a conduit of communication between our care managers and the SMO.

Role Description

The BH CM will responsible for acting as a liaison between the SMO, providers (PCP), members, and the care management team. The liaison will be responsible for outreach activity with members and providers and collaborate with the multidisciplinary team to ensure that member needs are assessed and addressed in a timely manner. The liaison will work to facilitate communication between the physical health team and the behavioral health team to maintain open dialogue, integration, and continuity of care.

Principle accountabilities:

- Develop, adopt, and promote primary care practice guidelines that support provision of behavioral services provided in a primary care setting, including pharmacy prescribing (e.g., ADHD prescribing)
- Support BH Medical Director in review of utilization trends (e.g., emergency, pharmacy, and quality outcomes
- Facilitate integration of behavioral health professionals into the PCP office setting
- Conduct outreach calls to coordinate with SMO contact(s), PCP and office staff, community resources ,and members
- Assist the physical health team in assessing member need for appropriate services, possible referrals, and care management services
- Attend monthly or ad hoc care management rounds/meetings with physical health provider, ACLA, and SMO.
- Collaborate with ACLA BH medical director to assess ongoing needs of members and PCP to enhance integration of services
- Develop training, in collaboration with BH Medical Director, for the PCP offices related to integration of BH/PH services and assessments, including depression, anxiety, and ADHD screening/treatment.
- Facilitate referrals between physical and behavioral health providers to ensure reciprocal communication of member needs and follow up
- Conduct site visits as appropriate to implement programs and provide support to other special programs
- Educate providers on available support services
- Promote Quality initiatives related to BH

J.2. Coordination of Carved Out Services

J.2 Describe how you will coordinate with the Medicaid Dental Benefits Manager for the management of shared members, including processes for reciprocal referral for needed services.

Overview

AmeriHealth Caritas' years of experience with Medicaid and CHIP programs have taught us the importance access to preventive oral and dental care for our members and their children. The crucial connection between oral health and overall health is part of what makes us committed to making sure our members have the tools and knowledge to maintain good dental hygiene and have access to a dentist.

ACLA has demonstrated a two-fold commitment to members' oral health through both the coordination of carved-out dental services and also through the offering of our expanded adult dental benefits. Our expanded adult dental benefits are an additional step that ACLA takes as part of our overall dental coordination and commitment to preventive oral care. To coordinate carved-out dental services, we work closely with the Medicaid Dental Benefits Manager to efficiently refer and co-manage our members' services so we can connect them with the correct dental resources. We also work with primary care providers (PCPs) and utilize our Care Management staff to assess member dental needs and coordinate their dental services.

Coordination for the Management of Shared Members

ACLA's goal is to collaborate in a way that genuinely changes referral and practice patterns, leading to improved outcomes. We will do this through communication regarding dental benefits with our members, as well as a reciprocal referral process with the Medicaid Dental Benefits Manager.

Communication of Dental Information to Members

We encourage the use of appropriate access to dental services by educating members regarding the availability of dental services through the Medicaid Dental Benefits Manager. Our experience is that a knowledgeable membership is more likely to follow relevant care plans and seek the appropriate level of care at the right time, resulting in a healthier population. Our communication strategy leverages community and educational outreach, knowledgeable employees, printed materials, and online content. Our grassroots connections to the communities we serve through our Community Education Outreach Team (CEOT), as well as the education and resources we are able to provide members, enable positive and effective communication regarding oral health and access to dental care services throughout the state.

Community and Educational Outreach

ACLA has Community Health Educators throughout the state. These associates are members of the communities we serve, and act as branches throughout the state that allow us to reach out in

partnership with dental providers. The CEOT works closely with Just Kids Dental, Kool Smiles, and Healthy Smiles at events and in their offices with informational tables. ACLA has brought these dental providers into Back-to-School, Summer Safety, Christmas, and other events we sponsor. They also participate with us at our annual Cinco-de-Mayo event. The dental providers bring literature, toothbrushes, toothpaste, floss, and even appointment cards.

These dental providers have also participated with us in our Member Advisory Council meetings with our CEOT. This allows us to gain another perspective on our members' dental needs and how to best work with the communities in connecting our members to these services.

Community Health Educators are also fundamental in meeting with members on a face-to-face basis. They help them overcome obstacles to health care by meeting through in-person meetings in order to empower members to take charge of their own health. We employ Community Health Educators who speak Spanish and Vietnamese for members who require or prefer communication in those languages. Our Community Health Educators, through interaction with members, encourage preventive care and assist with dental appointment scheduling.

Knowledgeable Employees

ACLA works collaboratively across the continuum of care to facilitate holistic care for members. We provide information about covered services through contact with our Member Services, Integrated Care Management (ICM), and Rapid Response teams.

Member Services

The Member Services department is the entry point for members who access the ACLA toll-free telephone line. The Member Services department is available to provide culturally sensitive service and information 24/7/365, including holidays, and in the event of business closure in response to inclement weather and/or other emergencies.

As front-line staff, Member Services Representatives (MSRs) are empowered to resolve various issues, including dental, on the spot. To serve members effectively and efficiently, MSRs have access to resources and information to resolve issues or, as necessary, to facilitate timely resolution through a warm transfer to the appropriate dental resource.

Integrated Care Management Team

For members who need assistance accessing their ACLA dental services, such as their cleanings, extractions, or medically necessary oral surgical procedures, Care Management staff is available to assist. They are also a notable resource for coordinating carved-out dental services and working closely with dental providers as necessary. Our Care Managers educate members on dental health through one-on-one interaction as well as by sharing information on dental issues.

When a member needs assistance with a dental service, care managers help contact the vendor, help members access transportation, and respond to situations when a member has a special need. They can also print educational materials from our approved library, Krames On Demand, and send educational information about oral health directly to members. We also have Bright Start care managers, who specifically help our prenatal population. Expectant

mothers are encouraged to access their dental benefit available through ACLA in their welcome letter into the Bright Start program. Bright Start care managers also discuss dental care in the the initial assessment to encourage oral health and dental hygiene as a measure to reduce premature birth and low birth weight.

Rapid Response team

The Rapid Response team provides proactive support to members with urgent care needs, including dental, through barrier resolution and self-management support. They also promote dental care access through their regular Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) outreach.

Rapid Response conducts regular outreach for EPSDT services, and provides assistance with well-visit appointments. During this outreach, the Rapid Response team promotes the importance of dental checkups and oral health. The Rapid Response team stresses the importance of establishing early dental care practices by scheduling routine (yearly) dental exams and informs members of available dental care services to encourage routine visits. The Rapid Response team provides members, parents, or guardians with the contact number of the Medicaid Dental Benefits Manager for scheduling these dental services. They are also encouraged to contact the Rapid Response team if they encounter scheduling issues.

Rapid Response follows up on urgent dental problems and issues identified through telephonic assessment, such as phone calls to our 24-hour nurse line, or at other program junctures. The Rapid Response team works to overcome barriers to dental care access and facilitates connectivity to the Medicaid Dental Benefits Manager. The Rapid Response team follows up with the member via phone to investigate and resolve any issues.

Printed Materials and Online Content

Our website offers general oral health guidelines for children and adults and links to oral health resources on the web. Adult members seeking access to their expanded dental benefits will also find a link to DentaQuest where they can find a dental provider in their area.

Members also have access to printed information on dental health. In addition to situation-specific materials that can be accessed by care managers on a case-by-case basis through our Krames On Demand educational library, we also provide printed educational materials through periodic mailings. Our birthday cards sent to members during the month of their birthday up to age 21 include a reminder about annual dental checks. Also, our award-winning quarterly Member Newsletter, “Healthy Now,” occasionally features dental articles, such as the one below:

Dental Care: **The Earlier, the Better**

The earlier a child begins dental health, the better his or her teeth will be in the years to come. Believe it or not, if a pregnant mother has a healthy mouth, it is more likely that her baby's mouth will be healthy too. You should brush your teeth 2 times a day for 2 minutes and floss once daily.

The American Dental Association (ADA) suggests that you start caring for your baby's mouth the first few days after he or she is born. You can start by wiping your baby's gums with a clean moist gauze pad or washcloth. You should do this even when your baby has no teeth yet. Then, make a dental appointment for your baby within 6 months after his or her first tooth appears.

Prevention is the key. *The American Journal of Pediatric Dentistry* says that many problems with teeth can be avoided if parents take good care of their child's gums and teeth. According to the ADA, early dental care helps avoid problems when the child gets older. Your role as a parent includes making sure your child learns healthy habits at an early age.

With AmeriHealth Caritas Louisiana, your child is eligible to receive dental care. Schedule a dental visit for your child and start a journey of good oral care. Ask the dentist if your child should have his or her teeth sealed to help prevent cavities.

If you need help finding a dental provider for your child, please visit the following link on the Louisiana Department of Health and Hospitals website: **http://new.dhh.louisiana.gov/index.cfm/page/823**.

www.amerihealthcaritasla.com Healthy Now 11 Spring 2014

Exhibit J.2-1: Dental Care Article in Member Newsletter

Process for Reciprocal Referral

Providers are an important resource in sharing information with members. We develop partnerships with in- and out-of-network care providers to support them in educating members about services available to them. ACLA will facilitate a reciprocal referral system between physical health and dental providers through our "Let Us Know" program.

Let Us Know

ACLA understands that not all provider offices contain administrative resources sufficient to connect members with all of their care needs. During a physical health examination, an ACLA provider may discover that a member is in need of dental services. To facilitate this process, we promote our Let us Know program, which encourages providers to contact our Rapid Response team for assistance with member needs, including dental. After the member's initial needs are coordinated, the Rapid Response team will connect the member to dental services and care.

Through the Let Us Know referral form, providers, as well as the Medicaid Dental Benefits Manager's dental staff, can send information related to the needs of a member directly to the ACLA Rapid Response team. The form allows providers to enter member information, provider information, and interventions requested, as well as any additional information.

The Let Us Know form will be easily accessible to both PCPs and dental care practitioners through our ACLA website. In addition to website access of the form, ACLA providers will receive copies of the form in their Welcome Packet and can request copies from their Provider Network Management account executive as needed. ACLA plans to provide education and referral programs for larger PCP practices to encourage use of the Let Us Know referral process. Additionally, the Medicaid Dental Benefits Manager staff will receive orientation in the use of the form, which can be shared with their providers.

The story below demonstrates the Let Us Know program at work in an affiliate plan.

A Keystone First provider needed help in getting a member to schedule an appointment to manage her diabetes. According to the provider's office, the member had not returned any outreach on their part to schedule an appointment, nor had she had her blood sugar checked in nearly two years. Through Let Us Know, the member was contacted by a plan Care Connector.

Through the phone call, the Care Connector learned two important things: The member had wanted to find a new PCP and she needed a glucometer—a device used by diabetes patients to measure their blood sugar. The Care Connector explained to the member that the best way to obtain the glucometer was to meet with her current PCP before changing to a new provider. She agreed. Her appointment was made and kept. She saw her PCP, scheduled another appointment to have her blood work done, and received her glucometer.

Plans for Future Collaboration with Medicaid Dental Benefits Administrator

Individuals with physical disorders often have co-occurring dental conditions that complicate the treatment and diagnosis of both conditions. Integration of care between providers of dental and physical health services is a critical step toward improving care and efficiency, resulting in improved outcomes and cost savings.

ACLA will work to facilitate meetings of the health plan leadership (including the medical director) with the Medicaid Dental Benefits Manager on a quarterly basis in order to explore the creation of collaborative education and referral programs. It is our goal to develop a plan that will address the needs and build the assets into a comprehensively integrated management and service delivery process.

Through our dental affiliate, PerformDental, we have begun to create innovative programs to optimize integrated dental and physical health care. These programs include the Children's Hospital of Philadelphia (CHOP) Referral Initiative, the Beyond Your Smile pilot, and a Federally Qualified Health Center (FQHC) partnership, all of which facilitate timely communication and coordination across disparate health care resources.

The CHOP Referral Initiative is a program that encourages CHOP-affiliated PCPs to make direct referrals for members who have not seen a dentist recently and/or who do not have a primary dentist to one of two local pedodontists for dental care. This initiative includes members up to the age of 21, thereby removing the barrier of where to go for care. PerformDental directly interfaces with the CHOP Primary Care Network's clinical leadership, as well as on-site medical directors, to facilitate dental education and member referrals. All of these processes encourage early access to dental care and close the care gap by eliminating member confusion concerning where to access dental care. On the provider side, it establishes a professional relationship between CHOP and local dental providers.

Beyond Your Smile provides an additional touchpoint in the delivery of member care through which to address and bridge any gaps in member dental and medical care. Beyond Your Smile is a collaborative and comprehensive initiative that provides members the opportunity to receive critical health screenings during a visit to a participating dentist, including:

- Blood Pressure (for members over 12 years of age)
- Body-Mass Index (for members over 12 years of age)
- Hemoglobin A1c (for members over 18 years of age who have not seen their PCP in six months)
- Cholesterol LDL/HDL (for members over 18 years of age who have not seen their PCP in six months)

The results of the screenings are sent by the participating dentist to the member's assigned PCP for follow-up care. This collaborative and comprehensive approach identifies potentially at-risk members who may require further care, as well as providing oversight to members who need monitoring. A primary future goal is to provide NaviNet access to all participating dentists as a tool to identify gaps in medical care.

Beyond Your Smile

Keystone First

Keystone First cares about your health and wants to make it easier for you to get care.

Regular visits to your dentist help keep your mouth healthy. We have asked your dentist to go "Beyond Your Smile" keeping the rest of you healthy too! If you have not been to your primary care practitioner (PCP) in 6 months, your dentist may want to do one of the following screenings:

- ☑ Take your blood pressure.
- ☑ Measure your body mass index (BMI).
- ☑ Check your cholesterol (heart disease).
- ☑ Check your hemoglobin A1C (diabetes).

The results of these screening tests will be sent to your PCP for review. Talk to your dentist about this program if you have any questions.

Beyond Your Smile – your PCP and dentist working together to keep you healthy!

The information in this notice is available in other languages and formats by calling Member Services at **1-800-521-6860** or **1-800-684-5505** (TTY).

Esta información también se ofrece en otros idiomas y formatos. Llame a Servicios para Miembros al **1-800-521-6860** o al **1-800-684-5505** (TTY).

Muốn đọc thông tin trong thông báo này dưới hình thức và ngôn ngữ khác, xin gọi Ban Dịch Vụ Hội Viên số **1-800-521-6860** hay số dành cho người khiếm thính giác **1-800-684-5505** (TTY).

ព័ត៌មានក្នុងសំបុត្រនេះមានជាភាសានិងទំរង់ផ្សេងៗទៀត ដោយទូរស័ព្ទទៅក្រសួងជំនួយសមាជិកលេខ **1-800-521-6860** ឬ **1-800-684-5505** (TTY) សំរាប់អ្នកថ្លង់។

Для получения сведений, содержащихся в данном уведомлении, на других языках звоните в Отдел обслуживания по телефону **1-800-521-6860** или **1-800-684-5505** (TTY).

此通知的资料包括其他语言及格式，如需要提供，请致电 **1-800-521-6860** 或 **1-800-684-5505** (TTY) 联系会员服务处。

100KF-1322-212

Coverage by Vista Health Plan, an independent licensee of the Blue Cross and Blue Shield Association.

Exhibit J.2-1: Beyond Your Smile Program

The FQHC Partnership provides health centers a chance to heighten awareness about the importance of oral health, facilitate clinical integration, and receive support in scheduling member appointments. PerformDental works with FQHC's to reach out to members missing their annual dental visit, schedule a block of patients for their medical appointments, and provide interactive oral health education to all patients in the waiting room. PerformDental also shares its own Dental Best Practice Reports with FQHCs to improve the delivery of dental care, including programs to encourage participating members to access dental care at the facility.

These initiatives will provide a substantial foundation from which to build a strong relationship with the Louisiana Medicaid Dental Benefits Administrator.

Expanded Adult Dental Services

ACLA understands that preventive dental care is significant in maintaining overall health. However, for our members with chronic and other health conditions it can be even more vital. Diseases of the heart such as endocarditis and cardiovascular disease have demonstrated links to oral bacteria. Periodontitis in pregnant women can cause premature birth and low birth weight in newborns. Chronic conditions such as diabetes and HIV/AIDS can also be greatly impacted by gum disease and mouth sores. In recognition of these numerous impacts, adult members of ACLA have always been eligible to receive one dental exam and one cleaning every year. This will be further expanded to include a $250 benefit that can be applied to bitewing X-rays, fillings, and tooth extractions. These expanded adult benefits are provided as part of our overall dental coordination and commitment to the health of our members.

J.3. Coordination of Carved Out Services

J.3 Describe your approach for coordinating other carved out services including but not limited to Person Care Services, Targeted Case Management and other waiver specific services. Please include a description of how you will identify that your members may be in need of these services and any processes you will have in place for referral to and follow up with the member and provider or payer as appropriate.

Overview

Carved-out services provide a host of essential benefits to our member population. Our ICM program supports all aspects of person-centered care for those who have chronic health care needs, including those not normally part of the managed care model.

Integration and coordination of an individual's care is the hallmark of ACLA's approach to care provision and care management. Our care management and care coordination programs and innovations are centered on the integration of care for members, particularly those with complex, comorbid conditions. This approach to care delivery builds bridges between the silos, so that care is provided comprehensively and treats the whole person.

ACLA has firsthand experience managing and coordinating care for carved-out services. The population receiving these services requires intensive outreach and intensive care management when needs are identified. ACLA has found that these members need assistance navigating the health system and coordinating services such as waiver programs. We help our members to understand what services and benefits they have and are eligible for, as well as who is administering those services.

Strategy for Coordination of Carved-out Services

It is our belief that the only effective care is integrated care, as the siloed health care delivery system creates inefficiencies and fragmentation across care settings. To remedy this, the plan builds a strong team of individuals to communicate with, advocate for, and support the members to ensure that they receive suitable care and stay well. Our ICM has a process to meet the health care needs of our members applying a systematic and consistent approach for evaluation of key elements affecting members' health care needs through medical, psychosocial, behavioral health, functional conditions, resources, and access or transition of care.

The Care Manager utilizes community resources and other available programs, including waiver services, to address select interventions and make referrals. If the Care Manager identifies that a member may benefit from any excluded services such as targeted case management for Chisholm members, Early Steps, or other available programs, the Care Manager educates the member about the program and refers the member to these to the applicable services. The Care Manager also helps if the member needs individual assistance with contacting the agency, understanding the program criteria, and completing the required paperwork.

ACLA's Interdisciplinary Care Team (ICT)

ACLA's care management team leads the ICT to address members' needs beyond the core benefits provided by ACLA. This team includes not only the member, but the member's primary care providers (PCPs), and any caregivers or other designated representatives. Our focus is to address the member's unique care needs, and includes all members of the team that support the member's unique care requirements. Further, the ICT should include behavioral health professionals, social workers, Home and Community Based Service (HCBS) providers, targeted case management providers, pharmacists, and potential community supports. This integrated approach to coordinated care best supports the member's ability to live independently in the community.

This collaborative approach to care coordination can improve outcomes for people with disabilities or complex health needs. It is a critical component to achieving the goals of improved care quality, greater member satisfaction with care, and enhanced system efficiencies.

For example, members who are identified as needing hospice services for life-limiting illnesses are managed by the Care Manager. Care Managers coordinate care with hospice teams, sharing requested information for intake with the member's approval and consent. It is a collaborative approach facilitating and coordinating with hospice nurses, physicians, and other medical professionals. The Care Manager remains actively involved to ensure the member is linked to the hospice service, receiving necessary supports including but not limited to prescribed treatments, medications, resources, and durable medical equipment (DME). Once the member's care is transitioned and Hospice assumes complete care of the member; the member is disenrolled by the Hospice entity and the Care Manager episode is closed. ACLA will use this experience to build our support provided for members receiving hospice benefits in the new contract period.

"John" was transferred to a care management nurse for assistance related to his personal care services. The member had moved and was no longer receiving his services. The Care Manager called DHH to get information first on the correct provider for "John" as he could not remember. The care management nurse called the provider, who indicated that since "John" had moved and did not notify the provider, he would have to reapply for services. "John" reported that he completed all the paperwork and faxed it in as requested. The Care Manager then connected with the Long Term Care (LTC) services vendor for DHH to determine if "John's" information had been received and to request that they expedite the process for "John." In the request, the Care Manager also offered the LTC vendor to inform ACLA if we could assist "John" to get any additional information needed to assist them in resuming needed personal care services.

Documented and Agreed-upon Procedures

ACLA will work directly with the providers of waivers and other carved-out services to establish procedures to coordinate service planning and effective and timely care transitions and delivery. Our goal is to create a seamless system whereby the member does not experience unnecessary barriers to care, delays in service, ineffective transitions, duplication, or inaccurate information. We share data, within the confines of the law, to enable caregivers to have all the

necessary information to provide the best care for that member. ACLA views the providers and community supports as partners for our members.

Designated Roles and Responsibilities

The care management team works directly with the providers of waiver services to identify specific needs or gaps in our members care. Once the member has been identified, the Care Manager will reach out to the member to assess their current services and any gaps in care. With the member's permission, the Care Manager will then reach out to the providers of the carved-out services to initiate the notification and coordination of the member's plan of care. Key information that is pertinent to our member's care will be shared with these providers under the confines of applicable HIPAA laws. ACLA will ensure that each entity has open access to the other through the use of the following tools:

- Procedures for service planning and referral
- Mechanisms for coordination, including scheduled and ad hoc coordination of care meetings
- Required policies and protocols for release of records and confidentiality

Similar coordination is being planned with targeted case management agencies for supporting the Chisholm population.

Effective Training

An understanding of the functions (and limitations) of all parties is key to effective communication and collaboration. A primary function of ACLA in this instance is the initiation of training to address issues of coordination for the member.

ACLA will continue to work with the waiver providers and targeted case management to set up ongoing training for the integrated care management team. The goal would be to also have a reciprocal training for the waiver providers about ACLA's care management team and role they play in coordinating care for the member. In some cases, ACLA may request that the waiver providers work with one or more plan staff members who will serve in a "train the trainer" capacity for the organization. The goal is to ensure our staff members are well equipped to best serve our members and fully leverage the state and local services available to them.

Sharing Information

Sharing member information is critical to achieve our goal and meet our vision of coordination, continuity, and integration. ACLA will work with the waiver provider(s) and targeted case management providers to determine the best method for sharing information. We will establish processes around what information should be shared, how, with whom, and within what timeframe. Diagnoses, treatment plan summaries, medications, referrals, case management notes, and service utilization rates are examples of the information we might share. To coordinate access to and sharing of this information, we will ensure that appropriate member

releases are in place and that all sharing of information is in full compliance with HIPAA and state privacy laws.

Coordinating Access to Care

Our integrated, holistic care coordination strategy actively seeks out community agencies and service organizations to augment the benefits available through ACLA. We maintain a library of organizations that provide services to individuals in the service area. This library/resource tool is updated regularly and used by care management to arrange for member treatment services. Resources are identified for all available waiver and community services, and guides are made available to providers and agencies across the service area to promote coordination. Members are also empowered with this information to encourage self-management to the best of their ability.

We ensure that our members are connected with the right community resources through our assessment and care plan tools. For the hard-to-reach members, our feet-on-the-street team of Community Health Educators and community partners make sure that members are connected to these vital services. These tools allow us to track community agency referrals and quickly identify whether the member has been assessed for community resource linkages.

Critical to this coordination will be the member's Individualized Care Plan, which serves as the road map for everyone involved in the member's care. Led by the Care Manager, this plan is a critical tool to ensure all treatment and services are aligned and rendered. However, if the member has a community-based clinician/Care Manager or targeted case manager who they prefer to take the lead, ACLA's Care Manager will take the role of an active participant on the team. Any difficulties experienced while coordinating a referral or authorization will be resolved through collaboration with others on the interdisciplinary care team to secure the best possible outcome for the beneficiary.

Identification of Members

Members Currently Receiving Carved-out Services

An internal tracking report has been developed by ACLA that lists the members who are currently receiving HCBS since they gained the ability to opt in to Bayou Health in July 2014. The report includes the following information:

- Member date of birth
- Gender
- Type case
- Aid category
- Begin and end dates
- Eligibility date

This data feed is received weekly via e-mail and automatic notification to the ICM and Rapid Response team. Rapid Response has an assigned Care Manager who contacts each of the members in order to complete a survey and screen to identify member needs. The Rapid

Response Care Manager will address any urgent needs of the member, including initiating communication with their waiver service provider. Interventions will be targeted to ensure the member's needs are being met; and they are not, the Rapid Response Care Manager will work with the member and providers to facilitate the services required. If the member agrees to further care coordination from ACLA's Care Manager, a referral to a complex Care Manager is made for continued follow up with the member, including all members of their care team.

As of September 2014, ACLA has received a total of 46 members identified as HCBS-eligible, of which 42 have been contacted by the Rapid Response team, resulting in 91 percent of the members being touched. Based on the needs assessments conducted, approximately 5 percent of the members were referred for more intensive care management.

Identifying Members who are Eligible for Carved-out Services

ACLA becomes aware of members in need of other services during our initial comprehensive assessment. At that time, the member's current resources, as well as needed resources, are established. Information can be shared in the event an external referral is received from the actual agency or a provider.

The Care Managers are provided a Resource Manual that has the list of available programs, and will assist and guide members, based on assessed needs and conditions, on the application process for the programs. ACLA will actively seek out community agencies and service organizations to augment the benefits available through the plan. We maintain a library of organizations that provide services to individuals in the service area. We will ensure that members are connected with the right community resources through our Assessment and Care Plan tools. These tools will allow us to track community agency referrals and connect members to applicable community resources.

Process for Referral

The ACLA Care Manager will work with the member, as part of the care coordination process, to identify any additional services that may be needed beyond the plan benefits or potential waiver services. If there are needs identified, the Care Manager will work with the member to supply the possible resources to determine whether the member wants to initiate the referral or prefers to have the Care Manager act on their behalf. Follow up with the member and any potential providers of services will be completed by ACLA's Care Manager and documented in the integrated data system.

The Care Manager will assist where needed and seek the assistance within DHH by directly contacting the program coordinator or intake department. Coordination of care starts once consent is in place. Information is shared with the member's consent including member identification and assessment of a member's needs with other health care entities through the following mechanisms:

- Printed/faxed copy of assessment tools and care plans
- Access to member clinical and medication history through the secure Provider Portal
- Phone consultation/referral

Providing Follow-Up

ACLA's Care Managers are required to set a Referral and Intervention activity in JIVA, our electronic record, documenting follow-up with the members on referrals in order to ensure the member has utilized the referral and has begun to receive the services they need.

Once we have determined that the member is receiving the appropriate services, our Care Managers will continue to check in with our members. Additional outreach is performed as part of the ongoing collaborative ICT approach to ensure that the member is receiving services and no additional barriers have been identified. The frequency of outreach and follow up is dependent on the member's condition and level of self-management.

Many members initially enrolled into care management require more frequent outreach to ensure their needs are being met and to strengthen their relationship with the Care Manager. Interventions included in follow up include: educating the member/caregiver on their condition and navigating the health care system, collaborating with providers, ensuring services are being delivered, assessing member responses to treatments/services, etc. Ongoing communication with the waiver providers, targeted case management, and the member's PCP are all part of the Care Manager's role and will be documented in the integrated data system. Members with complex service and/or health needs are discussed in our integrated case management rounds. ACLA will explore inviting members of the ICT to these discussions if a member's case is going to be presented. This will continue to facilitate a multidisciplinary approach to the members' care and needs. Updates to the ICT will be provided by the Care Manager to ensure the team has all the pertinent information needed to care for the member in the most appropriate way.

Monitoring Relationships with Carved-out Service Providers

ACLA recognizes that identifying and correcting problems early and in a sustainable way is very important to the success of integrating the needs of our members accessing carved-out services. ACLA is committed to the ongoing communication that will be needed with providers of carved-out services in Louisiana, and will continue to reach out to facilitate the communication needed to serve our members. This communication will be accomplished by face-to-face meetings, one-on-one contact with the Care Managers, ongoing training for both the plan and providers, and potential invitations to case management rounds.

K.1. Case Management

K.1 Describe your approach to MCO case management. In particular, describe the following:

- *Characteristics of members that you will target for case management services;*
- *How you assess member needs;*
- *How you identify these members;*
- *How you encourage member participation;*
- *What tools you will be using for patient engagement including technology or mobile aps;*
- *How you develop and implement individualized plans of care, including coordination with providers and support services;*
- *How you will get data feeds from hospitals when your member is admitted, discharged or transferred;*
- *How you coordinate your disease management and case management programs;*
- *How you will coordinate your case management services with the PCP; and*
- *How you will incorporate provider input into strategies to influence behavior of members.*

Overview

ACLA's Integrated Care Management (ICM) is a person-centered, population-based health management program providing comprehensive case management services. ICM targets Neonatal Intensive Care Unit (NICU) graduates, members who are pregnant, low- and high-risk members with chronic disease, and members with behavioral health conditions and special or complex needs. ACLA assesses our membership in order to design our programs based upon member needs. Our model of care is fully integrated; through it, members can move seamlessly from one component to another, based upon their needs. From this integrated solution, ACLA will continue to deliver and coordinate its care and disease management services.

Our model incorporates a member-based decision support system that drives both communication and care plan development through a multidisciplinary, patient-centered approach to management. This model is blended to provide comprehensive complex case and disease management services to plan members identified with complex health needs and/or disease states. The ICM process includes reassessing and adjusting the individualized care plan and its goals as needed. The overarching goal of the ICM process is to increase members' ability to self-manage and advocate for their own health. ACLA uses leading technology to integrate our medical management departments and functions, including pharmacy management, informatics, and operations.

ACLA's ICM team includes a Community Care Management Team (CCMT), Community Health Education team, nurses, social workers, Community Education Outreach Team (CEOT), clinical pharmacists, plan medical directors, primary care practitioners (PCPs), specialists, members and caregivers, and parents or guardians. This team works to meet our members' needs at all levels in a proactive manner designed to improve health outcomes.

Integrated Care Management

Our ICM program features five core components: Rapid Response, Pediatric Preventive Health Care (PPHC), Episodic Care Management (ECM), Bright Start (maternity management), and Complex Care Management (CCM). Each component includes targeted interventions for chronic conditions; special needs populations; and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) populations. Additionally, all of the core components coordinate and collaborate with the CCMT and our Community Health Educators.

Data analysis and reporting are an integral part of every aspect of ICM, from population identification through evaluation and effectiveness monitoring. In order to maximize the efficient use of resources, the ICM program balances services provided by vendors, such as Alere for the high risk pregnant population, and community agencies with those provided by ACLA employees. The figure below illustrates how our care management model brings together teams, tools, and individuals across the spectrum of care to improve health outcomes.

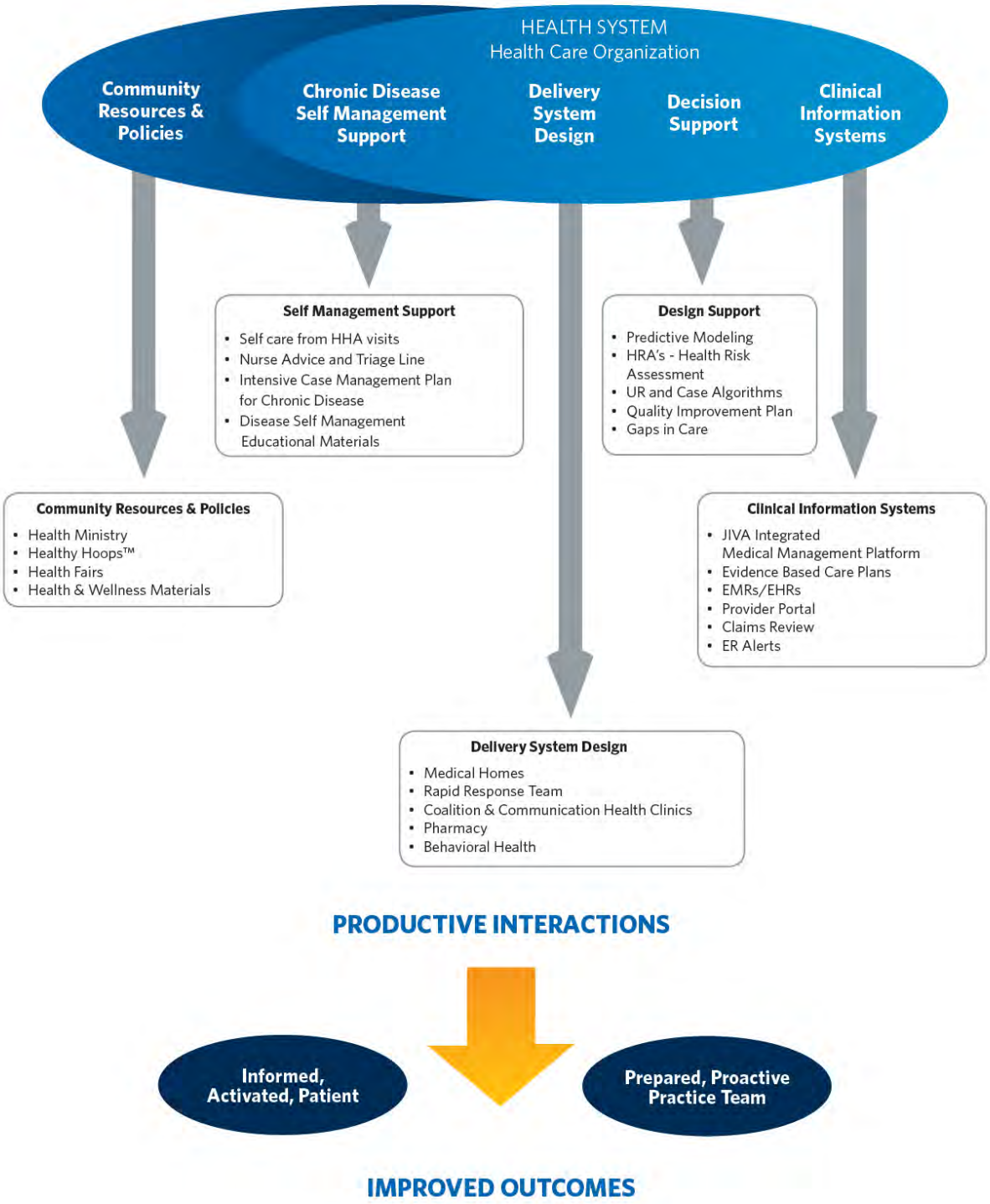

Exhibit K.1-1: ACLA's Care Management Model

Rapid Response

An important component of the ICM model, the Rapid Response team was developed to address the urgent needs of members and to support providers and their staff. The Rapid Response team comprises registered nurses, social workers, and non-clinical Community Care Connectors (CCCs) trained to assist members in investigating and overcoming the barriers to achieving their health care goals. The Rapid Response team addresses questions concerning how to obtain medications, supplies, or medical equipment; offers assistance in finding a PCP or specialist; and supports members in making and keeping appointments. The Rapid Response team fulfills their vital role in connecting members to care through the three key service functions described below.

Inbound Call Service

Members and ACLA providers may request Rapid Response support via a direct, toll-free Rapid Response telephone line. The Rapid Response toll-free number is provided as a contact point on all member mailings and automated messaging, encouraging members who need additional support or information to call. The number is also publicized to providers through provider newsletters, provider orientation, and interactions with the Provider Network Management Account Executive. Members are also referred to the Rapid Response team through various sources including Member Services, pharmacy services, utilization review, and provider services.

Outreach Service

The Rapid Response team reaches out to members by conducting assessments and telephonic surveys and supporting special projects or quality initiatives. Rapid Response employees also initiate follow-up calls to members recently discharged from the hospital and members who contacted the 24-hour Nurse Line the previous day. Additionally, to educate members in accessing appropriate levels of care, the Rapid Response team performs monthly outreach to high utilizers of ER services. They educate members on when and how to access care and assist them in surmounting barriers to receiving care in the appropriate setting.

Care Management Support

Care managers on the Rapid Response team provide clinical care management services to members with urgent health concerns. Calls are screened by the CCC, who involves the care manager when indicated by the urgent needs assessment or clinical situation.

CCCs work with care managers to support the individualized care plan. They assist members with appointment scheduling, make appointment reminder calls, and coordinate transportation and child care to ensure members keep their appointments. They send members targeted educational mailings to increase their health literacy and assist care managers with administrative tasks.

Both care managers and CCCs are well informed of available community services and are available to assist with the application process and follow-through until service delivery. For instance, the Rapid Response team has assisted members enrolled in Home and Community-based Services (HCBS) in their transition to Bayou Health since the initiation of a voluntary enrollment option for this population. Rapid Response reaches out to members receiving HCBS to assess their needs and refer them to ICM for intensive care management services related to their acute health care needs.

Pediatric Preventive Health Care

The PPHC, delivered by our Rapid Response team, is designed to improve the health of members under age 21 by increasing adherence to EPSDT program guidelines. We accomplish this by identifying and coordinating preventive services for these members. The PPHC combines scheduled written and telephonic outreach with state-of-the art informatics that provides point-of-contact notification of EPSDT needs to Rapid Response staff and providers. Care Managers reach out to connect with members who have gaps in care or are due for a well-visit. Following our approach to make every member contact count, care managers can also address any care gaps that exist for anyone in the family who is a plan member.

Episodic Care Management

The episodic care management program (ECM) program coordinates services for new adult and pediatric members of the plan and existing members with short-term and/or intermittent needs who have single-problem issues and/or comorbidities. These members are identified and engaged in the ECM program by Rapid Response and complex care managers. The care manager supports members in the resolution of pharmacy, DME and/or dental access issues, transportation needs, identification of and access to specialists, and referral and coordination with behavioral health providers and other community resources. Care managers conduct health surveys to identify and address member needs or required services. The ECM team has both registered nurses (RNs) and Masters of Social Work care managers.

Bright Start ® (Maternity Management)

Built on the Prenatal Care guidelines from the Institute for Clinical Systems Improvement, the Bright Start program provides maternity management by promoting healthy behaviors and controlling risk factors during pregnancy, with the goal of delivering a healthy, full-term infant. The Bright Start Program is managed by a dedicated team of care managers and CCCs who assist expectant mothers and coordinate care throughout the member's pregnancy and postpartum period, addressing various issues including dental care and depression screenings.

ACLA uses a variety of mechanisms, including internal and external assessments, to identify and promptly engage members who are pregnant as early as possible in their pregnancy. All

new female members are asked about their pregnancy status as part of the new member assessment and during every call made to or by the Rapid Response team. Current and historical claims data is also reviewed weekly to identify newly pregnant members.

The Bright Start team reaches out to pregnant members and collects information used to stratify the members into high- and low-risk categories. Members assessed as low-risk receive information via mailings with access to a care manager as necessary. Members identified as high-risk are managed by a team of both care managers and CCCs.

Members with any of the following conditions or circumstances are considered high-risk:

- Asthma
- History of preterm labor
- Pre-eclampsia or history of pre-eclampsia
- Cervical cerclage
- Diabetes (all types)
- Domestic abuse
- Drug or alcohol use
- High blood pressure
- HIV
- Lupus
- Multiple gestations
- PIH (pregnancy-induced hypertension)
- Placentia previa
- Sexually transmitted infection
- Smoking or tobacco use
- Thromboembolic disease
- Unstable living situation
- Mental/behavioral health condition (including depression)

ACLA reviews member data information regularly to assess whether their risk status has changed and more intensive support is indicated. Our reports are configured to consider office visits, inpatient stays, ultrasounds, procedures, and medication when reviewing weekly claims data to identify conditions such as gestational diabetes, gestational hypertension, preterm labor, hyperemesis, and other pregnancy complications. The Bright Start team also uses the information supplied by providers on the Obstetrical Needs Assessment Form (ONAF) to assess and stratify members for outreach. Lastly, the team will be reviewing the LEERS data to identify members with previous pregnancy complications including, but not limited to, previous preterm delivery.

Neonatal Intensive Care Unit

An offshoot of the Bright Start program, the NICU Graduate program identifies and follows infants who have a hospital stay involving NICU care. These infants are at risk for delay in discharge and increased incidence of readmission due to their medical, developmental, and psychosocial needs. The NICU Graduate Care Manager works with the family during the

hospital stay and follows the member with case management review for up to six months post discharge to ensure all barriers in care are addressed. The NICU Care Manager provides the ongoing concurrent utilization management reviews and collaborates with the hospital discharge planners and parent/guardians to ensure a successful transition to the home environment. Weekly NICU rounds with the ACLA medical director and neonatologists afford discussions to formulate intervention strategies to support the complex needs of NICU members. The NICU Graduate program has been very effective in decreasing the average NICU length of inpatient stay from 17.89 days to 14.89 days over the last year, a 20 percent decrease. Additionally, the NICU admits per thousand deliveries has gone from 6.4 to 5.1 admits per thousand deliveries. This reflects a 42 percent decrease in the overall NICU admits over the last year as well.

Complex Care Management

Members identified for Complex Care Management (CCM) receive comprehensive and disease-specific assessments and reassessments, along with the development of short-term and long-term goals and an individualized care plan, created with input from the member/caregiver and the physician(s). The CCM process includes reassessing and adjusting the care plan and its goals as needed. The CCM team contains registered nurse care managers and non-clinical Care Connectors. Under the direct supervision of the care manager, non-clinical Care Connectors assist the member with various interventions. Care managers coordinate care and address various issues, including but not limited to pharmacy, DME, dental access, assistance with transportation, identification of and access to specialists, and referral and coordination with behavioral health providers and other community resources. The care manager also assists with coordinating services that are outside the core benefits of the plan.

Under the direction of the Louisiana-based Medical Director, the Integrated Care Management Director, Complex Care Manager, and Bright Start Manager, oversee employees providing ICM services in ACLA's offices located in Baton Rouge. ACLA believes strongly that health care is local and therefore values and promotes the involvement of individuals and organizations throughout the local area. Local Care Management staff have direct knowledge of the culture of the population and the specific barriers members may experience. They also cultivate relationships with providers and hospitals, as many were hired from local hospitals, clinics and physician offices. This advantage helps to increase access to care and improve care coordination.

Members Targeted for Case Management Services;

The ICM program provides specialized services that support and assist members with the medical, behavioral, and/or social issues that impact their quality of life and health outcomes. Identified issues and diagnoses that result in a referral to the ICM program include but are not limited to:

- Pregnancy
- ADHD

- Multiple diagnoses (three or more actual/potential major diagnoses)
- Risk score indicating over- or under-utilization of care and services
- Pediatric members requiring assistance with EPSDT services
- Pediatric members in, or receiving, foster care or adoption assistance
- Infants receiving care in the NICU
- Members with high utilization of ER services
- Members with dual medical and behavioral health needs
- Members who are developmentally or cognitively challenged
- Members with a special health care need
- Members receiving hospice services
- Members covered under waiver programs
- Members with chronic diseases including:
    - Heart Failure
    - Diabetes
    - Asthma
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Sickle Cell
    - Hepatitis C
    - HIV
    - Obesity

Identifying Members

The ICM program is driven by the use of predictive modeling software to identify members that are appropriate for the various components of the program. However, members are also identified through new member assessments, provider referrals, member requests, and other health plan activities. Each identification process is summarized below.

Data Mining and Predictive Modeling

ACLA uses software algorithms provided by DSTHS Care Analyzer®, along with claims and pharmacy data. The CareAnalyzer® is an analytic solution that combines elements of patient risk, care opportunities, and provider performance to meet care management and other regulatory reporting requirements. The data is analyzed to identify individuals who are expected to have higher-than-average health care needs in the future. Prospective risk scores are used to trigger assessments for different care management programs. Predictive modeling is run on current claim data as well as historical data, as available.

New Member Assessment

ACLA collects assessment data on members who are new to the plan to identify ongoing conditions and potential health risks. Based on the assessment responses, members are triaged into the appropriate care management program.

Provider Referrals

Providers are encouraged to refer members to the ICM program. Information provided during the provider orientation program, as well as ongoing information and training presented to providers, explains the services available through the ICM program and encourages referrals. Our "Let Us Know" program supplies providers a referral form for sending information on the needs of a member directly to the Rapid Response team.

LET US KNOW PROGRAM

INSERT PLAN LOGO HERE

Member Intervention Request Form

Date: _____

MEMBER INFORMATION

Member Name	Date of Birth
Member ID #	Phone Number
Parent/Guardian Name (if applicable)	

PROVIDER INFORMATION

PCP Name	PCP ID#
Phone Number	Fax Number
Office Contact Name	PCP County

Please check the appropriate intervention(s):

- ☐ Non-compliance with prescribed medication(s)
- ☐ Inappropriate use of emergency room
- ☐ Not showing up for appointments or follow-up care
- ☐ Limited or no knowledge of Plan benefits
- ☐ Other: _____

Additional Information/Comments:

_____

_____

_____

_____

Please fax this form to the Rapid Response and Outreach Team at X-XXX-XXX-XXXX

Follow-up performed: _____

Comments: _____

339-SHARE-1222-05

Exhibit K.1-2: Let Us Know Form

Member Requests

We inform members through the Member Handbook and contact with Member Services that they can request care management services.

Health Plan Activity

Members are also referred to the ICM program through internal processes, provider service calls, and member service calls, and utilization management reviews. ACLA also receives referrals from the SMO, community partners, Targeted Case Management providers, and other carved out service providers.

Assessing Member Needs

ACLA stratifies members using a combination of predictive risk scores and assessment findings. The figure below illustrates stratification levels and the supports included in each.

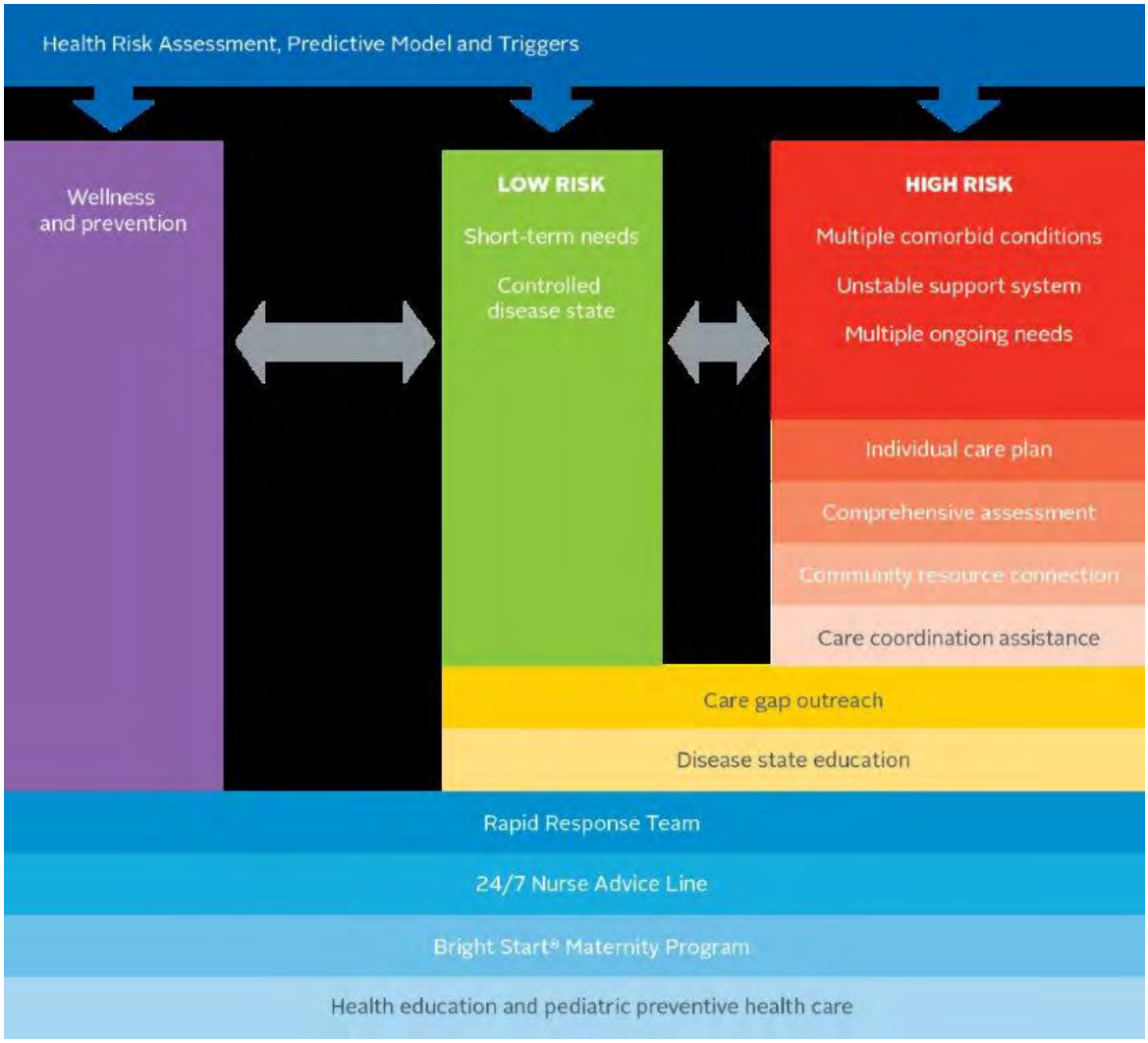

Exhibit K.1-3: Care Management Stratification Levels

Members with controlled chronic conditions and short-term needs are assigned to the low-risk group. The low-risk group receives educational materials in the mail, access to the 24/7 Nurse Line, and on-demand care management services from the Rapid Response team. Members without chronic conditions receive wellness and health promotion services, in addition to support from the Rapid Response team and 24/7 Nurse Line.

Members with an unstable medical, behavioral health, or support situation are assigned to the high-risk group. These members undergo a comprehensive assessment with additional focus on any identified problem areas. The assessment incorporates subjective findings from the member, such as perception of health (utilizing the SF-12 tool) and PHQ9 assessment. The assessment includes health literacy level, lifestyle choices (such as tobacco use, alcohol and drug use, and weight management), cultural and linguistic needs, and contact preferences. The topics addressed through our assessment are listed below:

Health Problems	Current health problems Length of time Knowledge related to cause and treatment
Medications	Medications used Dose/frequency Understanding of reason for the medication
Other Treatment	Cultural/traditional or home health remedies Other medical treatments
Medication Barriers	Reasons for not taking medication Assistance needed for medications
Awareness	Medication/condition alert bracelet/card Emergency support system
Physician Care	Frequency of doctor visits Date of next appointment Plan if not feeling well
Hospital/ER use	History of use Reason for event
Functional Status	Problems with daily activities Mobility limitations
Health Literacy	Problems reading or understanding information
BMI	Height/weight

	Frequency monitored
Nutrition	Type of diet Ability to adhere to diet
Substance Use	Tobacco use Drug use Alcohol use Frequency of each
Lifestyle	Frequency of exercise Cultural practices
Health Care Access	Available transportation Barriers to care
Behavioral Health	Depression Anxiety ADHD
Cognitive Assessment	Care Manager assessment of cognition
Condition-Specific: Asthma COPD Diabetes Heart Failure Pregnancy Sickle Cell Obesity	For each identified target condition: Understanding of condition Adherence to recommended clinical guidelines Lifestyle factors Self-management skills

Encouraging Member Participation

ACLA has found that a trusting relationship between the care management team and the member is a strong foundation from which to help members become involved in their health care and adopt recommended lifestyle changes. By establishing a relationship of mutual trust, ACLA helps members become more comfortable and educated in understanding health care, promoting increased participation in their care.

To accomplish this goal, our care managers and other employees work on a one-to-one basis with members to engage and motivate them as active participants in their health. Care managers structure their conversations using Motivational Interviewing (MI) techniques. All care managers complete a comprehensive MI training to assist in increasing not only member

engagement, but also member willingness to self-manage their disease process and be an advocate for their health care needs. MI includes open-ended questions, affirmation, reflective listening, and summarization. Using a non-judgmental, non-confrontational, member-focused approach, the care manager can increase the member's awareness of health risks and their consequences and gain support for goal setting.

One of the best ways to strengthen the collaborative relationship between care managers and members is for care managers to prompt members to identify their biggest concern about their current state of health. By starting with an issue important to the member, the care manager gains credibility and lays the groundwork for additional interventions. Members may initially be more concerned with personal goals than with health care goals related to clinical issues as defined in assessment findings and utilization data. For example, encouraged by open and responsive communication with the care manager, the member may express a desire to go hiking. By focusing on this desire, the care manager secures the member's investment in addressing related health issues like building an exercise regimen and eating nutritious foods. In this way, the individualized care plan is developed with the member influencing priorities and committed to working toward improved health. Care managers use this approach to address barriers and positively reinforce successful outcomes that result from adherence to the individualized care plan.

For members who can actively participate in their individualized care plan, the care manager assigns them a specific role. For instance, the care manager may ask a member with heart failure to call each week and report his/her weight. During the call, the care management team supports the member by positively reinforcing his/her activities, helping to instill a sense of accomplishment. These interactions often help members maintain an open, active dialogue with care managers that leads to improved care. Our care managers teach members to monitor and log blood sugar, weight, and other pertinent information so that a member's progress can be discussed during the engagement call. This fosters self-management with our members.

ACLA Care Managers aim to encourage members to reach out for assistance or information. Results of our 2013 Member Satisfaction Survey show we are succeeding. 96.55 percent of members stated they will contact ACLA or Care Management with any future questions as needed. 89.47 percent reported satisfaction with the Care Management program.

The ICM team makes outreach calls to the member or authorized member representative, and collaborates with the PCP and specialist to develop an individualized care plan. We use outreach letters and home visits, as appropriate, to engage members and address and resolve issues. The ICM team participates in interdisciplinary team meetings that include other employees, members, practitioners, inpatient and outpatient providers, community resource representatives, community behavioral health providers, and other parishes and/or state entities from which the member may be receiving services. These meetings ensure the member-specific treatment plan addresses all issues influencing access to appropriate care and services.

ACLA is piloting the CCMT program in Baton Rouge. An extension of our ICM program, the CCMT program features a team of CCCs who conduct in-person outreach to members have

been difficult to contact and have unmanaged chronic illnesses, high ER utilization, and multiple inpatient admissions. CCCs visit members in their homes to build a rapport and offer assistance such as monitoring for medication compliance and accompanying members to doctor's appointments for support and clarification of their care. ACLA presents members DHH-approved care management brochures and member welcome letters that include information on the Patient-centered Medical Home (PCMH) and the benefits of participating in a medical home. Care managers proactively facilitate PCP or PCMH appointments for members to ensure regular health evaluations. Appointment dates are entered into the member's care plan, automatically setting up work queue activities for the care manager and Rapid Response CCC to remind the member of the appointment, verify transportation arrangements, and assess other barriers that may prevent them from keeping the appointment.

Below, a member describes the support he received from a care manager that was beneficial to both his physical and emotional health.

"They said that I had diabetes. And ever since that, it changed my life completely because at first I didn't take it seriously like a lot of people don't. I didn't take care of my sugars and stuff like that very well. And so I ended up with a lot more complications, like the first thing was neuropathy in my legs. And then I started having more and more problems with stomach and digestion systems. I ended up getting really sick and ended up in the hospital several times.

A lot of the things that I try to do is just stay positive and keep going. The nurse at LaCare [now ACLA], she was telling me a lot of things about different organizations that I could call and it was very helpful. She was very, very helpful.

I was very depressed. Until I talked to her, I really didn't feel the incentive at the time to make a lot of changes that would do better for me like I have now. Like she asked a lot of questions about how I felt and trying to get a very good idea of just what she could do for me. She was keeping me informed on what I could do to call around and find out more about taking better care of myself.

She actually got to know me, the person. I got help in the right direction and then things seemed to go better.

It's good that she has got that friendly tone because it makes me feel more apt to call her and I'm not calling somebody that just sounds like so informal, like an operator. This person is a qualified nurse also, very qualified. She knows what she is talking about, and so I feel very comfortable with talking to her about making changes and things that I know are going to work for me.

She is very supportive and she seems like your friend, so it's easier to work with her. You can tell just by her voice that she is smiling and talking to you. It's not like just a job for her. She really cares about the people that she talks to."—"Robert," an ACLA member

Technology for Patient Engagement

Telemonitoring Pilot Program

ACLA has partnered with a vendor for in-home monitoring services starting October 2014. The targeted members will have a diagnosis of diabetes or congestive heart failure as well as multiple emergency room visits and/or admissions. The services include a combination of daily monitoring, provider coordination, and clinical assessment. Objective measures obtained include blood pressure monitoring, glucose monitoring, and daily weights. ACLA care managers will refer members to this program as one of the interventions within the disease management programs. Network providers will be educated on the benefit for members, including how to make referrals for telemonitoring to the care managers. This program has been in place in our South Carolina affiliate for more than 4 years. Recent outcome reports assessing members who had received service over 10 months from January 2013 through May 2014 demonstrated significant decreases in inpatient and emergency room utilization and total cost for those members stratified as high risk.

Smart Phone and Text Technology

ACLA is currently developing a program to provide members free cell phones for easy access to the plan and their care managers. The phones would be programmed with the text4health, text4kids, and text4baby modules to send texts with education information, reminders about general health and screenings, health surveys and recommendations of activities to improve health.

ACLA is working with DHH through the CMS grant to enhance the current text4baby initiative. The enhancements will allow the plan to add plan and DHH specific information to the text4baby program. Targeted to pregnant women and mothers of newborns, the text messages encourage members to make and keep appointments; take vitamins and eat healthful foods; avoid alcohol, drugs, and smoking; and consult with the doctor before taking any new medications during pregnancy. Information would continue into the postpartum period to support moms in caring for themselves and their newborns during this vulnerable time. The texts include the opportunity for follow-up action, such as phone numbers or links to more information. Messages can be presented in English or Spanish and will allow members to offer feedback on the program.

ACLA is planning to offer two additional texting programs. The text4kids program will offer similar information to members with young children; texts would include reminders to schedule vaccinations, dental appointments, and follow-up PCP visits. Text4health module will contain general adult health preventive screenings, as well as health surveys that member responses can be accessed by plan Quality and CM staff through a secure smartphone vendor portal.

ACLA is working with our corporate affiliate ACFC toward building a base mobile platform for future mobile applications and functionality. ACFC will launch the product in its DC market in

the 3rd quarter of 2014, with a rollout to other company markets, including Louisiana, in 2015. The initial functionality of the technology enables a member to:

- View/Fax their Member ID card
- View PCP information, including office location and phone number
- Access a searchable directory, including mapping functionality to provide directions to the office
- View/Update their Medication Cabinet, prepopulated with information on medications the member received through the ACLA prescription benefit, including a picture of the medication.

Exhibit K.1-4: Mobile Platform Application

Asthma Health® Tablet

ACLA's PBM, PerformRx, has partnered to create an asthma medication management program designed to increase medication adherence and reduce overall health care costs in treating moderate to severely persistent asthmatic members. ACLA will present identified members with a Wi-Fi and cellular capable Health Tablet computer through which we can deliver educational interventions for the child's primary caregiver and other relatives. The Health Tablet features tools that measure and increase adherence, as well as improve general and health literacy. These tools include a daily health survey, daily tips, biometric tracking (peak flow), individualized care plan instructions, medication management tool, asthma symptom tracker, and emergency medication tracker. Tools to help the provider manage member care include early warning reports that identify patients with potential problems, a tool that allows the provider to set a medication reminder schedule and track member compliance, a portal to

view patient survey responses and biometric tracking, and an individualized care plan writer. Additionally, the tablet is programmed with e-books to promote health literacy, health-related games, tutorials on using asthma inhalers, and content that can be spoken in English or Spanish.

Developing and Implementing Individualized Care Plans

In developing the individualized care plan, the care manager forms an overall picture of the member by integrating assessment data, physician findings, and input from all those involved in the member's care, including the member and/or authorized family representatives or guardians, specialists or subspecialists, and other involved health care and community-based service providers. Individualized care plans are structured around evidence-based guidelines and barrier-resolution strategies designed to optimize the member's health through direct intervention and development of self-management skills. The individualized care plan addresses medical, behavioral, and social service issues, consistent with the PCP's clinical treatment plan and medical diagnosis. ACLA's integrated care management system contains assessments that, based on the member's needs as documented by the care manager, populates evidenced based care plans. The care manager will then adjust the individualized care plan, if needed, to prioritize the goal that the member identifies as priority. As appropriate, the individualized care plan will include interventions to refer potentially eligible women to the Women, Infants and Children (WIC) program, as well as other community-based services, and provide any required diagnosis or medical information.

The individualized care plan will include identified high- and low-priority goals, expected completion dates, and interventions for each problem. Activities to complete the interventions will be assigned to the appropriate member of the care management team.

Receiving Data from Hospitals upon Member Admission, Discharge, or Transfer

ACLA leverages data from hospitals on member admission, discharge and transfer in a variety of ways. ACLA's Provider Portal allows facilities to enter inpatient admission, discharge and transfer information directly into the ACLA medical management platform. The facility is rewarded with the automatically generated case number and the information entered triggers care management alerts notifying members of the care team that the event occurred. This functionality enables ACLA to perform early outreach and intervention.

Discharge instructions and medication reconciliation are the focus of the initial outreach by the care management team. Follow-up is provided to ensure that the member has completed their discharge appointments, and the member is offered appointment follow-up reminder calls. During the discharge outreach call, transportation assistance is also discussed, as well as any other potential barriers to care.

In addition, ACLA's parent organization is building the infrastructure to take in automated Admission/Discharge/Transfer (ADT) feeds from hospitals and regional health information exchanges. We currently receive this information from 7 high volume facilities in the District of

Columbia and are in discussion with other facilities and HIEs in Pennsylvania and South Carolina. The ADT information will be used in several ways:

Workflow enhancement: The ADT data will populate key fields in the medical management platform to create automated activities to initiate discharge planning (on admission), discharge follow-up (after notification of discharge or transfer) and notification to the care manager of any ER or inpatient admission.

Focused care management alerts: As the ADT information is received, it will be matched against key indicators on the member's record to trigger specific focused outreach and activities. Some examples of activities under consideration include:

- Referral for a home visit for member with high-risk asthma who is discharged from the ER
- Alert to the Community Care Connector when a high-utilizer member is admitted to the ER

Automated messaging: ADT data indicating specific events for focus subpopulations will trigger an automated text or secure message to provide coaching and/or trigger a desired behavior. Some examples of message events include:

- Text message with the name and phone number of the assigned PCP and a reminder to schedule an appointment to a member upon discharge from the emergency room
- Secure alert to a PCP upon admission of an assigned member to the hospital
- Text message with the name and phone number of the care manager/rapid response team for a member discharged from the hospital

Coordinating Disease Management and Case Management Programs through Integration

ACLA uses a blended ICM model that combines case and disease management into a holistic approach. A "blueprint" is developed for each targeted condition. The blueprint outlines the population management approach and metrics used to manage that condition. Each blueprint includes the following sections:

- Importance – the relevance of the condition to the membership
- Clinical guideline – the guideline on which the program is based
- Program goals – specific goals related to the condition
- Outcome measures – specific metrics used to evaluate the program's success
- Stratification – logic used to stratify members into low- and high-risk groups
- Interventions – program interventions by stratification level
- Priority interventions – focused interventions for inclusion in all care plans and assessments
- Educational materials/resources – materials available for employees to use in providing disease-state education
- Innovations – synergistic initiatives that support the program goals
- Provider connection – method for involving provider in the program

- Internal education – list of internal education programs for employees
- External education – list of member and provider education related to program goals
- Reporting – list of dates program updates and evaluation provided for review

A comprehensive evaluation of each condition management program is conducted annually as part of the ICM program evaluation.

ACLA's blended ICM program integrates physical health, behavioral health, and social/environmental aspects of the member's care into one individualized care plan. The care management team includes individuals with backgrounds and expertise in behavioral health, physical health, and social work. As part of the assessment and triage process, the member's level of health needs is evaluated utilizing a four-quadrant approach. The figure below outlines the triage approach and resulting resource assignment.

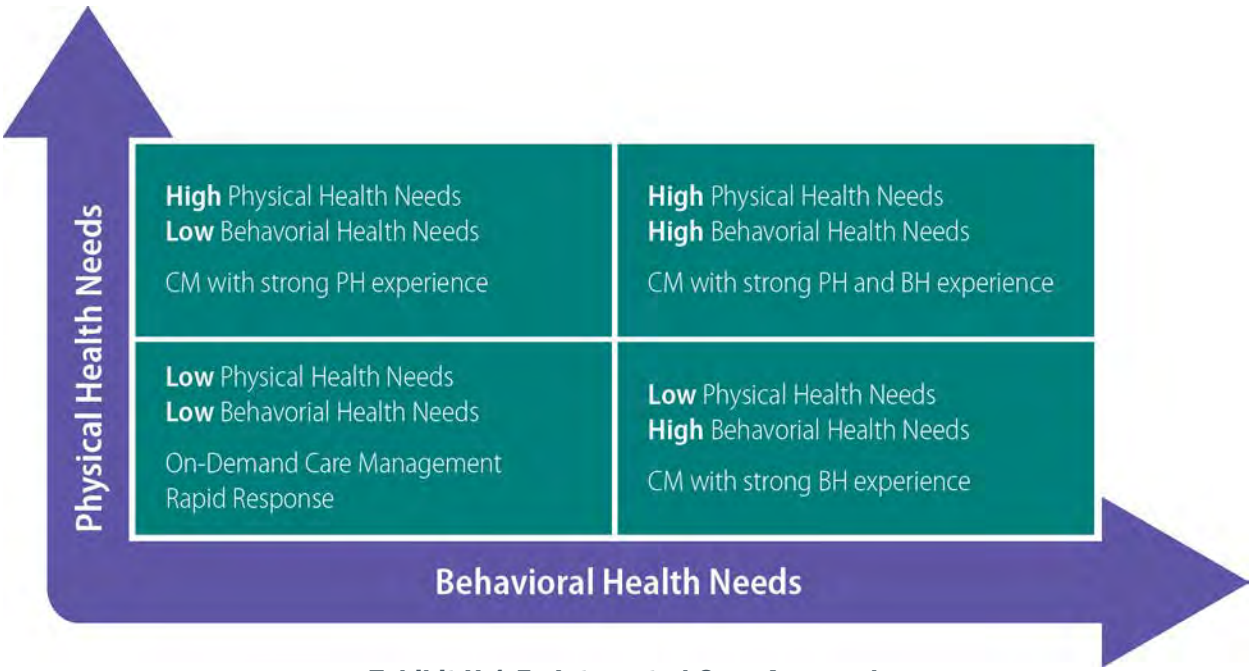

Exhibit K.1-5: Integrated Care Approach

Coordinating Case Management Services with the PCP

ACLA recognizes the importance of a strong relationship with PCPs in coordinating and delivering high-quality care. As part of the comprehensive assessment and treatment plan development process, our ICM employees contact each PCP during the member's initial enrollment into the program. We create the member's treatment plan using the PCP's treatment plan as a foundation. This allows us to complement the PCP's recommendations to develop an enhanced and holistic treatment plan specific to the ICM program. The ICM Care Manager will remain in close communication with the PCP during the implementation of the treatment plan to address any new concerns that may arise. The care management team contacts the member's current providers, including specialists and behavioral health clinicians, to determine the best process to use to support the member. This helps to reduce any redundancies and identifies

areas to coordinate and support efficiencies. We engage key providers and provide them the opportunity to be part of the development of the member's treatment plan.

Through the ACLA Provider Portal, providers and their office staff can view up-to-date information on a member's care, including gaps in care, member's visits, medical history, and list of medication as well as the date the prescription was filled.

Care managers assist providers in contacting members who have not been in for routine care and provide the practices with aggregate and member-specific data on performance with respect to clinical practice guideline recommendations. ACLA will continue to reach out to providers to ascertain their willingness to provide on-site care coordination services via an embedded care manager.

Incorporating Provider Input into Strategies to Influence Member Behavior

ACLA routinely solicits provider feedback and input regarding our ICM program. At the member level, the care management team routinely contacts providers to gain their perspective on the member's needs and to understand approaches that have worked or not worked with the member in the past. The information gathered is used in formulating the member's individualized care plan and guides the approach used with the member.

We have used provider feedback extensively to shape our care gap strategy. Care gaps are services recommended by nationally-accepted clinical practice guidelines for which there is no claim evidence of completion. Providers are alerted to these "gaps" when they perform an eligibility check through our Provider Portal, the Member Clinical Summary, and provider reports available on the portal. Providers use this information to reinforce the need for these important services during the member's office visit. Their feedback has helped us improve the program to display only the critical information needed to effectively intervene with the member.

The ICM team has invited physician providers to speak on special topics at ACLA. For example, Dr. Julie Kanter, a pediatric hematologist-oncologist and former director of the Sickle Cell Center of Southern Louisiana at Tulane University, provided an in-service to ICM staff on sickle cell disease and the Tulane program.

ACLA conducts an annual Provider Satisfaction Survey, collecting feedback on how we can improve the effectiveness of our program. As part of the provider questionnaire, we solicit input on methods we can implement to improve the program from all perspectives, including influencers of member behavior.

Additionally, ACLA's ICM program description is presented to the QAPIC for provider input and approval. Members of the QAPI Committee include six to eight practicing PCPs and/or Specialists. The QAPI Committee also assesses the effectiveness of ACLA's health management and chronic care improvement programs.

Providers are also involved through ACLA's Quality of Clinical Care Committee (QCCC). The QCCC is a forum to give providers a voice in our programs. Through the QCCC, providers and other stakeholders offer input and direction regarding ACLA policies, procedures, and programs, including mechanisms ACLA can use to influence member behavior.

K.2. Case Management

K.2 Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid MCO members.

Describe how you will leverage existing state and local resources to support health and wellness of your members including but not limited to:

- *Strategies you will use to work with the Louisiana Office of Public Health to utilize existing capacity in the state for services, outreach or education. Include models you have used in other states that are in partnership or utilize a state's public health infrastructure.*
- *Strategies to utilized faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services*

Overview

ACLA has found that a trusting relationship with members is a firm foundation from which to engage members in their own health care by encouraging the development of healthy behaviors, increasing health literacy, and assisting them to access appropriate health care resources. The relationships we form begin with interaction and education to support members in adopting healthy lifestyles. For example, simply making choices such as not smoking or eating a healthy diet can yield maximum results for member health. We create these relationships through one-on-one connections with our members, partnering with the Louisiana Office of Public Health and other established community leaders and organizations, and using culturally appropriate messaging.

Strategies that Influence the Behavior of Members

Care Management

Care Management assesses our members' lifestyle, culture preference, faith, language, social barriers, functionality, family dynamics, caregivers, engagement in community programs, and barriers. This comprehensive assessment helps to guide and determine realistic goals and needs in order to appropriately recommend referrals to community resources. Care managers are trained in motivational interviewing to coach, support, and influence members to make better decisions for their health. Our care managers promote effective self-management that leads the member to access health resources as needed. Furthermore, the Community Education Outreach Team (CEOT) informs our care managers about events for our members across the state.

Active Presence in the Community

From our strong local presence, ACLA has served members in Louisiana and the community at large since 2012. Our mission is to help people get care, stay well, and build healthy

communities. To support this mission, we employ local staff who interact personally with members and providers. This homegrown connection allows us to fully engage in the community, understand the local landscape and the resources available, and commit human and financial resources to building healthy communities. We develop and maintain close relationships with many local organizations. These relationships exist not only on the corporate level, but also extend to our employees and their individual involvement in the community. ACLA staff dedicated nearly 800 volunteer hours in 2013 to support local causes through the events and organizations shown in the figure below.

Organization	Total Hours Volunteered by ACLA Employees in 2013
American Diabetes Walk	24
Baton Rouge Food Bank	4
Baton Rouge Sickle Cell Walk	9
Bayou Titan Kids Group	25
Belfair Montessori Magnet Elementary	30
BREC	50
Breece-Locke Health Fair	2
Brusly High School	20
Capital City Coat/Toy Drive	8
Cinco de Mayo 2013	18
HOPE Ministries	248
Johnson Carver	12
Knowledge Effect	5
Kool Smiles	3
LACHON	24
Let's Move Louisiana	20
March of Dimes Walk	50
Miller Square	4
Macedonia Baptist Church	4

Organization	Total Hours Volunteered by ACLA Employees in 2013
Port Allen High School	20
Prevention Education And Resource Services	8
Red Cross	24
Ryan Elementary	20
Salvation Army	60
St. Mathilda's Church Youth Group	7
St. Vincent de Paul	16
Terrebonne Food Bank	30
YMCA	48
TOTAL	793

Exhibit K.2-1: Total Hours Volunteered by ACLA Employees at Community Events and Organizations

Exhibit K.2-2: ACLA Integrated Care Management Staff Volunteering at HOPE Ministries in Baton Rouge

One-on-One Connection

ACLA's Community Health Educators visit members who have gaps in care as evidenced by claims and utilization data, contact with providers, and encounter information. They help members remove barriers to care, such as transportation or child care, and arrange appointments. The rapport established during these visits is central to member access to care and engaging in health behaviors. Community Health Educators also engage with the community at large through participation at a variety of community sites, including food banks, church events, physician offices, and health fairs.

To extend our reach and bring additional support to members who most need it, ACLA is piloting the Community Care Manager Team (CCMT) program in Baton Rouge. The CCMT program is an extension of our Integrated Care Management (ICM) program and features a community team who conducts in-person outreach to members who have been difficult to contact and have unmanaged chronic illnesses, high ER utilization, and multiple inpatient admissions. The Rapid Response and ICM teams refer members for this intervention. Community Care Connectors (CCCs) from the CCMT visit members in their homes to establish contact, build a rapport, and offer assistance such as monitoring for medication compliance and accompanying members to doctor's appointments for support and clarification of their care.

Our high-touch ICM, Rapid Response, and EPSDT teams work together to engage members one-on-one via telephone contact, thus ensuring that needed services are provided and members have the ability to keep their appointments. By working on goals important to the member, our care managers create the trusting relationship necessary to achieve behavior change. All care managers are trained in Motivational Interviewing, which assists members to engage and make positive changes in their lives. Our CCMT program assists the member by meeting them in their environment, thus increasing their engagement.

Leveraging Existing State and Local Resources

The experience of ACLA and that of ACFC has shown that our principal strategy of connecting to members in their own communities fosters trust and encourages positive behavior. ACLA holds and participates in local health-related events to share wellness information with members and the community at large. By partnering with organizations that members know and trust, including the Louisiana Office of Public Health (OPH), community-based organizations, non-profit agencies such as Nurse Family Partnership and March of Dimes, faith-based organizations, and local neighborhood groups, ACLA establishes connections with members that result in expanded awareness of health issues and improved health outcomes.

Louisiana OPH

ACLA has a unique relationship with the Louisiana OPH. We consider the Louisiana OPH a community-based resource for preventive health programs, but also a valuable partner in quality reporting. Additionally, Louisiana OPH acts as an ACLA network provider.

Preventive Health Programs

ACLA uses the OPH as a valuable resource, obtaining information that will assist our membership through programs such as Genetic Disease, Hepatitis, Louisiana Birth Defects monitoring, and Tuberculosis Control programs.

The Children's Special Health Service program (CSHS) is the principal public agency ensuring that children and youth who have special health care needs in Louisiana have access to health care services. ACLA refers members and their families to CSHS as a resource for our most vulnerable members and their families.

ACLA partners with OPH in their Partners for a Healthy Baby campaign, connecting Louisiana moms and their families to health- and pregnancy-related resources, services, and information.

Collaboration in the Louisiana OPH Laboratory

ACLA also collaborates with the Louisiana OPH Laboratory in its efforts to protect the health and safety of the citizens and visitors to the state of Louisiana by exchanging accurate and timely laboratory data that is used by state officials, public health programs, and citizens of the state. Information produced and collected by the OPH Laboratory affects over 30 statewide public health programs, as well as state and federal law enforcement agencies that utilize OPH Laboratory data. These programs encompass Preventive Health, Environmental Health, Infectious Disease and Environmental Epidemiology, Emergency Preparedness and Disaster Response, and Forensic testing for biological and chemical agents and toxins. This exchange of information ensures that ACLA staff and members have access to critical information.

LINKS System

Louisiana Immunization Network for Kids (LINKS) is a statewide computer-based system designed to keep track of immunization records for members. Records from multiple providers are consolidated into one comprehensive record. ACLA reinforces the accurate and timely entry of provider immunization data in the OPH-operated LINK system that allows immunization tracking across state-wide providers. ACLA's Provider Network Management (PNM) account executives educate providers about the system during provider office site visits.

PNM account executives reinforce that LINKS assists medical practices in the following ways:

- Provides immediate immunization record information for new patients;
- Decreases amount of time staff spends retrieving immunization records from multiple sources; and
- Avoids missed opportunities to administer needed vaccinations.

Account executives reinforce that the use of LINKS can assist members/patients through:

- Easy access to records needed for school and child care; and
- Reduction in costs and discomfort to child of through the elimination of unnecessary immunizations.

Network Provider Partnership

ACLA partners with OPH via the contractual relationship ACLA has with school-based health centers (SBHCs), rural health clinics, and rural hospital affiliations and community based/public health clinics. ACLA supports the efforts of the Bureau of Primary Care and Rural Health through provider education collaboration and rural health care workforce development. ACLA understands well the need to help communities recruit and retain primary care health professionals to serve the medically underserved areas in Louisiana. ACLA contracts with OPH as a network provider via several state-owned-and-operated clinics, including STI clinics, prenatal clinics, and medical clinics (for preventive care such as immunizations and EPSDT visits). As the largest provider of family planning and STI prevention services, operating in 63 parishes across the state, OPH is a vital partner for ACLA in meeting member needs for these services. OPH's many pre-natal clinics throughout Louisiana are also an important resource for our members.

ACLA works in partnership with the Louisiana CAREWare Access Network (LaCAN). LaCAN is a collaborative effort between four Ryan White grantees in Louisiana to improve information technology capacity to collect and report client-level data to the HIV/AIDS Bureau, Health Resources and Services Administration (HRSA), and HHS. The LaCAN partners and ACLA contracted providers include the Louisiana Department of Health and Hospitals HIV/STD Program clinic sites and the NO/AIDS Task Force.

These partners use CAREWare as a central repository of client data and have agreed to exchange service information for the purpose of improving client care, data quality, and performance measurement. This relationship allows our members access to specialty care in handling the spectrum of physical, mental, emotional, and social complications of HIV. Through these mechanisms, members can benefit from resources offered by NO/AIDS including the HIV medical clinic, food pantry, home-delivered meals, housing, mental health, and peer support.

ACLA leverages our relationships with SBHCs to support and encourage Asthma Friendly Schools. This childhood asthma prevention and management program designates schools asthma-friendly when they participate in a process for identifying students with asthma and stocking fast-acting inhalers. School staff is trained to identify and reduce common asthma triggers in the school environment, such as dust and mold. They also implement a school-wide process to handle worsening asthma. ACLA plans to build upon asthma prevention and awareness by piloting an asthma home health assessment program through the use of our network home health providers.

Community-based Organizations

Our strategy of connecting with our members includes bringing health education and wellness activities, including health monitoring and preventive screenings, directly to where our members live. In addition, we marry education with entertainment to draw members to the events and engage them in health-related activities and learning. We distribute literature on

chronic disease states such as heart disease and diabetes at community health fairs and other events, always directing the member to their primary care doctor.

Some of our activities and partnerships include:

Dedicated schedule blocks: We engage provider sites to reserve days for our members to get their well child and adult screening appointments, and remind members of their appointments, encouraging them to complete required screenings.

Community fairs and festivals: ACLA participates in health fairs with providers and other stakeholders to provide important health screenings for cholesterol, blood pressure, and blood sugar. Our teams work in advance to make arrangements so that our chronically ill members and their families can attend. Care management employees at the event make sure that the results are shared with our members' PCPs and assist with coordinating any indicated follow-up care after the event.

Community Baby Showers

Community Baby Showers: In partnership with area clinics and OPH pre-natal sites, ACLA holds Community Baby Showers at various community sites such as neighborhood churches and community centers. ACLA Pre-natal nurses attend the Community Baby Shower Events and meet with pregnant members to discuss educational topics, such as the benefits of breastfeeding and prenatal care, and to answer questions the individual members may have. These events create an environment to build relationships with the community and share education that can improve birth outcomes. Attendees receive giveaways such as baby rattles and baby strollers. We have held these events at Health Starts of Greater Baton Rouge, Capitol City Family Health Center in Baton Rouge, Daughters of Charity in New Orleans, David Raines Community Health Centers in Shreveport.

These events provide a mechanism for identification and engagement of pregnant mothers for engagement in Bright Start, our maternity management program. Bright Start Nurse Care Managers attend the events to assess for pregnancy-related risks and begin the process of establishing a bond with the expectant mother.

Louisiana Behavioral Health Partnership (LBHP)

ACLA stresses the importance of behavioral health (BH) -physical health (PH) integration by fostering a collaborative relationship with the SMO. We currently work with the SMO on bi-directional, reciprocal referrals, coordinated care plans, and pharmacy collaboration. We provide specialized training on behavioral health comorbidities for our staff. In addition, we recognize the important part that providers play in the identification and treatment of basic behavioral health needs. We have a focused program to educate PCPs on screening, diagnosis, treatment protocols, and how to connect with more specialized services for members with greater behavioral health needs.

Because there was no formal referral process at the start of the Bayou Health contract period, ACLA identified areas that needed improvement in the referral process and created a

streamlined program. All participating Bayou Health plans now use this DHH-approved referral process. In collaboration with the SMO, our ICM behavioral health staff developed a referral form to assist with referrals to the SMO and referrals back to the physical health plan. The form provides an avenue for collaboration and a formal avenue for tracking member referrals. This referral form allows for the SMO to refer members to the physical health MCO, should they be identified as needing focused physical health care management. Because of the collaborative relationship between ACLA and the current SMO, referrals from the SMO are made directly to ACLA care managers.

Nurse-Family Partnership

The ACLA Bright Start (maternity) team collaborates with and refers first-time pregnant members to the Nurse-Family Partnership for additional in-person support. Nurse-Family Partnership staff visit the member's home and provide a follow-up plan of care focused on good health practices, adherence to prenatal and post-partum care recommendations, and education on how to care for an infant. Partnership staff performs hands-on assessments of the pregnant mother and, after delivery, of the child.

March of Dimes

Baby & Me — Tobacco Free

Evidence shows that women who quit smoking are less likely to have premature and low-birth-weight babies. Recognizing the prevalence of low-birth-weight infants in Louisiana, ACLA partnered with the March of Dimes Louisiana Chapter, which awarded a grant to the Cancer Association of Greater New Orleans (CAGNO) and Family Roads of Greater Baton Rouge to implement the Baby & Me — Tobacco Free program in Louisiana. Baby & Me — Tobacco Free is an evidenced based smoking cessation program to help pregnant women quit smoking and remain smoke-free postpartum. The Bright Start team establishes a working rapport through direct contact with the program coordinator and refers members identified as smokers to the program. Bright Start also informs members about the program through personal contact and articles included in the Member Newsletter. Participants in the program meet monthly with a tobacco cessation counselor. Upon successful completion of the program and maintaining a smoke-free lifestyle, participants are eligible to receive free diaper vouchers at each visit for up to 12 months.

Healthy Babies are Worth the Wait

Because of the high rate of premature births in Louisiana, ACLA partnered with the March of Dimes Louisiana Chapter to support Healthy Babies are Worth the Wait, a campaign to reduce premature births. The primary message in this campaign is to raise awareness about the important development that occurs during the last weeks of pregnancy. The program urges expectant mothers to do everything they can to carry their babies through at least 39 weeks to ensure full development.

Back-to-School and Safety Events

ACLA is involved in helping families, including our youngest members; achieve health and overall literacy by sponsoring and participating in back-to-school events in the community. We are present at these events to provide information and promotional items and answer questions. Some of these events include health screenings such as blood pressure, BMI, glucose, and immunizations. Events we have participated in include:

- Sci-Port, Shreveport;
- Capitol City Family Health Center, Baton Rouge;
- Southeast Community Health Centers (Tangipahoa, Livingston and St. Helena Parishes - Northshore);
- Gardere Initiative, Baton Rouge;
- Back-to-School Rally, New Orleans; and
- Back-to-School Event, Alexandria.

ACLA also promotes safety through events held in partnership with community organizations. For example, we sponsored the Baton Rouge Summer Safety Fun Day with BREC (Baton Rouge Recreation Department), in which the American Red Cross also participated. Activities included health and dental screenings, swimming safety information, and safety information for hurricane preparedness. At the Summer Health Expo in Houma, we distributed educational information and sponsored blood pressure, BMI, dental, and glucose screenings.

ACLA understands the influence that public officials can have in modeling behavior and reaching out to the community. For this reason, we join forces with government representatives in reaching members with both health literacy information and tangible resources. To that end, we partnered with Senate President Pro Tempore Sharon Weston Broome and Representative Regina Barrow at the 15th Annual School Supply Give-a-Way. Our Community Health Educators staffed an informational table and donated 300 backpacks to needy students in the community. We formed a similar partnership with Representative Ted James, providing information and donating backpacks at the Keep Kids First 3rd Annual Back-to-School Bash that he sponsored. We also sponsored House Speaker Chuck Kleckley's 2014 Health Fair at the Capitol. ACLA was present to distribute wellness information to members of the public visiting the Louisiana State Capitol.

Safe Playground Build Program

ACLA is committed to promoting health by encouraging physical activity. When children understand and adopt the importance of healthy activity, they bring this behavior to their families and help to promote a lifestyle of wellness. Unfortunately not all children have access to safe play areas. Accordingly, ACLA, in alliance with our parent organization and other community partners, has brought safe playgrounds to areas most in need in Louisiana. Safe playgrounds help promote healthy lifestyles by decreasing childhood obesity and preventing injuries that can result from obsolete or dangerous equipment. The Safe Playground Build program brings community members and ACLA employees together to build a new playground structure from the ground up, paint murals, and clean the surrounding areas—all

in one day. Professional contractors are on hand during the day to supervise construction. In October 2012, ACLA completed a Safe Playground build at Pierre Capdau Charter School in New Orleans. The project included building a playground, a children's outdoor fitness center, and two basketball courts, as well as incorporating a beautification program. ACLA completed another Safe Playground Build in October 2013 at Park Elementary School in Baton Rouge. ACLA plans to continue this program in Louisiana elementary schools with a 90–100% poverty rate in need of a playground. The next site for a Safe Playground Build is Queensborough Elementary in Shreveport, scheduled for November 2014.

Exhibit K.2-3: Playground Build at Pierre Capdau School in New Orleans

Exhibit K.2-4: Playground Build at Park Elementary School in Baton Rouge

Health Ministry Program

Through ACFC, ACLA offers the Health Ministry Program in Louisiana, which is a faith-based program that educates participants on important health topics, including breast cancer, diabetes, obesity, stroke and hypertension, medication adherence, heart disease awareness and prevention, stress, depression, and emotional and mental well-being. Offered through collaboration with church and ministry leadership of all faiths and denominations, the programs take place in local churches, synagogues, and mosques.

Because diabetes is a prevalent health issue in Louisiana, ACLA has made diabetes education the focus of our Health Ministry events. ACLA hosted a Health Ministry event that was a diabetic outreach day at Household of Faith in New Orleans in November 2012. ACLA members, as well as the community at large, attended the event. Glucose screenings were available, and a chef prepared gumbo in a healthy cooking demonstration. Diabetes educators were on hand to present on topics including diabetes prevention, healthy eating, being active, monitoring diabetes, taking medication appropriately, healthy coping, and individualized strategies for health.

ACLA also held a Diabetes Boot Camp in Baton Rouge in September 2013 as part of the Health Ministry Program. A team of diabetes educators presented strategies for fighting diabetes based on curriculum approved by the American Association of Diabetes Educators. Members could visit different stations to receive information including diabetes overview, healthy eating, benefits of exercise, monitoring blood glucose, medication adherence, and reducing risks. Attendees also received free A1C screenings, learned healthy cooking techniques, and participated in a line-dancing class. To continue this important educational outreach, we are currently confirming diabetes education classes to take place in New Orleans, Shreveport, and Lake Charles.

Member Advisory Council

The ACLA Member Advisory Council (MAC) provides a regional forum for members, advocacy groups, and providers to deliver input on ACLA programs and policies and to participate in the development of new programs. The MAC promotes collaborative efforts to enhance the service delivery system in local communities while maintaining member focus. Council members include representatives from local school districts, recreation departments, coalitions, and members. Meetings of the MAC take place in Shreveport, Alexandria, and Baton Rouge on a quarterly basis to foster relationships with, and solicit input from, community representatives and advocates. These meetings give ACLA the opportunity to receive community and member feedback regarding ACLA initiatives, activities, and programs. For example, after sharing information about our breastfeeding initiative, we learned about several community breastfeeding organizations, with whom we formed partnerships to further our mutual goals. As a result of this collaboration, we became the first Bayou Health Plan to partner with the Mary Amelia Douglas-Whited Community Women's Health Education Center. Additionally, we requested feedback from another MAC meeting regarding the discussion of communication methods for relaying information to our members. As a result, ACLA revised the 2014 Member Satisfaction survey to include a question regarding member's preferred methods of receiving information. Options included text messages, emails, and phone calls.

Culturally Appropriate Messaging

ACLA is committed to delivering care that respects the needs of each member and eliminates disparities in health care and outcomes caused by race, ethnicity, or income status. We dedicate our resources to close care gaps, reach the underserved, support growth in the community, and empower individuals and their families to achieve better health.

Culture in general impacts a person's approach to health. It is no different for our members, with often added burdens of social factors that impact decision-making and access. Care Management assesses ethnicity as well as preferred language, and utilizes certified health translators when communicating with members who speak different languages in order to meet their needs. ACLA also takes steps to ensure that the information we distribute and activities we sponsor and participate in are culturally appropriate for our members. ACLA connects

members with providers that are culturally and linguistically sensitive to their needs, enabling members to communicate and relate more easily as they discuss health concerns and goals.

In addition, we use principles of health literacy and adhere to DHH's requirements for grade levels, use of white space, simplified terminology, appropriate sentence structure, and use of familiar language. Our materials are produced in several languages, including Spanish, Vietnamese, and others as requested by members. We increase the relevance of our material by including items such as interesting graphics and healthy recipes.

ACLA sponsors multicultural events and maintains a presence in the community. Some recent events in which we have participated through sponsorship and distributing information and promotional items include:

Event	Partner	Location
Cinco de Mayo Event	BREC (Baton Rouge Recreation Department)	Baton Rouge
Que Pasa Festival	Cervantes Fundacion Hispanoamericana	New Orleans
Health Fair	Mary Queen of Vietnam Church	New Orleans
Dia de la Familia	Children's Coalition of NE LA	Monroe

Exhibit K.2-5: ACLA-sponsored Multicultural Events

Multicultural Health Care Distinction

The National Committee for Quality Assurance (NCQA) Multicultural Health Care initiative, offers a Multicultural Health Care Distinction. Three AmeriHealth Caritas plans have earned this honor. ACLA is evaluating opportunities to apply for this distinction in 2016. This initiative provides a path for health plans to monitor and improve linguistically and culturally appropriate services and reduce disparities in health care and health outcomes. The review examines the following areas:

- Practitioner network cultural responsiveness;
- Reducing health care disparities;
- Race/ethnicity and language data collection;
- Culturally and linguistically appropriate services and programs; and
- Access and availability of language services.

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Medicaid Managed Care *Works*

An angel in Baton Rouge

July, 2012. Karen Thompson was at her job at the local home store when she noticed a lump on the roof of her mouth. Her job did not provide health insurance, but she sought help from the only doctor in her small parish.

The doctor sent her for a consultation with doctors at Louisiana State University in Shreveport. A biopsy confirmed the worst: oral cancer. The tumor needed to be removed.

Karen adds,"I wasn't one to sit and cry. I just wanted to schedule the surgery and get on with it. I wanted to get back to work."

After a 12-hour operation, Karen gradually awoke to a new reality: over the next six months, she would undergo both chemotherapy and radiation. The treatment grew so taxing that Karen had to leave her job and seek Medicaid coverage. She joined AmeriHealth Caritas Louisiana in February 2013.

The surgery left Karen struggling with a quarter-sized hole in the roof of her mouth. For months she had been receiving nutrition through a feeding tube in her stomach. She couldn't eat solid food without gagging or aspirating food through the hole. One bad episode sent her to the emergency room.

Kevin Brown, nurse care manager for AmeriHealth's Rapid Response team, remembers learning all Karen had endured."Karen was referred to us by our Government Relations Department, after she reached out to Louisiana State Senator Neil Riser,"Kevin explains.

"Karen couldn't find an oral surgeon who would build an appliance to block the hole for less than $7,000,"Kevin says."She was down from a healthy 135 pounds to just about 100 after treatment. She couldn't eat any solids."

Karen remembers, "The very next morning I got a call from Kevin at AmeriHealth Caritas Louisiana, saying he had an appointment for me with a dentist in Baton Rouge. How wonderful is that?"

Kevin, along with AmeriHealth's team of care connectors and provider network specialists, continued working behind the scenes with Oral-Maxillofacial Surgeon Dr. Michael J. Maginnis to ensure that Karen's medical records and other arrangements would be handled. Over the next several weeks, Dr. Maginnis was able to fit Karen with a custom dental appliance. "

State Health Care Solutions:

- ✓ **Innovative**
- ✓ **Quality-driven**
- ✓ **Cost-effective**

AmeriHealth Caritas Louisiana is part of a family of companies currently providing health care benefits for almost five million members in 15 states and the District of Columbia who are covered by Medicaid, Medicare and CHIP programs.

"The very next morning I got a call from Kevin at AmeriHealth Caritas Louisiana, saying he had an appointment for me with a dentist in Baton Rouge. How wonderful is that?"

"We also learned that Karen had been driving more than 100 miles to her oncologist and radiologist appointments," Kevin says. "The trips to her oral surgeon's office were 160 miles one way. When I told her about our mileage reimbursement program, she was so relieved. The reimbursement actually allowed her to buy a much needed set of tires for her car."

Karen says, "Kevin is just so precious. He called me numerous days and I could talk to him just like a best friend—very caring, very sympathetic."

Karen called Kevin the day she got the appliance. "I hadn't had solid food in almost a year, and I just had to tell him I stopped on the way home and got a juicy hamburger. I sunk my teeth into it. And the tears streamed down my face while I sat in my car and ate the whole thing," Karen remembers.

"The people around me must have wondered what was wrong, but I didn't care. It tasted so good."

Since that time, Karen's oncologist is thrilled with her weight gain of more than 20 pounds. "I'm out power walking five miles every day. And I'm looking for a job now that I'm healthy again. I want to be able to help people like Kevin helped me."

"Karen is exactly the kind of person that Medicaid coverage really helps," says Kevin. She's worked all her life, raised three kids and put a daughter through college, and the young lady just landed a great job. It wasn't until Karen's health reached a crisis point that she needed assistance.

"It takes all of the AmeriHealth Caritas Louisiana team to chip away at the barriers our members face to make real progress," Kevin continues. "It's situations like this that remind us how all of our individual efforts come together to help make a difference in our members' lives," Kevin adds.

Karen calls it a miracle. "All these months I just assumed the prosthesis would never happen, but I prayed. The next morning, the call came from Kevin and AmeriHealth Caritas.

"I've got an angel in Baton Rouge."

Member Karen White says, "I want to be able to help people like AmeriHealth Caritas helped me."

www.amerihealthcaritasla.com

AmeriHealth Caritas Louisiana

L.1. Member Transition

L.1 Describe how you will coordinate transition of a member in the following scenarios to minimize member disruption and ensure continuity of care:

- *From one managed care entity to another (receiving and relinquishing a member); and*
- *Between fee-or-service to/from your MCO.*

Your processes should address interactions with and processes for engaging existing providers in the transition.

Overview

Transitions in care, whether they are between managed care organizations (MCOs), Medicaid programs, or even providers, have the potential to disrupt the services needed to optimize members' care plans and reduce member engagement. AmeriHealth Caritas Louisiana (ACLA) understands the important role our Care Management teams, Member Services representatives, and UM (UM) associates play in assisting members through the process and ensuring there is continuity of care.

For members transitioning into our plan, ACLA will carefully coordinate their care to support continuity and prevent disruption. Medically necessary services indicated in the member's care plan are continued throughout the transition period, and do not require prior authorization. Existing providers are allowed to continue service delivery throughout the transition period, regardless of whether they are contracted in ACLA's network. We honor any open service authorizations, which may be received from the state or from the relinquishing plan. Transitioning members also go through the welcome process, which is designed to help ACLA fully understand their ongoing and unmet needs.

ACLA recognizes that members who are pregnant, are in the hospital, have special health care needs, or are using durable medical equipment (DME) at the time of transition face higher risks while transitioning between MCOs or Medicaid programs. The transition period for these members includes additional coordination activities, and may include longer care continuation allowances.

When members transition out of our plan, ACLA assists the new MCO or fee-for-service representative in coordinating the member's care by forwarding, upon request, a copy of the member's records. This request is completed timely to support continuity in care. For members with open authorizations, special health needs, or who are admitted at the time of transition, ACLA proactively alerts the new MCO about the member's ongoing health needs to facilitate continuity of care.

ACLA's Care Management teams, Member Services representatives, and Utilization Management (UM) associates are dedicated to providing a high degree of care coordination to preserve continuity of care. This care coordination is available to members who are joining the plan, leaving the plan, or transitioning between providers or care settings within the plan.

Coordinating Member Transitions Into and Out of the Plan

Whether members are transitioning between MCOs or between the managed care and fee-for-service Medicaid programs, ACLA has the same goal: support members and ensure they receive the care they need. When receiving members, we do this by first identifying their health and coordination needs, understanding what has already been done to address those needs, coordinating the transition with the relinquishing health plan and/or service providers, and then ensuring that their known needs will continue being met and coordinating with members and providers to address any newly identified needs. When relinquishing members, ACLA assists the receiving entity in understanding member needs by sharing member-approved care data, including open authorizations and utilization history, with special consideration for members with open authorizations, special health needs, or who are admitted at the time of transition. ACLA continues to provide services to members until they are officially disenrolled from the plan.

Receiving New Members

ACLA learns of new members joining the plan through daily ASC X12N 834 Benefit Enrollment and Maintenance transactions sent by DHH's Enrollment Broker, as well as the Monthly Eligibility File, which contains the most current record for each recipient and their initial enrollment date information. ACLA also receives information on prior utilization through the Enrollment Broker report. Authorization data is received from the relinquishing health plans.

Using this information, ACLA's UM team reviews open authorizations and, if the member's records have not already been received, requests additional information from the relinquishing plans or program staff using the standard request form. Our UM team ensures that the received authorization data—including services approved, authorized date span or visit quantity, and facility/provider names, addresses, phone and fax numbers—is entered in our, our core clinical care management platform, ZeOmega Jiva.

Authorization data is automatically shared between Jiva and TriZetto Facets, our core claims administration platform, on a daily basis. By receiving and entering authorization data in a timely manner, ACLA ensures that claims submitted for previously authorized services are not denied.

ACLA honors authorizations approved by the relinquishing plan, and does not require additional prior authorizations during the transition period. The UM team contacts the member's primary care provider (PCP), or other providers as appropriate, to verify the member's health status and the need for continuation of services and facilitate arrangements to continue the care. Previous treatment plans remain in place for up to 90 days unless revised by a member and his or her PCP. This includes medication regimens. ACLA provides continued access to maintenance medications, antidepressants, antipsychotics, and other drugs that are not on our formulary or preferred drug list throughout the transition period.

Maintaining Provider Relationships

ACLA recognizes that maintaining provider relationships can be critical to continuity of care. During the transition period, our UM or Rapid Response team coordinates with members and their providers if, at the time of enrollment, they are participating in a previously authorized, ongoing course of treatment. This includes coordinating with out-of-network providers. As needed, our network management team will negotiate a single-case contract for continuing care with a non-participating provider.

During the new member welcome process, all new members are provided with information about ACLA, service information, emergency numbers, and instructions on who to contact to ensure that ongoing medically necessary covered services are continued.

Timeframes

The table below outlines the standard timeframes used when continuing and issuing new authorizations for ongoing services for members who are new to ACLA. Cases requiring ongoing approval beyond those outlined in the table are reviewed by an ACLA medical director.

Action	Timeframe
Continuation of services for chronic and acute medical conditions or behavioral health conditions when the member's current provider has terminated participation with the MCO	90 calendar days or until the member is reasonably transferred without interruption of care, whichever is less
Continuation of medically necessary covered services in addition to, or other than, prenatal services	90 calendar days or until the member may be reasonably transferred without disruption, whichever is less
Prior authorization for continuation of medically necessary covered services, without regard to provider's network status, after transition period	After 30 calendar days
Continuation of medically necessary covered prenatal care for members in first trimester of pregnancy, without any form of prior approval and without regard to provider's network status	Until member can be reasonably transferred to a contract provider without impeding service delivery
Continuation of medically necessary covered prenatal care by established prenatal provider for members in the second or third trimester of pregnancy	60 days post-partum or until member becomes ineligible for Medicaid, whichever is less
Continuation of medically necessary covered services for Medicaid or CHIP members with special health needs	90 calendar days or until the member may be reasonably transferred without disruption, whichever is less
Continuation of maintenance medications	At least 60 days after enrollment
Continuation of antidepressants and antipsychotics	At least 60 days after enrollment

Action	Timeframe
Continuation of medically necessary prescription drugs not on ACLA's formulary or preferred drug list	At least 60 days after enrollment
Continuation of medication prescribed while admitted in a state mental health treatment facility	At least 60 days after facility discharge, unless MCO's psychiatrist and facility's prescribing physician agree otherwise
Continuation of covered and/or previously authorized services for durable medical equipment, prosthetics, orthotics, and certain supplies	90 calendar days or until the member may be reasonably transferred without disruption, whichever is less
Forward a copy of member medical record and supporting documentation to receiving MCO's PCP	Within 10 business days of new PCP's request

Exhibit L.1-1: Timeframes for Continuation of Authorized Benefits Post-Transition

Continuity of Care for Pregnant Women

ACLA ensures that members who are pregnant have access to medically necessary covered prenatal services, delivery, and post-natal care while transitioning into the plan, without requiring additional prior authorizations. Care delivered by non-participating providers is covered until they are transitioned to a network provider (members in their first trimester), until 60 days post-partum (members in their second or third trimester), or until they become ineligible for Medicaid. ACLA Bright Start maternity staff will work with the member to assist with the transition to an in network provider if they are in their first trimester, and will reach out to the non-par provider to ensure the obstetrical needs assessment form (ONAF) is completed in order to obtain all pertinent pregnancy information for the member. This will also assist in ensuring that all pregnancy services by the out of network provider is covered and claims paid.

Once a pregnant member is identified, she is invited to participate in ACLA's Bright Start maternity management program, which provides care coordination for and member education about all components of perinatal care, including prenatal, neonatal, and post-partum services. Members with high-risk pregnancies receive intensive case management services. Bright Start associates are responsible for ensuring pregnant members can access the prenatal services they need to have the healthiest pregnancy possible and get the best care for their newborns.

Continuity of Care for Inpatient Members

For members who are in the hospital on their enrollment start date, a UM associate coordinates with the facility's Care Manager or discharge planners to facilitate discharge plans and identify the member's discharge needs. In some cases, for members in targeted populations, an ACLA Care Manager contacts the member to collect information on the member's living situation, contact information and available discharge supports. ACLA recognizes that the plan is responsible for any care the member receives that is not related to the hospitalization but is provided while the member is hospitalized. The UM department will provide the facility an

inpatient authorization to cover the ancillary and professional charges related to the inpatient stay. This authorization will be provided back to the date of the member's eligibility with the plan.

As discharge nears, an ACLA UM associate assists with authorizations or arrangements for follow-up care. Once the member is discharged, our care management team works with the member to complete a New Member Assessment and refer to a Care Manager depending on the member's transition and ongoing needs. If opened to case management, the Care Manager will complete a more detailed assessment, care plan with priority goals and ensure appropriate specialist and PCP follow-up is received.

Continuity of Care for Members with Special Health Needs

ACLA gives special consideration to members with significant health conditions, recent or upcoming surgeries, and chronic conditions that require ongoing monitoring. Previously authorized medically necessary services are provided for up to 90 days or until the member may be reasonably transferred without disruption. and the care plan has been developed and approved. Utilization review nurses will refer these members to the care management team for further follow up and coordination.

After identifying these members either from the relinquishing MCO, DHH prior authorization file, or UM referral, an ACLA Rapid Response associate or Care Manager will contact the member to perform an initial health risk assessment. If the assessment results indicate that the member would benefit from case management, the member is invited to participate in ACLA's Integrated Care Management (ICM) program.

ACLA sees every member encounter as an opportunity to assess for any indication of needed services. All departments—including Member Services, Rapid Response, Care Management, and UM—are encouraged to refer members to ACLA's ICM program.

After an ICM Nurse Care Manager completes a comprehensive clinical assessment, he or she collaborates with the member, the PCP, and any specialists treating the member to establish an individualized plan of care, which typically includes regular monitoring, member education, and coordination of needed services.

Continuity of Care for Member Receiving DME Services

Authorizations for members provided with or approved for durable medical equipment, prosthetics, orthotics, and certain supplies by another MCO or other Medicaid program are continued without need for additional approval for up to 90 days. ACLA works with members and their providers to ensure DME services meet medical necessity criteria and plan requirements. The UM department will contact the provider, in network or out of network, to ensure that services are not interrupted and authorization is entered in the system to facilitate this transition. If services are going to be needed past the 90 days, and being provided by an out of network provider, the UM review nurse will work to identify an in network provider and facilitate the

transfer of services if appropriate. The UM review nurse will also notify Provider Network Management if the out of network provider would like to start contracting with the plan. If so, the services would not be transferred to an in-network provider at that time.

Continuity of Pharmacological Care

ACLA has detailed processes and systems in place to provide members with continued access to maintenance medications, antidepressants, antipsychotics, and other drugs that are not on our formulary or preferred drug list for at least 60 days after they enroll in the plan, to prevent interruption to their medication regimens. During the transition period, care management and pharmacy benefit management associates work with the member and the prescribing practitioner to either transition the member to a formulary medication or secure ongoing approval for the non-preferred drug.

ACLA and PerformRx, our pharmacy benefits manager (PBM), are implementing an enhancement that provides new members with information about ACLA's pharmacy benefits, filling their existing prescriptions during the transition period, and steps they should take to either identify a covered alternative or continue with their existing prescription beyond the transition period.

Relinquishing Existing Members

ACLA continues to support members while they are transitioning out of the plan. After receiving notice from the enrollment broker or the new MCO that a member is transitioning out of the plan, ACLA's UM department reviews the member's authorization history and prepares the documentation to be sent. This includes:

- Services authorized.
- Authorized date span or visit quantity.
- Facility/provider names.
- Address, phone, and fax numbers.

All authorization information is sent via secure email to the new plan's point of contact. These medical records and supporting documentation are sent in a timely manner.

To promote continuity of care, ACLA's provider contracts include a provision requiring cooperation in the event the member transitions out of the plan. If the member transitions to a new MCO, the providers are to collaborate with the member and the new plan to support continuation of medically necessary services, including providing the member's medical record, during the transition period.

ACLA continues to provide members with medically necessary covered services, in accordance with their established treatment plans, up to the official date of disenrollment. If a member is hospitalized at the time of disenrollment, ACLA notifies the member's new MCO of that status, and continues to provide services related to the hospitalization until the member is discharged. As appropriate or requested, ACLA will collaborate with the new MCO and the member to plan the member's discharge.

Facilitating Transitions Between Providers

ACLA maintains as many provider relationships as possible. In instances where a member's treatment plan is managed by an out-of-network provider, ACLA may attempt to contract with the provider so that continuity may be preserved once the course of treatment is completed. If that is not possible for whatever reason, an ACLA Care Manager will work with the member and the existing provider to identify a point in time when the member's care can be transitioned to a network provider.

Continuation of care is provided for members with open active treatment plans if a provider managing their care is terminated from the network (either by ACLA or of their own volition unless termination is for quality or exclusion reasons). ACLA will actively work with members to identify acceptable alternative participating providers to transition their care. As part of continuity planning, members with open treatment plans may continue to receive services with the exiting provider (with exiting provider agreement) until such time as treatment is completed or 90 days whichever comes first.

ACLA may authorize ongoing care from non-participating providers, beyond the end date of the previous authorization or the continuity of care period, if there is not sufficient expertise or access within the regional network to provide appropriate care to the member. In those situations, a single case contract may be negotiated, documenting the approved services, duration, and payment in writing.

Member Snapshot: ACLA's Member Clinical Summary

ACLA enables network providers to quickly and easily review member history, and needs, facilitating the member's transition between providers and supporting continuity of care. ACLA's Member Clinical Summary provides a snapshot of the member's recent prescription history, chronic conditions, inpatient admissions, emergency room visits, and office visits. The Member Clinical Summary also includes the member's demographic information, open authorizations, and identified gaps in care. The summary is reflective of plan data and Fee For Service data that was received by the plan at the time of the member's enrollment. This clinical summary can be printed and sent to the receiving MCO or DHH care management department to allow for additional coordination of the member's needs upon entry into the new MCO.

The summary is accessible through ACLA's NaviNet Provider Portal which also enables providers to build customized reports from the member information stored in our core claims administration and clinical care management platforms. The Member Clinical Summary, and the other available or customized reports, can be printed or downloaded in CCD or Excel CSV formats, which can then be uploaded into providers' electronic health record (EHR) systems.

To protect member privacy, the Member Clinical Summary is automatically filtered to redact member information about HIV-related information as well as behavioral health (mental health and substance abuse) diagnoses and medications.

AmeriHealth Caritas Louisiana

Member Clinical Summary

Date of Report: 09/09/2014

Member Information

Name :
Address1 :
Address2 :
City/St/Zip :
Phone :
Gender : F
DOB :
Member ID :

PCP Information

Provider Name :
Address1 :
Address2 :
City/St/Zip :
Phone :

Medications (within past 06 months)

Fill Date	Name & Strength	Days Supply	Prescriber Name	Pharmacy Name
8/20/2014				

Chronic Conditions

There are no data records available for this section

Gaps in Care

Condition	Service	Status	Last Service	Next Service	Rule
EPSDT	Annual Hearing Test	Overdue	12/07/2012		At least once per year

ER Visits (within past 06 months)

Date	Facility	Reason

There are no data records available for this section

Inpatient Admissions (within past 06 months)

From Date	To Date	Facility	Reason

There are no data records available for this section

Office Visits (within past 06 months)

Date	Provider Name	Speciality	Reason
08/22/2014			

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

EPSDT Screening Services within the past 24 months

Date	Service	Age (Yrs)
7/31/2014		12Y
3/9/2012 1		12Y
3/9/2012 1		12Y
12/7/2012		12Y

Additional Vaccinations

Date	Service	Age (Yrs)
7/31/2014		12Y
2/4/2014 1		12Y
2/4/2014 1		12Y

Exhibit L.1-2: Supporting Continuity of Care through the Member Clinical Summary

ACLA's Commitment to Meeting Member Health Needs

As a member-focused MCO, ACLA is dedicated to identifying and fully understanding our members' initial, ongoing, and/or unmet health needs. From there, associates in our Care Management, UM, Rapid Response, and Member Services departments work with members and providers to ensure those health needs are met. This includes:

- Referring and providing scheduling assistance for members in need of specialty health care, transportation, or other service supports.
- Monitoring members with complex health conditions or comorbidities to identify gaps in care and evaluate treatment adherence/progress.
- Collaborating with members, facility staff, and providers to plan discharges and other transitions in care so that appropriate steps are taken to safeguard members' health and quality of life.

As members transition into our plan, ACLA works with each new member to collect information on their existing health needs, care plans, and service providers. This is primarily accomplished through the new member welcome process, which includes welcome calls, a welcome packet, and a New Member Assessment. Through these activities, ACLA can identify and provide the medically necessary covered services that the transitioning member will need, as well as what internal resources—such as intensive case management, maternity management, or disease management (e.g., asthma, sickle cell disease)—can support the member's continuity and ongoing management of care.

Sharing Information through the New Member Welcome Process

ACLA welcomes new members to our program through our welcome packets, welcome calls, and the Member Handbook. These materials are designed to inform members about the MCO and service information, emergency numbers, and instructions on how to obtain services.

Continuity of care provisions for ongoing courses of treatment are detailed in the Member Handbook. ACLA encourages the members to let us know—either on the call or through our New Member Assessment—if they have special health needs or are receiving ongoing care. These members are referred to ACLA's Rapid Response team to ensure appropriate care coordination and care management services are offered to the member to prevent service disruption.

Encouraging Member Engagement through the Welcome Packet

ACLA sends welcome packets that include a welcome letter, a Notice of Privacy Practices, the Member Handbook, and a copy of the New Member Assessment. The welcome letter informs members that they will be receiving a call from the plan, but encourages them to reach out to Member Services if they have any questions before then. The letter also includes a brief checklist that encourages members to:

- Read the Member Handbook.
- Select a network PCP if they haven't already.
- Schedule an appointment with their PCP within 90 days of enrolling in the plan.

Welcome packets are available in English, Spanish, and Vietnamese to ensure the majority of members can access the information. Through our translation vendor, ACLA can provide all member materials more than 200 additional languages—including French, Arabic, Nepali, and Burmese—upon request.

The Member Handbook included in the welcome packet details key information about ACLA, the Bayou Health program, covered services, and member rights and responsibility. This includes members' right to choose and their PCP, as well as a description of how to do so. Instructions on how to access care, prior authorization requirements, and advance directives are discussed, and a description of what constitutes fraud, waste, and abuse is also included. ACLA's care management programs are discussed, and encourage members to call the appropriate department for more information.

Introducing the Plan through the Welcome Call

The first interpersonal contact most members have with ACLA is the welcome call—for members transitioning from fee-for-service, the welcome call may be their first interaction with a managed care plan. After welcoming the member to the plan, a brief explanation of the program and a confidentiality statement is provided. Covered services, including the availability of interpretation and translation services, are discussed in a friendly and engaging manner.

The Member Services representative provides information about continuation of services through the transition period, and provides key contact information, such as Member Services, Rapid Response, and emergency numbers. The Member Services representative also asks questions to identify any current or ongoing health needs the member may have—including chronic conditions, special health needs, and/or pregnancy. These needs are communicated to ACLA's Integrated Care Management and/or Bright Start maternity management teams for further health assessment and care coordination.

Identifying Member Needs through the New Member Assessment

ACLA considers the New Member Assessment a critical component of fully understanding members' health needs. Data collected through the assessment enables us to triage members into appropriate components of our Integrated Care Management program. The assessment asks members to identify the services—both medically necessary and non-medical—they are receiving as well as their current providers. By capturing this information before claims data or data from the relinquishing health plan/program is received, ACLA can begin coordinating care immediately for members whose health needs are time sensitive.

For members with special health needs, accessing the care they need may rely on specialized transportation services. Identifying these members as soon as possible may help prevent disruption in care by transitioning them to ACLA's non-emergency medical transportation vendor.

Due to the critical role it plays in care coordination during the transition period, ACLA uses a number of outreach methods to connect with members and complete the New Member

Assessment. A hardcopy of the New Member Assessment is included in the welcome packet, and Member Services representatives can walk through the assessment with the member during the welcome call. Members may also fill out the assessment electronically through ACLA's secure member portal. Ongoing outreach attempts are made, even after the transition period, to engage members who do not have a completed assessment on record. For example, when members call the plan, their records are screened to identify whether they have completed the assessment; if they have not, they are encouraged to do so during the call.

Respecting Member Privacy while Transferring Medical Records

When ACLA forwards a copy of the member's medical records to the receiving health plan, we ensure that the member's privacy is protected consistent with federal and state confidentiality requirements, including protections in the Health Insurance Portability and Accountability Act (HIPAA) and 45 CFR Parts 160 and 164. ACLA maintains policies and procedures to ensure confidentiality is protected.

We understand that some protected health information is sensitive; therefore, ACLA reserves the right to deny access to sensitive information, such as information about sexually transmitted infections (STIs), HIV-related information, mental health records, substance abuse records, and/or genetic testing. Members (or their representatives) will be asked to sign and date a release form before ACLA releases these records to another party.

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L.2. Member Transition

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

- *Encourage Members who are expectant mothers to select an MCO and PCP for their newborns;*
- *Ensure that newborn notification information is submitted, either by you or the hospital, to DHH or its Agent within twenty-four (24) hours of the birth of the newborn; and*
- *Ensure that the birth is properly recorded in the Louisiana Electronic Event Registration System (LEERS).*

Overview

ACLA is committed to providing high-quality care to the mothers-to-be among our membership, and to their newborn babies after they are born. We invest in prenatal services and programs in order to reduce preterm birth rates and infant mortality, and normalize birth weights, among the members we serve. Additionally, we recognize that our outreach campaigns, programs, and connections to care are instrumental in fostering a culture of preventive care in Louisiana's newest citizens.

ACLA uses several strategies to encourage pregnant members to select a primary care provider (PCP) for their newborn, including member materials and member outreach. After identifying pregnant members, through self-reporting, provider reporting, or claims scraping, pregnant members are encouraged to join our Bright Start® program, which provides care coordination and guidance throughout the member's pregnancy. Both staff and member materials encourage mothers-to-be to select a pediatrician for their new arrival. ACLA will assist members with the PCP selection process, as requested; or, in the event that the mother does not select a PCP within 14 days after birth, ACLA will assign one using the DHH-approved algorithm.

To ensure that newborn members have access to medically necessary covered services, ACLA requires that our providers record births in the appropriate state systems. If the newborn is inadvertently enrolled in a Bayou Health plan different from the mother's, ACLA will work with DHH and the Enrollment Broker to enroll the newborn into our plan.

Identifying Members who are Pregnant

The first step in providing prenatal support and connecting newborns to doctors is identifying pregnant members. ACLA attempts to identify members as early in their pregnancy as possible through a variety of strategies. These include, but are not limited to, information from members' initial health assessments, referrals from internal ACLA Departments, self-reporting, and physician referrals. Bright Start associates also monitor reports that identify pregnant members through analysis of claims, labs, and eligibility files.

Members are encouraged throughout member materials, including the member handbook and member newsletters, to notify ACLA if they become pregnant. These same items also advertise our Bright Start program, and encourage interested members to reach out to the Bright Start team. Members are also encouraged to contact the plan through our community events and

community outreach activities, such as maternity tents at local health fairs and Community Baby Showers.

ACLA, in collaboration with key providers, conducts Community Baby Showers and Mommy Hours throughout Louisiana. Events have been held in Baton Rouge, New Orleans, and Shreveport.

It is important to remember to:

- Let AmeriHealth Caritas Louisiana and your health care providers know of any changes that may affect your membership, health care needs or benefits. Some examples include, but are not limited to, the following:
  - You are pregnant.
  - You have a new baby.
  - Your address or phone number changes.
  - You or one of your children has other health insurance.
  - You have a special medical condition.
  - You move out of the parish or state, including in response to a weather emergency or other disaster.

Exhibit L.2-1: Encouraging Self-Referral through the Member Handbook

We also encourage providers to alert ACLA if one of our members is pregnant. This is required by their contracts with ACLA and included in the Provider Handbook. Providers are also encouraged to directly refer members to the Bright Start program, and help their patients locate an appropriate maternity provider using ACLA's Provider Services contact center.

Giving Mothers and Babies a Bright Start

The primary purpose of the Bright Start program is to provide services that support and encourage pregnant members to have the healthiest pregnancy possible and get the best care for their newborns. Every newly identified pregnant member is sent a maternity outreach letter outlining the benefits of ACLA's Bright Start program, such as the resources available to them through the program—including care managers, assistance in selecting a doctor, and educational materials. The letter also provides information on WIC and other community, state, and federal programs, and includes a recommended prenatal appointment schedule.

Each member who agrees to participate in the Bright Start prenatal care program is monitored in accordance with their risk level. Low-risk members participating in Bright Start are provided with ongoing support throughout their pregnancy, while high-risk members are enrolled in case management and paired with an ACLA Bright Start care manager, who works closely with the member.

Each risk level is provided with pregnancy-related educational materials, and Bright Start staff contact pregnant members at least 60 calendar days prior to the projected delivery date to

reinforce healthy pregnancy guidelines for the last trimester, which includes encouraging them to select a PCP or pediatrician, as well as identify any barriers to care.

BRIGHTSTART

Give Your Child a **Bright Start**

The Bright Start℠ program helps you stay healthy when you are pregnant and helps you to have a healthy baby. The Bright Start program gives you information about the importance of:

- Taking your prenatal vitamins
- Eating right
- Staying away from drugs, alcohol, and smoking
- Visiting your dentist so you can keep your gums healthy

Women who are pregnant should see their dentist at least once during the pregnancy. A woman's gum health affects the health of her unborn baby. Women with gum disease can get an infection that can cause the baby to be born too early. A baby who is born too early is more likely to have health problems and disabilities that can last a lifetime. We will also work with your obstetrician and dentist to make sure you get the care you need. We have information to help with other services, like:

- Food and clothes
- Transportation
- Quitting smoking
- The WIC (Women, Infants, and Children) nutrition program
- Drug, alcohol, or mental health issues
- Domestic abuse
- Breast-feeding
- Home care
- Helping you understand your emotions

You may be eligible for home health care, special medical equipment, or transportation to office visits. Call us to find out more information. You can reach Bright Start toll free at **1-888-913-0327.**

It is important to choose a doctor for your baby before your baby is born. You will be asked about the baby's doctor at the hospital when you deliver. If your baby will be on LaCare and you need help choosing a doctor for your baby, please call Member Services at **1-888-756-0004.** If you are at risk for complications or have had a baby early, a LaCare care manager will help watch your pregnancy more closely by:

- Calling you monthly or more often, as needed
- Sending you written information about problems during pregnancy
- Giving you information to access health and wellness advice from a nurse 24 hours a day, 7 days a week

Healthy Now 6 Spring 2013

Member Services 1-888-756-0004
TTY 1-866-428-7588

Exhibit L.2-2: Encouraging Self-Referral through the Spring 2013 Member Newsletter

Encouraging Pediatrician Selection during Pre- and Post-Natal Care

We understand that selecting a pediatrician, or other appropriate PCP, for newborns is an important first step in cultivating preventive care values that improve health outcomes and manage costs. Through ongoing contact with members, the Bright Start staff will discuss the necessity and process for selecting a doctor for their newborn, as well as enrolling their newborn in the Louisiana Medicaid program. If the mother would like to choose a different MCO for her newborn after the birth, the Bright Start team will work with the mother to assist in contacting the Enrollment Broker to request the change.

The Bright Start team makes outreach calls to members right before their last trimester to ask if the member has chosen a PCP for the baby, and offer assistance if they need help making a selection. During the call, the Bright Start associate will also discuss what to do when they deliver.

Throughout their membership and their pregnancy, members receive materials prompting them to select a pediatrician before birth. These include newsletters, pamphlets, and letters that outline steps for a healthy pregnancy and support that is available to them through the plan and in their community. The post-partum letter that ACLA sends as soon as the delivery notification process is completed also offers mothers help to select a doctor for the newborn if necessary.

Important things to do before you leave the hospital

- **Call the Bright Start program to enroll your baby.** We need your baby's name to apply for Medicaid.
- Contact your Medicaid caseworker to complete enrollment for your baby.
- Make a follow-up appointment with your baby's doctor.
- Make an appointment with your OB doctor for your postpartum visit.
- Make an appointment with WIC (Women, Infants and Children).

Exhibit L.2-3: Encouraging Medicaid Enrollment in the Bright Start Pamphlet

At each contact with the Bright Start department, the member is reminded that a PCP/pediatrician needs to be chosen, if one has not been chosen already, for the newborn. The Bright Start staff will work with the member to facilitate this choice. Staff from the Bright Start program and Member Services provide guidance to members in choosing a pediatrician. Bright Start and Member Services will offer assistance as long as the member has not made a selection. ACLA also

encourages members to schedule a post-natal follow-up appointment with their chosen doctor, and will provide assistance, as needed, in scheduling and arranging transportation.

After Your Baby Is Born

You have already given your baby a bright start by using our prenatal (before birth) program. Now it is time to keep up the good work by making sure you offer your child the best postpartum (after birth) care possible.

LaCare would like to help you and your baby get off to a healthy start. After giving birth, it is important that you:

1. Contact Women, Infants, and Children (WIC) program. WIC is a program that will help you and your baby get food you may need. You can call WIC at 1-800-251-2229 and make an appointment or ask for assistance.

2. Call LaCare's Member Services department at **1-888-756-0004** to let them know the baby's name and the name of your baby's doctor. A Member Services representative can also help you choose a doctor for your baby.

3. After selecting a pediatrician (baby doctor) for your baby, call your baby's doctor and schedule an appointment for a well-baby checkup. It is recommended that this visit be scheduled between 2 and 4 weeks of age, unless the doctor recommends sooner. If you do not have a LaCare member ID card for your baby at the time of the first doctor visit, you can use your own LaCare member ID card for the baby's appointment.

It is also important to call your obstetrician and **schedule an appointment for your postpartum checkup.** This postpartum checkup should be done 21 to 56 days after delivery.

If you have any health questions, you can call LaCare's Maternity Management department at **1-888-913-0327.** After hours or on holidays and weekends, call LaCare's 24-hour Nurse Call Line at **1-888-632-0009.**

Don't Forget to Take Care of Yourself

Depression can affect your ability to take care of your baby. Signs of depression can be:

- Crying a lot
- Feeling sad, restless, irritable or overwhelmed
- Eating too much or too little
- Sleeping too much or too little
- Having trouble remembering
- Feeling afraid you may hurt yourself or your baby

If you have had any of these signs for 2 weeks or more, please call your doctor or the Bright Start number for help.

www.lacarelouisiana.com

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Exhibit L.2-4: Encouraging Post-Partum Care, Spring 2013 Member Newsletter

There may be instances when ACLA may not be aware that a member was pregnant until she presents for delivery. In these cases, ACLA recognizes that the pediatrician on call will provide services to the newborn following delivery. All newborn primary care services are reimbursed by ACLA without requiring prior authorization and regardless of the provider's participating status for 30 days following newborn birth.

If the member has not selected a PCP within 14 days after the birth, or by the time the newborn is enrolled in the plan through the 834 transaction file, whichever is more, ACLA will auto-assign a PCP for the newborn based on our standard policies and procedures and the DHH-approved auto-assignment algorithm. Members can call Member Services or Bright Start at any time to change their PCP.

Notifying DHH of Newborn Births

Hospital providers are on the front line of public health matters in the state. The use of electronic delivery records (EDR) facilitates the collection and transmission of valuable health data so that it may be analyzed for the benefit of public health. All participating network hospital providers are contractually obligated to report and properly record within 24 hours the births of newborns to enrolled members through DHH's Facility Notification System Newborn Manual and LEERS, the Louisiana Electronic Event Registration System. This requirement is outlined in the Provider Manual, and will be reinforced at hospital orientation and ongoing training programs.

> Hospitals must report the births of newborns within twenty-four (24) hours of birth for enrolled members using DHH's web-based Request for Newborn Manual system. If the mother has made a CCN and/or PCP selection, this information shall be reported. If no selection is made, the newborn will be automatically enrolled in the mother's CCN. Enrollment of newborns shall be retroactive to the date of the birth.
>
> Hospitals must also register all births through LEERS (Louisiana Electronic Event Registration System) administered by DHH/Vital Records Registry. LEERS information and training materials are available at: http://www.dhh.louisiana.gov/offices/page.asp?id=252&detail=9535

Exhibit L.2-5: Encouraging Provider Reporting of Newborns in the Provider Manual

ACLA monitors the inbound eligibility feed from the Enrollment Broker to ensure the newborn has been correctly enrolled through DHH's system. This also helps us monitor provider performance in reporting newborn births through the required systems. By cross-checking the eligibility feed against delivery admission claims, ACLA identifies which providers are out of compliance so that Provider Network Management representatives can address any problems.

This process also helps us identify whether a newborn may have been inadvertently enrolled in another MCO. If the newborn does not appear on the eligibility file after 30 days, ACLA will reach out to the Enrollment Broker and to DHH to follow up.

L.3. Member Transition

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

Overview

ACLA's frontline staff receive extensive training in customer service, member rights, CLAS standards, cultural awareness and sensitivity, serving members with limited English proficiency (LEP), and active listening. Our programs, training, and tools make certain that our staff treat members in a manner that recognizes their values, respects their worth as individuals, protects their dignity, and preserves their right to self-determination.

Since ACLA began operations in Louisiana, we have applied the programs and expertise that have made our parent company, the AmeriHealth Caritas Family of Companies (ACFC), a national leader in the delivery of Culturally and Linguistically Appropriate Services (CLAS). ACFC Medicaid plans represent three of the eight plans nationwide to receive NCQA's Multicultural Health Care Distinction.

ACLA is committed to treating members with respect and dignity. Our Member Services associates are expected to provide high-quality service without regard to race, color, national origin, age, religion, sex, gender, sexual orientation, disability, health status, or mental status. We strive to deliver care and coordination in culturally competent ways, including engaging members in preferred languages and with awareness of members' social and cultural preferences.

Applying this level of respect and understanding can often redirect disruptive, unruly, abusive, or uncooperative members to more positive outcomes. ACLA relies on frontline staff to identify the members who may benefit from a direct and hands-on approach to care. These members are paired with a care manager from our Integrated Care Management program, who serves as their single point of contact at the plan.

ACLA views member disenrollment as a measure of last resort. Instead, our care management team—in collaboration with PNM, UM, and ACLA's medical director—has worked with members to resolve their concerns and establish mutually agreeable treatment plans. To date, ACLA has not sought to disenroll any member of our plan.

Interventions for Challenging Members

To date, ACLA has not encountered a member that disrupted plan operations to the extent that disenrollment was appropriate. We believe this is because of the responsive, person-centered, culturally competent approach we use during all interactions with our members.

Some members do require direct, comprehensive management in order to ensure their health needs are met in a way that does not disrupt the plan's operations and that is not fraudulent or abusive. Members who are disruptive, unruly, abusive, or uncooperative present a multitude of

issues for the clinical and non-clinical staff with whom they interact. They often lack the internal and external resources to successfully negotiate the increasingly complex terrain of medical care in our society; additionally, some may have difficulty processing information; poor problem-solving or interpersonal skills; or a history of maladaptive, self-destructive responses to stress. These members often present with one or several of the following characteristics:

- They display angry, needy, blaming, manipulative, or self-destructive behavior that evokes anxiety, frustration, or anger in staff and caretakers.
- They have deficient problem-solving skills.
- They have difficulty accepting support and/or forming trusting, helping relationships, occasionally asking for assistance and then rejecting it.
- They do not or poorly adhere to treatment recommendations.
- They are incapable of realizing that their behaviors contribute to their difficulties.
- They develop severe anxiety, depression, or intractable physical complaints, often presenting with one issue after the next, including concurrent alcohol and drug abuse problems, or behavioral health issues.

When these members feel anxious, frightened, or worried, their feelings can come out as anger, intense dependency, neediness, avoidance, and/or anxiety. They tend to engage in non-productive, redundant efforts that do little or nothing to improve their situation, and often make it worse. They also tend to be chronically dissatisfied with care in any setting, and are extremely high utilizers of time, energy, and resources, which can exhaust the time, patience, and willingness of the caretakers, providers, and plan associates that try to help them.

ACLA identifies these challenging members based on the above stated triggers and behaviors. Our Integrated Care Management team then provides them with the structure and information needed to address their care, with the goal of significantly reducing engagement that yields little or no return. Only minor modifications in workflows and clinical approaches are necessary to implement this model modality.

Direct Intervention through Integrated Care Management

The first step in supporting one of these challenging members is identifying them. Member Services representatives are trained to refer members with unruly, disruptive, or abusive behavior to the Integrated Care Management team for outreach and intervention.

Referrals can come from many avenues, including our providers, other internal departments, or DHH.

Associates in our ICM programs and Contact Center directly intervene prior to seeking to disenroll a member as described in MCO Initiated Member Disenrollments. Since the implementation of Bayou Health, ACLA has not sought to disenroll any member for behavior-related issues. Reasonable measures will be used to work with the member to prevent advancement to MCO initiated disenrollment. This may include providing education and counseling from the care manager regarding offensive acts or behaviors, as this could impair the

member's ability to access care. Once the member has been identified from the referral source, the following approach is implemented with the agreement and understanding from the member:

- Management of the case will be confined to one care manager (contact person). With support of an integrated customer management and care management platform, all calls related to a specific member's case are directed to the single, assigned key point-of-contact.
- The care manager and the member agree to abide by pre-defined communication guidelines. For example,
    - All calls are responded to or returned within 24 hours by the assigned contact person.
    - No long (>1minute) voicemails from member.
    - Abusive language and tone are not appropriate and will not receive a response.
- The care manager provides reassurance that medical needs will be met and assists with coordination of care. An individualized care management plan will be created in collaboration with the member.
- The care manager will explore the feelings the member is experiencing regarding medical issues using motivational interviewing techniques to help them talk more directly and proactively about their concerns.
- The care manager will encourage the member to continue reaching out to them directly when they need assistance after the immediate issues have been resolved.
- Additional members of the Care Management team may be engaged to assist with suggestions on how to work with the member, i.e. plan medical director, behavioral health medical director, SMO, PCP, member's representative.

Through this structured approach, we aim to improve the treatment experience, efficiently utilize staff resources, and reduce conflict and unnecessary utilization of medical resources.

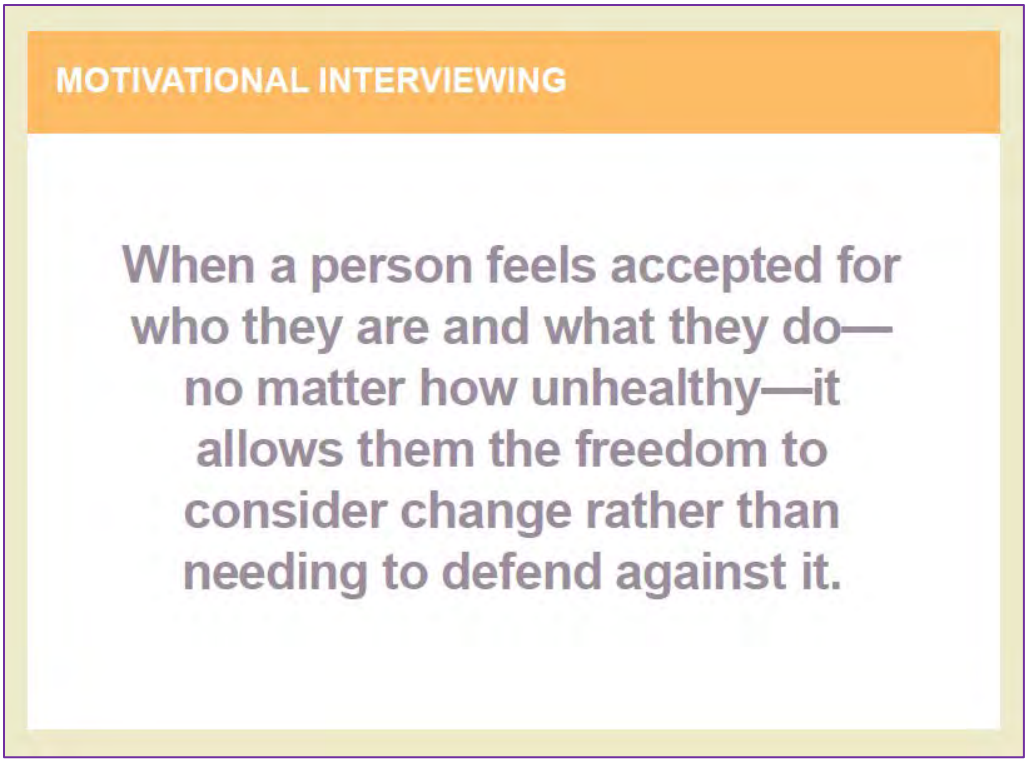

Exhibit L.3-1: Slide from Motivational Interviewing Training Given to ACLA Care Managers

Delivering In-Person Care

ACLA has developed Community Care Management Teams to connect members with the care they need. This team would be used, as needed, after the member worked with a care manager and agreed to work with this in-person team as part of the care management plan. Using the in-person team enables the care manager to develop a better "view" of the member's social situation, which may not have been evident or communicated over the phone.

Our Community Care Management teams are staffed by Community Care Connectors (CCC), who are hired from local communities and share the languages and life experiences of our members. Their primary goal is to engage members and help them navigate their complex and competing medical, behavioral, and social needs. This includes providing care coordination and helping members develop trusting relationships with local providers. The Community Care Management team works telephonically with ACLA's care managers to coordinate member care and provide feedback on successful implementation of care plan interventions. Because of their presence in and experience with their communities, our CCCs are uniquely positioned to engage members, serve as primary points of contact, and help members access the care they need.

Interventions for Members with Behavioral Health Conditions

ACLA recognizes that members may act in disruptive, unruly, abusive, or uncooperative ways due to behavioral health conditions. The Integrated Care Management team assesses the

member and works with him or her to identify any behavioral health conditions that may be causing the member's behavior or preventing consistent access to care.

If more specialized behavioral health interventions were needed, ACLA would—with the member's permission—initiate a referral to the Statewide Management Organization. An ACLA care manager would follow up with the SMO contact to document the ongoing behavioral health needs of the member, as well as any behavioral health specialist visits that the member attended.

ACLA will continue to work with the SMO on developing best practices for integrating basic behavioral health treatment and management in the PCP office visits, as well as co-managing members with severe mental illness.

Fraudulent Activity

All ACLA's associates are responsible for identifying suspected fraud, waste, and abuse (FWA) and referring them to our Special Investigation Unit (SIU) as part of their regular duties. SIU has a comprehensive plan for the prevention, detection, correction, and reporting of FWA across various categories of health care, including member fraud. The SIU conducts audits/investigations in response to referrals, which are an important method for monitoring and detecting potential FWA. Additionally, ACLA's frontline staff are trained in detecting member FWA during interactions with members, and are empowered to report suspected FWA through our Fraud Tip email box and/or our Internal Hotline.

When potential member fraud is uncovered by an ACLA associate, SIU informs and collaborates with DHH for further investigation into the matter. Members would be disenrolled only if convicted of fraud by the state. While ACLA has referred a member for further investigation, the member was not convicted of fraudulent behavior. To date, ACLA has not disenrolled a member based on fraudulent activity.

Supporting Member Rights and the Exercise Thereof

Members may behave disruptively or abusively if they feel they are not getting the care, support, or attention they believe their health concerns warrant. If a member feels that their rights have been violated, they have the right to file a formal complaint or grievance. ACLA gladly provides assistance to members through the entire complaint or grievance process, until the concern is resolved.

Associates who interact with members are trained in ACLA's complaint, grievance, and fair hearing processes, as well as when and how to assist members in using them. Having an official outlet, with defined steps, may help redirect member behaviors to be more constructive.

ACLA is dedicated to supporting member rights, believing that well-informed members are better able to participate in their own care and make educated judgments about the health choices available to them. We seek to inform members of their lawful rights through a variety of member materials, including the Member Handbook and Member Newsletters, as well as during Contact Center conversations.

MEMBER RIGHTS AND RESPONSIBILITIES

AmeriHealth Caritas Louisiana is committed to treating members with respect and dignity. AmeriHealth Caritas Louisiana, and its network of doctors and other providers of services, does not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation or any other basis prohibited by law. As a member, you have the following rights and responsibilities:

Exhibit L.3-2: Informing Members of their Rights and Responsibilities in the Member Handbook

LaCare Wants to Hear About Your Experience

We hope that you will always be satisfied with LaCare and our health care providers. If you have questions or concerns about your LaCare benefits or services, please call Member Services. Our Member Services representatives can help with most questions and concerns. If you still are not happy, you do have the right to file a grievance.

What is a grievance?

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

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

How do I file a grievance with LaCare?

A member grievance may be filed by a member, health care provider, or personal representative, either by a phone call or by mail, within 30 days from the action or occurrence. Call Member Services at **1-888-756-0004** or write a letter to:

LaCare
Member Services Supervisor
P.O. Box 7328
London, KY 40742

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

Exhibit L.3-3: Encouraging the Exercise of Member Rights, Winter 2013 Member Newsletter

Cultural Competency Principles and Awareness of Cultural Barriers

Members in the Medicaid population may face challenges in accessing needed services, communicating with providers and medical staff, and getting the care they need due to cultural barriers such as limited English proficiency (LEP), illiteracy, or different social norms. These can

make members seem disruptive, abusive, or uncooperative. ACLA's Care Management, Rapid Response, and Member Services teams are specifically trained to identify and address these cultural differences in order to mitigate the effects they have on the member's care.

Historically, training for frontline ACFC staff, including those dedicated to ACLA, have had training in CLAS standards, awareness of and sensitivity to varied cultural values and beliefs, understanding how culture affects communications, and serving members whose primary language is not English. This has included customer service skills such as active listening, call documentation, and verifying that members understand what was discussed before ending calls. In 2014, ACFC rolled out more comprehensive training modules on Health Equity, CLAS, and Cultural Health to educate our associates on the effects that health equity, health literacy, and health disparity may have on our members. The training also provides guidance on how to apply the knowledge during daily job performance.

We have also recently implemented spoken language assessments for our bilingual associates, to ensure that our staff can speak fluently with members who speak Spanish and Vietnamese . For members who speak other languages, our frontline staff are trained on identifying when to access the interpreter services offered through our subcontractor, Language Services Associates, to help facilitate care management and member services discussions.

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

Quý vị có thể có thông tin này bằng các ngôn ngữ và định dạng khác miễn phí. Quý vị cũng có thể có thông tin này thông dịch ra bất kỳ ngôn ngữ nào qua điện thoại. Xin gọi Dịch vụ Thành viên số **1-888-756-0004**.

Puede obtener esta información en otros idiomas y formatos sin costo. También se le puede interpretar esto por teléfono en cualquier idioma. Llame a Servicios al Miembro al **1-888-756-0004**.

Exhibit L.3-4: Alerting Members to Language Options, Summer 2014 Member Newsletter

Members with Sensory Impairments

ACLA's associates are also trained on using TTY (teletypewriter) and TDD (telecommunication device for the deaf) services to serve the hearing impaired. These services are at no cost to the member. For members who rely on American Sign Language, ACLA will arrange for face-to-face interpreters to go with members during office visits to help them communicate better with their physicians and providers. These services are provided at no cost to members.

If you are deaf or hard of hearing, our TTY number is **1-866-428-7588.**

You can also dial 711 Relay for TTY services, Internet relay services and video relay services. Charges for local and long-distance relay calls will be the same as your regular local and long-distance calling plan.

Exhibit L.3-5: Alerting Members to TTY Support through the Member Handbook

Compliance with Involuntary Disenrollment Requirements

ACLA will continue to treat involuntary disenrollment as a last resort. However, in the event that ACLA must resort to involuntarily disenrolling a member, we will comply with key contract requirements in doing so.

Notifying Member and Enrollment Broker of Disenrollment Request

We will provide written notice to the member that includes the reason(s) for the disenrollment request and specifies that the disenrollment request is for the following month. An ACLA care manager would complete the MCO Initiated Request for Member Disenrollment form, with the member's name and ID number, the detailed reason for the request, and the interventions attempted to resolve the conflict before submitting the request, which would then submitted to the Enrollment Broker. Copies of all disenrollment documentation would be stored in the member's record.

Ensuring Continuity of Care until Disenrollment

ACLA would continue to provide medically necessary covered services to the member, in accordance with their established treatment plan (if applicable) and standard policies, until the effective date of disenrollment specified by the Enrollment Broker. If the member is hospitalized at the time of disenrollment or has special health needs, ACLA will notify the member's new MCO of that status within five business days of the transition. Upon request, ACLA will work with the member's new MCO to transfer all appropriate member records in a timely manner.

M.1. EPSDT

M.1 Describe your system for tracking each member's screening, diagnosis, and treatment including, at a minimum, the components of the system, the key features of each component, the use of technology, and the data sources for populating the system.

Overview

ACLA's goal is to ensure that our youngest members have access to the right care at the right time. Assuring Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) compliance is an important part of improving health outcomes and supporting early childhood development. Our EPSDT care management system is developed to build trusting relationships between health professionals, the child and their family, and the community, as partners in building a healthy future.

Our EPSDT approach to coordinating care for our members is through our integrated information systems, which empower caregivers, members, and providers with access to information and ultimately, the ability to connect a member to the appropriate care. Our screening, diagnosis, and treatment tracking system enables our members to better adhere to the EPSDT periodicity schedule and other preventive care visits. Because we closely monitor each member's clinical history, we are able to intervene at earlier stages and more effectively target members who need assistance.

Below, please find an overview of our EPSDT information system technology model and how it supports the identification and tracking of EPSDT services and strategy for communicating missed services.

Components and Features of our EPSDT Tracking System

ACLA's Care Management System

If a gap in care is identified, ACLA staff receives alerts from the care management system, which also appear on the Member Services call screens notifying staff of gaps in care for a particular member. This allows ACLA employees to address and assist with coordination of missing and overdue services for members who contact ACLA for other reasons. For example, if a member calls the Member Services Contact Center to ask a question about a benefit, the member services representative will see on his/her computer screen that the member is missing a recommended EPSDT service. Before the end of the call, the customer service representative addresses the Care Gap using a pre-approved script and/or transfers the member to the Rapid Response team for assistance.

In addition, ACLA employees have the ability to access a "family link" in the system, allowing them to view missing services for other family members. This lets the employee remind and assist the member to coordinate care for other household members at the same time. Using this approach of "Making Every Member Contact Count" allows us to capitalize on each contact we

have with our members. Care Management, Utilization Management (UM), and Rapid Response members also have access to the EPSDT Clinical Summary for use in their interactions with the member/caregiver and treating providers.

Data Sources

The EPSDT tracking system begins with the data sources used to populate our HEDIS-certified software system, Inovalon. In order to screen and diagnose any gaps in care with our EPSDT eligible members, we load encounter data from Facets, eligibility, claims, pharmacy, lab, data warehouse, state agency supplied data and demographics data into the Inovalon system. Facets data is supplemented by data obtained from participating providers and the Louisiana Immunization Network for Kids Statewide (LINKS), which is received quarterly. The report can then be mapped to the data warehouse, where the member identification and condition is matched to each record.

Once the data is loaded and the member is assigned to specific conditions and/or measures, it is fed into the care management system, ZeOmega Jiva. From there, our care managers and member services associates are able to identify gaps in care and track if members are hitting their schedules, including well visits for the EPSDT-eligible population. ACLA uses:

- EPSDT Reports: The reports are pulled on a monthly basis and used to identify EPSDT care gaps, using information from Facets claims reports and DHH Claims Feed, obtained from the data warehouse. That information is used to determine if the member is compliant for the well-child periodicity appointment. These monthly reports use LINKS data that is loaded into our HEDIS repository.
- Interim Reports: Interim reports are also sent monthly to ACLA Quality Management and Provider Network staff. This report ensures that we are on target to meet our EPSDT quality measures. The reports include members who are non-compliant with appointments. Once the Rapid Response team reviews the reports, members are provided with reminders that an EPSDT service is due, via telephone outreach and materials sent to the home.

Data Validation

The data validation process is based on counts of records, missing member identification numbers, dates of service out of range, codes used, and tests populated. ACLA validates the members in the system by comparing the member IDs, names, and dates of birth to our data warehouse. We also ensure that all codes provided (procedure codes, diagnosis codes, etc.) are accurate. For standard quarterly/monthly files, the file volume is compared to previous months, and any significant changes in volume are noted and compared.

Provider and Member Use of Technology

Once our system, Inovalon, receives all data, it is disseminated using a variety of tools to our care management team, members, and providers to ensure that EPSDT services are being met.

Jiva

The data obtained from Inovalon and fed into the Jiva care management system can then be used when a member calls our Member Services or Rapid Response phone lines. Because member data is routinely updated, our care management staff is able to keep our youngest members on track with their EPSDT services. Exhibit M.1-1 is an example of a clinical summary that our internal staff is able to access to assist with keeping members on track with their well-visits.

INTERNAL USE ONLY

Please click on Filtered MCS for a copy that can be sent to external providers

Medical History Summary

Filtered MCS

Note: Information on this page is based on claim data.

Member Information

Member Name:
Date of Birth:
Gender:
Member Id:

Primary Doctor (PCP):
Address 1:
Address 2:
City, State, Zip:
Phone Number:

My Important Tests & Services (within the last 06 months)

Condition	Service	Status	Due by	Goal
EPSDT	Primary Care Visit 1 to 2 years	Up-to-date	05/15/2015	At least once per year
Preventive Health Screens	Lead Screening in Children	Due soon	04/2 /2015	Once
EPSDT	Well Child Visit 18 Months and Younger	Overdue		EPSDT Schedule

Medical Conditions

Condition
No chronic conditions were found

Medicine (within the last 06 months)

Date	Name & Dose	Supply	Prescribed By	Pharmacy
6/11/2014	CEFPROZIL 125 MG/5 ML SUSP	10	Brian Leblanc	POINTE COUPEE PHARMACY
6/11/2014	PREDNISOLONE 15 MG/5 ML SOLN	3	Brian Leblanc	POINTE COUPEE PHARMACY
5/15/2014	PREDNISOLONE 15 MG/5 ML SOLN	24	Jordan Whatley	LACOUR'S PHARMACY
5/15/2014	TRIAMCINOLONE 0.1% OINTMENT	14	Jordan Whatley	LACOUR'S PHARMACY

Ver: 5_2_5A

Powered by Jiva

Exhibit M.1-1: ACLA EPSDT Clinical Summary

Provider Portal

Providers are also able to make sure that their patients stay on track. Through the Provider Portal, NaviNet, providers who perform an eligibility check on a member through the portal receive an alert for any services that are missing or overdue. The provider can also access and print an EPSDT Clinical Summary that contains a log of all EPSDT screens and services performed by date. This allows the provider to adjust schedules for members who need care

according to the catch-up schedule. The Member Clinical Summary can be printed or downloaded as a Continuity of Care Document (CCD) for electronic integration into an electronic medical record. Providers can also pull reports on the EPSDT status of their entire panel—and print or download the information in an MS Excel or CSV file format.

Providers conduct outreach to members after pulling the reports and confirming that care gaps exist. An example Care Gap Worksheet is shown below in Exhibit M.1-2:

AmeriHealth Caritas Louisiana

September 09, 2014

Important Clinical Information

Print this document and place it at the front of the member's medical record for review by a healthcare professional

Care Gap Worksheet

Member :

Name: [redacted]

ID#: [redacted]

Age/DOB: [redacted]

SSN(Last 4): [redacted]

Phone: [redacted]

PCP Assigned :

Name: [redacted]

Address: [redacted]

Phone: [redacted]

***** Claims Processed Through End of Month July 2014 *****

Alert Service(s) - Due Soon/Over Due/Missing - Response Required

Condition	Service Due	Last Service	Last Value	Status	Frequency	Date Done	Result	Date Referred
EPSDT	Annual Vision Screen	06/13/2013		Overdue	At least once per year			
EPSDT	Annual Hearing Test	06/13/2013		Overdue	At least once per year			
EPSDT	Adolescent Well Care	06/13/2013		Overdue	At least once per year			
EPSDT	Annual Dental Visit 2 to 21 Years	03/07/2013		Overdue	At least once per year			

At Risk/Risk Service(s) - Information Only

Condition	Service Due	Last Value	Status	Frequency
Diabetes	Blood Glucose Monitoring		At Risk	At Risk indicates underutilization/absence of blood glucose testing supplies

Would you like help outreaching to this member?

☐ Yes, please help with the following _____

Would you like to exclude the member from a specific measure(s)?

☐ Yes, please exclude from the following measure(s): _____

The reason for exclusion must be included: _____

Please note, exclusion requests will only be accepted for reasons that conform to the HEDIS measure guidelines.

Page 1 of 2

Exhibit M.1-2: Provider Report Options, including EPSDT Care Gap Worksheet

Member Portal

Members and their caregivers are also able to access this same information through the secure Member Portal, as accessed through the homepage shown below in Exhibit M.1-3. Through the portal, they are able to print the EPSDT Clinical Summary for their records or to take with them to the physician's office.

AmeriHealth Caritas Louisiana

Text size: AAA Print

Home | Message Center (1 Unread) | Account Settings | Log Out

Contact Us

Quick Links

- My Primary Doctor (PCP)
- My Medicine
- My Recent Visits
- My Important Tests & Services
- My Medical History Summary
- Request a Member Handbook

My personal information
Call us to update

Name
JANE DOE

Address
1234 ANY ST
NEW ORLEANS, LA 70126

Phone
Home: (504) 555-1234

My Primary Doctor (PCP)
CRESCENT CITY PHYSICIANS

Member ID
12345678

Hello JANE. How can your health plan help you today?

Information For You
Read information about your health care as an AmeriHealth Caritas Louisiana Member.
Learn More

Find a Provider
You can use name, zip code or city/state to find a participating doctor, hospital or other types of providers.

Contact AmeriHealth Caritas Louisiana
Find out how to get assistance for appointments, transportation and other member benefits.

Notice of Privacy Practices | Privacy Policy | Terms of Use | AmeriHealth Caritas Louisiana

This site contains links to other Internet sites. AmeriHealth Caritas Louisiana is not responsible for the content of other Internet sites. Please see our Privacy Policy and Terms of Use.
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Exhibit M.1-3: ACLA Member Portal Homepage

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M.2. EPSDT

M.2 Describe your approach to member education and outreach regarding EPSDT including the use of the tracking system described in M.1 of this part and any innovative/non-traditional mechanisms. Include:

- *How you will conduct member education and outreach regarding EPSDT including any innovative/non-traditional methods that go beyond the standard methods;*
- *How you will work with members to improve compliance with the periodicity schedule, including how you will motivate parents/members and what steps you will take to identify and reach out to members (or their parents) who have missed screening appointments (highlighting any innovative/non-traditional approaches); and*
- *How you will design and monitor your education and outreach program to ensure compliance with the RFP.*

Overview

ACLA is dedicated to the principle that every child deserves to be healthy and that optimal health involves trusting relationships between health professionals, the family, and the community as partners in health practice. As a managed care company, we strive to provide continuity of care from infancy through adolescence for EPSDT services. Our approach combines ACLA's expertise and the local knowledge and success of the current EPSDT program.

Our Pediatric Preventive Health Care (PPHC) program is specifically designed to improve the health of members under age 21 by increasing adherence to program guidelines. The program combines scheduled written and telephonic outreach with state-of-the art informatics that provide point-of-contact notification of EPSDT needs to providers and ACLA employees. We partner with providers and community programs to ensure members have access to required services and use creative outreach strategies to assist members and their parents/guardians to use the services, even going to the pediatrician offices to help staff make appointments. This personal, face-to-face approach has improved EPSDT compliance in our youngest members.

We would like to thank you so much for your time helping our clinics get patients in for their wellness visits. It was such a great help! We had such a great response. We look forward to seeing you again soon!

Office Manager
Mansoor Pediatrics

The program operates under the direction of the Medical Director and the Maternal Child Health/EPSDT Coordinator, who is a Louisiana-licensed registered nurse located in the Baton Rouge office.

Approach to Member Education and Outreach

ACLA has developed a comprehensive program to educate members and caregivers on the screening and immunization recommendations, as required by DHH, as recommended by the American Academy of Pediatrics, and the Advisory Committee on Immunization Practices ACIP guidelines. Our Pediatric Preventive Health Care (PPHC) program is built on our successful experience serving parents and children in Louisiana to reach our youngest members. The goal of these activities is to educate, support, and encourage members to become informed, responsible, and active participants in their own health care and well-being.

The PPHC program focuses on:

- Identifying members who need EPSDT screening, immunization, and other preventive services.
- Providing electronic data and alerts to providers, empowering them to reach out to members who have missed or will soon be due for EPSDT services.
- Reaching out to PCPs about members who have missed EPSDT services.
- Reaching out to parents/guardians about upcoming and missed preventive services.
- Coordinating services for members requiring access or transportation support to receive needed EPSDT services.
- Coordinating services for members identified as having additional treatment services identified through EPSDT screening.
- Confirming EPSDT compliance.

The PPHC program operates under the direction of the Chief Medical Director and the Director of Rapid Response in the Integrated Care Management program, who is a Louisiana-licensed nurse.

ACLA enlists a number of techniques to contact EPSDT-eligible families and encourage them to make an appointment for the required components of EPSDT. These techniques include information through member materials, welcome calls, website articles, and on-hold messaging. In order that our members receive the services they need and require, it is necessary that any identified barrier or obstacles that impede the delivery of these services is assessed and remediated. ACLA will assist members with any transportation or language access accommodations as necessary. We recognize that these are not the only barriers that may be identified, but these often are the most prevalent.

Member Web Portal

All members will have access to a Member Web Portal. The portal allows parents/guardians to establish a user ID and password for secure access to a variety of information. Of most significance, the portal empowers the parent/guardian to review completed and missing/overdue EPSDT services. The parent/guardian can print the summary as a reminder to bring to the PCP office at the next appointment.

Family-centered Outreach

In addition, ACLA members and/or parents/guardians and employees have the ability to access a "family link," allowing them to view missing EPSDT services for other family members who are participating in the Bayou Health program. The ICM and Bright Start staff are able to view this family link within our ZeOmega Jiva medical management platform system that allows us to capitalize on each contact we have with our members. Care Management, Utilization Management, and Rapid Response team members also have access to the EPSDT Clinical Summary for use in their interactions with the member/caregiver and treating providers.

ACLA prides itself on making a personal connection with our members in order to maintain the wellness of our youngest members. We perform outreach reminder calls on a monthly basis to continue contact with our members with the goal of keeping their children healthy and on-schedule with all visits.

To ensure optimal results from each immunization, ACLA proactively identifies eligible members less than 24 months of age for priority outreach to coordinate the multiple immunizations and screenings needed for children in this age group. The Rapid Response team conducts monthly telephonic outreach for now-due and past-due EPSDT appointments for the EPSDT member population. Our non-clinical Community Care Connectors provide supportive administrative services for Rapid Response staff, including appointment scheduling, appointment reminders, transportation supportive services, conducting intake surveys to identify member needs. Community Care Connectors (CCCs) are essential staff in support of Rapid Response member outreach initiatives and fielding inbound calls.

Rapid Response Team

The Rapid Response team was developed to address the urgent needs of our members, as we have learned over the years that our members cannot achieve their long-term health goals if their immediate social or urgent health needs are not addressed. The Rapid Response team consists of registered nurses, social workers, and CCCs. Rapid Response employees are trained to assist members in investigating and overcoming barriers to accessing care and achieving their health care goals. Staff members can address questions such as how to obtain medications, supplies, or medical equipment; how to find a PCP or specialist physician; and how to access appropriate social services. The Rapid Response team remains available and involved through issue resolution.

Rapid Response Outreach Criteria for Missed/Overdue EPSDT Services

ACLA analyzes claims and related EPSDT data to identify the following populations for outreach calls:

- Pediatric members with missed or overdue services.
- Members between ages three months and one year with no claims for physician services.

The Rapid Response team conducts monthly telephonic outreach for now-due and past-due EPSDT appointments for the EPSDT member population. If a gap is identified for those

members who have not scheduled their appointments, an automated message is sent to the member's phone number on file as a reminder to schedule EPSDT appointments. The recorded message gives the parent/guardian the option for a warm transfer to a live Rapid Response member service line to make an appointment in that moment. During this campaign, Rapid Response staff review the family link of these members to identify additional members in one household that may be "late" or have missed immunizations and/or screenings. In speaking with members, when clinical issues are identified, the Rapid Response care manager is available to speak with and assist members. Campaign calls occur at different times of the day and evening. The soundbite vendor provides a report on outreach activity at the end of each monthly outreach campaign.

Our non-clinical CCCs provide supportive administrative services, including appointment scheduling, appointment reminders, transportation supportive services, conducting intake surveys to identify member needs. CCCs are essential staff in support of EPSDT member outreach initiatives and fielding inbound member calls.

Educational materials and reminders alone are often not enough to motivate members to take action. Once we use the data sources outlined above to identify members due for EPSDT services, ACLA's approach to EPSDT employs two key strategies, a "concierge touch" and convenience.

The "concierge touch" is provided through the Rapid Response team and is a core focus of ACLA services. Rapid Response CCCs are trained to listen and address a wide variety of member concerns. This enables the Community Care Connector to veer from the purpose of an outreach contact—such as a call to a mother of an 11-year-old boy about the need to schedule an appointment for Tetanus, Diphtheria, Pertussis, and Meningococcus vaccinations, along with a well-child check-up, vision, and hearing screen—to instead assist the mother with obtaining utility payment assistance. We understand that the mother's focus is on finding a way to keep the electricity on to power fans in the July heat, making a physician appointment for a child who is not sick a lower priority. By dealing with the mother's immediate need, the Community Care Connector not only eliminates a distraction to making the physician appointment, but earns the mother's trust, making her more likely to follow through with the child's care.

In addition, the Rapid Response team works with parents/guardians to identify barriers to well care appointments and devise solutions. They assist with transportation needs, advocate with PCP offices for convenient appointment times, and provide reminders of upcoming appointments. During an appointment reminder call, the CCC will probe for any unidentified issues, such as needing child care for other siblings during the appointment. They also work with the parent/guardian to identify a responsible adult to watch the siblings or make arrangements with the office to permit the other children to attend the appointment.

"David's" parents were not able to easily find a new PCP for their son, as their established PCP no longer accepted Medicaid plans. Distraught, David's parents spent hours looking for a new doctor for their son. "David's" father, "Mr. Y" decided to call ACLA to see if anyone could help find a PCP. That is when "Mr. Y" got the Rapid Response Department. We located a PCP for David, but it was a little bit of a drive and there was concern whether transportation would be an issue. "Mr. Y" then explained that he is disabled and unable to drive, and that his wife normally would have the car because she works.

I informed "Mr. Y" of the available transportation for our members, told him how it worked, and said that if he was okay with the location of the PCP, I would get everything set up. "Mr. Y" agreed, and I was able to schedule the next available appointment, as well as arrangements for transportation to and from the appointment.

Rapid Response called to remind them of the appointment on the day before, and we also called to follow up after the appointment. I asked "Mr. Y" if he and "David" were picked up for the appointment and if transportation was okay. When he started talking, I could hear it in his voice that this was going to be my "good" call of the day. He said that he was very impressed with the doctor, that he actually took the time to sit down and get to know them. "Mr. Y" said that the doctor must have been in the room with them a good hour. "Mr. Y" went on to say that he was so thankful that he got me on the phone when he did. He thanked me for everything that I had done and thanked me for taking the extra steps to see that his son got the health care that he needed.

I love when I can make a difference in someone's life for something that seems so small. It's a good feeling to have, and [I] hope that I can do that for many more of our members."
— ACLA Rapid Response team member

Provider Portal

ACLA's Provider Portal generates an alert for children missing EPSDT services at the time eligibility is checked. The alert will identify the missing/overdue service and can be printed for inclusion with the child's chart at the time of the PCP visit. The provider can access a complete record of EPSDT services by viewing, printing, or downloading the EPSDT Clinical Summary through the portal. Panel reports are also available for PCPs, identifying assigned members who are missing, due, or up-to-date with EPSDT services. If there are any gaps in care, a provider can fill out a "Let us Know" referral and send it to the Rapid Response team.

Another method available to providers is a more specialized care gap worksheet report for each member. The provider has the opportunity to update the sheet and send it back to ACLA, where we then update the member's file. A report is then generated to the Rapid Response team for outreach to the member.

Publications and Messaging

In addition to the outreach programs described above, ACLA includes information on the importance of EPSDT screening, immunizations, and mechanisms to access care in new member materials, Member and Provider Handbooks, newsletters, website articles, and on-hold messaging. We believe it is important to continually reinforce the critical nature of early preventive care, and we understand the importance of repetition in the learning process.

Culturally Competent Communications

We make special efforts to communicate with our members who do not speak or read English well. Bilingual representatives make outreach calls to Spanish-speaking parents/guardians, and we use language line translation services for less-prevalent languages. Additionally, we use a teletypewriter/telecommunication device for the deaf (TTY/TDD) line for calls to members, parents/guardians, and caregivers who are deaf or hearing-impaired. Lastly, our EPSDT postcards are written in both English and Spanish (and in other languages, as necessary) in simple terminology, which is compliant with the Bayou Health MCO RFP reading-level requirements. Materials are also available in Vietnamese.

Innovative and Non-traditional Outreach Methods

Birthday Cards

Reminder birthday cards are mailed on an annual basis to the parent/guardian of members age one and older to wish the child a "Happy Birthday" and educate the parent/guardian on EPSDT services that are needed in conjunction with the birthday. In addition, each birthday card contains information on age-appropriate developmental milestones and safety tips, as well as important resource agencies and telephone numbers. The content of the birthday cards is reviewed annually for accuracy.

Here are some tips from AmeriHealth Caritas Louisiana to help you have a healthy year.

First step – What you need to do...

Make sure you take your child to the doctor for all of his or her appointments. This is an important step to keeping your child healthy.

Screenings – What the doctor will check for...

During this age, when you take your child to the doctor, the doctor will check:

- Height, weight and growth development.
- Lead levels in the blood.
- Hearing and eye sight.
- Signs of Autism.
- Your child's teeth.

Shots – To keep your child healthy...

Shots, or immunizations, are needed as your child grows to keep him or her healthy.
Be sure to talk to your doctor about which shots your child needs now.

What's Happening – A general idea of what your child should be doing...

Your child age 1:

- Enjoys imitating people.
- Moves objects in and out of containers.
- Repeats sounds and gestures for attention.
- Can say "mama" and "dada."
- May be able to walk 2-3 steps without help.

Your child age 2:

- Likes to be around other children more.
- Uses simple phrases.
- Follows simple instructions.
- Walks alone.
- Begins to run.
- Can scribble with a crayon.

Be sure to talk to your doctor about how your child is growing and what he or she is doing at home.
Make sure you talk about any concerns you have.

Safety – Tips to keep your child safe...

- Block off stairs with a small gate.
- Put plug covers on all electrical outlets that are not being used.
- Do not smoke or let others smoke around your child. Children in a smoke-free home have fewer colds and infections.
- Louisiana state law says to use a car seat at all times until your child is age 4. Children ages 4 up to age 6 must use a booster seat.
- Do not leave your child alone in the car, not even for a moment.
- Keep medicines, cleaning products and other harmful products in childproof containers and out of reach.
- Check the temperature of your water. Keep the water temperature in your sinks and bathtubs at or under 110 – 115 degrees.
- Do not leave your child alone in or around water.
- Ask your doctor about testing for lead poisoning. Lead can be found in paint, dirt, painted toys and toy jewelry.

What else can I do as a parent?

Make sure you take your child to the doctor every year for his or her well checkup.
This is an important step to keeping your child healthy.

Exhibit M.2-1: ACLA Birthday Card

Magnets

The Rapid Response team also sends out magnets to members of PCP practices that have the largest volume of non-compliant members. The magnets are sent to families in English and Spanish in order to support the well-child visit schedule.

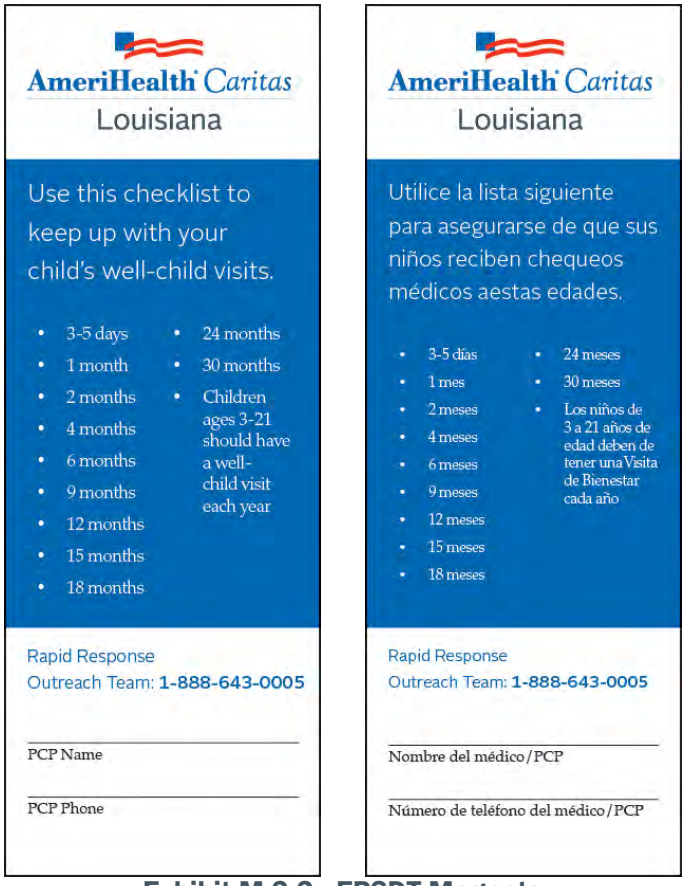

Exhibit M.2-2: EPSDT Magnets

Fact Sheets

The Rapid Response team also sends out fact sheets with an accompanying letter that provides contact information to reach a nurse.

AmeriHealth Caritas Louisiana

P.O. Box 83580
Baton Rouge, LA 70884

September 19, 2014

Head of Household
Member_add1 member_add2
member_city, member_state member_zip

Dear Member:

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

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

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

Thank you,

AmeriHealth Caritas Louisiana
Rapid Response and Outreach Team

Exhibit M.2-3: Letter that Accompanies EPSDT Fact Sheet

Stay Strong. Live Healthy.

Take your child for a well-child visit!

Your child is due for this important checkup

Well-child visits help make sure your child is growing and developing.

A well-child visit is a full head-to-toe physical.

It's not just shots! It may include:

- Eye and hearing tests.
- A blood pressure check.
- A dental checkup.
- A check for proper growth.
- Any needed immunizations *(shots)* to prevent disease.
- Tips for keeping your child healthy and safe.
- Lead screening before your child's 2nd birthday.

Use this checklist to make sure your child gets all of his or her checkups at these ages:

- 3 – 5 days.
- 1 month.
- 2 months.
- 4 months.
- 6 months.
- 9 months.
- 12 months.
- 15 months.
- 18 months.
- 24 months.
- 30 months.

Well-child visits are free

AmeriHealth Caritas Louisiana members will not be charged for well-child visits.

Please call your child's doctor to make an appointment.

If you need help, call Rapid Response at 1-888-643-0005.
If you have recently taken your child in for this visit, please ignore this card.

If you need help reading this, please call 1-888-643-0005.

You can have this information in other languages and formats at no charge to you. You can also have this interpreted over the phone in any language. Call Member Services at 1-888-756-6004. For TTY, call 1-866-628-7588.

Quý vị có thể có thông tin này bằng các ngôn ngữ và định dạng khác miễn phí. Quý vị cũng có thể có thông tin này thông dịch ra bất kỳ ngôn ngữ nào qua điện thoại. Xin gọi Dịch vụ Thành viên số 1-888-756-6004.

Puede obtener esta información en otros idiomas y formatos sin costo. También se la puede interpretar esto por teléfono en cualquier idioma. Llame a Servicios al Miembro al 1-888-756-6004.

ACLA-EZC-140

AmeriHealth Caritas
Louisiana
www.amerihealthcaritasla.com

Exhibits M.2-4: EPSDT Fact Sheet

Community Events and Partnership Programs

ACLA is a strong supporter of the community. We routinely include information and educational sessions on EPSDT services and immunizations at community events. ACLA is also working with the school districts on a way to expand the ability of School-Based Health Centers to provide primary care services, such as EPSDT screening and immunizations.

The ACLA Community Education Outreach Team (CEOT) routinely provides assistance to providers by scheduling appointments for members with EPSDT care gaps. We realize the importance of our members receiving the appropriate screenings and other care services, and our providers appreciate our support.

LaJuana has made a positive contribution in assisting Southwest Louisiana Primary Health Care Center in contacting patients. Due to barriers that we sometimes face with contacting our patients, LaJuana has provided us with the extra manpower to provide this much needed service. She has been instrumental in reaching our patients to ensure continuity of care. With her assistance, we can provide our patients with excellent quality health care services that is provided through our referral department.

Chief Executive Officer
Southwest Louisiana Primary Care Center

ACLA is committed to establishing relationships to give us access to non-traditional mechanisms for member education and outreach. We recognize that programs like the School-Based Health Center collaboration, discussed above, will enable us to effectively connect more members to services. ACLA has developed several initiatives to enhance EPSDT performance. A few examples are outlined below.

Maternity and Baby Community Programs

Adherence to well-visit schedules begins before the baby is born. ACLA is involved with national and community organizations that share their commitment to producing brighter starts for babies. ACLA demonstrates its commitment to moms and babies through our Bright Start Maternity Program. The program has been instrumental in helping new mothers stay healthy and have healthy babies by promoting healthy behaviors and controlling risk factors during pregnancy. Specialized prenatal care management staff is assigned to every pregnant member and helps the members schedule prenatal care appointments, coordinate the health care services they receive, and learn about healthy pregnancy behaviors. Those members considered to be at higher risk receive more intensive care management. Our Care Managers also assist members in choosing a PCP for their child and provide reinforcement of the importance of regular well-child visits.

Built on prenatal care guidelines, the Bright Start program is dedicated to promoting healthy behaviors, controlling risk factors during pregnancy, and educating mothers on EPSDT guidelines, with the goal of supporting the delivering of a healthy, full-term infant. Bright Start includes the oversight of the arrangement of home visits through our

Nurse Partnership program, a free, voluntary program for first-time moms. When enrolled in the program, a specially trained nurse visits the member throughout her pregnancy and until her baby turns two years old. During these visits, the nurse offers the knowledge and support members need to confidently create a better life for the baby and the mother. As part of the home nurse visit, the nurse reviews the EPSDT screening schedule and ensures that the infant is scheduled for the first visit.

Community Events to Promote Preventive Care

We have partnered with various community organizations to participate in and sponsor events where we also provide EPSDT educational materials. We specifically target locations where there are low compliance rates. A few examples that targeted the well-child (3–6 years) HEDIS measure include:

- Kool Smiles Dental Easter Bunny: Children were able to get a picture with the Easter Bunny in the New Orleans and Gretna communities. For one member who made and attended a well-child visit by the designated date, the member received an Annual Family Membership to the Audubon Institute Facilities.
- Plaquemines Easter Egg Hunt.
- Lights Out Easter Egg Hunt: ACLA participated in the egg hunt in East Baton Rouge Parish. A total of 5 sets of 4-pack tickets to the BREC (Baton Rouge Recreation Department) Liberty Lagoon Water Park were given to members in attendance at the egg hunt.
- Let's Move Louisiana.
- LaCare Fun in the Sun at the EXCELth Clinic.

ACLA also held events that targeted the Adolescent (12–21 years) well-visit HEDIS measure:

- NOLA For Life: Held at McDonogh Playground Algiers.
- Hoops for the Heart: ACLA targeted non-compliant adolescents in West Baton Rouge Parish.

Back-to-School Events

ACLA participated in a number of Back-to-School events in partnership with legislators. ACLA hands out educational materials, including EPSDT information, in addition to providing back-to-school supplies for children. We have participated at these events in:

- Sci-Port – Shreveport.
- Alexandria event.
- Southeast Community Health Centers (Tangipahoa, Livingston, and St. Helena Parishes – Northshore).
    - This event also included health screenings.
- Capitol City Family Health Center – Baton Rouge.
    - This event included health screenings and immunizations.
- Gardere Initiative – Baton Rouge.
- Back-to-School Rally – New Orleans.

Summer Safety Events

ACLA provided informational table materials, in addition to added services, at the following summer safety events:

- Baton Rouge Summer Safety Fun Day – Baton Rouge.
  - ACLA sponsored event with BREC and American Red Cross.
  - Health and Dental screenings, swim safety, Hurricane Disaster information.
- Summer Health Expo – Houma.

Multi-Cultural Events

ACLA provided informational table materials at the following multi-cultural events:

- Cinco de Mayo Event – Baton Rouge.
  - Sponsored the event with BREC.
- Cervantes Fundacion Hispanoamerican – Que Pasa Festival – New Orleans.
- Mary Queen of Vietnam Church – New Orleans.
- Dia de la Familia – Monroe, LA.

Children in Foster Care

We are well versed in the challenges of connecting children in foster care to timely well-child and EPSDT care. To assist the guardians of children in foster care, ACLA works with the Department of Children & Family Services to provide member-specific information on children in a foster care placement that the agency can provide to the foster parent. The EPSDT Clinical Summary contains currently available information on EPSDT screenings and immunizations the members received, and identifies those that are due soon. ACLA also provides a brochure describing services available for children and the toll-free number for the Rapid Response team. Foster parents are encouraged to contact the Rapid Response team for assistance coordinating needed EPSDT services or other care.

School-based Health Centers and Medical Homes

We are currently contracted with 65 School-based Health Clinics (SBHCs) across Louisiana to provider primary care services, which include EPSDT screenings and immunizations. We are currently contracted with all SBHCs to provide these services, just as we would be contracted with our PCP providers.

ACLA works with providers, community partners, and internal employees to make obtaining EPSDT care as easy and convenient as possible for members and providers. Our partnership with the SBHCs provides a convenient avenue for parents/guardians to get EPSDT services for their school-age children. As PCPs/medical homes, the SBHCs are also able to provide care for other children in the household, to further increase the convenience for parents/guardians.

Improving Compliance and Motivation

The success of our EPSDT program stems from our holistic Integrated Care Management (ICM), a program that consists of five core components: Pediatric Preventive Health Care (ESPDT), Episodic Care Management, Bright Start (Maternity Management), Complex Care Management, and Rapid Response. All are important for assuring comprehensive EPSDT compliance. By design, several services overlap each of the five core components—and targeted interventions for EPSDT is one of those services.

The Pediatric Preventive Health Care program (PPHC) is specifically designed to improve the health of members under age 21 by increasing adherence to program guidelines. The PPHC program combines scheduled written and telephonic outreach with state-of-the art informatics to identify, track, and support outreach of EPSDT needs to providers, staff, and members alike to improve compliance and motivation.

Member Incentives Program

In addition to working with ACLA community representatives and providers to design similar programs for members, we have implemented a member incentive program designed to promote preventive care by rewarding the member and parent/guardian for completing a well-child visit. ACLA will provide the members, ages 3–21, a $20 gift card when eligible pediatric members have completed their annual pediatric check-up. Members may receive this incentive once a year.

Children who complete their vision screening are also eligible for a value-added benefit. Members who have completed their well visit screening will be identified as eligible and will be included in a monthly file to the fulfillment vendor. A gift card will be mailed within 30 days after member validation is completed.

Members may also be targeted to receive incentives through our targeted “catch-up” campaign. This campaign is initiated annually and reaches out to targeted members who are identified as missing or behind on recommended EPSDT services. This special outreach campaign is a multi-targeted campaign that involves simultaneous communication to both the target member population and their PCP. Messaging includes recognition of gaps in service along with a description of the incentive for both provider and member to close gap by targeted date.

Improvement Results

Since 2011, due to the robust outreach and education programs, ACLA has exceeded the goals for HEDIS measures in a number of categories, as it related to EPSDT populations:

HEDIS Louisiana Incentive-based Measures		
HEDIS Measure	Pre-Bayou Health rate	ACLA 2014 HEDIS rate
Well Child, 3–6 (W34)	35.45%	57.17%
Adolescent Well Care (AWC)	25.16%	43.49%

Exhibit M.2-5: HEDIS Measures

Missed Service Strategy

New members are loaded into ACLA's Facets system from DHH eligibility files. All available historical health data is also loaded. Additional medical history is collected via the new member welcome call, a health risk assessment, and from a member's initial visit with their assigned PCP. Health information is then continually collected from ongoing claims data and encounter data.

Member medical history, along with claims data, is compared against EPSDT standards during scheduled nightly data jobs. These standards are kept up-to-date in our systems via system updates and data loads. On a daily basis, the updated Care Gap data is refreshed—identifying members with upcoming, due, and overdue EPSDT screenings. The daily refresh will also remove Care Gaps from the system, and track completion rates, as services are completed.

Care Gap data is loaded onto our internal information systems daily where Care Gaps appear as alerts. Alerts are triggered in our internal systems when a member ID number or name is entered, such as when a member calls Member Services. This information can be viewed by our internal staff, providers, and members.

For members identified as having missed recommended services, ACLA will use a multi-layer approach.

"Mrs. M," a Spanish speaker, received a letter from us about missing EPSDT appointments for her four children. Upon receipt of the letter, "Mrs. M" called the Rapid Response team, who connected her to a Spanish-speaking representative who helped her to schedule the required well-visit appointments.

"I also let 'Mrs. M' know that I would be making a follow-up call to her as a reminder and provided some education as to the importance of well-visits. I informed 'Mrs. M' of my name and that she could call me any time for any questions or concerns."
—Rapid Response team member

Provider Referrals

Providers are able to keep track of member EPSDT services through our Provider Portal. Should a gap in care be found, providers are able to send a referral to the ACLA Rapid Response team

using the "Let us Know" fax form, NaviNet care gap worksheet, or via phone call. This enables providers to request outreach to members, to assist with appointments, to refer to a health plan care management program, or to assist with additional care coordination services or appointment setting services (i.e., specialists, screenings). After the member's initial needs are coordinated, the Rapid Response team will connect the member to the necessary care management service programs for ongoing follow-up.

LET US KNOW PROGRAM

INSERT PLAN LOGO HERE

Member Intervention Request Form

Date: _____

MEMBER INFORMATION

Member Name	Date of Birth
Member ID #	Phone Number
Parent/Guardian Name (if applicable)	

PROVIDER INFORMATION

PCP Name	PCP ID#
Phone Number	Fax Number
Office Contact Name	PCP County

Please check the appropriate intervention(s):

- ☐ Non-compliance with prescribed medication(s)
- ☐ Inappropriate use of emergency room
- ☐ Not showing up for appointments or follow-up care
- ☐ Limited or no knowledge of Plan benefits
- ☐ Other: _____

Additional Information/Comments:

_____
_____
_____
_____
_____

Please fax this form to the Rapid Response and Outreach Team at X-XXX-XXX-XXXX

Follow-up performed: _____

Comments: _____

Exhibit M.2-6: Let Us Know Provider Referral Form

AmeriHealth Caritas Louisiana

September 09, 2014

Important Clinical Information

Print this document and place it at the front of the member's medical record for review by a healthcare professional

Care Gap Worksheet

Member :

Name: [redacted]

ID#: [redacted]

Age/DOB: [redacted]

SSN(Last 4): [redacted]

Phone: [redacted]

PCP Assigned :

Name: [redacted]

Address: [redacted]

Phone: [redacted]

*** Claims Processed Through End of Month July 2014 ***

Alert Service(s) - Due Soon/Over Due/Missing - Response Required

Condition	Service Due	Last Service	Last Value	Status	Frequency	Date Done	Result	Date Referred
EPSDT	Annual Vision Screen	06/13/2013		Overdue	At least once per year			
EPSDT	Annual Hearing Test	06/13/2013		Overdue	At least once per year			
EPSDT	Adolescent Well Care	06/13/2013		Overdue	At least once per year			
EPSDT	Annual Dental Visit 2 to 21 Years	03/07/2013		Overdue	At least once per year			

At Risk/Risk Service(s) - Information Only

Condition	Service Due	Last Value	Status	Frequency
Diabetes	Blood Glucose Monitoring		At Risk	At Risk indicates unauthorized/minimal use of blood glucose testing supplies

Would you like help outreaching to this member?

☐ Yes, please help with the following _____

Would you like to exclude the member from a specific measure(s)?

☐ Yes, please exclude from the following measure(s): _____

The reason for exclusion must be included: _____

Please note, exclusion requests will only be accepted for reasons that conform to the HEDIS measure guidelines.

Exhibit M.2-7: Provider Care Gap Worksheet

Designing and Monitoring Compliance Program

Since 2012, ACLA has designed its outreach and education programs in accordance with Louisiana contract requirements. Our program has emphasized a comprehensive outreach strategy. Specifically, we have based our reporting and care gap algorithms on the current American Academy of Pediatrics (AAP) Bright Futures periodicity charts and Advisory Committee on Immunization Practices guidelines. We incorporate information from these sources into our EPSDT educational material and post links to the source documents on the Provider Portal as a reference. Additionally, we enforce the use of the Vaccine for Children (VFC) Program by our providers to ensure that unnecessary costs are not incurred. We currently mandate VFC use in all of ACLA affiliates.

Partnering with Providers

ACLA has been successfully driving performance on pediatric well care visits using a combination of care gap reporting and through our Let Us Know program, which encourages providers to contact our Rapid Response team for assistance with member needs. After the

member's initial needs are coordinated, the Rapid Response team will connect the member to the necessary care management service programs for ongoing follow-up.

ACLA has been compliant with EPSDT reporting requirements, including those associated with the federally mandated CMS 416 report. We have successfully submitted the CMS 416 report. In addition, we have reported the required EPSDT and well-child services, blood lead screening, and preventive services, as outlined in Section 6.6.5 of the Bayou Health MCO RFP.

Program Monitoring

As outlined in M.1, our tracking system monitors the rates of adherence by members and providers in relation to EPSDT requirements. We are then able to target those who need assistance in adhering to the well-visit and periodicity schedule. Through this system, we are able to generate reports for both members and providers, encouraging empowerment and individual intervention.

Our Programs at Work: Improving Member Satisfaction

Our dedication to improving health outcomes for children has been demonstrated in the satisfaction of our members. As published in the Bayou Health Transparency Report, the parents/guardians of our youngest members ranked us first in customer service amongst all prepaid health plans serving the Bayou Health program.

	ACLA	LA Health Connections	Amerigroup
Getting Care Quickly	93%	90%	89%
How Well Doctors Communicate	94%	93%	94%
Getting Needed Care	87%	81%	84%
Customer Service	89%	85%	87%

Exhibit M.2-8: Child Member Satisfaction Survey

N.1. Utilization Management

N.1 Provide a detailed description of your utilization management (UM) policies and procedures including but not limited to:

- *Specific levels and qualifications required for UM staff;*
- *Training you provide your UM staff;*
- *Industry products (Milliman, Interqual, etc.) used and how*
- *Describe any differences between your UM phone line and your member services line with respect to bullets (2) through (7) in item R.1 of this part;*
- *If your UM phone line will handle both Louisiana MCO and non-Louisiana MCO calls,*
  - *explain how you will track Louisiana MCO calls separately; and*
  - *how you will ensure that applicable DHH timeframes for prior authorization decisions are met.*

Overview

AmeriHealth Caritas Louisiana's (ACLA's) Utilization Management (UM) program, policies, and procedures is a comprehensive, systematic approach that has served the Bayou Health population in Louisiana since 2012. Building on nearly 20 years of regional UM successes, our Louisiana-customized UM program employs nationally recognized guidelines, regular and ongoing evaluation, and a thorough employee training program to ensure that our members in Louisiana receive quality, medically necessary care. ACLA UM staff is regionally located in our South Carolina office to provide the oversight of nearly 30 years of managed care experience. This has proven to be an important factor in the success of introducing managed care in Louisiana. A local UM department, with Louisiana-based UM nurses, is now being added to work in state with the plan providers and facilities. This department will perform UM concurrent and prior authorization reviews, provider training, and requested face-to-face meetings.

We will continue to use this proven UM program as the foundation to ensure that ACLA members receive the most sound and effective care available, tailored to their needs and compliant with the requirements of the Bayou Health program.

Specific Levels and Qualifications of UM Staff

Staffing levels are addressed based on the volume of requests that are received. We have minimum staffing standards to meet the contractual turnaround times and will increase ratios in response to volume in order to maintain contractual turnaround times. This is accomplished by using UM regional staff to support increased requests. Licensed registered nurses (RNs) with varied clinical backgrounds are employed for prior authorization and concurrent inpatient reviews. Non-clinical intake staff qualifications include, but are not limited to, a minimum high school diploma/GED, call center experience, and medical coding experience.

Clinical Staff

Our clinical staff comprises RNs, Associate or Bachelor degreed, with varied clinical backgrounds. Requests for services requiring Medical Necessity determinations are made through ACLA staff supervised by an RN or Masters-level licensed health clinician. Decisions to approve coverage for care may be made by UM staff when they fall within ACLA's written UM guidelines. Any request that is not addressed by, or does not meet, the ACLA's UM guidelines is referred to a Physician Reviewer for a decision.

Non-Clinical Staff

Our non-clinical and intake staff answer phones, begin the authorization process for registered nurses, and answer basic questions. When hiring, we seek candidates who have a minimum high school diploma/GED, previous call center experience, and medical terminology knowledge. All staff also undergoes rigorous training, as detailed below.

Individuals Making Medical Necessity Determinations

Requests for benefit coverage or Medical Necessity determinations are made through employees supervised by an RN. Decisions to approve coverage for care may be made by UM employees when they fall within written guidelines.

Medical Necessity decisions made by a Physician Reviewer or designated licensed clinical professional are based on DHH's definition of Medical Necessity, in conjunction with the member's benefits, medical expertise, applicable criteria, and/or published peer-review literature. At the discretion of the Physician Reviewer, input on the decision may be obtained from participating board-certified physicians from an appropriate specialty. The Physician Reviewer or designated licensed clinical professional makes the final decision.

Any decision to deny or limit coverage for an admission, service, procedure, or extension of stay based on Medical Necessity, or to authorize in an amount, duration, or scope that is less than requested, is made by a Physician Reviewer or other appropriate designated licensed clinical professional under the clinical direction of the Physician Reviewer. The name and license indicator (MD, DO, PhD, etc.) of the Physician Reviewer or licensed clinical professional making the adverse determination is included in the written determination letter (Notice of Action).

UM Staff Training

ACLA training and orientation programs for our UM team are based on the proven programs utilized by the AmeriHealth Caritas Family of Companies (ACFC). The programs are designed to assist UM employees in understanding the delivery of health-related services to Bayou Health recipients, as well as the implementation of UM policies and procedures.

Additionally, ACLA recognizes the vital nature of ongoing training for its employees and will implement various training methods to ensure the expansion of their knowledge, skills, and job satisfaction.

New Hire Orientation

New hire orientation provides the platform to introduce new employees to the culture of ACLA, with a focus on its history, vision, and mission. New hire orientation for ACLA's employees outlines business operations, performance standards, and appropriate conduct, while defining expectations. The orientation includes the following items:

- ACLA's mission, values, and organizational structure;
- ACLA's policies and requirements of the programs;
- Louisiana and applicable federal regulatory requirements and accrediting body standards;
- ACLA operational procedures including documentation standards and style guide;
- Department policies and procedures;
- Performance standards and reporting requirements;
- HIPAA privacy/security as well as general corporate confidentiality requirements;
- ACLA compliance program;
- Diversity;
- Cultural competence/culturally and linguistically appropriate services (CLAS) and Louisiana-specific culture training;
- ACLA information systems;
- Clinical policy and benefit administration policy (as appropriate to the position); and
- False Claims Act detection and reporting obligations.

Department Training

In addition to the new hire orientation described above, new employee training is provided in each department. New employees are educated and trained on job duties by the department manager and program trainer. This enables each employee to receive a focused training from the individual who is responsible for evaluating his or her job performance. The department leader educates new employees on department policies, procedures, and position-specific responsibilities and expectations. Department orientation includes shadowing a colleague for a specified period of time, cross training, or other on-the-job training as appropriate. The length of orientation varies depending on the nature of the job and the competencies demonstrated by the new employees. For example, orientation for a UM technician can last 8 to 10 weeks, while training for an appeal review nurse will last more than 3 months.

Specific Training for Utilization Management Staff

All clinical and non-clinical UM employees complete a comprehensive competency-based orientation program and receive ongoing training on critical aspects of the program, processes, and associated timeliness. New employee orientation consists of an 8- to 12-week program combining classroom and hands-on training. Topics addressed in a classroom setting include customer service skills, confidentiality and HIPAA provisions, program integration, benefit availability, medical necessity criteria, documentation requirements, and notification policies. Utilization review skills are taught using scenarios that mimic the coverage needs of the Bayou

Health population and focus on commonly encountered requests. Basic system navigation and documentation is taught in the classroom. ACLA has in-house certified InterQual trainers at this time.

New employees are paired with a preceptor, assigned from their first day, to review cases side-by-side with an experienced employee in a similar role. New ACLA UM staff are trained by experienced in-office UM staff. ACLA is also able to utilize UM staff from other regional offices as resources if there is a business need.

UM employees initially shadow and observe their preceptor, and gradually progress to performing the job functions and tasks while under observation. Dual headsets are used, allowing the employee to hear all conversations during the shadow period, and allowing the preceptor to hear both sides of the call as roles are reversed. Once an employee reaches proficiency, he/she transitions to working independently with the preceptor on standby.

UM employees can also reference online desktop policies and procedures, training manuals, and written workflows, and are free to call department trainers, supervisors, and their preceptor with questions. Medical directors also respond to UM employees' questions and provide reinforcement of the learning process.

During the orientation process, the responsible department director, manager, or supervisor assesses the new employee's needs and comprehension to determine if additional orientation is needed. ACLA uses a competency-based orientation plan to assess the performance of an employee to identify areas where additional education, training, or resources should be devoted on an individual basis. Each employee is given an opportunity to evaluate the training they received and offer suggestions for future improvements.

Each case worked by a new employee is reviewed by an assigned preceptor and/or supervisor for a minimum of 3 months to ensure understanding of the review process, to ensure correct guidelines are applied, and to reinforce all appropriate resources are utilized prior to delivering a determination.

ACLA's clinical leadership team evaluates the orientation process annually to identify possible improvements and enhancements. This helps to ensure that ACLA offers an orientation program that meets the needs of the organization while maintaining the satisfaction of employees.

Topic	Method	Competencies
Learning about the Company		
Mission, Vision, and Core Values	Instructor-led discussion with reflective written exercise (Core Module)	Paraphrase or quote Mission and Vision List eight competencies and give example of how each relates to role
Learning about the Department		

ACLA UM Organizational Chart	Self-study exercise with written exercise (Core Module); Organization chart on Intranet	Identify senior corporate and Medical Management team Identify and describe purpose of sub-groups in Utilization Management (UM)
Program Description	Self-study with written exercise (Core Module); Program Description on Intranet	Understand the concept, goals, programs, and activities of UM Explain connection of personal role to Program Description
Learning about Your Role		
Job Description	Discussion with Supervisor/Manager — review description and performance expectations	Describe main job responsibilities and metrics used to measure performance Understand purpose of auditing in overseeing, measuring and improving performance Describe responsibilities consistent with training/education, licensure, certification, and State Practice Act Explain State/Federal Requirements specific to Job Function
Role-specific Workflows	Discussion with Supervisor/Manager or UM Preceptor	Locate and identify role-specific workflows Understand impact of role in completing workflows Explain impact of poorly executed workflow on members and co-workers
Goal Planning and Professional Development	Discussion with Supervisor/Manager - review corporate/ departmental goals on Intranet; review individual goal planner; resources for professional development	Locate corporate, company, and departmental goals on Intranet List at least three company goals related to role List at least three departmental goals Understand personal goals and explain how they relate to departmental and corporate goals Understand the performance review process Identify at least three sources for professional development
Policies and procedures	Self-paced; review policies and procedures on Intranet	Understand and identify job-related policies and procedures; including all relevant UM P&Ps, HIPAA P&Ps, and Medical Management P&Ps Locate policies on Intranet Know regulations for timeframes of UM activities

Grievance and Appeals process	Policy and procedure review with Supervisor/Manager or UM Preceptor	Describe grievance and appeals process in terms of member rights and role-specific activities
Quality of Care/ Service Concerns	Policy and procedure review with QM Nurse	Describe events that trigger Quality of Care/Service concern processes Explain processes from start to finish
Auditing criteria	Discussion with auditor; review of criteria and auditing policy and procedure	Explain purpose of auditing Reinforce understanding of auditing in overseeing, measuring, and improving performance Identify and understand criteria measured in audits
Accreditation Standards	Self-paced; read copy of accreditation standards related to role	List accreditation organizations Explain components of accreditation standards related to role Locate resources for reviewing standards and results of accreditation process
ACLA Code of Conduct	Web-based module with Code of Conduct forms	Understand personal responsibilities for complying with rules and the consequences for non-compliance Know the policies and procedures that guide professional conduct Understand how Fraud and Abuse is defined and what actions to take when discovered Understand how professional ethics are governed and what P&Ps guide ethical decision-making
Cultural Competency	Web-based module with online assessment	Describe purpose of Culturally and Linguistically Appropriate Services (CLAS) and how standards are followed in the company Explain how race and culture affect members' medical decision-making and health care behaviors Describe role-specific responsibilities regarding cultural competency
Your Tools		

Medical Management Information System	Instructor-led training with practice exercises in system training environment using role-based scenarios	Use search and navigation features View all cases, open and closed Start a new case and select data elements (e.g., treatment setting, bed type, etc.) appropriately Check member eligibility Approve, pend, deny a case Perform denial notification with appeal rights Perform member and provider data reconciliation Choose the correct diagnosis using the drop down and the Autocoder Add detail lines Add procedures For denials, select the correct denial letter Select appropriate template/tool to create proper documentation Use the Route To function appropriately Use the Next Review Date appropriately Close cases correctly Access and document using correct UM template or tool Use triggers for appropriate case referral and follow-up actions Use the Quality Management Indicators
Medical Management Information System (cont'd)		

InterQual Criteria Sets: InterQual Adult ISD (Intensity of Service, Severity of Illness & Discharge Screens) Criteria . InterQual LOC: Acute Adult (Episode Day 1-X) Criteria InterQual Pediatric ISD (Intensity of Service, Severity of Illness & Discharge Screens) Criteria . InterQual LOC: Acute Pediatric (Episode Day 1-X) Criteria InterQual Outpatient Therapy Criteria. InterQual LOC: Outpatient Rehabilitation & Chiropractic InterQual Home Care Criteria. InterQual LOC: Home Care Criteria InterQual Outpatient Procedures Criteria. InterQual Procedures (Adult or Pediatric) InterQual DME Criteria ACLA Clinical AmeriHealth Caritas Louisiana Clinical Policies	InterQual Certified Instructor-led training with practice exercises in system training environment using role-based scenarios Louisiana Medicaid Manuals available for Providers, Hospitals, Home Health Care, Durable Medical Equipment, Ambulance, Transportation, EPSDT and Family Support Services	Demonstrate ability to apply criteria to case studies Create InterQual reviews Obtain an IRR test score of greater than or equal to 90%
Phone System	Instruction and set-up with UM Preceptor	Use correct scripting for voicemail Know functions of phone system related to role
Language Interpreter Services; TTD	Instructor-led training with practice	Reinforce Culturally and Linguistically Appropriate Services (CLAS) knowledge related to language interpreter services and TTY Understand when and how to use language interpreter services and TTY.
Introduction to the State Program		

Louisiana DHH Overview	Self-study (Core Module)	Locate Louisiana DHH website Describe eligibility rules and benefits provided by program Cultural training to include geography and pronunciations.
DHH Policy and Procedure Manual	Self-study (Core Module)	Locate manual Relate DHH policies and procedures to corporate policies and procedures
DHH Contract	Self-study (Core Module)	Understand contract and reporting elements that are related to role activities Explain consequences of not fulfilling contract requirements

Table N.1-1: Orientation Plan for New Utilization Management Employee

Ongoing Training Programs

ACLA promotes ongoing training programs covering topics such as the Bayou Health MCO contract, customer service skills, accrediting agency standards, regulatory requirements, and other topics pertinent and necessary to maintain professional competencies. While training begins with the orientation process, employees at all levels undergo training throughout their employment with ACLA. The goals of ACLA's training programs are consistency, compliance, cross training, skill advancement, and capitalizing on strengths while minimizing weaknesses. Ongoing training is a critical component of employee productivity and satisfaction, leading to improved retention. Enabling employees to expand their skill set fosters a creative and energetic approach to performing job responsibilities. We consider our ongoing training programs to be an innovative corporate approach that is focused on each individual employee.

Examples of ongoing training include:

Corporate presentations through our Learning and Organizational Development department (outlined below)

- Off-site staff training seminars;
- Professional conferences, seminars, and/or continuing education courses;
- Peer-delivered care management presentations; and
- Web-based learning modules.

Additional training methods for UM staff include:

- Individual coaching;
- In-services; and
- Case rounds.

A log of all corporate seminars and conferences attended is kept on file in the Human Resources department. Documentation on department-specific training sessions (e.g., Clinical Updates) is kept on file with the responsible ACLA manager.

As described above, IQ training is provided upon hire. Refresher classes are provided quarterly, as needed by individual staff, and any time there is a change in the criteria itself. In addition, ongoing quarterly training is provided to include the discussion of Louisiana Medicaid Provider Manual topics/criteria, the review of UM criteria/guidelines and policies, the creation of denial letters to ensure specific guidelines used are communicated, and the development of easily understood language. Medical directors provide weekly educational opportunities covering topics such as Q Fever, Pertussis, Wiskott-Aldrich Syndrome, Acute vs. Chronic CHF, Type I DM, Community-Acquired Pneumonia, Disseminated Intravascular Coagulation in Adults, Medulloblastoma, and any topic pertinent to the health of our members discussed during UM/CM rounds.

Learning and Organizational Effectiveness

ACLA's Corporate Learning and Organizational Effectiveness (L&OE) department is a one-stop learning service for the organization's training needs. L&OE focuses on employee performance improvement by providing services that help develop the organization's people, processes, and business. Alongside our extensive functional job training we provide supervisor, management and leadership, and core competency development for individual contributors. These curricula provide the learning framework for our Talent Management Pipeline Program.

The goal of the L&OE program is to provide effective, business-specific learning opportunities that strike a balance between our corporate strategy and the needs of our nationwide business partners. Specifically, L&OE:

- Creates and maintains our strategic direction as a learning organization
- Delivers customized programs to support our Medicaid Managed Care, Care Management Programs, Medicare Managed Care, Pharmacy Benefits Management, and Behavioral Health businesses
- Provides solutions that support individual, team, and organizational competency needs
- Manages the organization's performance management process and recognition programs
- Implements and oversees learning curriculums that support our corporate vision, strategy, mission, and goals

Educational programs are delivered using a variety of methods to accommodate varied learning styles and to reach users in multiple locations. Delivery methods include instructor-led classroom training, computer-based training, and video conference training. Robust tools track attendance and manage assessment and reporting data. Testing, feedback, and other structured processes are applied to continuously improve training curricula and methodologies.

The range of programs available through Learning & Organizational Development includes:

- Team building
- Customer service
- Software skills (e.g., MS Access, MS Excel)
- Personal development
- State and federal government required training
- Basic work skills, including writing, time management, and conflict management
- Creative thinking and innovation workshops
- Civil treatment series
- Change management
- Performance management
- Leadership and influence workshops
- Effective communication
- Diversity
- Off-site staff training and seminars

ACLA offers each professional employee the opportunity to attend at least one conference, seminar, or continuing education course annually. Employees are able to choose educational opportunities that will contribute to growth in the professional competencies required for his/her individual position. As appropriate, participants are expected to disseminate information that they received during their training sessions. The information may be presented at a staff meeting or via e-mail, depending on the nature and relevance of the information to other employees.

Inter-rater Reliability

In addition, UM staff involved in the application of medical necessity criteria will participate in an Inter-rater Reliability (IRR) process quarterly. This process involves reviewing blinded actual case examples to check that staff are selecting the appropriate criteria and are either approving or pending the cases to a physician reviewer for approval if criteria appear to have not been met. The IRR testing is a written assessment based on specific case examples. Questions are created that test the individual's use of appropriate IQ criteria selection, and specific criteria points. Physician reviewers also participate in an IRR process twice per year. The IRR process helps to identify whether clarification or recommendations for modifying criteria are needed, or whether additional individual or group training is indicated. Action plans are developed to address identified variances. Performance results and action plan results are communicated to staff via individual sessions, team meetings, and departmental communications, and are reported to the Quality Assurance and Performance Improvement Committee (QAPIC).

In addition to twice yearly InterQual testing, medical directors convene educational sessions quarterly. Topics of discussion include:

- Cases that were denied and overturned on appeal or dispute by another medical director;
- Cases associated with inconsistencies in determinations;

- Problematic or instructive cases;
- Appeal and dispute cases with special interest to network needs and provider relations;
- Criteria, including those from InterQual, local sources, or the corporate Clinical Policy Committee, that pose problems in interpretation or application;
- Special reports by medical directors, based on their education, training, and experience; and
- New information, including:
  - InterQual and plan-specific criteria,
  - Nationally recognized guidelines, such as those from the American College of Cardiology/American Heart Association, American Diabetes Association, and National Heart, Lung, and Blood Institute, and
  - Relevant peer-reviewed medical literature.

ACLA has been successful in this area. The goal for IRR is 90% or greater. ACLA reports the following results:

	IRR Results for 2013	IRR Results for 1st Quarter 2014
Concurrent Review	93%	93%
Precertification RN	93%	91%

Exhibit N.1-2: ACLA IRR Results

Individual Coaching

UM cases, including information collection, criteria application, documentation, timeliness, and notification, are audited on an ongoing basis. Monthly, a supervisor will review the results with the individual employee responsible for the case and evaluate aggregate trends. Each employee receives coaching based on the individual results. Training initiatives are developed to address common opportunities for improvement.

Case Rounds

On a weekly basis, nurses, social workers, physicians, and care coordinators meet to review complex cases. This forum serves a dual purpose. It is a problem-solving session to develop creative solutions to complex management issues, as well as an educational forum to share information, resources, and example-based education. The rounds are also used to develop specific education and training programs, as described earlier.

In-service Training Sessions

UM staff members also attend in-service sessions on topics ranging from clinical updates to network utilization management capabilities and new operational policies. Whenever possible, outside representatives with knowledge of the program or topic are brought in to provide the education. In-service training sessions are scheduled several times a month. Employees are

required to attend all mandatory topics, such as criteria updates and changes to operational policies, and a percentage of other offerings. In-service training session records are reviewed quarterly as part of the employee's development plan.

Use of InterQual Industry Product

ACLA uses the nationally-recognized InterQual guidelines in the development and management of our UM program. To assure that all decisions are made appropriately, employees will use the following Quality of Clinical Care Committee (QCCC) and DHH approved criteria in making UM decisions:

- InterQual Adult ISD (Intensity of Service, Severity of Illness & Discharge Screens) Criteria. InterQual LOC: Acute Adult (Episode Day 1 – X) Criteria;
- InterQual Pediatric ISD (Intensity of Service, Severity of Illness & Discharge Screens) Criteria. InterQual LOC: Acute Pediatric (Episode Day 1 – X) Criteria;
- InterQual Outpatient Therapy Criteria. InterQual Outpatient Rehabilitation & Chiropractic Criteria;
- InterQual Home Care Criteria;
- InterQual Outpatient Procedures Criteria. InterQual Procedures (Adult or Pediatric) Criteria;
- InterQual DME Criteria; and
- Louisiana Medicaid Services Manual.

ACLA reviews and approves InterQual criteria annually – and more often when indicated – before it is used as part of the UM process. The QCCC, which consists of actively practicing Louisiana practitioners, is responsible for this annual review and approval as part of ACLA's Quality Assurance and Performance Improvement Program. Practitioners that serve on this committee will provide input in the development and revision of these criteria.

As needed, ACLA develops internal criteria to supplement InterQual. We use the following information sources during the development process for our UM policies:

- Results of the Hayes Incorporated (Hayes, Inc.) technology assessment report;
- Information from appropriate government regulatory bodies, such as the Food and Drug Administration (FDA) or the Department of Health and Hospitals (DHH);
- Published scientific evidence;
- Publicly available reference information (including web/online resources); and
- Information from a board-certified consultant(s) familiar with the specialty or technology area under review.

QAPIC Review

We review the InterQual criteria for approval at least annually—or more often if needed—during the QCCC meeting, which includes external physicians as members with voting privileges. Following the internal review, we review the proposed criteria with the QCCC for additional input. The final criteria are reviewed and approved by the QAPIC.

Differences between the UM Phone Line and the Member Services Line

The UM and Members Services phone lines are kept separate through different phone lines, with different call numbers leading into the different departments. Should a call go to the improper phone line, contact center staff is trained in the appropriate transfer of the call. Beyond the separate phone numbers, another difference between the UM phone line and the Member Services phone line is the role-specific training provided to employees. Employees servicing the UM phone line are trained in the prior authorization process. Employees servicing the Member Services phone line, explained in more detail in R.1, are trained to investigate and resolve claim payment issues and update member information. Included in staff training for the two departments is how to facilitate the seamless transfer to the correct department in order to best address the caller's need. To fulfill their different roles, UM and Member Services staff have access to different information sets in our systems. UM staff and Member Services staff can both access clinical detail related to the member's authorization, care gaps, care management assessment, care plan, and care coordination notes.

Tracking Separate Calls

The UM call centers use the same Contact Center technology as our Provider Services and Member Services departments. Calls are answered by a live ACLA representative within 30 seconds. Both UM phone staff and Member Services phone staff can use a warm transfer to move a call belonging to another team without requiring the caller to redial or restate the reason for the call.

In addition, both the UM phone line and the Member Services phone lines are answered by a representative 24-hours a day, 7 days a week. Calls received after business hours, on weekends, and on holidays are answered by our off-hours team. The off-hours team will contact the on-call UM nurse for any urgent issues. A medical director is also on-call to address any medical necessity determination requests.

Goal:

% Abandonment Rate <= 5%

Average Speed to Answer (ASA) <= 30 second

	% Abandonment	ASA	Average Hold Time
Average 2013	.6	6 seconds	32 seconds
January 2014	.4	8 seconds	34 seconds
February	.4	7 seconds	37 seconds
March	.4	8 seconds	45 seconds
April	.5	9 seconds	33 seconds

May	.5	7 seconds	30 seconds
June	1.2	21 seconds	38 seconds
July	1.0	7 seconds	29 seconds
August	1.0	13 seconds	32 seconds

Exhibit N.1-3: ACLA Call Rates

Ensuring Prior Authorization Timeframes Are Met

To ensure that prior authorization timeframes are met, as outlined in Section 8.5 of the Bayou Health MCO RFP, ACLA uses weekly turnaround time reports. We perform internal audits at random, sometimes on a daily basis. The UM team uses the turnaround time and aging report in compliance with DHH requirements. On average, five audits are performed per month.

	Non Urgent (Standard) Prior Authorization (2 BD*/14 CD*)	Urgent Prior Authorizations (3 CD*)	Concurrent (Inpatient) Review (1BD*)	Retrospective (30 CD*)
2013 Q3	93.34%/99.43%	100%	98.11%	100%
2013 Q4	87.33%/99.10%	100%	98.47%	100%
2014 Q1	85.01%/98.79%	96.67%	97.75%	100%
2014 Q2	85.09%/99.51%	100%	100%	100%

*BD=Business days; CD=Calendar days

Exhibit N.1-4: ACLA Prior Authorization Timeframes

Avaya is the system used to monitor and track calls and call metrics. This software allows for call monitoring using a pre-determined audit tool to makes sure provider questions are being answered. If there is a deficiency, we will institute education to improve the quality of the calls.

Using Call Volume to Manage the UM Workforce

Workforce Management is made up of people, processes, and technology all aimed at helping ACLA ensure the right people are in the right place at the right time to do the right work to meet commitments to our members and shareholders. To do this, a team of analysts works together to create forecasts for all the various types of work done within service operations and medical management. These forecasts are used to determine how many staff will be needed to complete the various types of work within the defined service level and timeliness goals in each unit. Additionally, this team helps supervisors and managers determine the best time to conduct meetings, training, and other non-production activities, and how many associates can be approved for leave daily while still ensuring that the work is completed. ACLA will record

100% of calls for our intake staff that will be monitored by supervisors, as we have implemented in our South Carolina affiliate. We will use this information to adjust our staff, based on changing call volumes.

N.2. Utilization Management

N.2 Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.

Overview

ACLA has been meeting the needs of the Bayou Health population since 2012 and has customized our UM program based on the population's needs. Part of this strategy is ensuring that services are not inappropriately denied or reduced. We achieve this through various strategies. First, we ensure that we base all decisions on well-established standards that consider all relevant clinical information by appropriately licensed professionals, including RNs and MDs. This process includes review of DHH-supplied prior authorization data and/or relinquishing MCO data files. The second strategy makes sure that the UM team is well-trained on all the standards. Third, we periodically audit the decisions to ensure accuracy. ACLA also provides a process for providers to appeal decisions. Lastly, we also use our prior authorization process to ensure that services are appropriate for each member.

Ensuring Services to Our Members

Well-Established Standards Strategy

As part of our first strategy, we base all UM decisions on objective and evidenced-based criteria. UM decisions are based on a hierarchy of criteria to include: DHH Contract, Medicaid Provider Manuals, ACLA Clinical Policies, National Imaging Associates (NIA) Criteria, and InterQual Criteria, detailed below:

- InterQual Adult ISD (Intensity of Service, Severity of Illness & Discharge Screens) Criteria. InterQual LOC: Acute Adult (Episode Day 1 – X) Criteria;
- InterQual Pediatric ISD Criteria. InterQual LOC: Acute Pediatric (Episode Day 1 – X) Criteria;
- InterQual Outpatient Therapy Criteria. InterQual Outpatient Rehabilitation & Chiropractic Criteria;
- InterQual Home Care Criteria;
- InterQual Outpatient Procedures Criteria. InterQual Procedures (Adult or Pediatric) Criteria;
- InterQual DME Criteria;
- National Imaging Associates Specialty Solutions: 2014 Clinical Guidelines for Non-emergent, advanced, outpatient radiology; and
- Louisiana Medicaid Services Manual.

ACLA reviews and approves InterQual criteria annually, and more often when indicated, before it is used as part of the UM process. The QCCC, which consists of actively practicing practitioners, is responsible for this annual review and approval as part of ACLA's overall

QAPI program. Practitioners that serve on this committee will provide input on the development and revision of these criteria.

The UM department also utilizes the DHH prior authorization (PA) data to confirm information of previously approved services by DHH. An example of this situation would be member who had PA for a transplant. This specific type of PA would initiate a referral to the Integrated Care Management (ICM) team in order to facilitate care coordination and services related to the transplant.

Clinical Information

Before we apply these criteria, UM employees request all necessary clinical information from the ordering practitioner and/or servicing provider to render a determination. We ask for only the information necessary to determine if the request meets the specified criteria. For example, if the durable medical equipment (DME) criteria state that a particular piece of equipment is appropriate if five requirements are met, we request information on those five requirements, rather than requesting that all DME requests need documentation for a request for that service. While applying the UM criteria, all employees consider the individual circumstances of the member as well as the characteristics of the local health delivery system.

For example, member considerations may include age, comorbidities, complications, progress of treatment, psychosocial situation, or home environment.

Local delivery system considerations include:

- Availability of subacute care facilities or home care in the plan service area for post-discharge support;
- Plan benefits for subacute care facilities or home care where needed; and
- Ability of local hospitals to provide all recommended services within the estimated length of stay.

Decision Making Process

Should the information provided not meet the elements of the UM guidelines based on any of the above considerations, a physician or designated licensed clinical professional reviews and renders the decision. Practitioners/providers are invited to discuss a determination to deny or limit coverage with a Physician Reviewer through ACLA's peer-to-peer process. The flowchart below summarizes the decision making process.

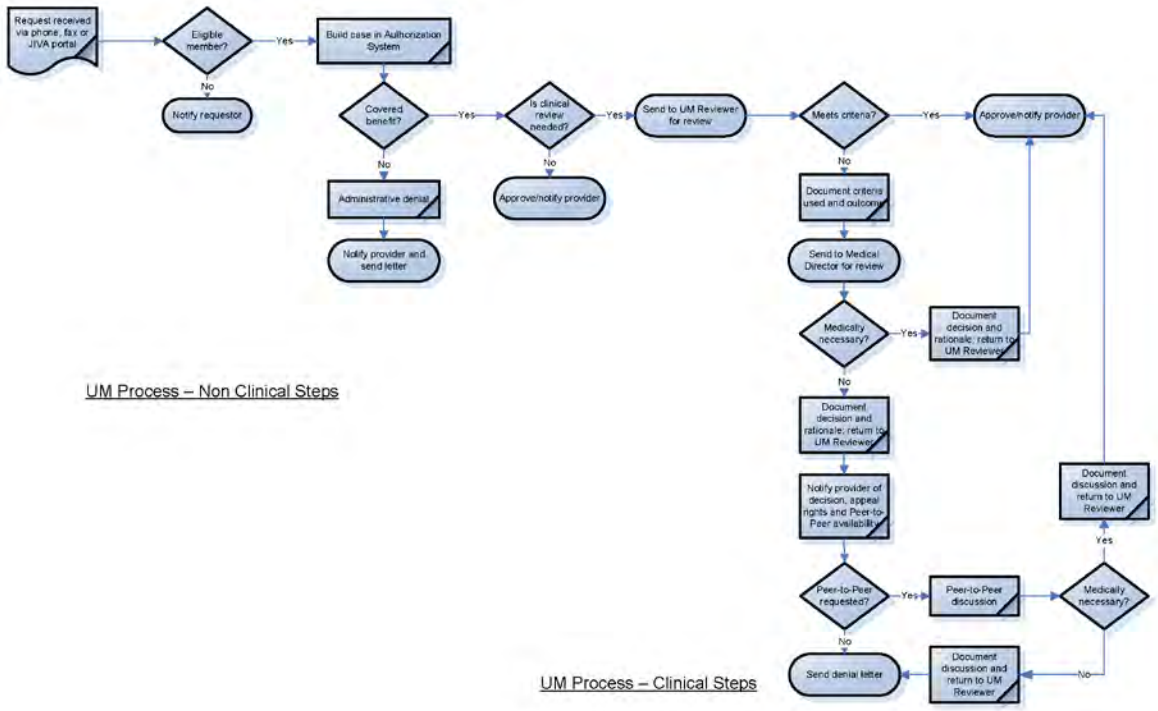

Exhibit N.2-1: Utilization Management Denial Workflow

Individuals Making Medical Necessity Determinations

Requests for benefit coverage or Medical Necessity determinations are made through employees supervised by a registered nurse. Decisions to approve coverage for care may be made by UM employees when they fall within written guidelines.

Any request that is not addressed by, or does not meet, guidelines is referred to the Physician Reviewer for a decision. Medical Necessity decisions made by a Physician Reviewer or designated licensed clinical professional are based on DHH's definition of Medical Necessity, in conjunction with the member's benefits, medical expertise, applicable criteria, and/or published peer-review literature. At the discretion of the Physician Reviewer, input on the decision may be obtained from participating board-certified physicians from an appropriate specialty. The Physician Reviewer or designated licensed clinical professional makes the final decision.

Any decision to deny or limit coverage for an admission, service, procedure, or extension of stay based on Medical Necessity, or to authorize an amount, duration, or scope that is less than requested, is made by a Physician Reviewer or other appropriate designated licensed clinical professional under the clinical direction of the Physician Reviewer. The name and license indicator (MD, DO, PhD, etc.) of the Physician Reviewer or licensed clinical professional making the adverse determination is included in the written determination letter (Notice of Action).

We will base all decisions solely on the appropriateness of care and service and on the existence of coverage. The Utilization Management team will provide services consistent with written

policies and procedures to ensure that criteria are applied appropriately and consistently. Our policies restrict adverse decision making regarding medical necessity to clinical professionals who possess an active, unrestricted license and have the appropriate education, training, or professional experience in medical or clinical practice. ACLA Physician Reviewers and licensed clinical professionals making medical necessity determinations attest that adverse determination will not be made for a medical procedure or service outside of the scope of the individual's expertise.

ACLA does not provide any financial incentives or rewards to encourage decisions that result in underutilization, denials, limits, or discontinuation of medically necessary covered services. The medical necessity criteria utilized by ACLA will be available upon request to all ACLA participating practitioners, providers, and members. We educate practitioners and providers on available review criteria and methods to obtain clinical criteria in our Provider Manual, information posted on the provider section of the ACLA website, and the written determination letter (Notice of Action).

Training on Policies and Procedures Strategy

The second strategy to ensure that services are not inappropriately denied or reduced is to make sure that our UM team is well-trained and performs services consistent with our policies and procedures. ACLA's Louisiana-based and licensed medical director is responsible for the development, implementation, and medical interpretation of medical policies; planning; and the administration of the UM department.

We base all decisions solely on DHH medical necessity definitions, the appropriateness of care and service, and the existence of coverage. The UM team will provide services consistent with written policies and procedures to ensure that criteria are applied appropriately and consistently. The policies restrict adverse decision making regarding medical necessity to clinical professionals who possess an active, unrestricted license and have the appropriate education, training, or professional experience in medical or clinical practice.

Accuracy of Decisions Strategy

In order to ensure appropriate and consistent application of criteria, ACLA implements its third strategy, which measures the accuracy of its decisions. UM employees (including physicians) undergo Inter-rater reliability testing on a regular basis to evaluate consistency in applying criteria. UM employees are also subject to periodic quality audits of case files. We develop action plans to address any identified variances. We communicate performance results and action plan results to employees via individual sessions, team meetings, and department communications. These results are also reported to the Quality Assessment Performance Improvement Committee (QAPIC).

Process for Appeals Strategy

If providers or members disagree with the decision, a member or provider may appeal the process. The appeals process provides a member, or an authorized representative acting on the

member's behalf and with the member's written consent, the opportunity to file an appeal with ACLA. Appeals may be filed orally or in writing. Members are permitted to present evidence and allegations of fact or law in person as well as in writing. The member or his or her representative may examine the case file before or during the appeal process. The member, or an authorized representative acting on the member's behalf and with the member's written consent, may request a State Fair Hearing after ACLA's appeal process has been exhausted.

Analyses of ACLA's member appeal determinations indicate a downward trend in overturns. The percentage of appeals overturned has decreased as follows:

- 49% in 2012
- 41% in 2013
- 31% in 2014

Although the number one cause for overturn on appeal continues to be the receipt of additional supporting evidence, providers are becoming more familiar with the prior authorization process and the supporting documentation required to demonstrate medical necessity. This year-over-year decrease is consistent with ACLA expectations. Of note, ACLA has been party to only one State Fair Hearing during the current contract term, in which the ACLA denial was upheld.

General Requirements

A member appeal is defined as a request for a review of an Action. An Action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner as described by DHH.

Members, authorized representatives, and providers appealing on behalf of a member with a member's written consent, may use the member appeal process for pre-service denials, including administrative and medical necessity prior authorization denials, or reductions in service according to the instructions as outlined in Section S.1: Member Grievances and Appeals of this response. Assistance is given to members who desire to file an appeal as described in Section S.1: Member Grievances and Appeals of this response.

Providers may use the appeal process if filing on behalf of the member and with the member's written consent, for pre-service denials, including administrative and medical necessity prior authorization denials or reductions. Pre-service reconsideration requests must be filed according to instructions indicated in Section S.1: Member Grievances and Appeals of this response.

Notice of Action

Oral and written appeals are acknowledged in writing and include the next step in the appeals process. The resolution notice of action is communicated in writing and in oral format for expedited resolution. All communications meet language and format requirements as described

by DHH. The information included in ACLA's Notice of Action letters adheres to the requirements of Bayou Health.

Standard resolution of an appeal is maintained as of 30 calendar days from the day ACLA receives the appeal. The timeframe may be extended under Section S.1 of this response. Expedited resolution of an appeal is maintained as 72 hours after ACLA has received the appeal. The timeframe may be extended as described under Section S.1 of this response. During ACLA's current contract with DHH, the average resolution time was 18.16 days for member grievances and 10.99 days for member appeals. The average turnaround times demonstrate ACLA's commitment to resolving member grievances and appeals as expeditiously as possible.

Appeals shall be resolved no later than the above stated timeframes, and all parties are informed of the decision. If a determination is not made in accordance with the above timeframes, the request will be approved as of the date upon which the final determination should have been made. The member, or authorized representative acting on the member's behalf and with the member's written consent, may file an appeal with ACLA and may request a State Fair Hearing after ACLA's appeal process has been exhausted.

Impartial Decision Making

ACLA ensures that individuals who make decisions on appeals, on denials that are based on lack of medical necessity, or on an appeal that involves clinical issues, have not been involved in any previous level of review or decision making, and are health care professionals who have the appropriate clinical expertise. ACLA staff is educated concerning the importance of appeal procedures and the rights of the member and providers.

Expedited Resolution of Appeals

For a request by a member or provider appealing on behalf of the member with the member's written consent, ACLA maintains a process to determine whether taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. If so, ACLA can conduct an expedited resolution of appeals process according to the instructions as outlined in Section S.1: Member Grievances and Appeals of this response.

Timeliness of Decisions on Request for Authorization

Another method that seeks to avoid arbitrarily or inappropriately denied or reduced services is our prior authorization process. In accordance with the Bayou Health MCO RFP, ACLA will continue to adhere to all standard and expedited requests are as follows:

- Standard Authorizations: ACLA will make 80 percent of standard service authorization determinations within 2 business days of obtaining appropriate medical information. In addition, 95 percent of concurrent reviews will be made within 1 business day.

- Expedited Authorizations: In the event that a member's life is in jeopardy, ACLA will issue an expedited authorization as soon as is possible, but no later than 72 hours after the request.

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N.3. Utilization Management

N.3 Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over-utilization) in the utilization pattern of a provider or a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.

Overview

ACLA employs a comprehensive collection, analysis, and reporting infrastructure that is the basis for our Utilization Management (UM) program. Through this program, we deliver a cost-effective system of care for our members that meet their targeted health needs. We have successfully worked within the Bayou Health system to reduce under- and over-utilization.

Collection, Analysis, and Reporting of Utilization Data

ACLA prioritizes the identification of overutilization and underutilization as critical to the quality of care and quality of life of members, thereby impacting directly on the cost of providing care and services. Over- and underutilization of care and services is ineffective, clinically inappropriate, and costly.

We also utilize several information sources and processes to identify utilization patterns and opportunities related to the quality and cost of medical care. ACLA's robust information systems facilitate analysis of utilization patterns at the plan, sub-population, provider, and member levels. Our multi-faceted approach generates information, which provides a global view of issues while enabling us to identify specific areas, providers, or members that require particular attention.

Our reporting infrastructure collects, analyzes, and reports utilization data for our members and providers. Data is collected from multiple sources, including eligibility records, claim transactions, authorization records, and supplemental files, such as historical claim data, pharmacy claim data, immunization registries, and lab results. This data on members, providers, authorizations, and medical claims is loaded from our transactional systems, Facets® and Jiva™, then to our data warehouse. The data warehouse is refreshed on a weekly and monthly basis, depending on the data source and the frequency with which it is received. Supplemental data files are loaded on receipt.

Our approach includes analysis of claim, authorization, and outcome data at the population, regional, and provider level, using risk adjustment to account for differences in member acuity, where appropriate. We also use processes that assist with clinical claim editing and reporting, and monitor quality-of-care concerns, both of which assist in identifying potential fraud and abuse.

We then extract data for reporting purposes from the data warehouse or the source system, depending on the level of granularity and data elements needed. The data are extracted and

reported using any combination of the following tools or applications: Microsoft Access, BI query, SAS, SQL, Crystal Reports®, Business Objects, and Excel. The Informatics Department generates a wide range of reports. Some are operational, such as the Daily Inpatient Census or Weekly Case Load reports, while others are more trend-oriented and performance-based. Specific reports used for the identification of over- or underutilization area described below.

Medical Expense and Trend Report

The Medical Expense and Trend Report is a report used by ACFC based on paid claims and membership data which illustrates the expense, utilization, and unit cost trends for all trend categories including Inpatient, Outpatient, Professional, and Retail Pharmacy claims, and several subgroup levels under each trend category. The data in the report are reported for a period of 24–36 months showing month-to-month run rates as well as period-over-period trend rates on the most recent 12/12 month, 6/6 month and 3/3 month trends comparisons. Trend comparisons over the various time frames allow the reviewer of the report to determine if increases are based on current or previous time frames. The report also captures emerging trends to alert health plan executives of areas driving increased expense. The report further alerts the reader to the components that are driving increases in relation to changes in utilization and unit costs. The report is available at Enterprise, Region, Line of Business (State), Member Aid Category (TANF vs. SSI), and geography levels. The report is created monthly at a summary level, with robust detail data stored in a variety of data warehouse environments for detail and specialized review and analysis.

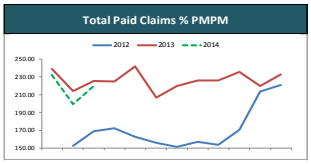
The Medical Expense and Trend Report has enabled successful interventions related to utilization and cost trends, and is an integral part of our cost containment strategy on an enterprise and state / line of business level. Most recently, the report has highlighted specialty pharmacy cost increases that have prompted ACFC's Pharmacy Benefit Management vendor to create a specialty pharmacy program. Reported high-cost radiology services have led to ACFC implementing a national high-tech radiology program with a goal to reduce costs, reduce testing, increase quality, and curtail over-radiation of children. Other areas in which the reports have been helpful are in curtailing increased utilization and costs related to durable medical equipment, and genetics testing.

This is a summary sample of the Medical Expense and Trend Report:

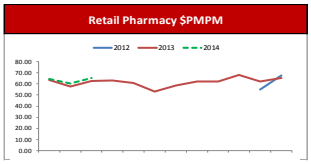
Trends by Total and Trend CategoryAmerihealth Caritas Louisiana - LOB 2100
Based on Paid Claims Incurred between Jan 1, 2012 and May 31, 2014- paid through Jun 30, 2014
Data Source - Facets

Amerihealth Caritas Louisiana - LOB 2100

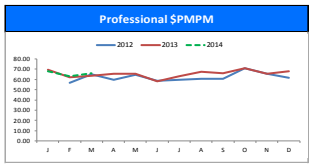
Period	Previous Month Avg	Current Month Avg	% Actual Trend
12 / 12 mo.	146,502	145,637	-0.6%
6 / 6 mo.	155,688	144,276	-7.9%
3 / 3 mo.	155,406	142,959	-8.7%



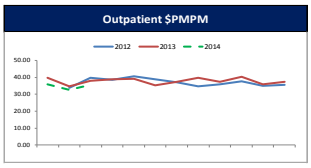
Period	Previous	Current	% Trend
12 / 12 mo.	$187.77	$223.86	16.1%
6 / 6 mo.	$214.03	$223.40	4.2%
3 / 3 mo.	$226.35	$217.23	-4.2%



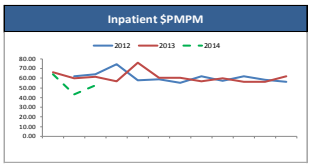
Period	Previous	Current	% Trend
12 / 12 mo.	$27.13	$62.14	56.3%
6 / 6 mo.	$51.07	$64.28	20.6%
3 / 3 mo.	$61.33	$63.34	3.2%



Period	Previous	Current	% Trend
12 / 12 mo.	$63.16	$65.65	3.8%
6 / 6 mo.	$65.59	$66.97	2.1%
3 / 3 mo.	$65.15	$65.71	0.9%



Period	Previous	Current	% Trend
12 / 12 mo.	$37.08	$37.19	0.3%
6 / 6 mo.	$36.77	$36.32	-1.2%
3 / 3 mo.	$37.47	$34.72	-7.9%



Period	Previous	Current	% Trend
12 / 12 mo.	$60.39	$58.88	-2.6%
6 / 6 mo.	$60.61	$55.83	-8.6%
3 / 3 mo.	$62.40	$53.46	-16.7%

Exhibit N.3-1: Medical Expense and Trend Report

Inpatient and Outpatient Authorization Key Indicator Reports

These reports compare inpatient and outpatient services that were authorized and requested from the current period to the corresponding prior period, both on a monthly and year-to-date basis. In addition to serving as a harbinger of claims, they allow the UM area to review the current services performance versus projected and historical results. The reports can also alert UM of a pending or developing increase in certain conditions such as influenza, heat-related conditions, and pregnancies. Using inpatient and outpatient authorization results, we monitor for unusual changes between specific periods of time.

ACLA's Key Indicator Report demonstrated significant decreases in recent Neonatal Intensive Care Unit (NICU) admissions and reductions in lengths of stay resulting from prenatal interventions, enhanced NICU rounds, and other innovative interventions. These interventions were implanted following the identification of increasing NICU trends in the past.

AHC Louisiana (LA/2100) Key Indicators
Incurred Dates: February 1 ,2012 - April 30, 2014

AmeriHealth Caritas Louisiana

NICU- IP Admits /1,000	Current Metric	% Trend
12 mo	7.0	18.7%
6 mo	6.8	4.8%
3 mo	6.3	-7.2%

NICU - IP Days /1,000	Current Metric	% Trend
12 mo	121.8	-0.1%
6 mo	113.5	-8.1%
3 mo	87.8	-33.0%

NICU - ALOS	Current Metric	% Trend
12 mo	17.45	-15.9%
6 mo	16.75	-12.3%
3 mo	13.99	-27.8%

Exhibit N.3-2: Key Indicator Report

Prevention Quality Indicators

ACLA also uses software developed by DHH that reports on selected conditions that produce rates of Prevention Quality Indicators (PQIs). PQIs relate to inpatient admissions that may have been avoided if appropriate ambulatory care had been provided. These reports are trended over time and can be generated by the plan, hospital, PCP practice, or member. We also indicate which members with high PQI rates are currently under case management. Those members with high PQI rates who are not participating in case management are contacted for engagement and assessment. We also work with individual hospitals and review their PQIs with the expectation of modifying the hospital's performance.

HEDIS Reports

While ACLA is required to report HEDIS results to fulfill state or accreditation requirements, we also use the measures to monitor the quality, access, and availability of care, and to identify health care disparities. We examine selected services on a summary and member level for opportunities to identify and remove any barriers to preventive and recommended services. HEDIS results enable us to compare our results to other plans as well as to national benchmarks. Outliers are identified and action plans are developed as needed to address such issues.

Over- and underutilization is monitored annually by comparing the results of select HEDIS measures with national HEDIS Medicaid benchmarks (90th percentile and 10th percentile for upper and lower thresholds, respectively). Measures are selected based on their demographic, clinical, and practical relevance to the member population. ACLA routinely monitors myringotomy, tonsillectomy, dilation and curettage, and abdominal hysterectomy, because these services can be of particular concern to women and children, both of which are present in high numbers in the Louisiana Medicaid population.

HEDIS reports support successful interventions in a variety of ways. We recently used these reports relating to the overutilization of ED services. The reports were analyzed by number of visits, category of ED level of care, and diagnoses driving the visits. These reports are then used by the Rapid Response team for targeted outreach to address member needs and barriers to appropriate care. Overutilization of ED services can be an indication of access barriers to primary care provider (PCP) utilization, inadequate outpatient management, a member's unawareness of his/her PCP, or an inadequate supply of PCPs. We also review inpatient utilization reports, because inappropriate and unnecessary hospitalizations place members at risk for medical errors. The majority of inpatient admissions arise from an ED visit. High inpatient utilization can indicate underutilization of outpatient services, or inadequate outpatient management. Low inpatient utilization can indicate barriers to admission.

Care Gap Reports

Care gaps occur when members do not receive (or there is no documentation that they have received) services recommended by evidence-based clinical practice guidelines. ACLA analyzes

claims data against evidence-based algorithms monthly to identify gaps in care. Care gap algorithms exist for a full range of preventive services and chronic disease states.

Care Gap reports, in the form of system alerts, are available to employees performing utilization management, quality management, care management, and member services activities. Employees see a system flag when the member's ID number is entered.

Providers also receive Care Gap reports, both as alerts during an eligibility check, and as full panel reports through the Provider Portal. When the member's ID number is entered in the portal, a pop-up alert appears notifying the provider that a Care Gap exists. When the provider clicks on the alert, a member-level report appears, identifying missing and overdue services, Care Gaps, and up-to-date services. The provider can also access a report of all Care Gaps for his assigned members, either as a printable document or as a comma-separated values (CSV) file that can be incorporated into other systems.

Monitoring Variances

ACLA will actively monitor variances in utilization to identify under-, over- or misutilization. The results of utilization monitoring reports are reviewed by the respective management team. We monitor performance; analyze cost, utilization, and outcome data; compare our results to benchmarks; and prioritize areas for program changes and initiatives. The highest priority is given to those areas that affect large segments of our population and evidence a strategic fit with our goals—improving efficiency, effectiveness, and customer satisfaction.

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

As part of the planning process, we form a workgroup consisting of representation from stakeholders, our analytic team, and subject matter experts. The workgroup conducts additional analysis to identify the drivers of the variance. Where appropriate, the analysis and findings are presented to the ACLA QCCC for additional input and feedback.

The findings and recommendations are reviewed by the ACLA management team and the QAPIC. Monitoring and reporting activities continue to evaluate the impact of any changes on the identified area.

Example of Data Utilization: ACLA-specific Utilization Programs and Results

Bright Start Maternity Program

ACLA runs a monthly program to identify pregnant members on medications contraindicated in pregnancy, the so-called pregnancy D and X drugs. Members and providers are contacted in an effort to discontinue the medication. The Bright Start maternity management program reviews the monthly pharmacy data and provides ongoing outreach to the members that were identified to educate them on medication safety and pregnancy interactions. The care managers also contact the prescribing or obstetrical provider to communicate the pharmacy fill history for

the member. If there appears to be a question of appropriate medication prescribing or standard of care adherence, the care manager will review with ACLA's medical director for peer-to-peer outreach. The medical director may also consult with the enterprise obstetrical consultant to provide further outreach and guidance if required. Additionally, this approach is also utilized if there is concern with underutilization of 17 alpha-hydroxyprogesterone caproate (17P) for our members that meet the criteria for these injections to prevent recurrent preterm birth.

Beyond the pregnancy D and X drugs, a related program identifies pregnant members on medications that identify them with high-risk conditions that may adversely affect the pregnancy, such as diabetes or hypertension. The Bright Start maternity care manager will reach out to these members and offer intensive case management.

Hepatitis C Drug Utilization Program

We also utilize designated care managers who assist hepatitis C patients through the system so that they are able to get their medication, which is often very costly. Once through the approval process, the care managers guide them through the rest of the process, making sure they take every dose of the initial prescription and then ensuring that patients get their refills on time so that no doses are missed, because even missing one to two doses renders the virus rapidly resistant to the treatment.

Sovaldi and Olysio were released in December 2013 to treat hepatitis C virus (HCV). They were approved by the FDA at the beginning of 2014 and chosen in federal guidelines as the two acceptable agents to treat HCV. In accordance with these guidelines, ACLA implemented updated Pharmacy & Therapeutics Committee (P&T) approved treatment guidelines to address the latest practice standards and the need for greater member education and direct intervention. Members who qualify for treatment through the program are required to comply with the regimen. Care managers reach out to members to encourage this compliance. Members who do not adhere to medication guidelines by not refilling prescriptions or by missing more than two doses are terminated from the program.

Key Criteria Changes

Key criteria for the HCV utilization program include a required attestation of abstinence from drug and alcohol, and program participation as documented by a copy of the note in the member's medical record. Nurse care managers are engaged to contact, educate, and follow up with every member approved for treatment to help ensure that the member receives the full benefit of these drug regimens through full compliance with the program.

Additionally, the program requires testing in the following measures, as verified by a copy of the testing results:

- ALT/AST, albumin, bilirubin, total and direct, prothrombin time
- CBC, ferritin, iron saturation
- TSH, ANA
- Serum Creatinine, glucose, uric acid
- ECG, echo cardiogram, stress test in the presence of heart disease

- Urine drug screen
- Blood alcohol level
- Pregnancy test in women of childbearing age
- Serum HBsAg, anti-HBc, anti-HBs, anti-HAV
- HIV serology (CD4+ T cell count and HIV RNA required for HIV co-infection
- Liver biopsy showing advanced to severe fibrosis (Ishak Stage > 3 OR Metavir Score > 2) OR non-invasive testing, Fibroscan or Acoustic Radiation Force Impulse (ARFI), to identify severe liver fibrosis

These efforts have ensured clinical and fiscal oversight, as well as compliance to treatment regimens, for the best positive outcomes. Prior to the implementation of stringent criteria and direct patient intervention, 31.5 percent of prior authorization requests were approved. Subsequent to the implementation of stringent criteria, 10.5 percent of prior authorization requests were approved. Of the 14 members who received either Sovaldi or Olysio HCV therapy following the above new guidelines and interventions, all but two members have been fully compliant with, and have successfully completed, treatment.

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N.4. Utilization Management

N.4 Describe your plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to DHH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions.

Overview

ACLA continuously mines utilization data to identify inappropriate utilization and inappropriate levels of provided care. For example, inpatient level of care for services provided in 2013 was identified as potentially inappropriate, and an audit of medical records was initiated at identified inpatient facilities. We successfully reduced the length of stays under two days, as described below, through one hundred percent physician review of all ambulatory sensitive conditions, identifying outpatient gaps in care and use of observation stays and close MD follow up.

In order to best utilize the resources of the Bayou Health program and to deliver person-centered, appropriate care to our members, ACLA has worked with DHH to invest in the establishment of Patient-Centered Medical Homes (PCMH) throughout the state. We have shown our commitment to the use of PCMHs as a best practice to reduce emergency room usage in multiple ways, including our dedicated staff. ACLA has one PCMH-certified content expert on our network management team and another five who are eligible for certification.

This knowledgeable team is assisting thirty primary sites in working toward the achievement of NCQA-certified status. We are committed to working toward the certification of additional PCMHs, and to ensure that our members receive primary care services outside of an emergency room and with their primary care physician (PCP). Our program is built on the belief that a PCMH develops a trusting relationship between the member, the physician, and the community.

Reduction of Inappropriate Inpatient Admissions with Lengths of Short < 2 Days

A statistical review of all inpatient admissions with less than and equal to two days' length of stay was performed using 3M analytics. There were a very high number of inpatient cases that were not medically necessary at the inpatient level and could have been provided in an outpatient environment. Almost half of those cases presented with conditions that were ambulatory sensitive and potentially preventable admissions (PPAs), suggesting gaps in outpatient care. Based on the 3M analytics, the following is a list of PPAs:

A List of PPAs, Based on 3M APR DRGs

- 053 - Seizure
- 054 - Migraine & other headaches
- 113 - Infections of upper respiratory tract
- 137 - Major respiratory infections & inflammations
- 138 - Bronchiolitis & RSV pneumonia
- 139 - Other pneumonia
- 140 - Chronic obstructive pulmonary disease
- 141 - Asthma
- 191 - Cardiac catheterization w circ disord exc ischemic heart disease
- 192 - Cardiac catheterization for ischemic heart disease
- 194 - Heart failure
- 198 - Angina pectoris & coronary atherosclerosis
- 199 - Hypertension
- 203 - Chest pain
- 244 - Diverticulitis & diverticulosis
- 249 - Non-bacterial gastroenteritis, nausea & vomiting
- 251 - Abdominal pain
- 383 - Cellulitis & other bacterial skin infections
- 420 - Diabetes
- 422 - Hypovolemia & related electrolyte disorders
- 463 - Kidney & urinary tract infections
- 465 - Urinary stones & acquired upper urinary tract obstruction
- 662 - Sickle cell
- 722 - Fever

Exhibit N.4-1: List of Potentially Preventable Admissions (PPAs)

To reduce this inappropriate inpatient utilization and improve outpatient management of these conditions, ACLA has implemented 100% MD medical review of requests for inpatient admission for any of these conditions. Cases not meeting medical necessity criteria will be denied for inpatient level of care and observation services will be coordinated with close MD follow-up to facilitate optimal outpatient management.

Providing Care in the Most Appropriate Setting

We utilize multiple programs with the intent to divert patients from using the Emergency Department (ED) and to encourage them to obtain care in the places most appropriate for their current ailments or conditions. ACLA's Emergency Department Diversion Program includes:

ER Diversion Program

The Rapid Response department's ED strategy enlists a multi-faceted approach and consists of three areas of focus:

- Education – Empowering members with information on the appropriate use of health care resources. This includes newsletter articles and educational materials, but is also embedded in the counseling of members and by addressing barriers to care. Care Coordination staff continuously support re-direction to the assigned PCP for care at the member's medical home.
- Prevention – Helping members receive care in the most appropriate setting. When a member is in need of care, the Care Coordination and the Rapid Response and Outreach Teams are available to assist with scheduling appointments and arranging for transportation. Members are encouraged to see their PCP annually and to complete age/gender appropriate wellness screenings and testing. In addition to the Care Management department, members also have access to a nurse for symptom counseling

and anytime health information provided by the ACLA Nurse Call Line. This service is available through a stand-alone, toll-free number and also serves as an after-hour service for our Rapid Response and Outreach Team. Members are encouraged to call the Nurse Call Line when they have symptoms and are unsure where to see care. Nurse Call Line staff direct the members to the appropriate level-of-care using evidence driven guidelines.

- Intervention – Identifying utilization and addressing members' needs. In partnership with the ACLA Informatics Team, the Care Coordination department reviews ER Utilization on a monthly basis. Members are identified based on usage, and stratified into three tiers (High, Medium, and Low) depending on frequency and timeframe.

Campaigns are designed to address each level of utilization, and include communication with the assigned PCP.

Below is the ED utilization review process:

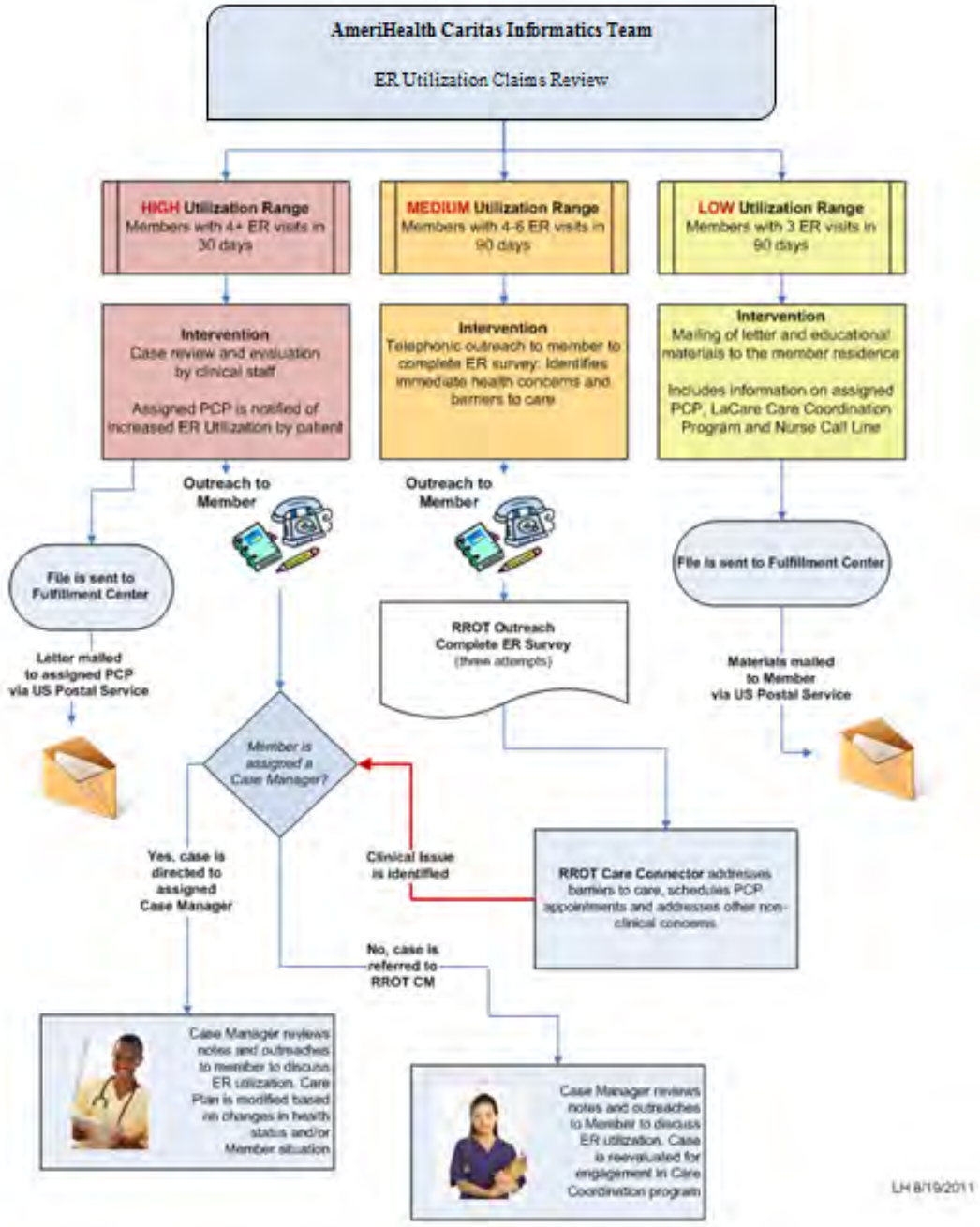

Exhibit N.4-2: ER Utilization Review Process

Patient Centered Medical Home (PCMH)

PCMHs have been shown to produce a number of consistent positive outcomes related to:

- Care cost reductions;
- Reductions in avoidable ER visits and admissions;
- Improvements in clinical outcomes; and

- Enhanced access to primary care services.

AmeriHealth Caritas' founding plan, Mercy Health Plan, was created as a pilot project with the Commonwealth of Pennsylvania in 1983 to create what is now known as PCMH. From AmeriHealth Caritas' corporate beginnings and in all our markets, we have been committed to providing coordinated care through our primary care providers and have deep roots in the PCMH model of care. The result is that we are uniquely positioned to offer assistance to our providers in meeting the requirements for NCQA certification.

ACLA is working to help thirty PCMHs achieve accreditation in Louisiana thus far. Our PCMH-educated staff provides the centers with:

- The technical support, tools, processes, and education necessary to become a PCMH and access to NCQA certification standards
- Training tools on PCMH standards and requirements
- Use of data, such as baseline assessments
- The setting of quality goals.

The ACLA strategy for the expansion of PCMH has three primary goals:

- To improve PCMH access to care for our members, and in our members, with chronic conditions;
- To incorporate the PCMH model of care as a core component of improving delivery of care and benefits; and
- To reduce unnecessary costs, including ER, avoidable admissions and readmissions, and by encouraging accountable behaviors in our members.

Through ACLA's unique experience with the PCMH model of care, we are providing effective integration with our already established programs and strategies to enable and foster higher performing primary care practices.

PCMH PCP QEP Program

ACLA feels that the patient-centered medical home, a delivery model that focuses on a coordinated team approach to patient care, is critical to the success of any value-based program and should, therefore, be formally recognized as a performance attribute. The existing ACLA Quality Enhancement Program (QEP) will be modified for the new contract period to incorporate an enhanced payment for performance in all categories that is also complimented by PCMH certification.

Urgent Care and Retail Clinics

While ACLA strongly encourages members to seek preventative care from their primary care provider, there are times when a member has an urgent care need; in these situations, members can obtain information about urgent care access through the member portal of the website, where a listing of contracted urgent care and retail clinics is posted or through contact with our member services hotline, Rapid Response, or Case Management Departments, where trained

staff are able to direct members to a network urgent care/retail clinic provider. Exhibit N.4-3 is an excerpt of an urgent care clinic list distributed to members. ACLA contracts with approximately 39 free-standing urgent care clinics across the state. Large network providers, such as Ochsner Health System, also offer members access to their urgent care clinics.

Members have access to urgent care through community pharmacies, such as Walgreens Take Care Clinics with 7 locations within the greater New Orleans area. Additionally, ACLA has finalized a contract with CVS/Caremark to bring an additional 7 CVS Minute Clinics to the ACLA provider network. CVS projects that they will add an additional 25 Minute Clinics to the state in 2015, bringing even greater accessibility and convenience to our members.

Children's Hospital After-Hours, Kids First Tiger Care, and Lake After Hours Kids all provide urgent care to our pediatric members and their families.

AmeriHealth Caritas Louisiana

Urgent Care Centers

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

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

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

Group name	Address	City	Phone number	Hours
Lourdes After Hours Carencro	3824 NE Evangeline Throughway	Carencro	1-337-565-2675	Mon – Fri 1:00 p.m. – 9:00 p.m. Sat – Sun 9:00 a.m. – 6:00 p.m.
Lourdes After Hours Breaux Bridge	1821 Rees St., Breaux Bridge	Breaux Bridge	1-337-442-6959	Mon – Fri 1:00 p.m. – 9:00 p.m. Sat – Sun 9:00 a.m. – 6:00 p.m.
Lourdes After Hours Lafayette	1700 Kaliste Saloom Road, Building 2, Suite 200	Lafayette	1-337-981-5085	Mon – Fri 9:00 a.m. – 9:00 p.m. Sat – Sun 9:00 a.m. – 6:00 p.m.
Lake Urgent Care Ascension Prairieville	14350 Highway 73	Prairieville	1-225-313-3930	Mon – Fri 9:00 a.m. – 9:00 p.m. Sat – Sun 9:00 a.m. – 5:00 p.m.
Lake Urgent Care Ascension	1702 N. Burnside Ave.	Gonzales	1-225-647-4988	Mon – Fri 5:30 p.m. – 11:00 p.m. Sat – Sun 9:00 a.m. – 9:00 p.m.
Lake Urgent Care Ascension Prairieville	17609 Old Jefferson Highway	Prairieville	1-225-744-4988	Mon – Fri 5:30 p.m. – 11:00 p.m. Sat – Sun 9:00 a.m. – 9:00 p.m.
Natchitoches Urgent Care	321 Keyser Ave.	Natchitoches	1-318-356-5566	Sun – Mon 1:00 p.m. – 5:00 p.m. Tues – Thurs closed Fri 1:00 p.m. – 5:00 p.m. Sat 8:00 a.m. – 12:00 p.m.
Uh Oh Pediatric Urgent Care	1549 E. 70th St., Suite 300	Shreveport	1-318-798-8464	Mon – Fri 2:00 p.m. – 9:00 p.m. Sat – Sun 8:00 a.m. – 8:00 p.m.
New Orleans East After Hours	5640 Read Blvd., Suite 550	New Orleans	1-504-658-2750	24 hours a day, 7 days a week
Urgent Care and Family Medicine Clinic	4802 Jones Creek Road	Baton Rouge	1-225-755-0095	Mon – Fri 10:30 a.m. – 6:30 p.m. Sat 10:30 a.m. – 2:30 p.m.

Member Services: **1-888-756-0004**
TTY: **1-866-428-7588**

www.amerihealthcaritasla.com

AmeriHealth Caritas Louisiana

Exhibit N.4-3: Member Material That Provides Available Urgent Care Centers

Member Outreach

We communicate available resources to members through the PCP/PCMH relationship, our member services line, relationships with urgent care centers, and directly to the member through educational materials. ACLA sends members who are medium and high-utilizers guidance on a quarterly basis, to educate them to seek the care they need in the appropriate setting. For example:

How and Where to Get Care

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

Is it an emergency?

CALL 911 for problems like:

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

Yes

I don't know

Before going to the emergency room:

Please call your doctor or the 24/7 Nurse Call Line at 1-888-632-0009.

No

Do you need urgent care?

Yes

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

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

No

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

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

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AmeriHealth Caritas Louisiana

Exhibit N.4-4: member Material for Accessing the Right Care

24/7 Nurse Hotline

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

24 hours a day/7 days a week

AmeriHealth Caritas Louisiana Nurse Call Line **1-888-632-0009**

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

ACLA-1322-MI

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

Quý vị có thể có thông tin này bằng các ngôn ngữ và định dạng khác miễn phí. Quý vị cũng có thể có thông tin này thông dịch ra bất kỳ ngôn ngữ nào qua điện thoại. Xin gọi Dịch vụ Thành viên số **1-888-756-0004**.

Puede obtener esta información en otros idiomas y formatos sin costo. También se le puede interpretar esto por teléfono en cualquier idioma. Llame a Servicios al Miembro al **1-888-756-0004**.

AmeriHealth Caritas Louisiana

www.amerihealthcaritasla.com

Exhibit N.4-5: Nurse Hotline Member Material

Interventions for Super-Utilizers

ACLA's goal is to target our interventions where they matter most: the super-utilizers. We go directly into the community to target the members who use the most care and need the most services. These members generally have multiple complex chronic medical problems, and in addition often have mental health issues and difficult social and economic situations. These are "high need" and "high cost" patients. Because these members need a different approach, we utilize tactics tailored for their needs, including the community based care management teams and community health workers that support connecting members to the right care at the right time. This results in benefits both to the member and the health care system.

Upon discharge following an inpatient stay, we use home health visits, medication reconciliation, and coordination of follow-up visits. The Rapid Response, CCMT, and CEOT are the core that drives down the inappropriate use of ED for these members.

Super-utilizers are identified by their medical records or following an inpatient stay. We then provide the outreach, intensive coordination, and in-person care management, if needed, to make sure that needs are met. The member story below is one that shows a member with chronic pain for whom we intervened with the CCMT to finally make a difference.

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

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

Rapid Response also receives follow-up calls from the nurse call line. This allows us to more quickly intervene for members that are calling the line for triage assistance. For example, if they are calling with an issue related to dental pain, we can then connect them with either the carved out dental provider for kids or our expanded dental benefit for adults.

Community Outreach Initiatives

Our CEOT and CCMT specifically address super-utilizers. For example, ACLA identified the top 100 ER utilizers starting in January 2014. The chart in Exhibit N.4-6 demonstrates a cohort of members identified as top 100 ED utilizers. This group was tracked for a period of 6 months starting in January 2014 with 682 ED visits. By February, the number made a tremendous drop with an incremental increase noted in March, but the trend continued to show a consistent decline in the months of May and June. Overall in the 6 month period, there was a 65% reduction in the number of ED visits for this group of members. This is a result of aggressive targeted outreach by the Rapid Response teams.

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

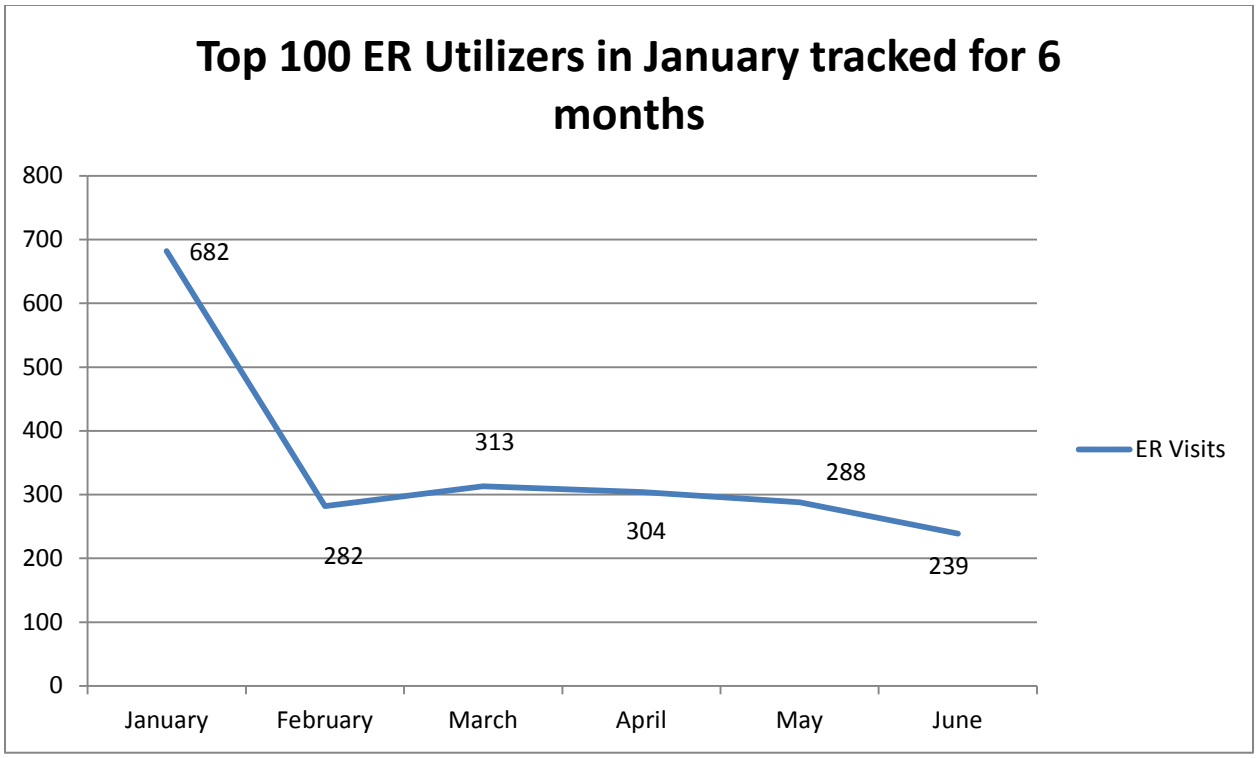

Exhibit N.4-6: ER Utilization

The Community-Based Care Management team was initiated this summer to serve as direct intervention for our most complex members who have been difficult to engage. We engaged ten members in the first two weeks. Our goal is to engage 45 unique members by the end of 2014 to focus on significant reduction of preventable inpatient and ER utilization.

N.5. Utilization Management

N.5 Discuss approach you will use to address high STI prevalence by incentivizing providers to conduct screening, prevention education, and early detection, including targeted outreach to at risk populations.

Overview

Sexually transmitted infections (STIs) remain a major public health challenge in the United States. In fact, southern states and many urban centers have higher rates of STIs than other areas. Undiagnosed infections put not only the infected person's health at risk but it also increases the risk they will spread the virus to others. Learning more about the prevention and detection of STIs is the first step in empowering affected communities and those who serve them.

ACLA's approach uses a combination of outreach, education, and incentives to address STI prevalence in our population. In order to support our providers, we will offer targeted outreach to our at risk population. Additionally, we will provide Continuing Medical Education (CME) opportunities to our providers regarding STIs. We will also offer a combination of direct payment and bonus program incentives to screen and offer early detection and prevention education for our members. Specifically, ACLA will offer monetary incentives through the PCP and the Perinatal Quality Enhancement Programs (QEP).

Supporting Providers through Targeted Member Outreach

ACLA continually strategizes in order to create more effective ways to impact the screening and treatment compliance of our members. We will support our providers by delivering targeted member outreach in the community. For example, our community outreach representatives will educate communities during health fairs and festivals. Additionally, we will disseminate information about STIs through distribution of educational materials. These pamphlets will also be available in provider offices.

The Bright Start® program will include information regarding this program in their case management and outreach. Bright Start® is a focused collaboration designed to improve prenatal care for pregnant members by promoting healthy behaviors and controlling risk factors during pregnancy, with the ultimate outcome of our members delivering health, full-term infants who will have a bright start in their new life. Care managers play a hands-on role, as necessary, in coordinating and facilitating care with the members' physicians and home health care agencies. They also outreach to ensure member follow-up with medical appointments, identify potential barriers to getting care, and encourage appropriate prenatal behavior.

Member Newsletter

ACLA creates quarterly member newsletters. These newsletters include topics relevant to the current Medicaid bulletins as well as other initiatives focused on improving quality. This newsletter is mailed to our members on a quarterly basis with editions as follows: winter, spring, summer, and fall. These newsletters can also be found on the ACLA website.

We have previously included articles in the member newsletter on STIs, and we plan to include more of the same throughout the new Bayou Health contract period. The spring 2013 member newsletter contained an article regarding the importance of getting a Pap test to screen for human papilloma virus (HPV). Additionally, the winter and summer 2014 issues of the member newsletters contained articles about chlamydia.

STI Screening and Prevention Brochures

ACLA will develop an STI Screening and Prevention brochure that will be distributed by our Bright Start department. This brochure will be given to all pregnant members, Community Outreach, and Provider Network Management for our providers to handout in their office. As well as through interaction with our members out in the community and by medical management staff who notice care gaps for the members they are counseling. An example is ACLA's pamphlet below regarding the HPV vaccine.

Taking care of yourself means you can be there for others. As women, we often have many roles:

- Wife
- Mother
- Daughter
- Sister
- Friend

All of these roles are very important, but it's time to put YOU first!

Preventing cervical cancer is in your hands.

- The number one way to prevent cervical cancer is to get a Pap test *(cervical cancer screening)* every year.
- Have a Pap test every year, starting at age 21.
- After age 30, if you've had normal test results, you can have a test every 2-3 years.

Getting a pelvic exam and Pap test are important, but it is probably not your favorite thing to do.

You may feel nervous, scared or embarrassed. Many women do.

Sometimes, we are not used to talking about our body. Remember that these tests are important for your health, and your doctor wants to help you. Many women feel more comfortable if they know what to expect.

- **Pelvic exam.** Your doctor checks the ovaries and uterus. It takes only a few minutes. You may feel pressure, but it should not hurt.
- **Pap test.** This test checks your cervix *(lower part of the womb)* for abnormal cells that can turn into cervical cancer. A brush is used to collect a sample of cells from your cervix. You may feel the brush on your cervix, but it should not hurt. Once the cells are collected, the sample is placed in a solution, which is sent to a lab for testing.

Get the HPV vaccine *(shot)*.

If you are under 27, talk your doctor about the Human Papillomavirus *(HPV)* shot.

- HPV is the main cause of cervical cancer in women.
- The HPV vaccine prevents high-risk types of HPV.
- The vaccine works best when given to young women before they are sexually active.

Exhibit N-5.1: HPV Screening and Prevention Brochure

Mailings and Phone Calls to Members

ACLA will send targeted mailings and make phone calls to our members, in order to remind those that have not had the appropriate STI screenings that they are due for a visit to their doctor. Information on our programs is provided to members through general and targeted member mailings, as well as case management outreach actions. Providers are educated through their Provider Account Managers and Provider Handbook.

Web Portals

Providers and members will also receive care gap alerts through their respective web portals. In addition, PCPs and medical homes are able to access care gap information at the panel level, allowing them to use population management techniques within their practice, including outreach to members to address missing and overdue services.

Care Gaps

Care gaps are clinically recommended services based on evidence-based clinical practice guidelines for which there is no claim evidence that the member received the service. We evaluate claim data at least monthly for all members. In the event there is no claim for a service, the system automatically generates a care gap.

We leverage information on care gaps in several different ways to promote follow-up and connections to medically appropriate services. Care gaps are used to conduct outreach campaigns. Enrollees who are missing or overdue for recommended services are contacted, educated on the recommendation, and assisted with appointments for care.

Incentivizing Providers through Continuing Medical Education Credits (CMEs)

Ongoing education and training is important for ACLA to better align with our providers in order to more effectively render STI prevention and care to our members. ACLA will host workshops and seminars for providers focused on STIs in the local community for additional provider education. ACLA's training tools will provide the latest health care industry news, information, and education.

STI Screening Update CME

ACLA is partnering with Xavier University of Louisiana College of Pharmacy's Center for Minority Health and Health Disparities, Research and Education for a live continuing medical education program addressing STI screening. The proposed date of the initial CME program is the 2nd quarter of 2015.

This course is designed to increase knowledge and make testing for sexually transmitted infections (STIs) a part of routine medical care in order to reduce the impact of STIs. Because many STIs have no symptoms, those at risk need to get tested and find out if they are infected. This course focuses on the updated U.S. Preventive Services Task Force (USPSTF) recommendations for STI screening /Center for Disease Control (CDC) STI Treatment Guidelines, and discusses the barriers clinicians experience for screening and testing of STIs. Proactive counseling and initiating questions for a thorough patient sexual history are the starting points for desensitizing a subject that with increased screening will lower the incidence of rising STI occurrences.

The course will meet the continuing medical education needs of family practice physicians, internal medicine physicians, general practice physicians, pediatricians, OBGYNs, nurse practitioners, physician assistants and other healthcare professionals.

Educational Objectives include the following:

- Description of the current epidemiology and trends of the most common sexually transmitted infections in the US.

- Application of the recently updated USPSTF recommendations for STI screening and CDC STD treatment guidelines.
- Recognition of barriers in practice to screen, test, and counsel patients about STI's.
- Integration of proactive counseling for all appropriate patients.
- Becoming familiar with the available technologies for office screening.
- Description of ways to improve health disparities with regards to STI screening.

Human Papilloma Virus (HPV) and Gardasil Vaccine

Additionally, we are partnering with the Louisiana chapter of the American Academy of Pediatrics (AAP) to increase awareness of a CME seminar on the HPV and the Gardasil vaccine to be held in 2014 Q4. Based on the interest and feedback on this session, ACLA will explore additional training opportunities on this topic with AAP throughout the new Bayou Health Contract period.

Monetary Incentives for Providers

Provider Incentive for Completion of the ONAF Form

ACLA requires our prenatal providers to fill out ACLA's Obstetrical Needs Assessment Form (ONAF) after the first prenatal visit that members attend. The ONAF tracks the member's pregnancy history and estimated delivery date, as well as the member's risk factors, including medical and psychosocial conditions. ACLA provides a financial incentive to providers who complete and fax the ONAF back to us. In 2015 we plan to have this available in the provider portal through NaviNet so that this can be completed electronically by the provider. The following components are being added to the original version of the ONAF on October 1, 2014:

Date and completion verification for the following tests:

- Chlamydia ____ Date of screening _____Results
- HIV _____Date of screening _____Results
- Gonorrhea _____Date of screening _____Results
- Syphilis _____Date of screening _____Results

PCP Bonus Campaign

Our PCP preventive services campaign is an opportunity to provide missing services to members, as well as for provider offices to earn bonus dollars. Eligible members missing certain preventive screens will receive a letter and an automated phone call encouraging them to call their provider office to schedule the test.

Chlamydia screening is currently one of for this PCP Bonus Campaign in the 4th quarter of 2014. In order to receive an incentive payment, the providers must complete the following steps:

- Identify eligible AmeriHealth Caritas Louisiana members who are due for an eligible service.

- Consult with eligible members and provide the eligible services needed.
- Submit a claim for the eligible service with appropriate CPT codes by following your normal claim submission procedures (via CMS-1500, UB-04 or the electronic 837 format).

Incentive payments of $15 for each eligible service provided to an eligible member will be processed in the first quarter of the following the end of reporting period with information identifying the members for whom your practice receives a bonus. Members who are scheduled and screened for the eligible service will also receive a gift card.

Quality Enhancement Program

ACLA's QEP, a provider incentive program, is designed to reward and encourage providers' performance with respect to guideline compliance. QEP was developed and implemented with the approval of the QCCC and the QAPIC. The QEP is ACLA's financial incentive system developed for participating primary care providers (PCPs) and perinatal providers. The QEP is intended to be a fair and open system that provides incentives for high-quality and cost-effective care, member service and convenience, and submission of accurate and complete health data. Quality performance is the most important determinant of the additional compensation. As additional meaningful measures are developed and tracked by the plan and our oversight agency, the quality indicators contained in the QEP will be refined.

PCP QEP

QEP is a system that provides financial incentives over and above a PCP practice's base compensation. The program focuses on the performance of PCPs with greater than 500 members on their panels as eligible for participation in the QEP.

The payment amount is calculated based upon how well a PCP office scores on each bonus component relative to other qualifying AmeriHealth Caritas Louisiana participating PCP and perinatal offices of the same specialty type. The five performance components utilized in determining the overall qualification for QEP are as follows:

- Quality Performance.
- Severity of Illness.
- Cost Efficiency Management.
- Non-Emergent Emergency Room (ER) Utilization.
- Improvement Incentive.

ACLA recognizes the importance of STI screenings in our members. Therefore, STI Screenings for HIV, Syphilis, Chlamydia and Gonorrhea will be included as a value-based incentive in the most heavily weighted "Quality Performance" section of the ACLA PCP QEP.

Perinatal QEP

It is important for women to be aware of the harmful effects of STIs and how to protect themselves and their children against infection. The Perinatal QEP Program is a unique reimbursement system developed by AmeriHealth Caritas Louisiana for participating obstetric

and midwife providers. The Perinatal Program offers financial incentives over and above the provider group's base compensation for prenatal care services. Incentive payments are not based on individual provider performance, but rather the performance of the overall practice in providing comprehensive prenatal care service in accordance with standard American Congress of Obstetricians and Gynecologists (ACOG) guidelines. ACLA will include STI Screenings for HIV, Syphilis, Chlamydia and Gonorrhea for pregnant women as a value based incentive in the QEP program.

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N.6. Utilization Management

N.6 Describe your plan to address prematurity prevention and improved perinatal outcomes. The plan may include but not be limited to the following:

- *Routine cervical length assessments for pregnant women;*
- *Provision of injectable or vaginal progesterone for every eligible pregnant woman with a history of pre-term labor or a short cervix found in the current pregnancy.*
- *Incentives for vaginal birth after cesarean (VBAC);*
- *Provider or patient incentives for post-partum visit provision within recommended guidelines of 21-56 days post-delivery;*
- *Incentives for use of long acting reversible contraceptives, which are to be provided to the member without prior authorization; and*
- *Interventions to reduce Cesarean section rates including but not limited to prior authorization for induction of labor prior to forty-one (41) weeks gestational age.*

Overview

ACLA understands that lifelong health complications can follow babies who are born premature or at low birth rates, and that establishing a healthy population begins with supporting the health of Louisiana's youngest citizens. We have developed several key programs and partnerships to reduce pre-term births and improve perinatal outcomes.

This includes a unique perinatal provider incentive program that encourages obstetricians to provide prematurity interventions and sexually transmitted infection (STI) screening. We also have a maternity management program—Bright Start—that provides health and lifestyle guidance, care coordination, and maternity-focused case management. We have also partnered with the March of Dimes to support our pregnant members, including sponsoring initiatives for smoking cessation, 39-week deliveries, and continuing medical education for perinatal providers.

ACLA also has a program to support pre-term infants who have been admitted to the Neonatal Intensive Care Unit (NICU). Through this program, ACLA's NICU care managers help families with discharge planning, and then go on to provide ongoing case management support to mitigate any barriers to care. We have also worked with DHH to provide support to members who indicate interest in having another child through education and guidance on pregnancy spacing.

We will continue to build on our current successes and partnerships to promote healthy pregnancies and lifelong health for our members.

Prematurity Prevention

ACLA is dedicated to providing pregnant members with high-quality care and support throughout their pregnancy and after birth. We recognize that premature babies are at lifelong risk for health complications, and that pre-term birth is a leading cause of newborn deaths. ACLA has adopted a number of strategies to address this critical public health issue.

A Bright Start for Mothers and Children

The first step is identifying those members who are at higher risk for pre-term births. Some of the common causes include abnormalities in the cervix or uterus, chronic conditions such as diabetes or high blood pressure, multiple pregnancies, and previous pregnancy complications, such as a prior premature birth, miscarriage, or stillbirth. ACLA requests that providers alert our maternity program when they discover that one of our members is pregnant, which is detailed in our provider handbook, training, and newsletters.

Outside of provider notifications, ACLA identifies pregnant members through eligibility information, as well as claims and laboratory data. ACLA member materials, including the member handbook and member newsletters, also encourage members to self-report their pregnancies. Members are then enrolled in our maternity program, which helps members coordinate prenatal care and provides members with intensive case management. The DHH file that will be provided to the plan from vital records will greatly assist the care managers to quickly identify high-risk members in order to provide education and targeted interventions.

ACLA conducts Community Baby Showers throughout Louisiana. These community health events have been held in collaboration with key providers in Baton Rouge, New Orleans, and Shreveport.

Obstetrical Needs Assessment Form

The provider handbook requests that obstetricians fill out ACLA's Obstetrical Needs Assessment Form (ONAF) after the first prenatal visit that members attend. Providers who complete the ONAF are eligible for a $15 enhanced payment above their normal initial visit reimbursement. The ONAF tracks the member's pregnancy history and estimated delivery date, as well as the member's risk factors, including medical and psychosocial conditions.

Currently, the ONAF inquires about STI history. In future versions, ACLA plans to specifically ask for screening dates for STIs to prompt OB/GYNs to perform and document the screenings.

An excerpt from ACLA's current ONAF is included below.

AmeriHealth Caritas Louisiana

P.O. Box 83580
Baton Rouge, LA 70884

Obstetrical Needs Assessment Form

Please fax this form to ACLA at (888) 877-5925. If you have questions, please call Bright Start at (888) 913-0327. Use Billing Code 99420 for a $15 reimbursement for completion of the form.

Member Information		Member ID number / Medicaid ID number:		
Last name:	First name:	Date of Birth:		
Address:		City:	State:	Zip:
Phone number: ( )	Date of initial prenatal visit:	Completion date of pregnancy form:		

Pregnancy Information and History

Gestational age at 1st visit	EDC	Gravida	Para	Pre-term	Living	Abortions
						Spontaneous:
						Induced:

Risk Factors (Past or Current)

- ☐ No Risk Factors
- ☐ Diabetes / GDM / LGA baby
- ☐ DVT / PE
- ☐ Eclampsia / pre-eclampsia
- ☐ Fetal congenital anomaly or disorder
- ☐ Fetal death
  - ☐ 2nd trimester ☐ 3rd trimester
- ☐ Hypertension / GHTN
- ☐ Incompetent cervix
- ☐ IUGR / SGA baby
- ☐ Late and/or inconsistent prenatal care
- ☐ Low birth weight < 2500 grams
- ☐ Multiple gestation
- ☐ Placenta abnormalities
  - ☐ Abruption ☐ Previa
- ☐ Premature ROM
- ☐ Pre-term (specify gestational age)
  - ☐ Delivery: _____
  - ☐ Labor: _____
  - 17P candidate? ☐ Yes ☐ No
  - ☐ Previous delivery within 18 mos. of EDC
  - ☐ Renal disease
  - ☐ Rh sensitization
  - ☐ Sickle cell disease / trait
  - ☐ STD history _____

Active Medical Conditions

- ☐ None
- ☐ Advanced maternal age
- ☐ Asthma
- ☐ Auto-immune disease(s) _____
- ☐ BMI (low or high): _____
- ☐ Hepatitis
- ☐ HIV
- ☐ Seizure disorder: _____

Thyroid disease – Treated?
- ☐ Yes ☐ Other (specify)
- ☐ No

_____
_____
_____
_____
_____
_____
_____
_____
_____

Social, Economic, Lifestyle

- ☐ No Risk
- ☐ Behavioral health condition _____
- ☐ Domestic violence
- ☐ Housing issues
- ☐ Identified social, economic, lifestyle issues _____
- ☐ Intellectual impairment
- ☐ Lack of support system
- ☐ Literacy issues
- ☐ Mental / physical / sexual abuse (current or Hx of): _____
- ☐ Postpartum depression
- ☐ Smoking / tobacco use: Individualized intervention offered?
  - ☐ Yes ☐ No
- ☐ Substance abuse:
  - ☐ Alcohol: _____
  - ☐ Drug Abuse: _____
- ☐ Teen pregnancy: _____
- ☐ Other (specify): _____

Exhibit N.6-1: ACLA's Obstetrical Needs Assessment Form

Once members are identified and their risk factors captured, ACLA identifies whether they are low- or high-risk pregnancies. Categorizing the risks enables our care managers to focus their efforts on members who are at high risk of preterm labor and/or other pregnancy complications.

Bright Start Case Management

ACLA provides perinatal case management support through our Bright Start maternity program. Every newly identified pregnant member is sent a maternity outreach letter outlining the benefits of ACLA's Bright Start program. This includes the locally based care managers available through the program, assistance in selecting an obstetrician, and educational materials that provide guidance on having the healthiest pregnancy possible and getting the best care for their newborns.

Each member's prenatal care routine is monitored in accordance with their risk level. Low-risk members participating in Bright Start are followed by a care connector for ongoing support throughout their pregnancy. High-risk members are enrolled in case management and paired with an

ACLA Bright Start Care Manager, who works closely with the member. The Bright Start care team works with members to help them connect to additional community social supports and services.

The Bright Start care team contacts pregnant members at least 60 calendar days prior to the estimated delivery date to reinforce healthy pregnancy guidelines for the last trimester. This includes taking prenatal vitamins and avoiding alcohol, tobacco, and recreational drugs, as well as selecting a primary care provider for the newborn. Care team members also identify and help mitigate any barriers to care the member is facing.

If behavioral health or substance abuse issues are indicated, the Bright Start care manager may make a referral to the Statewide Management Organization to co-manage their care.

Partnership with the March of Dimes

Over the past three years, ACLA has formed a close, collaborative relationship with the March of Dimes. This includes joining forces on several pregnancy health initiatives throughout the state. We look forward to collaborating on more initiatives to improve the health of Louisiana's newest citizens.

Baby & Me – Tobacco Free®

ACLA is the only Bayou Health Plan to have partnered with the Louisiana Chapter of the March of Dimes to offer a nationally recognized smoking cessation program to Louisiana's mothers-to-be. This program is the first program of its kind in the state. The Baby & Me – Tobacco Free® program is specifically designed to support women during pregnancy and post-partum to encourage healthier behaviors.

Smoking during pregnancy can result in preterm birth, a leading cause of newborn death. Women can reduce the risk of preterm birth if they quit smoking and get regular prenatal care.

Healthy Babies are Worth the Wait

To encourage full-term pregnancy, ACLA partnered with the March of Dimes for the Healthy Babies are Worth the Wait awareness campaign. While some pre-term births are unavoidable, many babies are now being delivered early by choice—either by caesarean section or early inducement.

ACLA has presented the March of Dimes with funding since 2012 to further the advocacy efforts for Healthy Babies are Worth the Wait. This money was used for television and radio spots encouraging full-term births of 39 to 41 weeks.

The goal of the Healthy Babies are Worth the Wait campaign was to inform expecting mothers about the significant growth developments that occur in the final weeks of pregnancy, such as

important organs including the brain and lungs. Over the course of their lives, people born early often face lifelong health challenges and tend to have higher rates of hospitalization and illness.

Continuing Medical Education Programs on Pregnancy

Through this partnership, ACLA and the March of Dimes have sponsored statewide Continuing Medical Education (CME) programs focused on perinatal care during 2014, including 17-P injections. Together, we also sponsored Maternal and Child Health Summit, which included discussion on 17-P, vaginal progesterone, lowering caesarean section rates, and the 39-week initiative.

Reducing Pre-term Labor Using Progesterone Treatments

ACLA provides a number of services that specifically aim to reduce the chances of premature births, including 17P injections and vaginal progesterone. These progesterone treatments have been found to reduce the risk of pre-term labor for many women. ACLA provides information to eligible members about the treatments, and encourages them to talk to their obstetrician or a Bright Start care manager if:

- They have a history of pre-term delivery for a single birth (17P injectable).
- They have a shortened or incompetent cervix (vaginal progesterone).

ACLA has partnered with Alere to provide in-person care and monitoring for members with high-risk pregnancies. Alere's services include preterm labor education, providing 17P injections in the home.

Progesterone Treatment (17P) and Preventing Preterm Birth

What is preterm birth?
Preterm birth is when a baby is born more than 3 weeks early. Babies that are born too early can have health problems. Preterm birth is also the leading cause of infant death in the U.S.

What is 17P?
17P is a progesterone medicine for pregnant women who have already had a preterm birth. Progesterone is a hormone that a woman's body makes during pregnancy. Extra progesterone can help prevent preterm birth for some women.

What are the side effects of 17P?
Side effects are very rare. Some women report soreness, swelling, itching or bruising at the site of the injection. Taking acetaminophen and/or using a warm compress can help with these symptoms. You should also always contact your OB doctor if you experience any of these side effects.

Should I get 17P?
When all of the following things are true, you should talk to your OB doctor about getting 17P:

- You are pregnant now.
- You have already had a preterm birth of a single baby.
- There was no identified medical reason for the preterm birth.
- You are carrying only 1 baby during this pregnancy.

Questions? If you have questions, contact your OB doctor, or call the Bright Start® department at **1-888-913-0327**.

Exhibit N.6-2: Informing Members of the 17P Treatment through the Fall 2013 Member Newsletter

Prematurity Performance Improvement Project for Next Contract Term

ACLA has begun developing a performance improvement project (PIP) to reduce premature births to Medicaid-eligible women by 15 percent. Using HEDIS measures and March of Dimes National Data, ACLA intends to accomplish the following goals through the PIP:

- Increase timeliness of prenatal care.
- Increase frequency of ongoing prenatal care.
- Decrease low birth weight (live births <2500 grams).
- Decrease very low birth weight (live births <1500 grams).
- Decrease preterm births (< 37 weeks).

ACLA's 2014 HEDIS rates and total membership prematurity rates will be used as the baseline data set. The 2013 HEDIS Quality Compass National Average 50th percentile data as well as the March of Dimes Perinatal Data Center's National data will be used to establish baseline benchmarks.

ACLA will work with DHH to fully develop the project, including finalizing the aims, measures, and any needed changes. Once the project is fully developed, and approved by DHH,

ACLA will identify and engage stakeholders and start the project. Outcomes will be assessed annually during the next contract term and appropriately reported to DHH.

Improving Perinatal Outcomes

Ensuring that members access appropriate and timely prenatal and neonatal care is key to improving perinatal outcomes. ACLA has adopted a set of evidence-based clinical guidelines for routine prenatal care, which are available on ACLA's website. These are intended to guide providers in the care of ACLA members; they are not requirements, and are not intended to replace providers' clinical judgment or responsibility for member care. ACLA's Integrated Care Management and Bright Start care teams use these guidelines to assist members.

Periodicity schedules for prenatal and neonatal care are included in the provider handbook and are available on ACLA's website. ACLA recommends the Bright Futures schedule created by the American Academy of Pediatrics.

ACLA encourages members to take advantage of the national "Text4Baby" program, which provides maternal health information and topics via phone text messaging at no cost to the member.

ACLA has also devoted significant resources to developing a network with the necessary maternity providers and specialists to deliver all covered services to our membership. Our network includes more than 450 OB/GYN providers, certified nurse midwifes or obstetric nurse practitioners, which can be seen at 701 sites throughout Louisiana. ACLA requires delivering hospitals to report the birth to the plan and DHH in order to enroll the newborn in the Bayou Health program so that services such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services can be provided to the newborn member.

ACLA's Perinatal Quality Enhancement Plan

ACLA has a variety of initiatives and programs directed at improving pregnancy outcomes. One of these is a unique reimbursement system to encourage participating obstetric providers to deliver high-quality, cost-effective, and timely care, as well as submit accurate and complete health data on our pregnant members. Participating providers earn incentive payments by improving performance on maternity and perinatal quality measures. While the program focused on delivery outcomes, participating providers are encouraged to view the entire pregnancy as an episode of care.

The quality measures selected for the Perinatal QEP will be monitored and amended as needed in consultation with ACLA's QCCC. The primary goal and objective is to choose measures that have the greatest potential to improve the quality of health for our Bayou Health members. Collecting data on these quality measures will support larger DHH initiatives, such as reducing cesarean section rates and neonatal intensive care occurrences. Over time, the program's measures will be adapted to changes in member behavior and DHH's goals.

The Perinatal QEP provides financial incentives over and above the participating provider's base compensation. Because ACLA views the entire pregnancy as an episode of care, incentive

payments are not based on individual performance. Incentives are only earned when delivery outcomes for ACLA's members meet or exceed the established quality measures.

Selected Quality Measures

Our perinatal quality performance measures were created using ACLA's Preventive Health Guidelines and other established clinical guidelines and are consistent with Healthcare Effectiveness Data and Information Set (HEDIS) or other nationally recognized measures. The incentive payment is based on the completion of these metrics for pregnant members who have received the care outlined in the quality measures below on a semi-annual basis. These measures, as described below, are based upon services rendered during the reporting period and require accurate and complete encounter reporting.

Metrics	Description
Antenatal progesterone administration	Percentage of attributed singleton delivery members who were at risk for premature birth that received a progesterone injection (17P) during the measurement period.
Post-Partum Care	Women who received postpartum care service on or between 21 and 56 days after delivery
STI Screenings - Chlamydia	Improved screening for and plans for treatment of communicable diseases: chlamydia - Percentage of attributed eligible members who received a chlamydia screen per HEDIS definition
STI Screenings – HIV	Improved screening for and plans for treatment of communicable diseases: HIV - Percentage of attributed eligible members who received an HIV screen or test
STI Screenings - Syphilis	Improved screening for and plans for treatment of communicable diseases: syphilis - Percentage of attributed eligible members who received a syphilis screen or test
STI Screenings - Gonorrhea	Improved screening for and plans for treatment of communicable diseases: Gonorrhea - Percentage of attributed pregnant members who received a Gonorrhea screen or test
Obstetrical Needs Assessments Form (ONAF) Completion	Submission to ACLA of at least one ONAF risk screening form for each member who delivered during the prenatal care period.
Frequency of prenatal care	Women who received ≥81 percent of expected number of prenatal visits based on state of pregnancy at enrollment and recommended number of visits by gestational age during the reporting period.
Timeliness of prenatal care	Women who received a prenatal visit within in the first trimester or within 42 days of enrollment in the plan.

Exhibit N.6-3: Perinatal Performance Measures Included in ACLA's Quality Enhancement Plan

Funds for the Perinatal Program will be equally distributed per delivery and will be the basis of the funds for the incentive program. A provider will be eligible to earn additional incentive dollars by completing the quality metrics during the measurement period. Each quality metric will be scored per delivery to calculate the multiplier that will be applied to the per delivery amount to determine the incentive at the delivery level. All incentives earned by the provider group will be summed to determine the final payment.

Eligible provider practices that do not qualify for an incentive in a certain measure, but show at least a 10 percent improvement compared to their performance in the previous measurement cycle, will be given an improvement incentive.

The Perinatal Program will be modified within the existing funding model to incorporate an enhanced payment for overall network cesarean section performance. All obstetric and midwife providers are eligible to receive an enhanced incentive based on reducing the network cesarean section rate.

Spacing Pregnancies to Improve Birth Outcomes

Becoming pregnant within 12 months of giving birth can result in increased risks for the pregnancy. This timeframe can be even longer for women pursuing a vaginal birth after cesarean (VBAC). Waiting for more than five years between pregnancies also introduces additional pregnancy risks.

ACLA has addressed this concern in its member materials, encouraging members to discuss birth spacing with their doctors. In fact, ACLA was the first Bayou Health plan to begin using the Interconception Care (ICC) model to proactively engage members about reproductive health and family planning during the post-partum period. ACLA's inter-pregnancy program was shaped, in part, through collaboration with DHH on a pilot program.

As part of the pilot, ACLA used a DHH-supplied ICC survey with delivered members and provided the collected member feedback to DHH. ACLA used this feedback to develop a more formalized ICC program that targets members who have delivered a pre-term or low birth weight newborn.

ACLA used a DHH-supplied ICC survey to develop tools and formalized our ICC program, which targets members who had a pre-term or low birth weight newborn.

Pregnant members receiving case management services are assessed to identify those who delivered a pre-term or low birth weight newborn. These members receive targeted outreach after delivery to inform them of family planning options and optimal pregnancy spacing. Members with chronic diseases that complicate pregnancies/deliveries are referred for long-term care management if they indicate future plans to have another baby.

NICU Graduate Program

Infants who have had a Neonatal Intensive Care Unit (NICU) hospital stay are 'enrolled' in ACLA's NICU Graduate Program to help control and possibly reduce their chances of readmission due to medical and developmental complications. Through this program, our NICU Graduate care manager performs an inpatient concurrent review and assists with the discharge planning needs of the newborn and family.

ACLA hires NICU Level III trained nurses as NICU care managers to perform the reviews and help the parent(s) during the inpatient stay and the transition home. Weekly NICU rounds are held with an ACLA-hired neonatologist to present complex cases and discuss any required

interventions with the plan medical directors during the NICU stay. This helps proactively identify and resolve barriers to a timely and appropriate discharge.

The NICU care manager follows each newborn post discharge, and provides up to six months of follow-up case management. Extremely complex members that require case management beyond six months are referred over to ACLA's pediatric complex care manager for continued coordination and follow up.

Additional Assistance for Women, Infants, and Children

ACLA recognizes that Bayou Health members often need assistance that is available through community organizations and other public assistance programs, such as the Women, Infants, and Children (WIC) program. This supplemental program provides assistance in the form of supplemental foods and nutrition education to low-income mothers who have infants or children under the age of six who are found to be at nutritional risk.

ACLA member materials, including the maternity outreach letters and member newsletters, provide information on WIC and other community, state, and federal programs. Associates in the Bright Start program and Member Services can provide assistance to members who wish to enroll in the WIC program.

ACLA encourages members to apply for WIC so they can take advantage of the services provided through the program, including breast feeding guidance and breast pump loans. Breast feeding has proven to have significant health benefits for newborns and new mothers.

The WIC program requires physician-supplied medical information to determine eligibility and process applications to the program. ACLA describes this process in the provider handbook, encouraging providers to proactively assist in the member's application process.

Maternity Blueprint

Lastly, ACLA is formalizing the development of a maternity management blueprint to standardize our ongoing efforts in prematurity prevention and improving perinatal outcomes. The Maternity Blueprint will document ACLA-accepted clinical guidelines, levels of stratification with corresponding interventions, and key educational materials that will be utilized by staff during outreach. Key program goals include improving prenatal visit compliance, facilitating access to needed services and resources, improving neonatal health outcomes, and increasing post-partum family planning. ACLA currently tracks related HEDIS measures; access to and delivery of prenatal, post-partum, and pediatric preventive care; and NICU admissions. This evidence-based tool will advance ACLA's ability to communicate maternity program features, goals, and measures to providers, further strengthening our partnerships in improving birth outcomes in LA.

N.7. Utilization Management

N.7 Explain how you will Identify and address underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives and appropriate pain management approaches in patients with sickle cell disease.

Overview

ACLA recognizes that addressing underutilization is just as critical as reducing overutilization to the long-term management of population health. It is a necessary step in ensuring that at-need members have appropriate access to and information about the services that can help them manage their health conditions. ACLA uses several strategies to identify and address underutilization of key services, including quality reporting, provider incentives, care gap alerts, and member education on available condition-specific services.

Identifying Underutilization of Key Services

Identifying underutilization of preventive and maintenance services is critical to our members' quality of care and quality of life, as those services enable providers and members effectively identify and manage health conditions before they become crises.

Our robust information systems facilitate analysis of utilization patterns at the plan, population, provider, and member levels. This provides a global view of the issues that enables us to identify specific services, providers, or members that require particular attention.

Internal Reporting

Our reporting capabilities enable ACLA to collect, analyze, and report on utilization data. Data are collected from multiple sources, including eligibility records, claim transactions, authorization records, and supplemental files, such as historical claim data, pharmacy claim data, immunization registries, and lab results. Analyzing this data at the population, regional, and provider level enables the plan to identify utilization patterns and develop plans to address them through the appropriate strategies—such as direct outreach to providers, adapting our QEP, or providing information to ACLA members.

Our Informatics Department is responsible for constructing and generating the reports necessary to monitor a variety of Bayou Health activities. This includes specific reports that can query populations against performed services to identify underutilization, as well as provider profiling, reporting on performance measures, and the identification of care gaps. These reports are used to inform the interactions our care managers, Member Services associates, or Provider Network Management account executives have with members and providers.

Data from source systems, such as TriZetto Facets or ZeOmega Jiva, our core administration and care management platforms, are loaded into our data warehouse, a dedicated repository that stores our eligibility, care management, provider information, authorization, and claims data, at least monthly. Once data is extracted from the warehouse, reports can be run using any

combination of our tools or applications, including Microsoft Access, BI query, SAS, SQL, Crystal Reports®, Business Objects, and Excel. Reports can also be pulled directly from the source systems if more granularity or data elements are needed.

Medical Expense and Trend Report

The Informatics Department runs the Medical Expense and Trend Report on at least a monthly basis. An integral part of ACLA's cost containment strategy, this report provides key stakeholders with the information they need to successfully address utilization and cost trends. By comparing trends across various time frames, ACLA can identify unusual decreases in utilization and costs. The Medical Expense and Trend Report can also identify—at the enterprise, regional, local, population, and geography levels—which services or medications are driving the trends.

Provider Profiling

ACLA's claims and authorization data is used to create provider profiles that help ACLA evaluate provider-specific performance in meeting utilization and quality goals, as well as identify trends and areas for improvement. The profiles are created using industry-validated methods, and the results are risk-adjusted to account for the provider's acuity mix so that meaningful comparisons can be made across the provider population.

Information on the profiles is routinely shared with providers. If a provider's profile indicates that specific utilization or quality goals have not been met, ACLA will reach out to that provider. Our Provider Network Management account executives provide written education regarding potential process changes that could address the issue. Associates from Provider Services or Medical Management may visit a provider to lend further assistance.

Provider profiles are created for primary care providers, selected high volume specialists, and acute care hospitals that care for a minimum number of members. Ad hoc reports are produced to evaluate specific areas of concern.

Reporting on Performance Measures

During the initial contract term, ACLA has regularly collected data for the clinical and administrative performance measures that DHH has established. These have included Healthcare Effectiveness Data and Information Set (HEDIS) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, among others.

ACLA also uses these performance measures to monitor the quality, access, and availability of care to identify areas of potential underutilization. Services are examined at summary and member levels to identify the barriers to preventive and recommended services that we need to focus our attention on; for example, HEDIS results enable us to compare our results to other plans as well as to national benchmarks. Once outliers are identified, action plans are developed to address them.

Underutilization is also monitored on an annual basis by comparing the results of select HEDIS measures with national HEDIS Medicaid benchmarks. ACLA selects the measures that are relevant to the demographic, clinical, and practical relevance to the Bayou Health population. These feed into ACLA's Quality Enhancement Plans (QEP).

AmeriHealth Caritas Louisiana

Quality Enhancement Program Profile

Payment Cycle: February 2012 through June 2013

Claims Cycle: July 2012 through June 2013

Practice Name:		Average Panel Count:	1,432
Group ID#/Specialty:	Pediatrics	Peer Average Panel Count:	938

Quality Performance **Target Quality Measures** (Aggregated for Incentive Payment)	Practice Score (Current)	Practice Score (Prior)	Peer Percentile Ranking	PMPM Payment	IMP*
Comprehensive Diabetes Care (HbA1c Testing 1x/year)			n/c		
Adults Access to Preventative Amb Health Serv (AAP)			n/c		
LDL-C < 100 for Diabetics			n/c		
Diabetes Care (CDC) Dilated Eye Exam			n/c		
Diabetes Care (CDC) Nephropathy screening test			n/c		
Chlamydia Screening in Women (CHL)	74%		n/c		
Well-Child Visits 3 to 6 (W34)	61%		n/c		
Adolescent Well Care Visit	31%		n/c		
Aggregate Score	48%		45%	$0.00	

* 10% or more peer percentile bracket improvement achieved compared to prior cycle, but still <55th percentile compared to peers

Exhibit N.7-1: Sample QEP Report Card

Addressing Underutilization of Key Services

Once identified, ACLA takes various steps to ensure members are connected to the services they need. Information on members who are missing key services is disseminated through a variety of channels. Providers receive alerts when checking member eligibility in the on-line provider portal and can pull practice-level reports identifying all of their members missing recommended care. These same alerts appear in the Member Service and Care Management information system, enabling ACLA staff to facilitate access to needed services any time they are in contact with a member.

Provider and member education programs are designed and implemented to raise awareness and issue a call to action for critical care gaps. We also design and implement provider incentive programs to encourage providers to proactively seek out and address key service needs. Additionally, our members are encouraged to ask about recommended services through our member materials, which highlight prevalent health issues and covered treatments for them.

ACLA's Quality Enhancement Programs

ACLA developed unique financial incentive systems for participating primary care providers (PCPs) and perinatal providers. The PCP and Perinatal QEPs are designed to encourage the provision of high-quality and cost-effective care, member service and convenience, and

submission of accurate and complete health data. A central tenet of these programs is the provision of appropriate care to avoid underutilization of needed services.

Quality performance is the most important determinant of the additional compensation. Incentive payments are calculated based upon how well a provider scores on each performance component relative to other qualifying participating offices of the same specialty type.

The program includes value-based performance measures, cost-efficient management, support for patient-centered medical homes, among others. Both the PCP and Perinatal QEPs include sexually transmitted infection (STI) screenings—including HIV, syphilis, chlamydia, and gonorrhea—as a value-based performance measure. As additional meaningful measures are developed and tracked by ACLA and our oversight agency, the quality indicators contained in the QEP will be refined.

Care Gaps Alerts and Reports

By analyzing claim data against system rules developed in accordance with evidence-based clinical guidelines, ACLA can identify the recommended services that members have not received. System rules have been developed for a full range of preventive services and chronic health conditions.

Care gap alerts appear when a member's ID number is entered into one of our source systems or the Provider Portal. This includes when utilization management, care management, and Member Services associates are helping providers or members, or when providers check for member eligibility.

Care gap reports are also given to providers both as alerts and as full panel reports through our Provider Portal. When the member's ID number is entered in the Provider Portal, a care gap alert pops up. When the provider clicks on the alert, a member-specific report appears detailing received services as well as missing or overdue services. A report that lists all care gaps for a provider's assigned members is also accessible as a printable document or a CSV file that can be incorporated into other systems.

AmeriHealth Caritas
Louisiana

August 11, 2014

Important Clinical Information

Print this document and place it at the front of the member's medical record for review by a healthcare professional

Care Gap Worksheet
Member :

Name:
ID#:
Age/DOB:
SSN(Last 4):
Phone:

PCP Assigned :

Name:
Address:

Phone: 504-362-8930

*** Claims Processed Through End of Month June 2014 ***

Alert Service(s) - Due Soon/Over Due/Missing - Response Required

Condition	Service Due	Last Service	Last Value	Status	Frequency	Date Done	Result	Date Referred
EPSDT				Missing	At least once per year			
EPSDT				Missing	At least once per year			
EPSDT				Missing	At least once per year			
EPSDT				Missing	At least once per year			

Would you like help outreaching to this member?

☐ Yes, please help with the following _____

Would you like to exclude the member from a specific measure(s)?

☐ Yes, please exclude from the following measure(s): _____

The reason for exclusion must be included: _____

Please note, exclusion requests will only be accepted for reasons that conform to the HEDIS measure guidelines.

*The above services may be part of the Quality EnhancementProgram(QEP). To update the member data, complete the columns in the "Response Required "section above. Sign below and fax a copy of the updated worksheet to 1-866-928-5136 .

_____ _____
Physician Signature Date

Page 1 of 2

Exhibit N.7-2: Care Gap Worksheet

Promoting Primary Care Engagement

Primary care relationships play a critical role in assuring that members receive appropriate preventive care and/or chronic care management, and that they have the resources they need to manage any acute needs that arise unexpectedly—leading to unnecessary, non-emergent emergency care utilization. Underutilization of primary care services can mean that members do not receive screenings that can recognize and address conditions before they become urgent.

To support our members in receiving the care they need and to help establish relationships with their PCPs, ACLA's local Community Education Team outreaches to identified members who have not seen a PCP during the preceding 12-month period. Initially, the community educators attempt to reach the member by telephone to discuss the importance of the primary care relationship, evaluate the member's satisfaction with their current PCP assignment, and assist with changing the PCP if the member so requests. If telephonic attempt is unsuccessful, the community educator will outreach to the member at their home to deliver these messages in person

ACLA recognizes that many of our members will be at work or unavailable when we arrive. If no one answers the door, the community educator will leave a 'Door Knocker' message asking the member to contact the community educator at a more convenient time. From February 2014 through August 2014, the CEOT successfully outreached to 383 members identified as underutilizers of primary care services.

A representative from the AmeriHealth Caritas Louisiana Outreach Team visited you today because:

- ☐ You need to make an appointment with your doctor.
- ☐ Your AmeriHealth Caritas Case Manager needs to speak with you.
- ☐ You or a member of your family is eligible for a health screening. I can help you make an appointment.
- ☐ Other _____
- ☐ I would like to invite you to the following event:

Event: _____ Date: _____

Time and Location: _____

Exhibit N.7-3: Excerpt from 'Door Knocker' Message Left by Community Educator

Sharing Information about Conditions and the Services to Manage Them

ACLA provides guidance to network providers regarding industry-standard and evidence-based approaches to key conditions to encourage recommended behaviors and reduce unnecessary variations in care. These are provided as practice guidelines and condition blueprints, which are available on ACLA's website and in the provider manual; ACLA associates mail hardcopies if requested.

We have adopted clinical practice guidelines for a number of conditions, including pregnancy and sickle cell disease. These include recommended prenatal services, including screening for HIV and syphilis, as well as recommended pain management modalities.

Clinical Practice Guidelines

With the goal of reducing unnecessary variations in care, AmeriHealth Caritas Louisiana has adopted clinical practice guidelines for treating member. These guidelines represent current professional standards, supported by scientific evidence and research and are intended to inform, not replace, the physician's clinical judgment. The physician remains responsible for determining the applicable treatment for each individual.

- Asthma
- Asthma (Abridged) (PDF)
- COPD (PDF)
- Diabetes
- Diabetes (Type 2) in Children and Adolescents (PDF)
- Heart Failure (PDF)
- Heart Failure (Abridged) (PDF)
- Hypertension (PDF)
- Pregnancy (PDF)
- Sickle Cell Disease (PDF)

Exhibit N.7-4: Clinical Practice Guidelines Available on ACLA's Website

Promoting Service Utilization through Member Materials

ACLA believes that informed members are more empowered to access and manage the care they need. To that end, our member materials are designed to provide guidance and highlight services that can assist them. All member materials that address specific conditions or services direct members who are interested in learning more to call ACLA for more information.

Our Rapid Response and Member Services departments are trained to assist members in a variety of ways. This includes providing members with additional educational materials, sharing more information on the services available to them, and even helping members set up appointments with providers who can address their specific health needs.

Promoting STI Screening for Pregnant Women

ACLA understands that identifying and addressing STIs as early as possible can help improve birth outcomes. Many STIs result in pregnancy complications pregnancy; this can include causing birth defects or pre-term labor, and there is also a risk—notably with HIV and syphilis—of passing the infection to the baby. Infection typically happens during delivery, but can also occur through breast feeding. Infected newborns often face lifelong health complications, including chronic infections, immunodeficiency, and organ disease or failure.

ACLA's Bright Start maternity management team encourages screening for chlamydia by tracking it on the Obstetrical Needs Assessment Form. The next version of the form will prompt providers to screen for additional STIs, including HIV and syphilis.

Our PCP and Perinatal QEPs include measures for HIV, syphilis, chlamydia, and gonorrhea screenings. ACLA also reaches out directly to members to inform them of the risks of STIs and services available to them through the health plan.

The Truth About Chlamydia

1 It is easy to treat and test for chlamydia.

2 Often there are no warning signs. If there are, they may include unusual discharge (liquid leaking) from the vagina, pain with urination, or menstrual-like pain in women. Men can also have pain and swelling in the penis and prostate areas.

3 The best way to prevent getting the disease is by not having sex or having sex with only 1 partner.

4 Women are at greater risk. However, men and women who are ages 25 and younger and sexually active, or who have more than 1 partner, should be tested for chlamydia once every year. Even if a man has no symptoms, he can still pass the infection to his partner over and over, no matter how often the partner gets treated.

Help yourself and your partner. Next time you're seeing a doctor or nurse for any reason, ask about getting a urine test for chlamydia. It's painless, private, simple, and chlamydia is easy to treat.

Healthy Now 2 Winter 2013

Member Services 1-888-756-0004
TTY 1-866-428-7588

Exhibit N.7-5: Facts about Chlamydia in the Winter 2013 Member Newsletter

ACLA has focused on improving the incidence of chlamydia screenings, which remains a public health concern in Louisiana. A number of steps were taken to encourage screenings throughout the initial Bayou Health contract term. This included listing chlamydia screenings for pregnant women as a performance measure and including a field for chlamydia screening on ACLA's Obstetric Needs Assessment Form (ONAF). To prompt providers to discuss these STI screenings with their members, ACLA is adding HIV, syphilis, chlamydia, and gonorrhea screenings to our QEPs, and plans to broaden the STI section on the ONAF to capture all STIs. ACLA's member materials will continue to address the public health issues that are most relevant to Louisiana, such as HIV and syphilis.

Providing Effective Pain Management to Members with Sickle Cell Disease

Using predictive modeling tools, ACLA identified that sickle cell disease (SCD) is a high-need condition for our plan based on a high frequency of readmission among members with this diagnosis. Additionally, members with SCD under the age of 5 tend to have incomplete vaccination status and impairment of the spleen because of the disease, leading to a high risk of infection. Unfortunately, until a cure for SCD is found, ACLA recognizes that effective and proactive disease management is the best available approach to helping members with SCD address the health and quality of life complications caused by the disease.

Identifying Members with SCD

As previously discussed, ACLA uses a variety of methods to identify members who have chronic health conditions that require long-term, ongoing management, including sickle cell disease (SCD). These include data analysis, new member surveys, and referrals. Providers are encouraged in the Provider Handbook to refer their members to our care management programs, and members can self-refer themselves.

Strategies for Sickle-Cell Disease

Sickle-cell disease is a lifelong blood disease caused by a genetic disorder. It is most common among Africans and African-Americans. Parents with sickle-cell disease may pass it on to their child. But it is also possible for a child to get sickle-cell disease, even if neither parent has the disease.

People with this disease can have painful episodes called "sickle-cell events." These events happen when clumps of red blood cells block blood flow to organs and limbs. The result is throbbing or stabbing pain in the limbs, chest, stomach, shoulders, or back. The pain can last for a few hours or up to several days.

Sickle-cell events can damage bones and organs. They also can cause permanent damage to the heart, brain, kidney, spleen, liver, and bones. Sickle-cell disease can cause problems like blindness and stroke. Be sure to call your doctor right away if you have:

- Fever
- Swelling in the stomach
- Swollen feet or hands
- Trouble breathing
- Unexplained fatigue
- Weakness on one side of the body
- Yellow eyes or skin

Thanks to better treatments, the outlook for those with sickle-cell disease is better than ever. Proper care can help people with the disease live nearly normal lives. Here are some tips for good health for those with sickle-cell disease:

- **Focus on good nutrition.** Choose folate-rich foods like spinach, dry beans, and fortified cereals. Folate helps the body make new blood cells to replace damaged ones.
- **Drink plenty of water.** Being dehydrated can make red blood cells more likely to clump.
- **Exercise regularly.** This can help prevent a sickle-cell crisis.
- **If you smoke, quit.**
- **Avoid temperature extremes, such as extreme hot or cold.**

Sickle-cell events often can be treated at home. Here's how:

- Ask your doctor which over-the-counter drugs will ease mild pain. For stronger pain, you may need a prescription pain reliever.
- Apply a heating pad to the sore area, or try taking a warm bath. Massaging the area may help.
- Read, listen to music, call a friend, or work out to get your mind off the pain.
- Repeat to yourself, "I'll get through this."

Exhibit N.7-6: Strategies for Sickle Cell Disease' in the Spring 2014 Member Newsletter

Disease Management and Pain Management

Once referred to the sickle cell disease management program, members are categorized into low- or high-risk groups, which are reviewed on a quarterly basis or as indicated. Recent inpatient admissions or emergency room visits, inconsistent or untimely lab work, high pain levels, recent blood transfusions, and unstable health or social situations are factors in the determination.

Members in the low-risk group receive focused mailings and reminders about the condition, its complications, and available treatments, as well as ongoing monitoring of key indicators by ACLA care managers. Members in the high-risk group receive additional care management interventions, starting with a comprehensive health assessment and an Individualized Care Plan.

ACLA's care managers work closely with these members' providers to identify, communicate, and address any gaps in care, and our care teams reach out, relative to the member's level of disease intensity, to monitor the member's disease state and care plan, including their

medications, symptoms, and triggers. These communication mechanisms, in addition to the system rules established in accordance with the clinical practice guidelines for SCD, enable our care teams to identify when a member with SCD may be underutilizing the services recommended for their care.

ACLA is currently working to develop a set of Chronic Pain Management guidelines to help providers who may not be familiar with the intricacies of pain management.

For example, hydroxyurea is one of the most effective, but underutilized, treatment modalities for reducing the recurrence of acute pain crises. Additionally, prophylactic antibiotics, such as amoxicillin or erythromycin, can also be a key preemptive measure for members at high risk for infections.

To increase utilization of these and other treatments associated with SCD, ACLA is developing a letter to send to providers, encouraging them to consider prescribing these valuable therapies for their patients. Additionally, to make prescribing easy for providers, ACLA does not require prior authorization for hydroxyurea, as that administrative requirement—an essential tool in managing service overutilization—can create a barrier to timely and appropriate use by members with SCD.

In addition to the letter, some of our affiliate plans have developed pre-populated prescription templates for hydroxyurea and prophylactic antibiotics to distribute to targeted providers.

Treatment for Sickle Cell Disease

Sickle cell disease is a lifelong blood disease caused by a genetic disorder. People with this disease can have painful episodes called sickle cell events. These events happen when clumps of red blood cells block blood flow to organs and limbs.

Sickle cell events can damage bones and many organs. They also can cause stroke, infections, gallstones and blindness. Today, thanks to better treatments, the outlook for those with sickle cell disease is better than ever. Proper care can help people live nearly normal lives.

If you have sickle cell disease, your doctor will work with you to decide the best treatment. Treatment will depend on things like:

- Your age, overall health and medical history.
- How severe your sickle cell disease is.
- How well you can tolerate certain medications, procedures or therapies.
- How your doctor expects your disease to progress over time.
- Your opinions or preferences.

The goals of treatment are to prevent organ damage and complications, to prevent infection and to treat symptoms. Treatment may include:

- **Pain medication.** This is to treat pain from sickle cell events.
- **Drinking plenty of water daily (8 to 10 glasses).** This is to prevent and treat pain. Sometimes IV fluids are needed.
- **Blood transfusions.** A blood transfusion is a safe, common procedure in which you receive blood through an IV line inserted into one of your blood vessels. Blood transfusions may be used for anemia (low iron) and to prevent stroke.
- **Vaccinations and antibiotics.** These are used to prevent infections.
- **Folic acid.** Folic acid will help prevent severe anemia.
- **Hydroxyurea.** Hydroxyurea is a medication that has recently been found to help reduce the frequency of pain crises and acute chest syndrome. It may also help lower the need for frequent blood transfusions.
- **Regular eye exams.** These are done to screen for damage to the part of the eye called the retina. This type of damage is called retinopathy.
- **Bone marrow transplant.** Bone marrow transplants have cured some people with sickle cell disease. The decision to undergo this procedure is based on the severity of the disease and ability to find a suitable bone marrow donor.

You can call Member Services at **1-888-756-0004** *and ask about being a part of our Disease Management Program for Sickle Cell Disease. We are here to help.*

Exhibit N.7-7: 'Treatment for Sickle Cell Disease' in the Summer 2014 Member Newsletter

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N.8. Utilization Management

N.8 Explain how you will reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than seven years of age.

Overview

ACLA recognizes that overutilization of services and medications can adversely affect the quality of care that members receive, as well as their quality of life. Service and medication overutilization is typically ineffective, clinically inappropriate, and costly; at best, it inconveniences members and at worse can significantly impair their health.

ACLA continuously mines utilization data to identify overutilization and inappropriate levels of provided care. We use several utilization management (UM) strategies to ensure our members receive appropriate and medically necessary services and medications, including:

- Prior authorization.
- Data collection and analysis.
- Provider monitoring and education.
- Retrospective claim reviews.
- Collaboration with our pharmacy benefits manager (PBM), PerformRx.

Using these methods, ACLA has developed initiatives to address overutilization or inappropriate utilization of services and medications. This includes encouraging appropriate utilization and follow-up care for children ages three through six who are prescribed ADHD drugs, as well as reducing inappropriate short-stay admissions.

General Strategies for Addressing Overutilization

Utilization management is a key concern for ACLA. We have adopted, and continue to develop, policies, procedures, and strategies that identify and address the potential for overutilization of covered services, as well as inappropriate use of covered services.

Authorizing Services based on Medical Necessity Criteria

ACLA's prior authorization requirements were designed to ensure that members are provided with appropriate, medically necessary services in manners consistent with evidenced-based standards and the member's individual needs. Medically necessary services are those needed to diagnose, cure, alleviate, or prevent the worsening of a member's health conditions. Additionally, prior authorization enables ACLA to assure that services or medications are only prescribed and delivered by qualified providers who have the appropriate education, training, or professional experience, as well as limits on the frequency, types, and dosages of services or medications based on peer reviewed and provider approved clinical guidelines.

If a provider feels that a member would benefit from a treatment or procedure that requires prior authorization, they are required to submit supporting clinical documentation that demonstrates the requested services meet medical necessity requirements. This includes:

- Diagnosis for which the treatment or procedure is being sought.
- Goal of the treatment or procedure so that progress can be measured.
- Details on previously attempted treatments or procedures that have been unsuccessful in addressing the health need.

Any decision based on medical necessity to deny or limit coverage for the requested treatment is made by a physician reviewer or other appropriate designated licensed clinical professional under the clinical direction of the physician reviewer. ACLA's reviewers work collaboratively with providers regarding medical necessity criteria for requested services, including peer-to-peer consultations.

Data Collection and Reporting

ACLA collects data from multiple sources, including eligibility records, claim transactions, authorization records, and supplemental files, such as historical claim data, pharmacy claim data, immunization registries, and lab results to identify utilization patterns. The Informatics Department uses the collected data to construct and generate reports on the services utilized by plan members. By analyzing reported data, ACLA can identify utilization patterns and develop plans to address at the global, population, provider, and member levels.

Medical Expense and Trend Report

The Medical Expense and Trend Report prepared using membership and paid claims data to illustrate utilization, expense, and unit cost trends for all trend categories, including inpatient, outpatient, professional, and retail pharmacy claims, along with several subgroups of these categories. Using this information, ACLA can compare current utilization and costs against the utilization and costs from previous months, quarters, or years to identify significant and unexpected increases. The report also details which area and services are driving the increases.

Through the Medical Expense and Trend Report, we have implemented initiatives to control specialty pharmacy costs, high-cost radiology services, over-radiation of children, durable medical equipment costs, and genetics testing.

Measuring Annual Quality Performance

Overutilization and underutilization is monitored annually by comparing the results of select Healthcare Effectiveness Data and Information Set (HEDIS) measures with national HEDIS Medicaid benchmarks (90th percentile and 10th percentile for upper and lower thresholds, respectively), which were selected based on their demographic, clinical, and practical relevance to the Medicaid population.

Addressing Issues in Provider Utilization

ACLA holds providers accountable for delivering appropriate, medically necessary care. We leverage several strategies to identify and address patterns of provider behavior that result in overutilization.

Provider Profiles

ACLA also uses collected data to create provider profiles—reports that detail selected demographic, utilization, and quality measures for providers who meet membership and other criteria. The profiles include a risk-adjusted analysis of actual versus expected utilization for the provider's panel, enabling us to better compare providers against their local, regional, and national peers and evaluate their performance in meeting utilization and quality goals.

Providers shown to be utilization outliers receive education and recommendations for process changes. ACLA's Provider Network Management account executives and Network Medical Director are trained on measures and methodology to help PCPs use the data to improve their performance. Selected providers may also be visited by associates from Provider Services and/or Medical Management if necessary to address the issues.

Sharing Clinical Guidelines with Providers

ACLA has developed evidence-based clinical policies that based on reviews of the medical literature. These are shared with our network providers through several avenues, including our provider website. The policies are designed to summarize industry-standard approaches to the treatments and procedures for which ACLA has established prior authorization requirements as well as fair and consistent administration of Louisiana Medicaid benefits. This includes reducing unnecessary variations in care by sharing information on the latest scientific evidence and research with our providers. These policies are not intended to replace a provider's clinical judgment or indicate which treatments would advisable for any individual member.

Medical Records Review

As with our provider profiling processes, Medical Record Reviews present an opportunity for ACLA to identify issues in the quality of care and other opportunities for improvement for our network providers. Medical Record Reviews are audits designed to assess the provider's compliance with ACLA's Medical Records Documentation Standards, including guidelines that pertain to medical record content, confidentiality, consistency, organization, completeness, and ease of retrieving medical records.

Medical Record Reviews are performed by the Quality of Clinical Care Committee (QCCC), a subcommittee of ACLA's Quality Assessment and Performance Improvement Committee (QAPIC). The QCCC is responsible for monitoring over-/under-utilization and the medical appropriateness/necessity of health care services provided to the plan's members utilizing provider quality and utilization profiling.

ACLA focuses Medical Record Reviews on our primary care providers (PCP), who typically have the most interaction and involvement with our members. OB/GYN and specialist providers may also be targeted for Medical Record Reviews, as needed. A minimum of five records per site are selected for review using a random number methodology among members assigned to the provider for a minimum of six months.

All office sites surveyed are notified of their practice-specific performance scores. Provider Network Management works with sites that fall below the expected performance benchmark to improve documentation processes prior to a follow-up review in six months. If a provider continues to fall below the expected benchmark, a Corrective Action Plan (CAP) may be developed. Providers who fail to comply with the CAP or continue to fall below benchmarks are referred to ACLA's Medical Director and/or Credentialing Committee for further review and action.

The medical record performance scores and any resultant CAPs are placed in the practitioners' credentialing file. An annual summary of performance is presented to the QAPIC for their review and recommendations.

Detecting Fraud, Waste, and Abuse

One of the causes of overutilization is provider fraud, waste, and/or abuse (FWA). To address this, ACLA proactively identifies providers whose patterns of care indicate potential FWA. This is done through monitoring and analyzing provider billing, claims, and prior authorization data. Our Special Investigations Unit (SIU) utilizes anti-fraud technology to detect suspected FWA.

The application evaluates collected data using established algorithms to identify atypical claims or payment activity. FWA detection is focused on known high-risk indicators, including overutilization, excessive time units, unusual claims volume, or uncommon combinations of service/medication codes. Senior leadership of ACLA meets monthly with ACFC to review providers under investigation by the enterprise's SIU.

Process in Action: Speech Therapy Authorization Policy

Two years ago, ACLA decided to remove the prior authorization requirement for speech therapy services. Our routine monitoring of authorization requests and claims activity showed that there was a low denial rate. Additionally, we wanted to reduce the administrative burden for our providers, some of whom had requested the removal, and prevent any delays in accessing the service for our members.

Not long after removing the requirement, ACLA's ongoing monitoring indicated that there had been a sharp increase in utilization and claims for speech therapy. Due to concerns about inappropriate utilization, ACLA reinstituted the requirement for concurrent and ongoing medical necessity reviews.

Identifying and Addressing Drug Overutilization

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee is a subcommittee of the QCCC that meets to monitor drug utilization patterns, pharmacy benefits management procedures, and quality concerns. The P&T Committee also approves pharmacy policies and criteria, including reviewing and approving prior authorization programs and monitoring drug utilization patterns. They are also responsible for identifying opportunities to address utilization issues, such as provider education or pharmacy lock-in.

Our Regional Medical Director chairs the P&T Committee, which consists of at least three participating network providers, a pharmacy provider, and representatives from PerformRx, ACLA's PBM. The committee meets a minimum of three times per year. The minutes, recommendations, and actions of the committee are submitted to the QAPIC for its review and approval.

Drug Utilization Review

ACLA, in conjunction with our PBM has implemented a robust Drug Utilization Review (DUR) program to encourage proper drug utilization, identify drug interaction risks, and address over-prescribing situations. Through the program, ACLA monitors the prescribing patterns of network physicians, and evaluates potential misuse of controlled substances, enabling us to educate providers on appropriate medication interventions and prescribing practices. Collected data also enables ACLA's care team to identify members who need additional intervention and support.

The DUR program includes standards and utilization management processes for therapeutic duplication, drug-drug interaction, maximum daily dosage, and therapy duration. ACLA also employs drug utilization edits performed on pharmacy claims, including age-specific edits.

Pharmacy Lock-In Program

ACLA will enroll members in the Pharmacy Lock-In Program to encourage appropriate use of Medicaid prescription benefits when evidence indicates overutilization due to member abuse or misuse of prescription medications. On a monthly basis, ACLA will analyze prescription utilization data to identify members with inappropriate patterns of use. Criteria will include, but are not limited to, use of multiple pharmacies and/or providers, utilization patterns inconsistent with their peers, duplication/inappropriate use of controlled or psychotropic drugs, and/or potential harm to the member. In addition to data analysis, members may be referred into the program by ACLA departments, DHH, providers, or pharmacists.

ACLA's Medical Director will review the member's pharmacy utilization data for potential inclusion in the Pharmacy Lock-In program. If restriction is recommended, the member will be asked to select the retail pharmacy they will be locked into for one year. If the member does not select a pharmacy, ACLA will assign a pharmacy after 30 days.

During the lock-in period, ACLA will offer care coordination and case management to members to assist with managing their health conditions. The member's utilization data will be continually reviewed to identify positive or negative pattern changes. ACLA will use this information to determine whether early disenrollment or continued enrollment is warranted.

In addition to monitoring member data, ACLA will also verify that the assigned pharmacy is not contributing to the member's pattern of misuse.

Encouraging Appropriate Utilization for ADHD Drugs

Our South Carolina affiliate recently implemented a program to encourage the appropriate use of ADHD (attention deficit hyperactivity disorder) drugs and follow-up activities, as well as reduce ADHD drug utilization in children between the ages of three and six. The program established drug-specific age limits for the treatment of ADHD, which restrict the use of certain ADHD medications.

Since the limits were implemented, more than 75 requests for ADHD medications have been referred back to the prescriber due to children below the age limits not meeting diagnosis guidelines. Associates from Pharmacy and Medical Management reached out to the prescribers to discuss non-pharmacologic treatment alternatives for those members.

Since implementing the program, utilization of ADHD medication in children six and younger has been successfully decreased. The table below demonstrates the declining trend in prescriptions filled for children between the ages of zero and six during 2014.

Month (2014)	JAN	FEB	MAR	APR	MAY	JUN	JUL
Total Members Ages 0-6	614	611	614	572	525	426	422

Exhibit N.8-1: ADHD Medication Utilization in Members Ages 0-6

ACLA is currently in the process of implementing this program in Louisiana.

Provider Outreach

ACLA will perform chart audits for providers with 20 or more new ADHD prescriptions in a quarter to assess whether they are using appropriate diagnostic tools and prescribing guidelines. We will also assess whether recommended treatment and follow-up care is continued through the first year. These providers will be selected using pharmacy data, and will be sent an audit notice, along with education and guidelines on ADHD medications. Feedback from the chart audits will be shared with the providers; if a provider's raw score was to fall below 80%, additional oversight and audits will be performed.

Member Outreach

In addition to prior authorization requirements and the chart audits, the ADHD utilization program will follow selected members to ensure they receive the appropriate interventions and follow-up care. P&T approved guidelines recommend follow-up with providers within 30 days of filling the initial prescription, as well as at least two follow-up visits within nine months of the initial prescription fill. These visits are to enable providers to monitor compliance with treatment regimens and identify whether additional interventions are necessary.

ACLA will use pharmacy data to identify members who have filled new ADHD prescriptions. ACLA will contact members to assist with making appointments and arranging transportation if needed. ACLA will use automated messages as necessary to remind members of their need to follow up after the initial fill.

PerformRx Foster Care Drug Therapy Management (DTM) Program

In collaboration with PerformRx, ACLA is developing a drug therapy management (DTM) program to optimize drug therapy for children in foster care. Studies have found that children in foster care are significantly more likely to receive psychotropic drugs than children who remain with their families. With unstable social supports, these members are also more likely to experience preventable adverse events due to medication-related problems. Through medication oversight and care management, the goal of the Foster Care DTM program will be to optimize medication regimens and improve health outcomes for enrolled members.

Program enrollment would consist of members in foster care who had either a unique drug count of ≥4 in the previous 90 days, or any behavioral health medication filled in the previous 90 days. More than 400 ACLA members would match these criteria.

The expansion of the DTM program to other "at risk" populations will be mutually determined by PerformRx and ACLA guided by experience of this DTM program.

DTM interventions would be identified by pharmacists after reviewing member profiles. This includes both member and prescriber interventions. Prescriber interventions will be addressed directly, while member interventions will be addressed with the member's legal representatives through existing case management relationships or through an ACLA care manager. An ACLA-affiliated pharmacist will be available to assist with counseling or communication at any point.

Periodic reviews and follow-up will be performed by the plan's pharmacist to evaluate the effects of the interventions. Notably, the pharmacist will identify whether the member's drug therapy has changed post-intervention in a manner that reduces the potential incidence of adverse drug events, and improves quality of life.

Reducing Inappropriate Short-Stay Inpatient Admissions

Through data analysis, ACLA identified that services provided at the inpatient level of care during 2013 were potentially inappropriate, and so initiated a medical record audit was

performed for targeted inpatient facilities. The audit results indicated that a very high number of inpatient cases with lengths of stay (LOS) less than two days were medically unnecessary, and that services could have been provided in an outpatient environment.

Additionally, a statistical review was performed on all inpatient admissions with LOS less than and equal to two days using 3M analytics. Almost half of those cases presented with conditions that were ambulatory sensitive and potentially avoidable, suggesting gaps in outpatient care. The conditions identified as potentially preventable admissions (PPAs) are listed below.

- 053 - Seizure
- 054 - Migraine & other headaches
- 113 - Infections of upper respiratory tract
- 137 - Major respiratory infections & inflammations
- 138 - Bronchiolitis & RSV pneumonia
- 139 - Other pneumonia
- 140 - Chronic obstructive pulmonary disease
- 141 - Asthma
- 191 - Cardiac catheterization w circ disord exc ischemic heart disease
- 192 - Cardiac catheterization for ischemic heart disease
- 194 - Heart failure
- 198 - Angina pectoris & coronary atherosclerosis
- 199 - Hypertension
- 203 - Chest pain
- 244 - Diverticulitis & diverticulosis
- 249 - Non-bacterial gastroenteritis, nausea & vomiting
- 251 - Abdominal pain
- 383 - Cellulitis & other bacterial skin infections
- 420 - Diabetes
- 422 - Hypovolemia & related electrolyte disorders
- 463 - Kidney & urinary tract infections
- 465 - Urinary stones & acquired upper urinary tract obstruction
- 662 - Sickle cell
- 722 - Fever

Exhibit N.8-2: List of PPAs Based on 3M APR DRG Software

As a result, ACLA has implemented 100% medical director review of requests for inpatient admission for any of the listed conditions to reduce inappropriate inpatient utilization and improve management of these conditions in appropriate settings. Cases not meeting medical necessity criteria will be denied for inpatient level of care; additionally, observation services will be coordinated with close medical director follow-up to facilitate optimal outpatient management.

N.9. Utilization Management

N.9 Identify how you will assess the quality and appropriateness of care furnished to enrollees with special health care needs.

Overview

Members with special health care needs comprise individuals of any age with a mental or physical disability or other circumstances that put their health and their ability to fully function in society at risk, requiring individualized health care services. It is especially important that these members receive high-quality, targeted care to ensure the best possible outcomes. ACLA has a long history of successful programs and processes to improve health outcomes for members with special health care needs. ACLA works closely with providers, governmental agencies, and community based organizations to secure the best possible services for our members. Using a multidisciplinary approach, we assess and evaluate services to ascertain quality and effective care for these members.

Blended, Holistic Care Management

The underlying theme in assessing the quality and appropriateness of care for members with special health care needs is our multidisciplinary approach. Members with special health care needs often have multiple chronic, comorbid illnesses that impact both physical and behavioral health. ACLA care managers develop holistic treatment plans that make it possible to customize care by combining approaches to address these comorbidities, such as chronic illness, behavioral health issues, and psychosocial problems. Each care plan is unique and built to address the specific needs of each member, including the need for social and environmental supports. Using a modular approach, ACLA identifies comorbidities in the initial assessment and follows with more detailed, condition-specific assessments. This blended methodology allows us to create one individualized care plan that combines all assessments to support the body and the mind.

Identifying Special Health Care Needs

ACLA uses several methods to identify members with special health care needs in order to ensure quality and appropriateness of medically necessary services, and to connect the enrollee with the appropriate level of care. Members who meet our DHH-approved criteria are identified within 90 days of our receiving the member's historical claims data, if available. The PCP may indicate that members have special health care needs. Members may identify themselves as having special health care needs to the Enrollment Broker, ACLA, or their PCP. The Enrollment Broker must then provide notice to ACLA of those members with special health care needs.

ACLA sees every member encounter as an opportunity to assess for any indication of needed services. All departments, including Member Services, Rapid Response, Utilization Management, Community Health Educators, and the 24-hours Nurse Line, are encouraged to

refer members. If a member is identified as having a special health care need, the member is referred to Rapid Response for an initial health risk assessment. This screening is completed by a Care Connector, one of our non-clinical staff trained to assess for health risk triggers.

If the screening indicates further clinical review or if there are any concerns, the member is referred to a care manager, who completes a mini assessment to further identify needs and barriers. A nurse care manager completes the assessment and determines a plan to include regular monitoring. This results in a referral for ongoing case management. In the case of new members, assessment information is used as the data source. In the case of ongoing members, claims data is reviewed.

Some of the populations with special health care needs, and the factors involved in assessing the quality and appropriateness of their care, are discussed below.

Seriously and Chronically Ill Persons

Once identified, these members receive Integrated Care Management that focuses on the whole person. In this way, member care is addressed from a comprehensive perspective, allowing us to consider and address additional or wraparound services that are needed. The care manager works to ensure that treatment is accessed and that barriers to care, such as transportation or child care needs, are eliminated through the arrangement of supportive services.

For example, patients with End Stage Renal Disease (ESRD) may have a number of other comorbidities in addition to diabetes or hypertension, each with unique conditions that require intensive care management. Care required for members with ESRD could include home- and community-based support services or medical services, such as regular visits from skilled nurse or home health aides visits. Family caregiver education and support is also implemented. Assessing the needs of the patients and then coordinating care with the variety of providers and services required are central activities to providing holistic, person-centered support for our members.

For members undergoing a transplant, service coordination of this time-critical process is crucial. The care manager works collaboratively, coordinating with the member, their family and support network, doctors, specialist, clinics, transplant coordinators, and hospital discharge planners. As the patient's advocate and liaison, the care manager provides education for the patient on pre-screening activities, medications, the importance of keeping all doctor appointments, and linking the member to any needed community resources.

Persons with Behavioral/Physical Health Dual Diagnoses

ACLA coordinates care for members who have behavioral health issues in addition to their medical diagnoses. ACLA has successfully interfaced with the current SMO for the past three years. Members are screened using the PHQ-9, a depression screening survey. We refer members who need intensive behavioral health treatment to the SMO and coordinate with them in member care.

The ICM team has integrated rounds with the SMO to discuss these referrals. This facilitates the follow-up required and assists the team in discussing any continued gaps or barriers. These rounds include the SMO's psychiatrist, who reviews the case and provides recommendations as appropriate. ACLA participates in monthly meetings with the SMO to review joint cases and cases that have been identified by ACLA staff for potential referral. Behavioral Health care managers track the members that are co-managed with the SMO, PCPs, and other specialists if necessary.

Our care managers also work with the SMO to help members access their supportive services, including group meetings or day programs. Medication adherence and appropriateness is of special concern. In addition, care managers work with members and their families or support network to address any barriers to care, such as providing transportation through our contracted vendor.

The following story demonstrates our success in helping a member with severe co-existing conditions:

"Tasha" is a 16-year-old with a history of childhood obesity (she weighs 500 pounds), sleep apnea, and clinical depression secondary to her obesity. She is the oldest of three children who reside with their mother with no active involvement from her father. Her mother has a history of substance abuse and was not very supportive of previous care plans.

"Tasha" was hospitalized three times in the previous year for sleep apnea complicated by her obesity. During her multiple hospitalizations, "Tasha" increasingly demonstrated signs of depression and suicidal thoughts. She was referred for Care Management by the Utilization Review nurse, and our care manager began working with the mother, PCP, and behavioral health provider.

Interdisciplinary meetings with the behavioral health provider revealed that "Tasha" had tried and failed multiple weight loss initiatives over the past three years, contributing to her depression. As a result of the meetings between the medical and behavioral health providers and ACLA's Care Management team, a plan was developed to gain "Tasha" admittance into a facility that could help her reach her weight loss goals, monitor and treat her sleep apnea, and provide psychological interventions for her depression.

"Tasha" is now 17 years old. She spent 14 months in the facility and lost more than 250 pounds, stabilized her sleep apnea, and regularly attends ongoing outpatient treatment for weight management and depression. She returned to school in a traditional setting and has not had any further hospitalizations for sleep apnea or depression.

Persons with Developmental Disabilities

Members and caregivers who live with developmental disabilities need holistic support in order to address a variety of issues. Upon medical request, ACLA arranges special support according to member needs, especially when arranging service such as dental care or gynecologic exams. We assess the quality of these service providers via health outcomes and surveys presented to caregivers (including families, foster care, or group homes). ACLA works to help our members access the right care with the supports that successful administration of

that care requires. Other key areas of focus for members with developmental disabilities include support of caregivers, coordination of community services, and coordination with state agencies.

The Children's Special Health Service program (CSHS) is the principal public agency ensuring access to health care services for children and youth who have special health care needs in Louisiana. ACLA refers members with disabilities and their families to CSHS for support and resources.

Medically Fragile Children

ACLA care managers smoothly coordinate care and services for children with multiple diseases of prematurity, children waiting for transplants, and other medically fragile children. In addition, ACLA will outreach and coordinate care for the Chisholm opt-in population starting in 2015. The care managers work to form collaborative relationships with targeted case management providers in order to ensure that all elements of the settlement are satisfied and members are receiving the appropriate services until moved to the HCBS waiver services program. Care managers develop, implement, and maintain individualized care plans that are evidence-based and focused on the special needs of each child. We also work with community groups and state and local agencies to make sure that children in Medical Foster Care homes or other substitute care have a patient-centered medical home that is consistent in giving appropriate and evidence-based care.

Our ICM program is made up of a dedicated staff, including pediatric nurses who have experience with children's medical services. The care manager will collaborate with the Utilization Review nurse to ensure that services being requested are addressed and reviewed using the plan's comprehensive review process. We provide caregiver support and education, coordinate with school systems, and provide preparation for age-related or other transitions to other supportive programs.

The ACLA interdisciplinary team, including UM, Rapid Response, and Complex Care Management, coordinates the complicated process of transplants, from arranging flights for out of state families, to transportation to and from a receiving facility or home. We work with vendors to help with meals and execute single-case agreements for services as necessary. ACLA teams work together with providers, vendors, and organizations to coordinate the care our members need.

The following illustrates how we practiced this strategy in helping coordinate care for a five-year-old child with a serious illness, while also addressing the accompanying needs of caregiver.

"Max" is a five-year-old member who was referred through our Utilization Management team. "Max" was admitted to have a small bowel transplant. "Max" had frequent hospital admissions prior to transplant for central line infections, and we had been unable to connect with his mother on previous attempts to engage in Case Management.

"Max" was receiving care at an out-of-state facility. His mother was the primary caregiver for several other young children and had limited family support to care for those children while she was out of town with him. His mother had been reported as noncompliant in the past, and "Max" was frequently in the hospital.

"Max" had a very lengthy stay in the out-of-state facility, and his mother had to return home several times to take care of business at home, and then to deliver her baby. She was having a difficult time handling J.'s prolonged stay out of state along with all of her life demands, with limited support from family.
Our care manager helped to facilitate travel arrangements for his mother between their home and the facility. The care manager also educated his mother on the treatments "Max" was receiving and benefits available to assist them, as well as providing her with support while she was away from home with "Max" and assisting her when problems arose that required her to return home. The care manager educated J.'s mother on how to navigate the health system and empowered her to have more open discussions with providers.

The care manager worked closely with the discharge planning team at the out-of-state facility and ACLA's Utilization Review team to address any needs and barriers to discharge. The care manager has been following up with "Max" and her mother on a weekly basis since their return home to monitor compliance with treatment plan and follow up appointments, assist with any DME needs, and monitor for barriers in following the plan of care. "Max" has improved in his ability to tolerate feedings and has required less frequent admissions. His mother has been compliant with appointments, feedings, and the medication regimen. "Max" has been stable enough to enroll in school and is now attending.

Assessment of Quality and Appropriateness of Care

Assessing the quality and appropriateness of care for members with special health care needs depends upon careful examination of data from a variety of sources. UM is involved not only to prevent costly duplication of services, but also to make sure that services are in place to address all of the member's needs.

To ensure that appropriate services are in place, Utilization Review nurses review service requests individually for all members, with an eye for underlying conditions and situations that warrant special attention. Requests are reviewed to ensure that the member is connected with the most geographically accessible provider, that the most appropriate services are being requested, and that the number of units or visits are appropriate to help the member regain function as close to baseline as possible. The review includes a comparison of the services requested to the services the member is receiving or has received in the past to avoid both duplications and gaps.

Sometimes terminology itself is found to be a barrier to appropriate care. For example, ACLA may receive a request for occupational therapy for a member who is receiving physical therapy. Upon review of the assessment notes and evaluations, the nurse may find that duplicative physical therapy is actually being requested under an erroneous name. Conversely, the review may indicate a need that is not being addressed. A request for a wheelchair, for instance, may indicate the need for physical therapy or for a hospital bed, depending on the accompanying notes and assessments. If this service would benefit the member but has not been requested, the

Utilization Review nurse will outreach to the provider to discuss the suggested service or equipment and make arrangements for their delivery. The Utilization Review nurse will also refer these members to the Care Management team to initiate a team approach in addressing he member's needs. Care managers have reached out to providers in many instances to advocate for what service may be needed or appropriate for the member. The care manager will provide reciprocal feedback to the Utilization Review nurse in order to expedite the review process and ensure timeliness of delivery of medically necessary, quality services. In this way, proper services are facilitated through ACLA's approval process.

Should the review of the services and member information identify an issue with the provider, service, or amount of service requested, the Utilization Review nurse contacts the provider for clarification. Should further input be needed, the nurse seeks the guidance of the plan Medical Director. If the request is for the continuation of previous services, the nurse closely reviews the progress made as well as any additional services recently utilized to include inpatient stays or recent discharges.

All service requests are reviewed by Utilization Review nurses according to established medical necessity criteria. ACLA uses the nationally-recognized InterQual guidelines in the development and management of our Utilization Management program. As needed, ACLA develops internal criteria to supplement InterQual. We use the following information sources during the development process for our UM policies:

- Results of the Hayes Incorporated technology assessment report
- Information from appropriate government regulatory bodies, such as the Food and Drug Administration (FDA) or the Department of Health and Hospitals (DHH)
- Published scientific evidence
- Publicly available reference information (including web/online resources)
- Information from a board-certified consultant(s) familiar with the specialty or technology area under review

To assure that all decisions are made appropriately, employees will use QAPIC and DHH-approved criteria in making decisions on medical necessity. If a request does not meet our criteria, the nurse can present the request to ACLA's Medical Director for review. The Medical Director works with UM staff and providers to attain all the additional information necessary to substantiate the request and ensure its quality and appropriateness or to select a more appropriate service. This cooperative approach between ACLA and providers ensures the delivery of appropriate services by facilitating conversations with providers.

ACLA makes prior authorization determinations in a timely manner and in accordance with DHH requirements. Indeed, in cases of urgent needs, UM expedites the process. Even those requests not marked urgent can be expedited if there is a concern that a member needs the service or equipment right away. UM will engage care managers or the Rapid Response team if assistance is needed for expedited approval of equipment or services as triggered by special health care needs.

ACLA's approach: To make sure all members get the right care at the right time.

Members and their families are also fully involved in the process of assessing quality of care and services. Providers, UM, and ICM work together with the member and their families to gain feedback on services provided and establish that appropriate care is being delivered. The member may also designate other representatives to be involved in care. Additionally, other experts are engaged as needed to support the member's unique care requirements; this may include physician specialists, mental health professionals, substance use treatment providers, social workers, nutritionists/dieticians, direct community care workers, pharmacists, waiver program providers and community support representatives.

These experts provide the knowledge, skill, and expertise necessary to identify the member's full array of needs accurately, pinpoint appropriate services, and design specialized programs that address those identified needs. The composition of this team and the member's individualized care plan may evolve to reflect and address changes in identified needs.

From the vantage point of whole-person care, ACLA educates members and their families about covered and additional services available to them. We develop relationships with providers and community partners to coordinate additional services. Our integrated software facilitates an active care coordination program, allowing providers to collaborate on appropriate interventions. The case study below shows how ACLA works to deliver the most appropriate and holistic care.

"A few years prior [to "Alicia" becoming an ACLA member}, when "Alicia" was 17 and living in California, her grandmother "Rose" took her shopping on Christmas Eve to pick up an iPod she wanted. Driving in the predawn light along the California coast, "Rose" hit a patch of black ice, lost control of the car and flipped it. "Rose" suffered several broken ribs, but "Alicia" was thrown from the vehicle and had landed on the pavement. She suffered a traumatic brain injury as well as a spinal cord injury that would leave her paralyzed below the waist for the rest of her life.

Following the accident, "Rose" left her career of 30 years as a registered nurse and assumed the role of "Alicia"'s full time caregiver. As "Alicia" recovered from her initial injuries, the family relocated from California to Louisiana to allow "Alicia" to pursue educational opportunities. Upon moving, "Rose" had experienced multiple roadblocks and barriers in getting "Alicia" connected with the equipment, doctors, and services she needed. By the time "Alicia" was enrolled with ACLA and the Rapid Response team began to interact with "Rose", her frustration had turned to full-blown anger. Most calls ended with "Rose" ended with her hanging up on whomever was on the other end of the line.

Over a span of roughly 9 months, "Rose" went from being an adversary to a respected confidant and a friend. It was a long, labor-intensive process that typifies the team approach that accompanies ACLA's philosophy of Integrated Care Management—everyone working together to achieve success.
Our ACLA care managers and Utilization Review nurses put an enormous amount of work into getting the specifications and codes needed for a powered wheelchair approved for "Alicia" and Provider Network Management negotiated a single-case agreement with a DME provider. Throughout this process, care managers maintained contact with "Rose" and provided updates. This resulted in the successful delivery of a powered wheelchair. A. had developed a Stage IV pressure

ulcer on her bottom, and the new powered wheelchair made it easier to shift positions and alleviate the pressure.

When "Alicia's" condition was sufficiently stabilized, she was transferred to ACLA's Integrated Care Management department and given a regular care manager for longer term care management. "Rose" continued to call Rapid Response to discuss different situations concerning "Alicia'"s medical care. She began to treat the team as her allies and confidants to help with navigating the many twists and turns of the health care system. Unfortunately, "Rose" called us to say that "Alicia" had suffered a seizure from continued medical problems and slipped into a coma, passing away shortly thereafter. "Rose" thanked all of the workers at ACLA who had helped along the way. To hear these words from this tough, determined, intelligent woman was one of the highest compliments we have received. It's one we will never forget."- Rapid Response and Utilization Review teams

Once appropriate care is in place, care managers continue to make sure that the member has the most appropriate care they need and to orchestrate all of the services they need. Utilization Review nurses work with care managers to facilitate access to medical equipment or arrange home health services, therapy, or any services that will help the member achieve quality of life and improvement in health outcomes. We assess the ongoing performance of our providers via ongoing quality assessment survey of members and providers.

Additionally, our interdisciplinary approach is reinforced by systemic processes such as Grand Rounds. These educational meetings are held weekly as a forum for UM nurses and care managers to discuss complex cases and how to consistently meet member needs. This setting affords the ideal opportunity for the team to work together to review service needs and care goals, anticipating the next steps in our ongoing role of assuring quality health care for all of our members.

O.1. Chronic Care Management Program

O.1 Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for Bayou Health. Include information on work you have conducted in other states, if applicable. Include how you measure success for each of the populations (i.e. 20% reduction in 30-day readmission rate for members with diabetes); any state models you plan to implement in Louisiana; and how you plan to partner with national, state, or community foundations to support this work. Your plan should include but is not limited to:

- *How recipients will be identified for inclusion into the Chronic Care/Disease Management program, including populations of special interest to Louisiana e.g. reproductive aged women with a history of a prior poor birth outcome and members with Diabetes, HIV, Hepatitis C and sickle cell disease.*
- *How you identify which disease states/ recipient types will be targeted for the Chronic Care/Disease Management program.*
- *How you identify members who require in person case management services.*
- *Plans to integrate with existing resources/programs in Louisiana as well as your plans to have case managers "on the ground" in addition to telephonic case management*
- *How the Chronic Care/Disease Management program will coordinate information and services with the PCP.*
- *Methods for case management in ways other than simply telephone management. These may include the use of pre-existing community organizations, community hubs, community health workers etc.*
- *How you engage patients (in person, mobile apps, telephonic) and explain your model of case management including what types of personnel (lay health workers, nurses, social workers) are providing case management.*

Overview

Since 2012, AmeriHealth Caritas Louisiana (ACLA) has been committed to improving the health outcomes of our most chronically ill members in Louisiana. Our proven Integrated Care Management (ICM) program uses a person-centered, holistic approach to address the complex health care needs of members with asthma, obesity, diabetes, heart failure, chronic obstructive pulmonary disease, and sickle cell anemia. The programs have improved health outcomes, increased quality of care, and reduced avoidable hospital admissions. We use several methodologies to evaluate the effectiveness of program interventions including Healthcare Effectiveness Data and Information Set (HEDIS) and HEDIS-like measures, and member satisfaction surveys.

Our comprehensive, proven ICM program effectively address the complex health care needs of Bayou Health recipients who are living with chronic illnesses, resulting in better health through delivery of clinically recommended health care, and connections to appropriate community resources and supports. An integral part of our ICM approach, our Chronic Care Management programs have a history of improved health outcomes, increased quality of care, and reduced avoidable hospital admissions. We are committed to continue our work to improve the health status of our sickest members by continually measuring the success of our chronic care programs.

We incorporate a deep understanding of the impact of the social determinants of health on an individual's ability to achieve optimal wellness. For example, our outreach and engagement programs take into consideration the dynamics of the communities in which our members live—we often partner with local community agencies and faith-based centers. These partnerships give our outreach efforts additional credibility, making it easier to engage members in health-related activities. We hire care management and outreach staff from the local area, improving our effectiveness and investing in the community.

We have built our programs to reach members in their own communities. For example, ACLA has enrolled 200 high-risk pregnant members in the Bright Start program by our community health educators and touched approximately 600 households through their work in the community, including those with chronic conditions.

Chronic Care Management Member Identification

On an annual basis, member population and subpopulation are assessed and reviewed to update the Chronic Care/Disease Management program. This is accomplished by using internal reports that are developed by the medical economics department in collaboration with the ICM director and manager. This allows the plan to consider the characteristics of the member population and revise the ICM program accordingly. The findings and subsequent interventions and opportunities will be reported in the ICM program evaluation each year. ACLA identifies members in need of chronic care management using several distinct mechanisms:

- Data mining - Current and historic medical and pharmacy claim data are analyzed to identify members belonging to targeted chronic condition populations. ACLA's algorithms incorporate analysis of medical, behavioral health (as available), and pharmacy claims to identify members who are actively diagnosed with the condition, and avoid false-positive identification of members who are being ruled-out for a condition.
- New member assessment - ACLA actively contacts members to have them complete a New Member Assessment to assist in the identification of chronic conditions and Special Health Needs prior to the availability of claim data.
- Provider referrals - Providers are encouraged to refer members to the ICM program by telephone and fax referrals.
- Louisiana Behavioral Health Partnership (LBHP) State Management Organization (SMO) referrals. Using ACLA's reciprocal referral process, the SMO refers members with chronic care needs to the ICM program.
- Member requests - Members can contact the ICM department to request chronic care management services.
- Health plan activity - Members are also referred to the care coordination program through internal processes such as utilization management, provider service calls, and Member Services calls.
- Predictive Modeling - In conjunction with our data mining efforts, ACLA uses proprietary algorithms licensed from 3M to assign members to Clinical Risk Groups (CRGs). CRGs are a clinically-based classification system used to measure a population's

burden of illness. 3M CRGs use standard medical and pharmacy claims collected longitudinally to assign each individual to a single, mutually exclusive risk group. 3M CRGs relate the historical, clinical, and demographic characteristics of the individual to the amount and type of health care resources that the individual will consume in the future. To further differentiate members with in high-risk CRG assignments, ACLA reviews accumulated utilization history to identify Potentially Preventable Events (PPEs) using an additional 3M algorithms. This analysis assists ACLA to target not just members with a chronic disease, but members who are also incurring potentially preventable episodes of care. CRG and PPE analyses are conducted using a combination of historical (when available) and current claim data sets.

The 3M CRGs are a clinically-based, rather than a regression risk-adjustment model. They create a language that links the clinical and financial aspects of care. This "language" is easily understood by clinicians and therefore actionable.

In the 3M CRG system, an individual is assigned two descriptors:

- *Base CRG: Each individual is assigned to a single base CRG that reflects the full range of diagnoses for that individual*
- *Severity-of-illness subclass for the base CRG: The subclass addresses individual differences relating to severity of illness*

Typically, there are four severity-of-illness subclasses (in some instances, there may be more than four). The subclasses are numbered sequentially from one to four and indicate, respectively, minor (1), moderate (2), major (3), and extreme (4) severity of illness.

Once identified, members are stratified into a program based on their level of risk, PPE history, assessment findings, and ability to return to self-management. Members in the program are periodically reassessed and moved into different program arms as their needs change. Enrollment for all chronic care management programs is automatic. All members have the right to "opt-out" of any program at any time.

The Rapid Response team serves as the intake point for referrals from providers and internal health plan activity. Staffed by experienced Care Managers and non-clinical Community Care Connectors (CCCs), Rapid Response employees serve as front line contacts for members and providers who need assistance accessing or coordinating care. The Rapid Response team is trained to identify and address urgent needs, while probing to uncover ongoing issues and connect the member to the appropriate ACLA program or community resource.

Populations of Special Interest

In addition to the member identification methods described above, ACLA also identifies recipients in select sub-populations for additional care management interventions. Our processes focus on identification of conditions that require ongoing management, such as HIV/AIDS, and specific services, including home health care, therapy, and equipment or oxygen rental, that may indicate an ongoing course of treatment. We aggressively pursue care coordination for these fragile populations.

The indicators we use to identify members with complex and/or chronic conditions and special health needs, as outlined below, match the priorities identified in the DHH Bayou Health program. We focus on high prevalence conditions, such as diabetes, hypertension, and heart disease, along with ongoing treatment for cancer and renal disease.

Diagnoses	Services	Provider Types
Pregnancy (and prior pre-term birth) Asthma Autism Cardiac Artery Disease Chronic Obstructive Pulmonary Disease Depression Diabetes Heart Failure HIV/AIDS Hypertension Sickle Cell Anemia	Cancer Treatment (chemotherapy or radiation therapy) Home Health Care Oxygen DME rental Therapy (PT,OT,ST) Dialysis	Home Health Therapy (PT,OT,ST) DME Transportation Dialysis Hospice

Exhibit O.1-1: Chronic and Special Health Needs Indicators

Members identified as having complex and/or special health care needs are automatically triggered for complex care management. They receive a comprehensive assessment and an individual care plan along with focused care management support. Each care plan addresses the medical, mental health, and social/support needs of the individual member and includes education for the caregiver on the disease process and treatment regimen, as appropriate. Care plans for complex and special needs members also include assessments and interventions focusing on caregiver support.

Specific subpopulations of focus include:

Members Receiving Home and Community Based Services (HCBS)

The ACLA ICM department receives an automatic weekly report identifying HCBS members. The report includes the member's name, Member ID number, and aide category. Each time the report is generated, an email alert is sent to a distribution list of ACLA managers and supervisors to ensure that there are no gaps in notification and follow-through.

A designated Rapid Response Care Manager is assigned to review and contact each of the members assessing their medical needs. A screening survey is completed by Rapid Response to assess any immediate barriers, service participation, caregiver availability, medical needs, and other member needs. If the member needs assistance seeking other waiver services, the care manager provides information about those services and connects the member to the appropriate

waiver coordinator and/or explains the application process. If the member needs more intensive care coordination, the member is referred to Complex Case Management for ongoing follow-up.

As of September 2014, ACLA received a total of 46 members identified as HCBS eligible, of which 42 (92%) have been contacted by the Rapid Response team. Two members connected with a Complex Care Manager for more intensive management.

HIV

For our members with HIV, ACLA develops a HIV-specific care plan including interventions surrounding disease management, medication education, self-management, infection control prevention, and nutrition. Members are also referred to external community programs and resources that have programs for financial, housing, medications, and personal care services.

Working with Louisiana Office of Public Health STD/HIV Program, we use a listing of contact information for all of the Ryan White Community Based Organizations throughout the state so that we can give members an overview of services that are provided at each agency that serves those with HIV. This information was also given to the care management staff as a resource guide to help members.

Hepatitis C

The ICM team works closely with the ACLA pharmacy department to identify and manage members on Hepatitis C medication therapy. Members with Hepatitis C are frequently prescribed costly and specialized medications. Noncompliance with their treatment regimen can lead to unsuccessful eradication of the disease. To prevent this, ACLA utilizes a number of interventions. Our Hepatitis C program has two dedicated care managers. They are trained in collaboration with our pharmacy PBM, PerformRx, on medications, treatment, risk factors, possible adverse reactions, and medication risks. They also have daily access to live pharmacy transaction data, resulting in a smoother process and decreased risk of delay.

The ACLA ICM department obtains weekly pharmacy reports from Perform Rx that lists newly identified members who are prescribed and dispensed Hepatitis C medication therapy including:

- Pegasys ™ (peginterferon alfa-2a-injection).
- PegIntron™ (peginterferon alfa-2b-injection).
- Copegus™ (ribavirin-tablet).
- Rebetol™ (ribavirin-capsules or oral solution).
- Sovaldi™ (sofosbuvir-tablets).
- Olysio™ (simeprivir-capsules).

The report details the member identification, medication, fill date, metric quality, and days supplied. The report enables the care manager to better discuss medication adherence with the member, in addition to providing education on their medication regimen.

Our care managers conduct medication adherence surveys and provide ongoing coaching for this population. In addition to working directly with the member, the ACLA Medical Director will involve the member's provider/prescriber as necessary.

To facilitate the prescribing process, providers have direct access to the criteria and prior authorization requirements used to review Hepatitis C medication through the provider portal. ACLA's medication criteria were reviewed and approved by the Pharmacy & Therapeutics Committee, which includes practicing physicians familiar with the use of the medication.

Prenatal Services and Prematurity Prevention

ACLA is committed to preventing preterm births statewide. ACLA identifies high-risk pregnant members as soon as possible. To do this, we use historical claims reports to identify current members that delivered a preterm or other high-risk baby in the past. Information is also gathered from the prenatal provider by completion of an Obstetrical Needs Assessment Form. The forms can be faxed or information for the form can be gathered telephonically.

Once identified, maternity care managers perform telephonic outreach to assess these members for risk factors. For high-risk members, a plan of care is developed to assist the member with any needs she might have during her pregnancy, including assistance with obtaining progesterone therapy that may help prevent preterm labor. Maternity Care Managers also help to facilitate the coordination of medication needs with providers.

Additionally, we send many educational materials to pregnant mothers to encourage proper care during and post-delivery. Some examples include:

- Prenatal fact sheets sent out with the Member Welcome Packet.
- Prevention of SIDS brochures sent to new mothers.
- Signs of preterm labor.
- March of Dimes: Healthy babies are worth the wait – If your pregnancy is healthy its best to stay pregnant at least 39 weeks. Baby and Me Tobacco Free.
- Centering Pregnancy: A better way to get prenatal care.
- Text4Baby.
- When you need to know about Progesterone Treatment (17P) and Preventing Preterm Birth.
- Well-baby check up.
- Postnatal: when to call the doctor.
- Pregnancy: your First Trimester Changes.
- The Benefits of Breastfeeding.
- Kick Counts.
- Asthma and pregnancy.
- Smoking.
- Anemia during pregnancy.
- Nutrition during pregnancy.
- STI screening and prevention.
- Dental care during pregnancy.

We frequently feature articles on prenatal and postnatal issues in our Member Newsletter. Our Bright Start maternity program is fully described in a brochure made available in English, Spanish, and Vietnamese. Preterm labor and 17-P injections are among the topics explained in the brochure. Our Integrated Care Management team uses automated messages to survey postpartum mothers about their experience in our Bright Start program.

Inter-conception Care Program

ACLA also helps members understand the importance of spacing pregnancies. The program goals include encouragement of birth spacing, improvement in future birth outcome, and education on birth control options.

All pregnant members who are enrolled in our Bright Start maternity program are assessed during the port-partum period. During this assessment, our Care Managers provide information on developing a reproductive life plan, educating on the importance of the postpartum visit follow-up and depression screening. The discussion includes optimal birth spacing, birth control options, choosing a PCP, and health care needs between pregnancies, including annual exams, and nutrition recommendations.

Members who do not have a co-morbid condition, and remain eligible with ACLA, receive quarterly follow-up calls from an ACLA Community Care Connector for a year after the delivery. During the calls, members are encouraged to discuss family planning options and are educated as to the importance of early prenatal care for future pregnancies. Members who have a comorbid condition and remain eligible with ACLA are followed by a care manager for ongoing care management. The care manager develops an individual care plan with the member. As part of that care plan, the care manager discusses family planning options to encourage proper spacing and risk management with subsequent pregnancies.

ADHD

ACLA is implementing an ADHD program with the goal of identifying members who are newly started on ADHD medications so that they may receive appropriate follow-up care within 30 days with their prescribing provider. Members with ongoing or new prescriptions for ADHD medication will receive written education materials and calls from our outreach team that address medication compliance, and compliance with follow-up appointments. Members identified as having barriers to recommended care will be referred to the complex care management team for further assessment and intervention.

ACLA launched a Drug Therapy Management (DTM) program focusing on foster children. The DTM program targets foster care children with at least one of the following conditions:

1. A unique drug count of 4 or more in the previous 90 days.
2. A behavioral health medication (including medication for ADHD) filled in the previous 90 days. ACLA 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 SMO for additional care coordination.

Sickle Cell

One of ACLA's 2014 internal operating performance goals is to reduce re-admission rates for members with chronic disease, including sickle cell, by four percent. After analyzing our population with sickle cell disease, we found that many members were not prescribed hydroxyurea, or they were treated with hydroxyurea but were not consistently filling/taking the medication. These members were also some of the most difficult to reach and manage. ACLA care managers are assigned to continually track members with sickle cell disease to educate and encourage compliance with treatment. Members who do not respond or are unable to be found are referred to the Community Education Outreach Team for face-to-face contact.

ACLA has also developed a number of initiatives and partnerships that target compliance and education for our members with sickle cell disease and their providers.

- Medication promotion: ACLA developed member and provider education materials about the medication, hydroxyurea, and its evidenced-based results to improve clinical outcomes for members with sickle cell. Members are educated on the medication and encouraged to ask their provider whether the medication is the right treatment for them. ACLA is also getting ready to distribute filtered water bottles to our members with sickle cell disease who are engaged in our Care Management program to stress the importance of hydration to avoid sickle cell crisis. ACLA also plans to distribute the following magnet to members:

Sickle Cell
Staying Healthy All Year

Medicines
- Folic acid daily for everyone.
- Penicillin for children through age 5 (sometimes longer).
- Ask your doctor if **hydroxyurea** is right for you.

Pain management
Work with your doctor to set up an action plan.
It will help control the pain that can happen at any time.

Spring is in the air	Summer heat
• Avoid outdoor pollen. • Avoid triggers. • See your doctor for breathing problems and infections.	• Drink plenty of fluids. • Avoid caffeine. • Take rest breaks when working out. • Eat a healthy diet.
Fall bounty	**Winter cold**
• School action plan. • Yearly flu shot. • Yearly physical exam and immunizations (shots). • Yearly eye exam.	• Avoid infections. • Dress in layers. • Avoid smoke. • Manage stress.

Call AmeriHealth Caritas Louisiana for help: **1-888-643-0005.**

AmeriHealth Caritas Louisiana | CARE IS THE HEART OF OUR WORK

Exhibit 0.1-2: Sickle Cell Member Magnet

- Sickle Cell and Anemia Foundation: The ACLA ICM department also partnered with East Baton Rouge Sickle Cell and Anemia Foundation to serve as a referral source for members who are identified as needing assistance. The Foundation provides onsite educational seminars for ACLA Care Managers with education about their program and the services offered.
- Louisiana State University (LSU) Telemedicine Partnership: To provide better care for our members with sickle cell, ACLA partnered with LSU Shreveport to provide telemedicine services. This program specifically allows ACLA to refer members to facilities located in rural areas who can then access university-based medical specialists via a video link. This referral process facilitates care coordination for our members who are in need of specialty services.

Obesity

Because members who are obese often have chronic, co-morbid conditions, ACLA has developed a number of initiatives with the goal of improving member health and reducing the incidence of obesity. The Make Every Calorie count program is one example of this strategy. Initiated in 2014, this program targets members who have a diagnosis of obesity and other co-morbidities such as diabetes, hypertension, depression, asthma, and sleep disorders. The goal of the program is to see modest, sustainable weight loss. The initial goal to lose 7- 10 percent of body weight is tracked and reported from initial obesity assessment and reassessment.

The Make Every Calorie Count program involves care managers for both children and adults in helping the member to establish personal healthy goals. The care managers are not only the nurse care manager, but also the motivator for these members. All members undergo a disease and age- specific Health Risk Assessment (HRA) that addresses lifestyle, activity, nutrition, medication changes, and other areas impacting weight.

An individualized plan of care is then generated to focus on setting patient-specific goals. For instance, the member's goal may be to be able to walk with their child in the park. Interventions are developed to help the member reach the personalized goal. Members also receive applicable educational materials on calorie counting, portion sizes, and nutritional guidelines. For those members who participate in the Make Every Calorie Count program, the member and care manager agree to follow-up engagement frequency. For example, a member may be called by the care manager weekly, during which the care manager monitors caloric intake, activity, weight, provides ongoing weight management education, and monitors the member's response and progress towards meeting goals.

ACLA also has a weight management welcome packet tool kit will be used to help members fulfill their weight management plan. The packet will contain items such as a pedometer, measuring tape, a calorie count log book and an informational packet inclusive of healthy habit information and addressing various areas such as exercise, nutrition, and activity. In addition to aiding the member, the toolkit helps the care manager to obtain patient reported data during follow-up calls, such as how many steps the member took since the last call and how much caloric intake the member has had. This information helps to drive the care plan and monitor progress towards meeting goals.

Start slow and small Try to make 1 or 2 easy changes each day.
Find a personal reason why you'd like to be healthier, and focus on that. Stick to your plan to meet your goals. There will be days when you go off-track, and that's OK. Surround yourself with positive influences like friends, family and co-workers to help you reach your goals. Our nurses are here to help and support you, too.

Your Welcome Kit... *things to help you*

TAPE MEASURE
The size of your waist can help tell if you're at risk of having obesity-related illnesses like diabetes or artery disease.

How to use it: To measure your waist, put the tape measure around your bare/naked stomach, just above your hip bone.

The tape should be touching your skin but not tight. The tape will lock in place to make it easier to read. Breathe out and measure.

You could be at risk if your waist is:
- More than 35 inches (female, not pregnant)
- More than 40 inches (male)

PEDOMETER
A pedometer is a small gadget that attaches to your waistband. It counts your steps. It will help you track how much exercise you're getting.

How to use it:
1. Clip the pedometer to your belt or waistband, above your hip. This will keep the pedometer from resetting each time you bend or sit.
2. Reset the pedometer to "0" before starting your exercise. Reset it at the end of each day, too.

FOOD AND EXERCISE JOURNAL
This handy food and activity log helps you track what you eat and drink and how much you exercise. It's an important tool in this program.

How to use it: Write down your calories and activities each time you eat, drink and exercise. Make sure to write down each thing you eat. Keep your journal with you, so if you're in the car or eating out you can track all calories.

"5210" LET'S MOVE
These are simple steps to help you make small but important habits. Try to add one at a time to your new lifestyle.

- 5 or more fruits and vegetables each day
- 2 hours or less of computer, TV or game time
- 1 hour or more of exercise and movement
- 0 sugary drinks; drink more water and low-fat milk

This message is adapted from Let's Go! www.letsgo.org

This program is about making every calorie – every meal, every step, every day – count toward better health for you. It's a way of life!

Exhibit 0.1-3: Obesity Program Welcome Packet Member Material

To further advance the weight management program and increase success of the member, nutritional counseling will be offered as an expanded benefit. Members actively participating in care management and the Make Every Calorie Count program will be offered one-on-one nutritional counseling services via telephone. The member will be referred by the care manager and the member will be provided an initial session and one subsequent session to address nutritional educational needs. The care manager will be the central collaboration point between the member, dietician, and the member's provider, as needed.

Care managers also frequently attend conferences that arm them with tools to help obese members. ACLA participated in the 2014 Childhood Obesity & Public Health Conference by Pennington Biomedical Research Center where Care Managers learned of statewide programs that are available in the community that the pediatric population can be referred to as applicable. As a participant, ACLA was educated on a number of topics related to children's health and obesity:

- To recognize the different ways that local environments shape our children's health.
- To identify resources and successful strategies to create healthy spaces for children throughout Louisiana.

- To discover how parks, neighborhoods, and schools shape our children's health and learn from key leaders about how to create more happy faces in your community.

Diabetes

The ICM department educates and encourages members to self-manage their diabetes and improve their quality of life while also reducing the number and frequency of long-term complications and other adverse events. Members with diabetes receive focused outreach to encourage medication adherence, and compliance with recommended monitoring activities, including regular physician care, HgbA1c testing, physical activity, kidney and vision monitoring and foot care. Care management and Provider Portal system alerts at the point of contact identify members in need of recommended services.

Asthma

The ICM department has an Asthma program designed to improve the health status and quality of life for members with asthma by providing education, encouraging patient self-management, promoting adherence to asthma clinical practice guidelines and reducing physician practice variance. The goal is to reduce ER visits and hospital admissions. Members are stratified into low-risk and high-risk groups, based on resource utilization rates (ER visits, medications, and inpatient stays) and predictive modeling results. Each group then receives risk-appropriate interventions. Targeted efforts at reaching members are performed by our Rapid Response to members that have had lapse in refills of their long acting corticosteroids. The Rapid Response staff will make calls to address any barriers the member may be experiencing in getting consistent refills and assist the member in obtaining the medication.

Medication Management Program on Asthma using a Health® Tablet Computer system

ACLA plans to partner with our corporate pharmacy affiliate, PerformRx, to create an asthma medication management program designed to increase adherence and reduce overall health care costs associated with the treatment of members with asthma. This program is designed to determine the impact of the Health® Tablet system when incorporated into the ACLA program for moderate to severely persistent asthmatic patients.

The overall objective of this program is to positively impact medication adherence and management by incorporating this novel program into the patient medication routine and serve as a two-way communication device between members and their care team. The tablet educates and empowers members by allowing them to create an asthma action plan, sending medication reminders, providing access to eBooks, how-to videos, and asthma-related games. The tablet also provides members with an easy way to connect with their care team.

Exhibit 0.1-4: FDA-approved Asthma Management Tablet

Identification of Disease States for Chronic Care/Disease Management Programs

ACLA's Chronic Care/Disease Management Programs are based on evidence-based guidelines reviewed and adopted by the ACLA Quality Assurance Performance Improvement Committee (QAPIC) and Quality of Clinical Care Committee (QCCC). Guidelines from national specialty organizations form the basis of our diabetes, asthma, cardiac disease, obesity, and sickle cell chronic condition management programs. National standards for condition monitoring and management form the basis of our care gap analytics. We use the following considerations to identify disease states to target in our Chronic Care/Disease Management program:

- Incidence of the identified disease state in the population.
- Ability of evidence-based health care to improve the health state of the affected member.
- Availability of current professional standards, supported by scientific evidence and research.

Identified conditions are prioritized and reviewed by ACLA's QCCC, which includes ACLA-contracted providers.

For example, ACLA recently added an obesity program based on understanding of the incidence of obesity, the resultant health impacts, and the availability of evidence-based treatment guidelines. Future programs include ADHD and a possible chronic pain program, due to the utilization and quality issues identified by the plan and DHH.

The following table outlines the disease states currently targeted for Chronic Care / Disease Management:

Chronic Condition	Clinical Guideline
Diabetes	ADA Standard of Medical Care in Diabetes update published online 1/9/2014 • Summary of Revisions http://care.diabetesjournals.org/content/37/Supplement_1/S4.full • Executive Summary http://care.diabetesjournals.org/content/37/Supplement_1/S5.full.pdf+html • Full Report, Standards of Care in Diabetes—2014 http://care.diabetesjournals.org/content/37/Supplement_1/S14.full.pdf
Heart Failure	• 2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults http://circ.ahajournals.org/cgi/content/full/119/14e/e391 • Treatment of Hypertension in the Prevention and Management of Ischemic Heart Disease http://ahajournals.org/cgi/content/full/115/21/2761
Asthma	• Global Initiative for Asthma (GINA) 2009 http://www.ginasthma.com/Guidelineitem.asp??l1=2&l2=1&intId=60 • National Institute of Health (NIH) 2009 http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm • Supporting Clinical Guidelines: Global Initiative for Asthma (GINA) 2010 http://www.ginasthma.org/Reports/reports-dissemination-and-implementation.html • Guidelines for the Diagnosis and Management of Asthma. [National Institute of Health (NIH) 2009] http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm
COPD	• Global Strategy for the Diagnosis, Management and Prevention of COPD, Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2008. http://www.goldcopd.com/guidelineitem.asp?l1=2&l2=1&intId=989 • Global Strategy for Diagnosis, Management, and Prevention of COPD updated: http://www.goldcopd.com/guidelineitem.asp?l1=2&l2=1&intId=989 • February 2013
Sickle Cell Disease	• National Heart, Lung, and Blood Institute: Division of Blood Diseases and Resources: The Management of Sickle Cell Disease http://www.nhlbi.nih.gov/health/prof/blood/sickle/sc_mngt.pdf • National Heart, Lung, and Blood Institute: Division of Blood Disorders and resources: The Management of Sickle cell Disease http://www.nhibi.nih.gov/health/prof/blood/sickle/sc mngt.pdf • CDC-Sickle Cell Disease http://www.cdc.gov/NCBDDD/sicklecell/data.html • Center for Preventive Health-Office of Public Health-Louisiana Department http://www.dhh.louisiana.gov/offices/page.asp?ID=263&Detail
Pregnancy*	• Institute for Clinical Systems Improvement: Routine Prenatal Care, 14th ed. July 2010 http://www.icsi.org/prenatal_care_4/prenatal_care_routine_ful_version_2.html
ADHD	• American Academy of Pediatrics Clinical Practice Guideline for Diagnosis, Evaluation and Treatment of ADHD in Children and Adolescents http://guideline.gov/content.aspx?id=36881&search=adhd

Chronic Condition	Clinical Guideline
Cholesterol	• ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a.citation
High Blood Pressure	• Guidelines on the prevention, detection, evaluation and treatment of high blood pressure National Heart Lung and Blood Institute http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.htm • The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure- Complete Report, date of publication 2004
Obesity	• Obesity guideline: 2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society. Circulation published online November 12, 2013 http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437739.71477.ee.citation
HIV	Guideline References: References: • http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm • http://aidsinfo.nih.gov/guidelines
STD/STI	Guidelines 2010 • http://www.guideline.gov/content.aspx?id=25577&search=sexually+transmitted+diseases

*Although pregnancy is not a disease or a chronic condition, information on pregnancy is included here as many of the same population management techniques are used to coordinate care and improve outcomes for pregnant women.

Exhibit O.1-5: Clinical Guidelines use in the Chronic Care/Disease Management Program

Identifying Members for In-person Case Management Services

In supporting members with complex conditions, building trust and open communication is key to understanding the member and his/her needs. In certain scenarios, ACLA believes that face-to-face communication enables a foundation for trust to begin.

To support face-to-face communication, ACLA launched a physician-directed Community Health Worker team to provide face-to-face care management for the top tier of complex members. Comprised of a physician, social worker, nurse, and non-clinical outreach workers, these teams engage identified members through face-to-face interaction in the member's home or community setting. Following an in-person need assessment, the Community Health Worker communicates with the member, the assigned PCP, and other treating providers to develop a holistic plan to address the member's needs, as described more fully below.

Type of Member

ACLA uses different levels of in-person care management to meet the needs of distinct populations.

Super-utilizers

Super-utilizers are referred for intense Community Care Management and include members who:

- Are high cost users of potentially preventable events; they overuse emergency departments instead of primary care and as a result have too many hospital admissions.
- Generally have multiple complex chronic medical problems, and in addition often have mental health issues and difficult social and economic situations. These are "high need" and "high cost" patients.
- Often do not see their PCP or medical home. Their health care tends to be uncoordinated and haphazard, and they do not respond well to the traditional health care system. This is a relatively small number of members in the general population with unmet needs, and overall poor health quality and outcomes, and yet they are responsible for a large percentage of the health care costs.
- Require different approaches to help them manage their health and some of the complexities of life. By engaging these patients and helping them to address these issues, there should be an improvement in their health while reducing overall health care costs.

Elevated Risk - Unable to Contact

Members with an acute risk who do not respond or cannot be located through telephonic contact are referred to the Community Education and Outreach team. These members include those who were discharged home from the hospital, started on new medication, have a high-risk pregnancy, or are in need of provider-recommended follow-up.

How We Find Members for Inclusion

Where possible, we hire our field-based staff directly from the communities they serve, as they know the resources and communication patterns of their assigned neighborhoods. In addition to knocking directly on the member's door, ACLA community workers talk with neighbors and individuals at local businesses, churches, and other community gathering places to assist in locating difficult to reach members. The field team wears clothing carrying the ACLA colors and brand and carry photo identification to identify themselves to our members and other individuals in the community.

The field staff will also leave a DHH-approved post card in the door if there is no answer at the member's address. We have found that members are often reluctant to open the door if they do not know the person knocking. The postcard contains the community worker's contact information. In many cases, the member will call and agree to a visit after receiving the card.

Exhibit 0.1-6: Sample Door Knocker for In-person Visit Notification

Field staff also coordinate and research potential member contact points contacting providers and pharmacies used by the member to obtain additional phone numbers and addresses. As they are able, the field team will leave a contact post card with the pharmacy and ask the pharmacist to pass it on to the member when the next refill occurs. Our staff also collaborates with emergency rooms and will request that the emergency department (ED) contact us when a high-risk member registers. As we build out our ability to take in automated Admission/Discharge/Transfer data feeds from hospitals, we will build mechanisms to use these feeds to alert field staff that a member they are looking for has registered at an emergency room. We will receive a report from DHH data feeds, where the Rapid Response team is then able to use the reports as part of their ED outreach program. Upon contact with the member, field staff is able to assist the member with their chronic care management needs.

Integration with Existing Resources and Plan to Have Case Managers "On the Ground"

ACLA partners with and sponsors several programs to provide additional "on the ground" care management services to members with special needs.

High-Risk Pregnancy Case Management

As an additional resource, ACLA contracts with Alere to provide in-person care management support to high-risk pregnant women. Alere is a collaborative partnership to promote and educate providers on use of progesterone. Alere staff provides care coordination and monitoring services, focused on assisting the member to deliver a healthy, full-term infant.

Services available through Alere include:

- 17P Administration Nursing and Care Management Service with in-home administration of weekly injections.
- Nausea and Vomiting Management with nurse administration of continuous antiemetic therapy.
- Preterm Labor Prevention Education and Management.
- Diabetes in Pregnancy Program.
- Hypertensive Disorders in Pregnancy services.
- Coagulation Disorders in Pregnancy with home-based treatment.

Embedding Care Managers

ACLA is also exploring options to embed care managers in high-volume facilities and primary care practices. We have successfully used this model in other ACFC markets. The embedded care manager works directly with the member and the provider staff to coordinate additional services, initiate follow-up for treatment plan changes, and provide direct member education in support of treatment goals.

Nurse-Family Partnership

The ACLA Bright Start team collaborates with and refers first-time pregnant members to the Nurse-Family Partnership for additional in-person support. Nurse-Family Partnership staff visits the member's home and provides a follow-up plan of care focused on good health practices, adherence to prenatal and post-partum care recommendations, and education on how to care for the infant. Partnership staff performs hands-on assessments of the pregnant mother and, after birth, of the child.

HIV Management

ACLA actively participates in the Louisiana HIV Medical Care Coordination (MCC) Task Force along with other health plans. The purpose of this task force is to improve quality and effectiveness of HIV medical care coordination/case management services and to avoid duplication of services. Another goal is to align services with meeting the needs of people living with HIV. This task force focused on transition plans, care coordination, and care planning to efficiently collaborate and coordinate care for members included in the STD/HIV program, Bayou Health plan, and Ryan White Part A & B Community based organizations. A shared network matrix between the health plans and Louisiana Ryan White community based organizations were distributed and ACLA shared this information with care managers for use as a resource tool. The task force continues to meet and discuss coordination strategies.

Diabetes Boot Camp

To improve the health outcomes for members with diabetes, ACLA held a Diabetes Boot Camp in Baton Rouge in September 2013 as part of ACLA's Health Ministry Program. A team of

diabetes educators presented strategies for fighting diabetes based on curriculum approved by the American Association of Diabetes Educators. Attendees also received free A1C screenings, learned healthy cooking techniques, and participated in a line-dancing class. To continue this important educational component, we are currently confirming diabetes education classes to take place in New Orleans, Shreveport, and Lake Charles.

Coordinating Information and Services with the PCP

ACLA uses a variety of mechanisms to coordinate information and services related to chronic care/disease management activities with a member's PCP. Members with high-level chronic care management needs are assigned to a care manager who serves as a single point of contact for the member and PCP. Additionally, ACLA's Provider Portal provides PCP offices with point of care alerts and population-based reports on care needs and performance related to chronic care conditions.

Single Point of Contact

ACLA is dedicated to a person-centered, single point of contact approach to communication. We coordinate care with our member's PCP and other providers to ensure the easy flow of information and services. Dedicated care managers serve as a single point of contact for both the member and the provider, developing a trusting relationship with each. This process allows us to detect and address potential care issues before chronic problems arise.

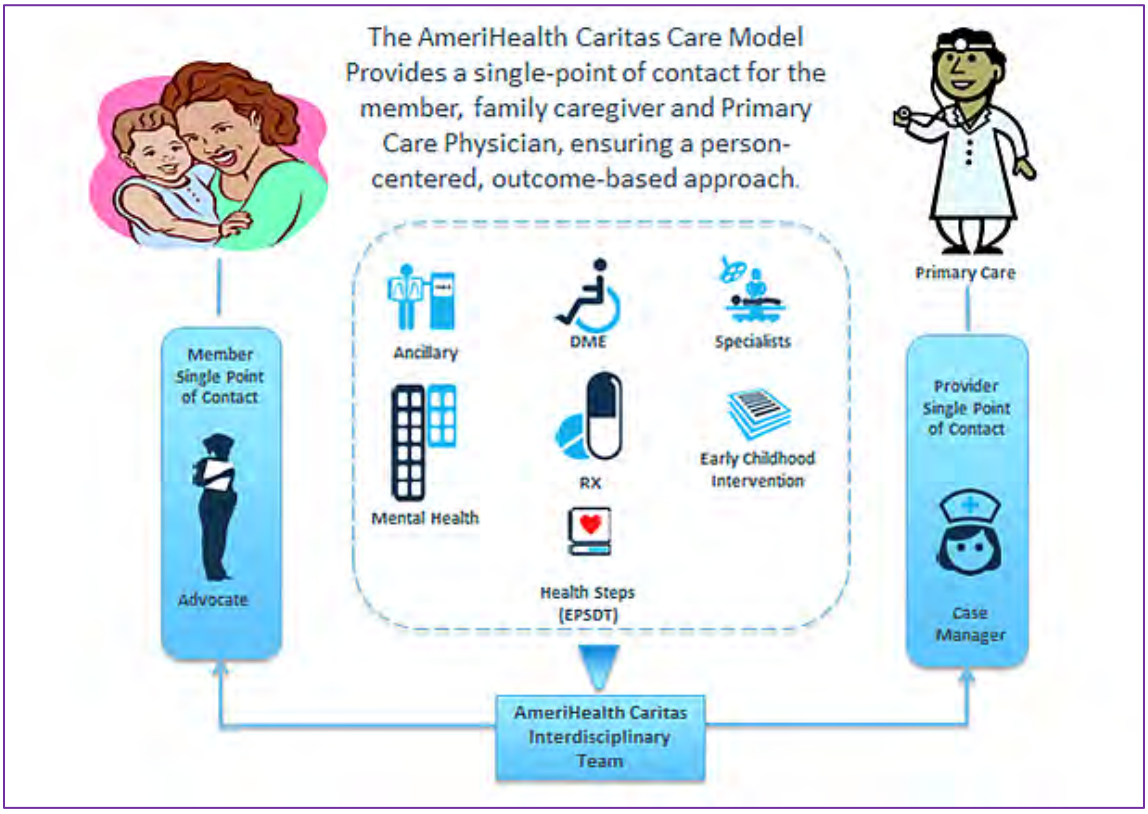

Exhibit 0.1-7: Single Point of Contact Approach

As part of the care management assessment and engagement process, the ACLA care manager contacts the PCP for input into the member's goals and needs. When the initial plan of care is agreed upon with the member, the care manager sends notification to the PCP to confirm the prioritized goals and the contact information for the assigned care manager.

Provider Portal

ACLA's Provider Portal provides direct access to information to assist the PCP to better manage a member's chronic care needs. Available information includes:

- Clinical Alerts: Pop-up alerts for key missing or overdue chronic care management services appear on the portal screen when the member's ID number is entered. Clicking the alert displays a care gap worksheet outlining the overdue and missing services, along with completion dates for up-to-date services. Care gaps are clinically recommended services based on evidence-based clinical practice guidelines for which there is no claim evidence that the member received the service. Claim data is evaluated at least monthly for all members. Care gap algorithms exist for a full range of preventive services and chronic care/disease states. For example, members missing recommended chronic condition management services, or demonstrating an uncontrolled disease condition, such as high use of short-acting asthma medications, are identified and flagged as having a care gap in ACLA's internal medical management and member service information systems and the Provider Portal.

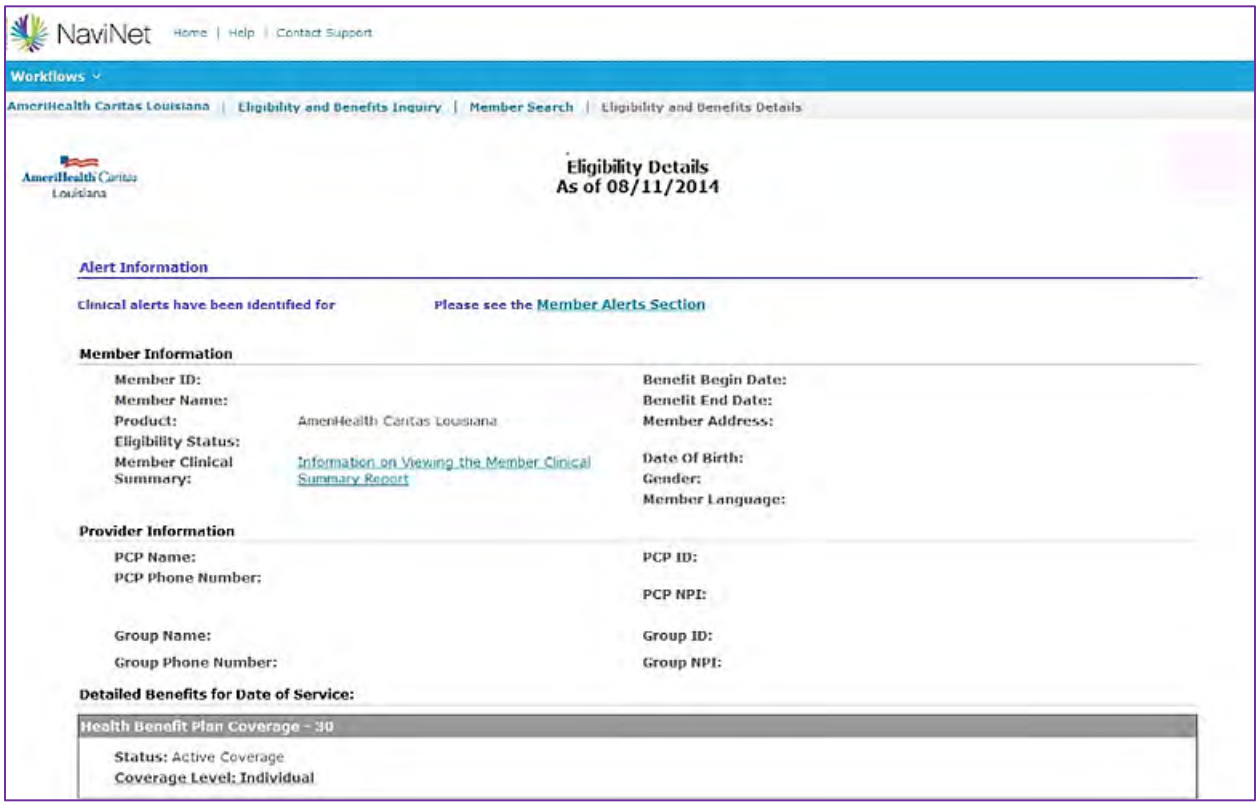

Exhibit 0.1-8: Clinical Alerts

- Clinical Summary: A summary of the member's clinical conditions, outstanding and up-to-date care gaps, filled prescriptions, and major service claims is available from the member information and referral screens in the provider portal. Available information includes the following:
    - member's name, dose, fill date, and prescriber for medications
    - dates, diagnosis, and facility for inpatient admissions and ED visits,
    - provider name, specialty, date and diagnosis for office visits and dates, study name, facility and diagnosis for radiology studies.

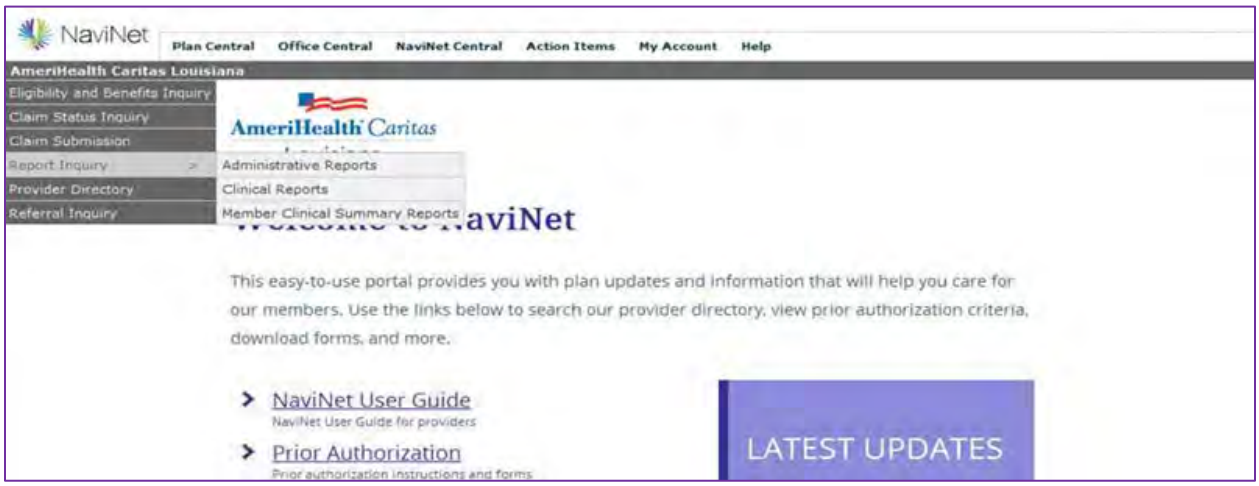

Exhibit 0.1-9: Report Inquiry Options

- Panel Reports: On-demand reports outlining the status of recommended chronic care management services for all members with that condition on the PCP's assigned panel.

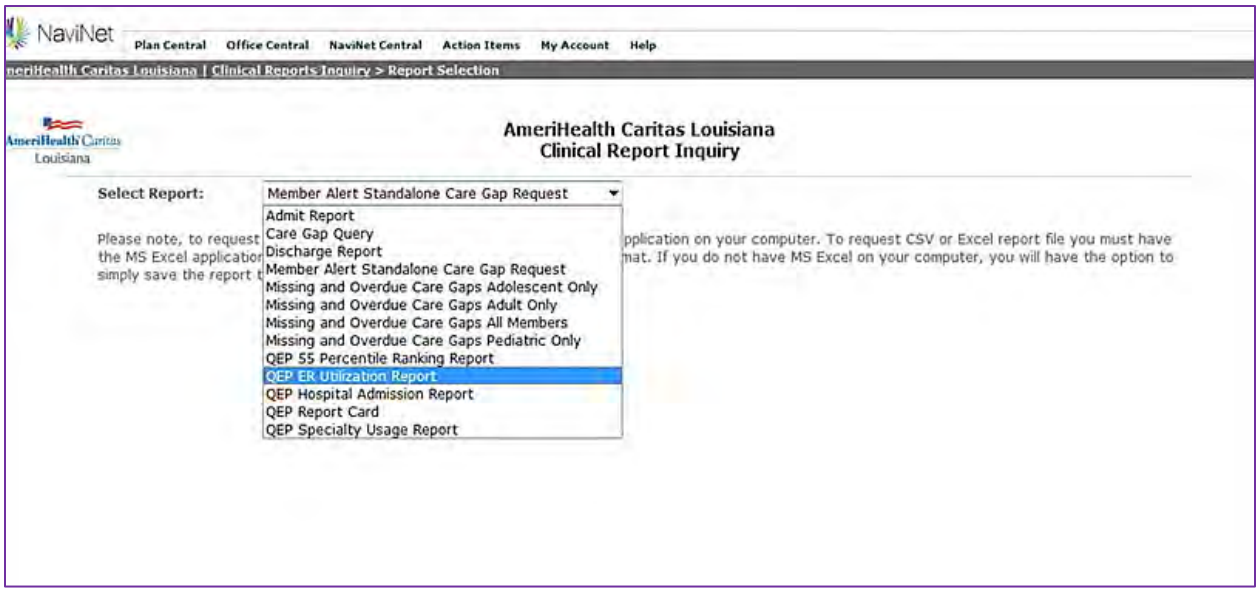

Exhibit 0.1-10: Clinical Report Options for Providers

Let Us Know Program

The Let Us Know program is a support service provided through the ACLA Rapid Response team that assists providers to connect their patients to the right care. ACLA provider account executives reinforce the use of the Let us Know program with PCP offices at each visit. Let Us Know provides a mechanism for PCP offices to request assistance from the ACLA Rapid Response team to address member needs identified during an office visit. Rapid Response provides assistance coordinating follow-up appointments, arranging transportation, and connecting members to community services, such as utility assistance or food pantries. The PCP can also ask the Rapid Response team to follow up with the member when treatment changes have been made, such as starting a new medication or changing a medication dose.

The PCP office can contact Rapid Response via phone or via fax, whichever method aligns better with the office's workflow. A sample of the Let Us Know form follows below:

LET US KNOW PROGRAM

INSERT PLAN LOGO HERE

Member Intervention Request Form

Date: _____

MEMBER INFORMATION

Member Name	Date of Birth
Member ID #	Phone Number
Parent/Guardian Name (if applicable)	

PROVIDER INFORMATION

PCP Name	PCP ID#
Phone Number	Fax Number
Office Contact Name	PCP County

Please check the appropriate intervention(s):

- ☐ Non-compliance with prescribed medication(s)
- ☐ Inappropriate use of emergency room
- ☐ Not showing up for appointments or follow-up care
- ☐ Limited or no knowledge of Plan benefits
- ☐ Other: _____

Additional Information/Comments:

_____
_____
_____
_____
_____

Please fax this form to the Rapid Response and Outreach Team at X-XXX-XXX-XXXX

Follow-up performed: _____

Comments: _____

399-SHADE-1222-05

Exhibit 0.1-11: Let Us Know Form

Community-based Care Management

While telephonic care management is a proven and effective means of engaging members in getting care and staying well, additional in-person care management support is sometimes also necessary. ACLA's ICM Program incorporates several non-telephonic care management methodologies to address the needs of its diverse population. Our approach incorporates different levels of in-person contact. We are also skilled at connecting members with complex and/or special health care needs and chronic conditions to available resources in the community. We work closely with the staff, agencies, and government entities already involved with the chronic care population, to augment, not duplicate, available services. ACLA is also committed to innovative engagement methods through a combination of high-touch service and technology.

In-person Care Management Outreach

We have adopted a two-pronged strategy as an extension to our telephonic care management approach led by the Community Education Outreach Team (CEOT) and Community Care Management Team (CCMT). The two teams provide distinct, yet complimentary, roles in reaching out to members with chronic conditions who require care management assistance.

Community Education Outreach Teams

Our CEOT performs community education services by partnering with community organizations for events and educational offerings. They develop and maintain community relationships, collaborate with internal departments, and outside organizations to obtain and use data for health promotion projects. CEOT members attend the events, during which they interact one-on-one with members. Through these interactions, CEOT staff provides targeted health education materials and serves as a plan point-of-contact for questions and connection to other plan programs. Information on specific community events appears later in this section.

As part of their member outreach activities, the CEOT also performs individual follow-up for members with focused needs, to extend the reach of the telephonic care management team. The CEOT team is activated after care management staff has repeatedly failed to reach a member with care gaps by phone. This may occur for a variety of reasons, e.g., the member may have moved and/or changed his/her phone number, wishes to avoid seeing a doctor, or suffers from behavioral health challenges. These members typically have a variety of challenges — visiting EDs instead of a physician's office, avoiding preventive care, battling the symptoms of chronic illnesses, and facing multiple access issues. CEOT staff work in the community, knocking on doors, introducing themselves to members with care gaps and their families, and state the purpose of their visit. If a member doesn’t answer the door, CEOT staff leave a "call to action" card (see below). "We are the feet on the street," says Luis Lugo, CEOT field supervisor. Every member with a care gap is asked by CEOT staff: “How can I help you schedule an immediate appointment?”

The CEOT staff works to schedule an appointment with the member’s PCP or assist the member to find a local PCP who is accepting new patients. They also address access barriers like helping

to arrange transportation. In addition to helping members schedule and keep doctors' appointments, the CEOT team also communicates with provider offices to confirm member information, and support Medical Affairs and Care Coordination teams in ongoing efforts to manage preventive care and improve health outcomes. Finally, they help distribute information about upcoming health education events and screenings to members in the community.

"Mary" is a member with a high-risk pregnancy, but had been not been keeping up with her 17P (progesterone) injections, an American College of Obstetricians and Gynecologists (ACOG)-approved treatment for reducing the risk of spontaneous preterm birth. Care management staff made repeated attempts by phone to contact this hard-to-reach pregnant member. The home care agency involved in her care was prepared to discharge her from its rolls.

After care management reached the extent of their pursuit, they passed the ball to the CEOT team, who sprang into action. On his second attempt, a CEOT team associate finally made contact with "Mary", updating her contact information. He was alerted that our home care agency had also made last-minute contact with "Mary" and had just administered the overdue 17P injection to her on the previous day. She initially declined care management services, preferring instead to rely on future weekly nurse visits and 17P injections from the agency.

The CEOT team associate persisted, describing to "Mary" all of the health benefits of care management. As "Mary" wasn't able to use her current cell phone for care management, the CEOT team associate lent "Mary" his own cell phone to use for these calls. Ultimately, "Mary" was convinced to enroll in care management services, where she currently receives regular preventive care management.

The CEOT team made it possible to contact a hard-to-reach pregnant member at high risk for preterm birth, who was then re-engaged and reconnected to regular preventive preterm care by the determined action of CEOT and care management staff.

Community Care Management Team: Innovation on the Ground

In June of 2014, ACLA implemented an innovative program for our members with complex chronic conditions who receive the majority of their care in the ED and inpatient setting. The needs of these "super-utilizer" members are not adequately met by the traditional health care delivery provided through intermittent physician visits and telephonic care management. The goal of the program is to extend care management services by connecting with these chronically ill members in their own environment, using Community Care Connectors (CCCs) to build and nurture trusting relationships. The expectation is that these in-person care management services function as a viable and cost-effective alternative to inpatient admissions and emergency room visits for poorly managed chronic illnesses.

Care coordination is performed by mobile community-based health care teams consisting of a registered nurse, CCC, and social worker, under the overall direction of a supervising physician. Consultants in pharmacy, behavioral health, and medication management are engaged as needed. The CCCs engage super-utilizers in their community through frequent, high-touch, in-person interaction, and provide follow-up to address physical, behavioral, and socio-environmental needs. The team also functions as a convener of services for members,

working with independent practitioners in the community and other stakeholders, as necessary, to ensure that hard-to-reach members with chronic disease(s) or at high risk of hospitalization are adequately supported and engaged.

The multi-phase approach includes: 1) identifying high-risk members with the highest utilization patterns through data mining or referral; 2) finding and engaging the members in the community where they live; 3) assessing and addressing immediate medical, behavioral and social need(s); 4) establishing a connection to the medical and behavioral health neighborhood and social services; 5) monitoring and supporting execution of a common plan of care by addressing barriers and closing care gaps; and 6) promoting independence in self-management where appropriate. The Community Care Management Team Workflow accomplished through regular visits in-home and community based interventions follows in the Exhibit below:

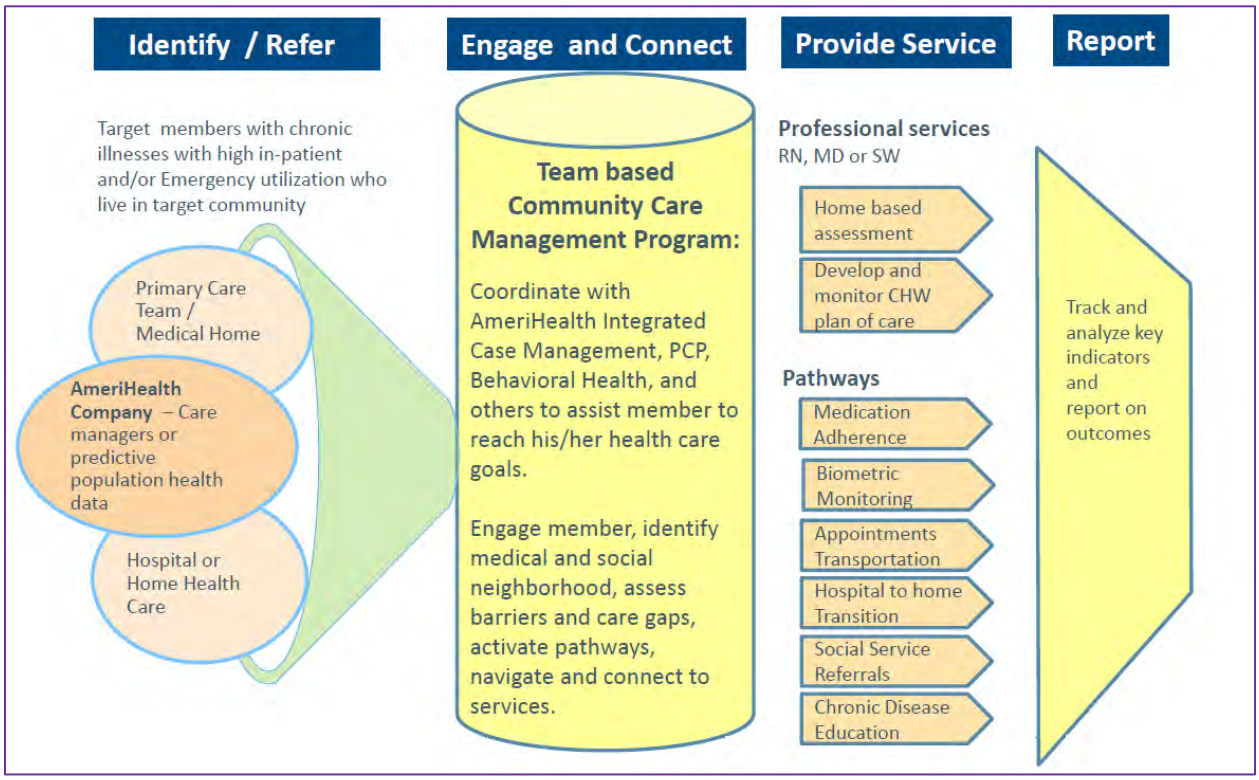

Exhibit O.1-12: Community Care Management Team Workflow accomplished through regular visits in-home and community based interventions.

The key to the success of the CCMT program is the relationship between the member and the Community Care Connector (CCC). CCCs are hired from within the community and share language and life experiences of members served. CCCs are able to develop a critical trust link between the medical delivery system and individuals in the communities where they live. CCCs become knowledgeable about the local ecosystem for social services, and help members sort through complex and competing needs (many of which are not medical). CCCs are passionate about helping others and become anchors in a chaotic life.

The CCMT approach is currently active in Baton Rouge, LA, in addition to ACFC affiliate locations in Charleston, SC; Philadelphia, PA; and Chester, PA. ACLA currently has 15 super-utilizer members enrolled in this program, with another 29 identified as potential participants through our screening processes.

The program has shown impressive promise thus far, reducing costly inpatient care by 40% for engaged members. While the program is in its early stages in Louisiana, we believe that similar outcomes will occur in all of our markets that institute this program.

The example of a single member—one of our earliest participants in our affiliate Pennsylvania plan—illustrates the success of this approach. "Sam" is a 46 year-old male living in a residential boarding home with type I diabetes, coronary artery disease, and a cognitive disability. His medication and glucose monitoring are managed by the boarding home staff. Care management was unable to engage him telephonically. When the CCM team first engaged "Sam," he had not seen his provider for a year, and had 32 admissions in 18 months for diabetes with ketoacidosis. In the month following CCM team engagement, he had one 11-day hospital admission and for the next two years following engagement, he had only one additional five-day hospital admission. The 2011 pre-engagement claim cost for "Sam" alone was over $180,000, and was reduced by 96 percent after one-year post-engagement (August 2012–2013).

"Jeanine" is a 21-year old smoker with sickle cell anemia and asthma. The sickle cell anemia causes her much pain and interferes with her functioning effectively at work. Latifah, a Community Care Connector, noticed an increase in her inpatient use corresponded to the time period during which her mother moved out of state. "Jeanine" herself had recently moved out of her grandmother's house and began living with her partner. Latifah explained to Jeanine that she was unnecessarily making visits to the hospital to receive medication that she could otherwise administer effectively at home. Latifah also convinced "Jeanine" to see a dentist and an OB/GYN, whom she has never been to see, and also arranged transportation for that visit.

Latifah did much more than guide Jeanine through the health care system. She assisted "Jeanine" in arranging her social security benefits, which then encouraged "Jeanine" to arrange additional benefits on her own. Since "Jeanine" has an artistic bend, Latifah signed her up for art therapy and online community college classes. To improve her nutritional health, Latifah shared several of her own recipes and worked with "Jeanine" to prepare nutritious dishes in her own kitchen.

As "Jeanine's" case makes clear, the long-term goal of the program for each member is to give them the tools and the confidence to eventually function more independently in the absence of a Community Care Connector. Therefore, the Community Care Connectors have to begin to foster such independence on a case-by-case basis. "We don't want to be a crutch to our members, because we won't be there forever."

Embedding Care Managers in PCP offices and High-volume Facilities

As mentioned above, ACLA is communicating with providers to investigate their willingness to provide on-site care coordination services via an ACLA embedded care manager. These discussions are ongoing.

Collaboration with Existing Programs

ACLA has a strong history of partnering with existing community and government programs to provide comprehensive chronic care/disease management services to our members. An integral part of the ACLA strategy is to strengthen current relationships with community-based organizations aligned with our mission, while building new relationships throughout the state to continue our grassroots efforts to reach members with holistic care. Because many members are challenged by transportation barriers, we strive to provide face-to-face support. ACLA partners with housing authorities in all of the large cities in Louisiana to establish a presence that facilitates building a rapport with residents and educating them on healthy living. Examples of our partnerships and collaborative arrangements are described below:

March of Dimes

To further address the high rate of premature births in Louisiana, ACLA partnered with the March of Dimes' Louisiana Chapter to support "Healthy Babies are Worth the Wait," a campaign to reduce premature births. Sometimes late, preterm births—those occurring between 34 and 36 weeks—are the result of the mother's choice to be induced or undergo a C-section because she is feeling uncomfortable in the last weeks of pregnancy. The program urges expectant mothers to do everything they can to carry their babies through at least 39 weeks to ensure full development. ACLA Bright Start (maternity) Care Managers incorporate program materials and education in their interactions with pregnant members.

We have also joined with the March of Dimes to help the Cancer Association of Greater New Orleans and Baton Rouge to implement a "Baby & Me — Tobacco Free" program. The first program of its kind in Louisiana and in the southern region of the United States, Baby & Me – Tobacco Free is an evidenced-based, incentive smoking cessation program that helps pregnant women quit smoking and remain smoke-free after delivery. Participants in the program meet monthly with a tobacco cessation counselor and receive free diaper vouchers at each visit for up to 12 months.

ACLA also served as the March of Dimes Prematurity Prevention Sponsor for the 2014 Provider Education Lecture Series. The goal of the presentation is to make providers more aware of progesterone therapy and its use in high-risk eligible patients to prevent preterm births.

Our Lady of the Lake - Asthma Program

We routinely partner with local organizations to improve health outcomes. For example, we worked with Our Lady of the Lake (OLOL) on the Community Asthma Management Program (CAMP). CAMP targets the pediatric population with moderate to severe persistent asthma who have had multiple ER visits and admissions to OLOL. A respiratory therapist works with the members to train them on the proper use of inhalers and the importance of medication adherence. Our members received additional asthma management, education, and care coordination from ACLA Care Managers. The partnership allowed our care management staff to reach more members and educate them about asthma and available treatment options.

Community Events

ACLA partners with numerous organizations in the community to offer screenings and chronic condition management activities at school health fairs, faith-based collaborative health events, and local fairs and festivals. Health screenings can include glucose, hemoglobin A1C, and blood pressure.

Our partnership with the community also includes sponsorship of and participation in local events that raise awareness about targeted chronic conditions, including:

- American Heart Association: Go Red for Women & Heart Walk April 2014.
- American Cancer Society: Relay for Life Events in Shreveport and Bossier City area.
- Sickle Cell Disease Association of America: Sickle Cell Walks.
- NAMI LA: NAMI Walks New Orleans October 2014.

Playground Builds

ACLA is committed to promoting health by encouraging physical activity. When children understand and adopt the importance of healthy activity, they bring this behavior to their families and help to promote a lifestyle of wellness. Unfortunately safe places to play are not always available to children. Accordingly, ACLA has worked with our parent organization to bring safe playgrounds to areas most in need in Louisiana. Safe playgrounds help promote healthy lifestyles by decreasing childhood obesity and preventing injuries that can result from obsolete or dangerous equipment.

The Safe Playground Build program brings community members and ACLA employees together to build a new playground structure from the ground up, paint murals, and clean the surrounding areas—all in one day. Professional contractors are on hand during the day to supervise construction. In October 2012, ACLA completed a Safe Playground build at Pierre Capdau Charter School in New Orleans. The project included building a playground, a children's outdoor fitness center, and two basketball courts, as well as incorporating a beautification program; it was the largest build to date. ACLA completed another Safe Playground Build in October 2013 at Park Elementary School in Baton Rouge. ACLA plans to continue this program by targeting elementary schools in Louisiana with a 90–100% poverty rate that need a playground. The next site selected for a Safe Playground Build is Queensborough Elementary in Shreveport, scheduled for November 2014.

Louisiana Public Health Institute (LPHI): The Inter-pregnancy Care (IPC) Formative Evaluation Project

As part of the Louisiana Birth Outcomes Initiative, the ultimate goal of the IPC project is to improve the health of low-income women and children by reducing pre-term and low-birth weight infants born in New Orleans and connecting women who have experienced adverse birth outcomes to primary care. We collaborated and partnered with this group, identifying members who are interested in participating in the program.

Health Ministry Diabetes Event

ACLA collaborates with our parent organization to offer the Health Ministry Program in Louisiana. The Health Ministry Program is a faith-based health education program designed to educate participants on important health topics, including breast cancer, diabetes, obesity, stroke and hypertension, medication adherence, heart disease awareness and prevention, stress, depression, and emotional and mental well-being. Offered through collaboration with church and ministry leadership of all faiths and denominations, the programs take place in local faith-based settings, such as churches, synagogues, and mosques.

Because diabetes is a prevalent health issue in Louisiana, ACLA hosted a Health Ministry event at Household of Faith in New Orleans in November 2012. Plan members, as well as the community at large, attended the event. Glucose screenings were available, and a chef prepared gumbo in a healthy cooking demonstration. Diabetic educators were on hand to educate participants on a full-range of topics including:

- Diabetes: definitions, disease process, and treatment options.
- Eating healthy: food groups and carbohydrate counting, portion size, and meal planning.
- Being Active: benefits of exercise, effect of exercise on blood glucose, increasing activity levels, personal exercise plans.
- Blood glucose monitoring and goals.
- Medication management.
- Strategies for making behavior changes: problem-solving, goal setting.
- Plans for travel, sick days, and other non-routine situations.
- Reducing Risks: hypoglycemia and hyperglycemia; microvascular and macrovascular effects; immunizations, foot, eye, skin, and dental care; managing stress and emotional adjustments; preconception and pregnancy management; smoking cessation.
- Support resources.

Community Education Partnerships

Our community health educators work closely with Family Road Healthy Start of Greater Baton Rouge. We have presented 4 Mommy Lunch and Learn sessions to educate pregnant mothers on improved health and wellness. We also have plans to work in partnership with Healthy Start New Orleans to develop and present information on reproductive health to members, and to refer women who are pregnant or have a child under two to Healthy Start New Orleans for outreach, health education, and case management. Additionally, we will participate in bi-monthly Community Action Network meetings.

The CEOT also has strong relationships with organizations including local YMCAs, Recreation and Park Commission for the Parish of East Baton Rouge (BREC), Family Road of Greater Baton Rouge, HOPE Ministries, Sickle Cell Associations, David Raines Community Health Centers, Southeast Community Health Systems, MLK Community Center in Alexandria, Urban League of Greater New Orleans, Habitat for Humanity, and many school boards and schools. We routinely partner with these organizations to support education and outreach to improve awareness and health outcomes related to chronic illnesses.

Member Engagement and Case Management Model

ACLA uses a variety of robust strategies to promote member engagement. Our approach incorporates specialized staff training, electronic outreach, and culturally appropriate messaging. Our ability to engage members is the foundation of our person-centered ICM model. Designed to holistically address identified member needs, our model combines data-driven decision support with individualized plans of care, delivered through an interdisciplinary team including nurses, social workers, non-clinical care connectors, and medical directors.

Member Engagement Strategies

Our approach to engagement starts with focused training for staff on engagement principles and motivational interviewing techniques. We supplement those strengths with messaging and materials that are aligned with the cultural preferences of our population. We are working to expand the interactivity of our member portal and are building both mobile and tablet-based applications to serve as platforms for future care management engagement.

Staff Training and Engagement Approaches

Our care managers complete a comprehensive motivational interview (MI) training course to assist in increasing not only member engagement, but to also increase the member's willingness to participate in self-management of their disease process and be an advocate for their health care needs. After completing the initial motivational interviewing course, ACLA care management interactions are monitored by a MI trainer who provides ongoing coaching to assist the Care Manager to improve his/her technique.

Our staff uses their training to establish a trusting relationship between the member and the care management team, a key factor in influencing member behavior. Through this relationship-building process, the member becomes comfortable and active with the management of his or her own care. As a first step toward building a collaborative relationship, the care manager will begin by identifying and addressing the member's biggest concern with his/her current health state. That concern may not be related to the issue identified in the member's assessment findings and utilization data.

The care manager begins by asking the member to identify personal goals (as opposed to health care goals). By focusing on the member's concerns, like wanting to walk a child to school or go dancing with friends, the care manager can address items like nutrition for healing of a foot wound or proper use of asthma medication. Once plans are in motion to address the member's personal goal, the care manager will work toward addressing additional issues revealed in the assessment findings and utilization data. For each intervention, the care manager will focus the discussion on how the particular intervention will benefit the member.

For members who can actively participate in the plan, the care manager will assign the member to a specific role in the care plan. For instance, the care manager may ask a member with heart failure to call each week and report his/her weight. During the call, the care management team supports the member by positively reinforcing his/her activities, helping to instill a sense of

accomplishment. These interactions often help members maintain an open, active dialogue with care managers that leads to improved care.

Culturally Appropriate Messaging

Another component of our engagement strategy is the use of messaging that is focused on the cultural and linguistic preferences of our population. All care management staff is trained in cultural competency upon onboarding and annually to help assure their communication is sensitive to the members' background. They also can utilize the telephonic interpretation line if the member prefers to speak about their health care in another language. In 2014, ACLA care managers were also provided with a Cultural Resource Guidebook that contains cultural norms, communication tips and barriers to care for our members' top six cultural backgrounds (African American, Latino, Vietnamese American, etc.) in addition to information about other relevant member populations, such as those surviving in poverty and LGBT (Lesbian, Gay, Bisexual, Transgender) populations.

In addition to training and education, care management staff engages members with culturally and linguistically appropriate written materials, soundbites, and scripts. For instance, we use female voice talent when sending messages about mammograms or pap tests. We have the state-approved scripts transcreated into Spanish. Transcreation is a method of translation that ensures that the true meaning is conveyed, not just a literal translation of the words. When creating any materials for a specific culture, transcreation ensures the message is conveyed in a culturally appropriate manor. Written health education materials for members are pulled from an extensive vendor-run library so that they can find materials that are most relevant for that member and their health education needs. All materials written and produced in-house are reviewed by the Cultural Competency Coordinator to assure that they reflect our population and are below a 6.9 grade level. Finally, all materials, whether produced in house or by a vendor, can be translated into any requested language.

Engaging Members through Technology

ACLA recognizes the importance of reaching members through multiple methods: print, face-to-face contact, and technological tools that promote virtual engagement. Members may read articles, but it often takes more steps and multiple encounters with the information before it becomes actionable and memorable. This principle is at the heart of ACLA's strategy to supplement passive reading with member interaction by incorporating technology. For example, when we featured an article in the Member Newsletter about BMI, we made further information available via a BMI calculator that we hosted on our website. Members were able to read about BMI, its importance, and the range for healthy BMI. They could then take the next step in making the information personal and meaningful: the article directed members to visit the site to calculate their own BMI.

Additionally, because many members increasingly rely on smart phones to meet their information needs and manage their daily lives, we are integrating interaction capabilities into our printed materials on an ongoing basis. Our Member Newsletters include QR codes so that

members seeking additional information on a topic can scan the code in the article and be directly connected to the associated website. Our website is constructed with searchable tools including the provider directory, pharmacy directory, and formulary. These tools put members and providers in quick touch with up-to-date information.

ACLA has additional technology-based programs, some current and some in development, focused on fostering member engagement, including pre-programmed mobile phones, text messaging capabilities, mobile phone applications, and condition-focused tablets/software.

Telemonitoring Pilot Program

Recognizing the importance of telemedicine for our rural members and to provide services for our most chronically ill members, ACLA has partnered with a vendor for in-home monitoring services that begins in October 2014. The targeted members will have a diagnosis of diabetes or congestive heart failure, as well as multiple emergency room visits and/or admissions. The services include a combination of daily monitoring, provider coordination, and clinical assessment. Objective measures obtained include blood pressure monitoring, glucose monitoring, and daily weights. ACLA care managers will refer members to this program as one of the interventions within the chronic care/disease management program. Network providers will be educated on the benefit for members, including how to make referrals for telemonitoring to the care managers. This program has been in place in our South Carolina affiliate for over 4 years and recent outcome reports, assessing members who had received service over a 10 month period through May 2014, demonstrated significant decreases in inpatient and emergency room utilization and total cost for members stratified as high risk.

Pre-Programmed Cell Phones/Health-Coaching Text Messages

ACLA is launching a program to provide members with free cell phones for easy access to ACLA and their care managers. In addition to free calls to the health plan, members will receive 250 free cell phone minutes each month. The phones will also deliver health-coaching messages relevant to the member's gender and age. The text messages contain screening reminders, health surveys and education quizzes, and healthy lifestyle challenges that address wellness and chronic conditions. For example, obese members are also able to join weight loss and exercise challenges to improve their health. A companion txt4kids program will offer similar information to members with young children. Txt4kids messages include reminders to schedule vaccinations, dental appointments, and follow-up PCP visits.

ACLA is a current sponsor of txt4baby, and promotes member access to this free prenatal care reminder service to all pregnant members. Targeted to pregnant women and mothers of newborns, the text messages encourage members to make and keep appointments; take vitamins and eat healthful foods; avoid alcohol, drugs, and smoking; and consult with the doctor before taking any new medications during pregnancy. Informational texts continue into the postpartum period to support moms in caring for themselves and their newborns during this vulnerable time. The texts include the opportunity for follow-up action, such as phone numbers or links to more information. Messages are available in English or Spanish and allow members to offer feedback on the program.

Automated Outreach

In addition to written materials and online tools, ACLA uses automated messaging to deliver health reminders. Using soundbite messaging and automated telephonic tools, ACLA delivers preventive care reminders, requests member feedback, and connects members to the Rapid Response or Member Services teams.

Members targeted for the messaging are identified through a review of demographic and utilization data. Targeted members are contacted via telephone and also receive an automated message. Soundbite messaging is used to deliver reminders for mammography and other preventive care services, remind diabetic members to make appointments for HgbA1c monitoring, and remind members with asthma to obtain refills of their controller medications. The system allows for interactive communication between the member and the ACLA care management team. Messages routinely contain an option for the member to be warm transferred to the ACLA Rapid Response team for additional assistance, including appointment scheduling, by pressing a number on the phone pad.

Health® Tablet for Asthma Medication Management

ACLA partnered with our Pharmacy Benefit Manager (PBM), PerformRx, to create an asthma medication management program designed to increase adherence and reduce overall health care costs associated with the treatment of members with asthma. This program is designed to determine the impact of the Health® Tablet system when incorporated into the AmeriHealth Caritas Louisiana program for moderate to severely persistent asthmatic patients.

Members, or the parent/guardians as appropriate, will receive a Wi-Fi and cellular capable Health® Tablet. The tablet device incorporates several tools to measure and improve medication adherence and improve general and health literacy, including:

- Daily Health Survey.
- Daily Tips (see sample in Appendix A).
- Biometric Tracking (Peak Flow).
- Care Plans (specific instructions for each patient).
- Medication Management Tool.
- Asthma Symptom Tracker.
- Emergency Medication Tracker.

The program, supplemented with information collected through the tablet, also provides tools and updates for the member's physician, including:

- Early warning reports that quickly identify patients with potential problems.
- Medications reminder & scheduling tool. Allows provider to set a reminder schedule for patients and view patient compliance. The schedule is downloaded to the patient tablet.
- Care plan writer.
- Portal to view patient survey responses and biometric tracking.
- Additional content available through the Health® Tablet include: Clinic Manager Portal that can manage access to the system for providers and patients. This is an optional item that can be turned on/off for each clinic.

- National Institute of Health Literacy content adapted for eBooks. Speaks content to members in English or Spanish.
- Asthma – Tips to Control Your Asthma.
- Veterans Administration Health Literacy content adapted for eBooks. Speaks content to members in English or Spanish.
- Children's Asthma educational content. Speaks content to members in English.
- HealthEworks content adapted for eBooks. Speaks content to members in English.
- eBooks to improve literacy.

Mobile Technology

ACFC and ACLA are working toward building a base mobile platform for future mobile applications and functionality. ACFC will launch the product in its Washington, DC market in the 3rd quarter of 2014, with a rollout to other company markets, including Louisiana, in 2015. The initial functionality of the technology enables a member to:

- View/Fax their Member ID card.
- View PCP information, including office location and phone number.
- Access a searchable directory, including map functionality with directions to the office.
- View/Update their Medication Cabinet, prepopulated with information on medications the member received through the ACLA prescription benefit, including a picture of the medication.

Exhibit 0.1-13: Mobile Platform Application

The next version of the ACFC mobile application will provide the member with alerts based on the member's care gaps and health and wellness-based coaching messages.

ACFC also has a number of pilot initiatives that include programs for members with the following conditions:

- Asthma (Child/Adolescent): This mobile pilot, in partnership with school-based health clinics, will include text coaching, medication and trigger-prevention reminders, and symptom assessment.
- Pregnant Women: This program features customized messages and text coaching according to member race/ethnicity/age.
- Hepatitis C T-Med Tablet: This tablet-based pilot focuses on medication adherence and risk reduction for members with Hepatitis C.

Care Management Model and Personnel

As detailed in Section K, Case Management, ACLA's ICM program addresses the physical health, behavioral health, and social/environmental concerns found in many of our chronic care/disease management members. Care management employees include individuals with backgrounds and expertise in behavioral health, physical health, and social work.

ACLA's Chronic Condition Management programs are embedded within each component of the ICM program. Chronic Condition Management programs exist for asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart disease, obesity, and sickle cell disease. A synopsis of the model is provided below.

Member Identification

Members are identified for care management intervention through data mining (predictive modeling, care gap analysis, utilization monitoring), member/provider referral, and ongoing health plan activity (utilization requests, emergency room notification, nurse-line contact, and new member health risk assessment).

Assessment and Stratification

Members are initially stratified into low- and high-intensity groups. Members in the low-intensity group receive ongoing surveillance and education/reminders for overdue health care services. Members in the high-intensity group are contacted to address urgent issues and begin a more in-depth assessment process. The assessment tools used are specific to the member's medical and behavioral health needs. The process includes review of available claim and utilization history, as well as contact with the PCP for input and direction on the member's needs. Members can move between the low- and high-intensity groups based on their care needs and self-management skills.

Individual Care Plan

Members in the high-intensity group are assigned to a Complex Care Manager who works with the member to set and prioritize care plan goals. Care plans typically address member-identified issues such as housing, utility assistance, transportation, or behavioral health care needs. Chronic care/disease management components of the care plan usually include, but are not limited to medication adherence, condition-specific education, and connection to follow-up appointments with PCP and specialists, as needed. Our materials, guidelines, and care plans are consistent with the NCQA Disease Management requirements. Care Managers also establish a plan for frequency of outreach with members, providing clear expectations.

ACLA also recognizes that family caregivers are often an invisible workforce supplying vital resources to the health care system. Our care plans include problems and interventions around care giver support and respite arrangements, along with ensuring the caregiver has access to the 24/7 Nurse Line and Rapid Response team for added support.

Once the care plan is developed, the ACLA Care Manager sends a copy to the PCP for review and additional input.

Ongoing Evaluation and Adjustment

As the plan is implemented, the Care Manager works with the PCP and other members of the care team to review progress and make adjustments to the plan. Care mangers participate in interdisciplinary team meetings that include other ICM staff, the member, practitioners, inpatient and outpatient providers, community resource representatives, community behavioral health providers, and other county and/or state entities from which the member may be receiving services. These meetings ensure the member-specific treatment plan addresses all issues impacting a member's access to appropriate care and services.

Care Management Staffing

ACLA's ICM team includes nurses, social workers, non-clinical CCCs and CEOT staff, clinical pharmacists, ACLA medical directors, behavioral health clinicians, PCPs, specialists, members and caregivers, and the member's parent/guardians, as appropriate.

Care Managers are registered nurses or social workers licensed in the state of Louisiana. Many nurses also hold a master's of science in nursing degree (MSN) or a bachelor's degree in psychology. ACLA Care Managers typically have LA-specific health care systems experience ranging from minimum of 3 to 5 years of practice to more than forty years of experience in a clinical setting. ACLA hires staff from a wide variety of clinical backgrounds, to provide a diverse experience set within the care management team. The current care management team contains staff with expertise in:

- PICU experience.
- Home Health.
- Intermediate Care Facility for Developmental Disabilities (ICFDD) populations.
- Geriatric Psych Rehabilitation.

- Skill Nursing.
- CRITICAL CARE.
- ER experience.
- Trauma experience.
- Wound care experience.
- Home Health Home Infusion.
- Pediatric Day Health Care experience.
- Trauma ICU, MICU, SICU, CICU, IP Case Management (Critical Care, Transplant ICU).
- Med-Surg.
- Cancer Clinical Trials.
- Psychiatric male forensic patients.
- Pediatric Medical Daycare.
- Pediatric special needs.
- Special needs members under age 21.
- Oncology.
- CICU.
- Substance abuse.
- HIV-large population.
- GYN-Oncology-Chemo.
- Hospice.
- Paramedic/EMS experience.

Many of our staff also holds certifications, including:

- PALS, NALS, ACLS, CCM, CCRN, ACLS, BLS.
- OASIS.
- CWCA - Certified Wound Care Associate.
- PICC Insertion.
- Certified Flight Nurse.

How we Measure Success

ACLA tracks a variety of metrics to evaluate the success of its chronic care management programs. These metrics range from population metrics that evaluate all members with the identified conditions, to program-specific metrics that focus on relevant subpopulations. The ACLA Chronic Care Management program has documented a strong track record of improving health outcomes and lowering costs for the Bayou Health population. We use a combination of process and outcome measures, including assessment timeframes, utilization rates, clinical outcomes (HEDIS and HEDIS-like measures), and satisfaction surveys to drive continued program improvement. Additional measurements used include, ER utilization provider visit rates, hospitalization rates, per-member-per-month costs, functional status (SF-12) and medication adherence rates.

As part of our measurement processes and strategy:

- We will continue to use standardized HEDIS measures to define and monitor adherence to recommended care, and to evaluate our performance. Selected measures, appropriate

to the population of concern, are monitored over time as well as compared to national benchmarks, when available.

- We will continue to report health processes and outcome indicators that we will use to measure improvements in adherence with evidence-based guidelines for care and care coordination, and such indicators will be measured for the population annually.
- We will continue to measure participant satisfaction with our programs and changes in functional status.
- We will continue to provide data identified by specific sub-groups (e.g., children and adults), and will work with DHH to develop the characteristics of any other desired groups.

ACLA is at the forefront of improving HEDIS measures for those enrolled in our chronic care/disease management programs. Since 2012, ACLA has achieved the following successes for Bayou Health recipients, customized based on outcome monitoring:

Readmission Rates

ACLA monitors readmission rates as one measure of program effectiveness. Through the interventions and outreach described in this section, readmissions for members identified as having one or more Dominant Chronic Condition (DCC) (diabetes, heart disease, HIV, sickle cell disease, COPD, hypertension) or Asthma (using data algorithms licensed through 3M) have decreased by 8.8% through July 2014, compared to 2013.

Medication Adherence

ACLA monitors medication adherence, using the percent of days covered (PDC) metric. PDC measures adherence by calculating the number of days the patient was "covered" by at least one drug in the therapeutic area based on the prescription fill date and days of supply. Through focused member outreach and education, ACLA increased the PDC rate for medications related to the chronic conditions of diabetes, hypercholesteremia, hypertension, and asthma for members with low adherence by 5 to 24% during 2013, when compared to 2014 rates.

By Drug Class	Jan	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov	Dec
Antihypertensives	-4.6%	-4.0%	-2.3%	0.8%	4.4%	8.7%	12.4%	16.7%	18.6%	21.2%	23.1%	24.1%
Asthma Controllers	-7.5%	-9.0%	-8.8%	-8.2%	-6.9%	-6.4%	-6.2%	-5.0%	-3.4%	0.0%	3.0%	5.2%
Hypoglycemics	-2.8%	-3.3%	-1.7%	0.7%	3.4%	6.8%	9.8%	13.3%	16.1%	18.6%	19.6%	22.4%
Statins	-5.1%	-5.0%	-3.0%	-0.3%	3.8%	8.1%	12.2%	16.9%	19.5%	22.9%	24.3%	25.5%
Overall Variance from Baseline	-5.6%	-5.9%	-4.7%	-2.6%	0.4%	3.3%	6.0%	9.3%	11.5%	13.8%	16.8%	18.4%

Exhibit 0.1-14: Medication Adherence Rates

Potentially Preventable Events/Dominant Chronic Conditions

ACLA further analyzes members with a Dominant Chronic Condition (DCC) or asthma to identify those with Potentially Preventable Events (PPEs). For these members, ACLA tracks additional metrics and has demonstrated the following results year to date through August 2014:

Outcome	Metric	Result
Adherence to recommended care guidelines	Open Gaps in Care (See Exhibit O.1-16 for a list of chronic-condition-related Care Gaps)	Decreased 2%
Appropriate Utilization	Potentially Preventable Events (admissions, readmissions, ER visits, ancillary services)	Decreased ~20%

Exhibit O.1-15: Potentially Preventable Event and Care Gap Results

Condition	Activities
Asthma	Asthma Medication Management
Cardiac Artery Disease	Medication Management: ACE/ARB utilization Antiplatelet therapy Beta-blocker therapy Lipid Testing
Heart Failure	Medication Management: ACE/ARB utilization Anticoagulation Therapy Beta-blocker Therapy LVF Assessment
Diabetes	Eye Exam Microalbumin test HgbA1c testing

Exhibit O.1-16: Chronic Condition and Associated Activities

In addition, ACLA's population-health based approach to chronic condition management has achieved the following results through July 2014, compared to 2013:

Asthma

- Decreased admissions per 1000 members over 60%**
- Decreased ER visits per 1000 members over 60%**

Diabetes

- Decreased admissions per 1000 members of over 20%**
- Improved HgbA1c testing rate by 9%*
- Improved LDL-C screening by 11%*
- Improved nephropathy testing rates by 2%*
- Improved Eye exam rates by 39%*

COPD

- Decreased admissions per 1000 members 16%**
- Decreased ER visits per 1000 members over 14%**
- Increased flu vaccination rate 47%**

Congestive Heart Failure

- Decreased admissions per 1000 members 5%**

HIV

- Decreased admissions per 1000 members 12%**

Sickle Cell Disease

- Decreased admissions per 1000 members 31%**
- Decreased ER visits per 1000 members over 6%**
- Increased flu vaccination rate 5%**

* HEDIS 2013 results compared to HEDIS 2014
** Calendar year 2013 compared to YTD 2014

Member and Provider Satisfaction Surveys

We actively measure member satisfaction with our chronic care/disease management program (by disease state and overall). We will continue to use a customized tool for the collection of member satisfaction data, and work with DHH to implement a system that reflects the needs of participants and the goals of the department.

The results for the 2013 chronic care/disease management member satisfaction survey are as follows:

Measure	Total	Asthma	Heart Failure	Diabetes
Do you feel the Care Manager helped you with your health care needs?	90%	90%	87%	93%
Was it easy to contact the Care Manager?	87%	86%	87%	87%
Was the information you received helpful?	92%	94%	90%	94%

Exhibit 0.1-17: Member Satisfaction Survey Results

Analysis of member responses indicated that majority of members were satisfied with ACLA's chronic care/disease management program. In an effort to continue to improve the members' experience with the program, the ICM department is revising the survey tool in 2014. The revised tool will use branching logic to ask respondents who answer negatively for additional information related to their answer. For example, members who answer "no" to the question

"After working with your care manager, do you feel you were better able to manage your own health?" will be prompted to choose an additional response from the below list:

1. I needed more time with my care manager
2. My questions were not answered
3. I needed help from other community resources
4. Other

This information assists ACLA with the refinement and improvement of our chronic care and disease management programs.

P.1. Non-Emergency Medical Transportation

P.1 Describe in detail your proposed approach to providing non-emergency medical transportation (NEMT) services, including, at a minimum:

- *What administrative functions, if any, you will subcontract to another entity (If subcontracting this function, the subcontractor information must be provided in response to item F.4.);*
- *How you will determine the appropriate mode of transportation (other than fixed route) for a member;*
- *Your proposed approach to covering fixed route transportation;*
- *How you will ensure that pick-up and delivery standards are met by NEMT providers, including training, monitoring, and sanctions;*
- *How you will ensure that vehicles (initially and on an ongoing basis) meet vehicle standards, including inspections and other monitoring;*
- *Your approach to initial and ongoing driver training;*
- *How you will ensure that drivers meet initial and ongoing driver standards;*
- *How your call center will comply with the requirements specific to NEMT calls; and*
- *Your NEMT quality assurance program (excluding vehicle inspection).*

Overview

Ensuring access to care includes providing transportation for members who lack transportation resources. Accordingly, AmeriHealth Caritas Louisiana (ACLA) has developed a relationship with a non-emergency medical transportation (NEMT) vendor. Through this relationship, we have been delivering efficient NEMT to our members in Louisiana using an established process that includes determining the best transportation method, monitoring standards, and measuring quality. The results of a recent satisfaction survey (included at the end of this document) for NEMT services in Louisiana show an overall satisfaction rate of 98.75 percent.

ACLA recognizes our responsibility to provide members with NEMT to services covered within the scope of the Bayou Health MCO RFP, as well as carved-out services, including dental and behavioral health. In anticipation of the new contract, ACLA has already begun working with our vendor to adjust the scope of our current agreement to include a robust trip validation process to meet the requirement for expanded transportation services cited in the Bayou Health MCO RFP.

Dedicated Transportation Services Manager

ACLA has a dedicated Transportation Services Manager to ensure that ACLA transportation needs are fully met. This individual's primary responsibilities include credentialing oversight, complaint resolution, and acting on information reported on a monthly and on an ad hoc basis. In addition, when the need arises for new or improved processes (e.g., hospital discharges), the dedicated manager works with the transportation vendor to develop, implement, and monitor the indicated processes. The Transportation Services Manager is also responsible for developing

and conducting all staff training related to NEMT services, which assures that all member-facing points of contact at ACLA are familiar with how to support members seeking transportation services and that they understand how to interface with the transportation vendor to assist the member in scheduling appropriate trips.

Administrative Functions Subcontracted to Another Entity

ACLA contracts with an experienced NEMT vendor that evaluates member capabilities and coordinates transportation resources to ensure that every member is served by the least costly, most appropriate mode of transportation available.

For non-emergency medical transportation services, the following administrative functions are subcontracted to the vendor:

- Contact Center (routine reservations and urgent trip scheduling).
- Credentialing.
- Contracting.

Performance standards are developed and monitored in accordance with ACLA's policies and procedures on subcontracting with providers for covered services, and in accordance with DHH requirements.

Determining Appropriate Mode of Transportation

ACLA is committed to providing members with the most appropriate mode of transportation in the most cost-effective way. To do so, we leverage a level of need assessment process. This assessment is an efficient, effective process for reviewing and documenting the medical necessity of requested modes of transportation. Generally, public transportation is the first choice for the appropriate level of care. However, public transportation is not always available.

Prior authorization from ACLA's Care Coordination team is required when a member requests/requires a higher mode of transportation. For example, a member might require elevated level of service due to medical conditions such as immune suppression or the need to remain in a supine position during transit.

If an elevated level of service is determined to be necessary, the contracted vendor will assign paratransit services as appropriate, followed by ambulatory sedan/van (curb-to-curb, then door-to-door), or wheelchair transportation (curb-to-curb, then door-to-door). Door-to-door services will be assigned only after thorough assessment resulting in certification documenting that the member has a physical, sensory, mental, developmental, or cognitive disability that requires this level of service for the member's safety. ACLA and its subcontractor authorize non-emergency ambulance when the member's needs dictate these modes. The Rapid Response team or the Care Coordination team also coordinate exceptional transportation services such as air travel, lodging, meals, and transportation upon approval when a member must travel a great distance for treatment.

The foremost concern is member safety at all times. ACLA and its subcontractor collaborate directly with the medical community as necessary to ensure that the most appropriate mode of transportation is scheduled. The success story below demonstrates how ACLA and the transportation vendor worked to assist a member who needed assistance with travel and transportation, lodging, and meals.

ACLA and Transportation Delegate Success Story

"Raquel" is a 38-year-old ACLA member who is a mother of three. She was seven months pregnant and vacationing in Houston, Texas, when she went into labor and had her baby prematurely. She had to make the difficult decision to leave the baby in the custody of the University of Texas Medical Branch hospital NICU and return home to attend to her other children. "Raquel" contacted ACLA's Rapid Response team regarding resources to travel from Louisiana to Texas to care for her premature baby.

Rapid Response contacted the transportation vendor the same day and expressed "Raquel's" urgent need to travel excessive miles for education on how to take care of a premature baby as well as to give her one-on-one time to bond with her baby during these difficult times. The transportation vendor assisted "Raquel" with reliable and on-call/standby transportation during the days and weekends she was staying in Texas to travel between the Ronald McDonald House and the hospital.

At one point, "Raquel" no longer met the criteria to stay at the Ronald McDonald House, but the transportation vendor worked diligently to provide her with transportation services for three consecutive months until the infant was healthy enough to safely travel home to Louisiana. "Raquel" expressed hardship in obtaining meals for herself and her children, and the vendor expediently provided meal reimbursement. The vendor assisted "Raquel" and her three children with transportation, meals, and lodging until the infant was discharged. The transportation vendor continues to provide transportation services for the infant. With knowledge of the infant's medical background, the vendor still provides urgent transport to enable "Raquel" to attend all medically necessary appointments.

Public Transit (Fixed and Deviated Route)

As fixed route is the most cost-effective mode of transportation, this will always be the first mode of choice for ambulatory members. The vendor determines directly if the member's pick-up and drop-off locations are within a half mile of a fixed route stop. The vendor will not assign transportation to a provider if the trip distance is less than a half mile, unless the member cannot travel the distance independently.

Rural Transportation

ACLA ensures that all members are transported to their appointments on time and with the appropriate transportation modality. Rural areas can provide a particular challenge. ACLA ensures that the NEMT vendor maintains a network of transportation providers that enables members in rural areas to access transportation services. In order to support rural transportation there are instances in which a trip may be in excess of 50 miles. For trips greater than 50 miles, our Rapid Response team will review the trip request. This provides an opportunity to validate the need for the appointment and/or to assist the member with finding an appropriate provider, coordinating needs, or providing assistance in locating a facility closer to where they are

located, if possible. Members needing to travel great distances may receive $50/day meal reimbursement and up to $150/day for hotel reimbursement for trips arranged with the support of the Care Management team.

In situations where a member is located in an area where no public transportation services are available, the transportation vendor will seek the least costly mode of transportation, as appropriate, in order to provide the necessary transportation to medical services.

Mileage Reimbursement

If a member is ambulatory and has access to a personal vehicle owned by the member or a family member/friend, ACLA approves mileage reimbursement at a rate set by the plan. The member must complete a trip log to request reimbursement, which their physician must sign to verify that the appointment occurred. The member returns the request, and the vendor processes the reimbursement. When necessary, the vendor will confirm that the appointment occurred before processing payment to the member.

Americans with Disabilities Act (ADA) Paratransit Services

If a member is certified for ADA services, the vendor can arrange transportation directly with the ADA provider and arrange for the appropriate reimbursement to the ADA provider.

Special Needs Requiring Higher Modes

Some members experience physical or mental disabilities to the extent that using public transit could result in a health or personal risk. In these cases, a health care provider, Care Coordinator, or a Care Manager from ACLA can submit an assessment indicating the need for a higher mode of transportation due to a qualifying medical reason. The vendor then arranges the most appropriate form of transportation based on the physical and cognitive abilities of the member. This mode most commonly consists of demand response transportation services but may occasionally include air travel. The following rules are used when making such determinations:

- A member who is ambulatory or can transfer out of their mobility device without assistance and has no cognitive disabilities receives shared van/sedan/taxi transportation with curb-to-curb service depending on availability.
- A member who is ambulatory or can transfer out of their mobility device with assistance and has severe cognitive disabilities receives shared van/sedan transportation with door-to-door services.
- A member who is in a mobility device, does not require assistance, but cannot transfer into a vehicle and has no cognitive disabilities is assigned curb-to-curb wheelchair transportation.
- A member who is in a mobility device, is not able to transfer, and has cognitive limitations receives door-to-door wheelchair transportation.
- A member who is supine and/or needs medical assistance, such as intravenous line administration during transport, receives non-emergency ambulance services.
- Exceptional transportation requests: Requests for air ambulance, commercial air, commercial bus, commercial train, meals and lodging, etc., are handled individually

through transport completion by specialized vendor resources in collaboration with our Utilization Management and Rapid Response teams.

Proposed Approach to Covering Fixed-Route Transportation

During the reservation process, a number of factors are considered to determine the appropriateness of fixed-route public transit services for members. Unless the member has already been designated as ineligible for public transportation, or public transportation is not an available option in the member's location, the vendor may ask a series of questions during the reservation process to guide the member to mass transit, such as:

- Is transit service running between the pick-up and drop-off locations?
- Does the member have any medical condition that prevents him/her from riding on public transit vehicles or accessing public transit stops?
- Is the service reasonably timely?
    - Note: Service may involve transfers, but the wait for transfers must be reasonably brief. Also, the member must not be delivered to the health care facility too early, nor be required to wait too long after the appointment.
- Is the member able to understand common signs and directions?
- If either the pick-up or drop-off location is too far from a transit stop for walking, would it be cost-effective to provide a short ride to the closest transit stop?
- Is the member scheduled to receive treatment such that they could utilize mass transit on the initial trip to the appointment but will need a vehicle to pick them up for the return trip because they may be too weak (chemotherapy, radiation, dialysis, etc.)?

Once the vendor has determined that the most cost-effective and medically appropriate means of transportation is via fixed-route transportation, the vendor will work to provide the member fixed-route travel training. As part of the training, the vendor will ascertain whether the member's medical appointment is a one-time event or a recurring appointment. This travel frequency, along with the timing of the appointment, will determine how the vendor will cover fixed-route travel expenses for the member. For example, if the travel appointment is scheduled far enough in the future, the vendor will arrange to courier travel remuneration—bus passes or tokens, for example—to the member. If the timing of the medical appointment does not allow for courier service, the vendor will work with the member to provide reimbursement for fixed-route travel expenses. If the medical appointment(s) is recurring, the vendor may elect to provide the member with a monthly pass.

Ensuring Pick-up and Delivery Standards are Met by NEMT Providers

Through our transportation vendor, ACLA monitors transportation on-time performance through a 100 percent trip reconciliation process. Transportation providers must record their pick-up and drop-off times and submit driver logs to the vendor for payment authorization. Vendor staff carefully reviews the trip logs to identify any inconsistencies and documents them to track performance.

ACLA and its vendor hold the contracted transportation providers to high standards, expecting at minimum a 90 percent on-time performance threshold. If at any time a transportation provider is delayed, the member is contacted and kept informed of the issue. In these cases, an alternate transportation provider is utilized if needed.

Quality Service Coordinators closely monitor the overall complaint percentage and the number and nature of complaints concerning transportation providers. When warranted, transportation providers are placed under corrective action plans (CAP). CAPs are reviewed for performance improvement. If noticeable actions have not resulted and performance has not improved, other measures may be taken, such as reducing the transportation provider's available capacity in the system, closing them to new trips until compliance has been met, or terminating them from the vendor's network.

Ensuring that Vehicles Meet Vehicle Standards

ACLA requires that vendors have policies to conduct vehicle inspections of all provider vehicles that will serve the contract prior to the provision of services and annually thereafter. Periodic inspections also occur throughout the year. All procedures call for complete vehicle inspections for all transportation providers to verify that vehicles meet the requirements and transportation provider guidelines, and to ensure that safety and comfort features are in good working order (e.g., brakes, tire tread, signals, horn, seat belts, air conditioning/heating). If any vehicle is found to be substandard, ACLA has the right to submit a request for the vehicle to be repaired, to be removed from service until repaired, or to be permanently removed from service, depending on the severity of the issue.

The vendor follows the state's credentialing policy. All vehicles undergo the stringent credentialing process. Required information for credentialed vehicles includes:

- State's vehicle ID number.
- Vehicle Identification Number.
- Current vehicle registration.
- Current insurance card.
- Insurance minimum information.
- Safety inspection documentation for each vehicle.
- Regular maintenance documentation.
- Current vendor vehicle inspection.
- Safety equipment.

It is the transportation provider's responsibility to maintain all vehicle records. The provider must keep vehicle credentialing information up-to-date with ACLA's vendor.

Initial and Ongoing Driver Training

Adequate driver training is a critical component in ensuring member satisfaction and safety. ACLA requires various training sessions for drivers to ensure they are able to respond appropriately to specific NEMT-related issues. To ensure drivers receive this necessary training,

ACLA requires transportation providers to submit proof of completed training, along with proof that the training was obtained from a reputable source, for each of the drivers who provide transportation to ACLA members. The driver training program includes:

- Basic first aid and defensive driving.
- Orientation on client and NEMT procedures.
- Tips on the processes for working with NEMT.
- Overview of passenger assistance techniques, including sensitivity training; proper loading, unloading, and mobility device securement procedures; and emergency procedures.
- Techniques for neutralizing tense situations.
- HIPAA guidelines and requirements.
- Receiving trip assignments.
- Calling in member no-shows.
- Collecting pick-up and drop-off information, including member signatures.
- Recording pick-up and drop-off information appropriately.
- Billing and trip reconciliation.

Upon training completion, the transportation provider must upload information pertaining to the specific training received, the driver's signature, and the date of completion. All required training must be completed within 90 days of the driver's hire date, and providers are required to develop and maintain an annual Driver In-Service Schedule to ensure drivers receive ongoing training. If any driver is identified to have a critical deficiency in performance, ACLA asks its vendor to discontinue using that driver for providing transportation services to any of our members.

Ensuring Drivers Meet Initial and Ongoing Driver Standards

The transportation vendor requires that all drivers be actively approved and credentialed by DHH according to its standards. DHH maintains information on credentialed drivers. In our annual delegation audit, we review credentialed drivers for the following information:

- DHH credentialed.
- Driver's license.
- Driver's license expiration date.
- Date of birth.
- Criminal background check.
- DMV report.
- Serious infractions.
- Negative drug screen.
- Defensive driving certificate.
- First aid training certificate.
- Not excluded from participating in Medicaid or Medicare.
- Not on State/National Child Protection or Sex Offender Registry.

The vendor makes the individual transportation provider's credentialing documents available to ACLA on demand, and as part of the pre-delegation audit and any subsequent annual delegation review. If, despite being notified of a pending expiration, the transportation provider

does not update the credential, the vendor contacts the provider. If a credential expires for any driver, that driver will not be allowed to transport any member until the credential is updated in the database.

The annual delegate review is a core component of delegation oversight. Such reviews are performed according to ACLA's delegation oversight policies. The purpose of the pre-delegation review was to ensure the vendor's compliance with ACLA and state standards. The most recent review was performed July 29-30, 2014. The incumbent transportation delegate passed all elements of the review. The review assessed delegate's overall corporate and Contact Center policies and procedures, general transportation policies and procedures, and plan-specific requirements. Artifacts examined included enterprise policies and procedures, training materials, administration policies and procedures, Contact Center policies and procedures, Louisiana provider agreements, and Louisiana driver and vehicle records. All elements of the review received high scores, as illustrated below.

Review Component	Score
General Elements	100%
Call Center Review Tool	96%
Louisiana Drivers	100%
Louisiana Vehicles	98%

Exhibit P.1-1: Delegation Review Results

As follow-up to the review, a plan was developed to address minor opportunities identified during the review.

Driver and Vehicle Compliance Management

The transportation vendor has Louisiana-specific staff whose on-the-ground activities ensure the closest possible management of individual transportation providers. This team is led by a Regional Manager who focuses solely on Louisiana and who spends the majority of their time interfacing with the transportation providers, ACLA, and the DHH NEMT Program Manager. Activities are centered on driver credentialing and compliance of vehicles used to support ACLA members. In situations where individual drivers and vehicles are found to be non-compliant, they are removed from servicing ACLA members until the identified deficiencies are cured.

The dedicated ACLA Transportation Services Manager interfaces with the Regional Manager on a frequent basis to ensure that ACLA's needs are fully met. In addition, the Regional Manager participates in all vendor partnership meetings with ACLA.

Contact Center Compliance with Requirements for NEMT Calls

Hours of Contact Center Operation

To ensure optimum service, members have 24/7/365 access to the transportation Contact Center. By calling the dedicated toll-free telephone line during regular business hours, members or their representatives have the ability to schedule transportation services. In addition to maintaining sufficient, appropriate staffing to handle calls during regular business hours, the vendor also maintains capable staff to answer after-hours calls; weekend, holiday, and back-up support is provided as needed. The vendor call center provides 24/7/365 service for hospital discharges.

Training Contact Center Staff

The Contact Center's number one priority is to provide professional, prompt, and polite customer service to all members and their representatives. To ensure high-quality service, a comprehensive training program educates Contact Center staff on treating all callers with dignity, respect, and confidentiality. With programs consisting of the following topics, we ensure that all incoming calls for NEMT services are handled in a timely, responsive, and courteous manner:

- Background on the NEMT industry and Medicaid.
- Scheduling services in compliance with state regulations.
- Contact Center application and technology tools.
- Contact Center management system.
- Confidentiality, including HIPAA safeguards and compliance.
- Business ethics and conduct.
- Reporting fraud and abuse.
- Cultural diversity, sensitivity, and Culturally and Linguistically Appropriate Services (CLAS) standards.
- Using the Language Line and TTY/TDD services.
- Customer service soft skills, phone etiquette, and professionalism, especially when working with members with special needs or managing difficult behavior.
- Active listening, documentation, and restating trip details before concluding the call.
- State requirements and protocols, and vendor policies and procedures.

Contact Center Monitoring

The Transportation Services Manager tracks the required Contact Center statistics and is responsible for reporting the performance of the vendor on a monthly basis to the ACLA Quality team. Primary metrics tracked and reported Average Speed to Answer and Abandonment Rate. Other metrics that are tracked include:

- Total incoming calls.
- Number (and %) of calls answered.
- Number (and %) of calls answered within 30 Seconds.
- Number (and %) of callers who choose interactive voice response (IVR) assistance.

- Number (and %) of callers who choose to speak to a Customer Service Representative (CSR).

For those callers choosing to speak with a CSR, the following are tracked:

- Total Hold Time (seconds).
- Average Hold Time (hh:mm:ss).
- Total Call Length (seconds).
- Average Call Length (hh:mm:ss).

Performance metrics are closely monitored every month. If there is a decline in performance, the Transportation Services Manager works closely with the transportation vendor to ensure that a plan is proactively developed and implemented so that metrics are met in subsequent months. Since inception, metrics have been met the required performance levels.

When performance slips, the Delegation Oversight team engages the vendor to remediate the situation. In situations when the subcontractor experiences three consecutive months of substandard performace, a formal Corrective Action Plan is implemented.

As shown on the following graph, after more than a year of acceptable service level (Average Speed to Answer) performance, the transportation vendor slipped below the acceptable service level of 90 percent in April 2014. When May results were also subpar, ACLA proactively engaged the vendor to perform a root-cause analysis and discuss actions required to reverse the trend to achieve acceptable results. The root cause was determined to be a staffing issue associated with movement of the Contact Center that supports ACLA from Phoenix, Arizona, to Austin, Texas. Planned corrective actions by the vendor were deemed appropriate by ACLA's transportation services manager. Frequent monitoring during June revealed a dramatic reversal (92 percent) of the negative trend, obviating a Corrective Action Plan. From June through August 2014, service level performance rose to an average of 97 percent.

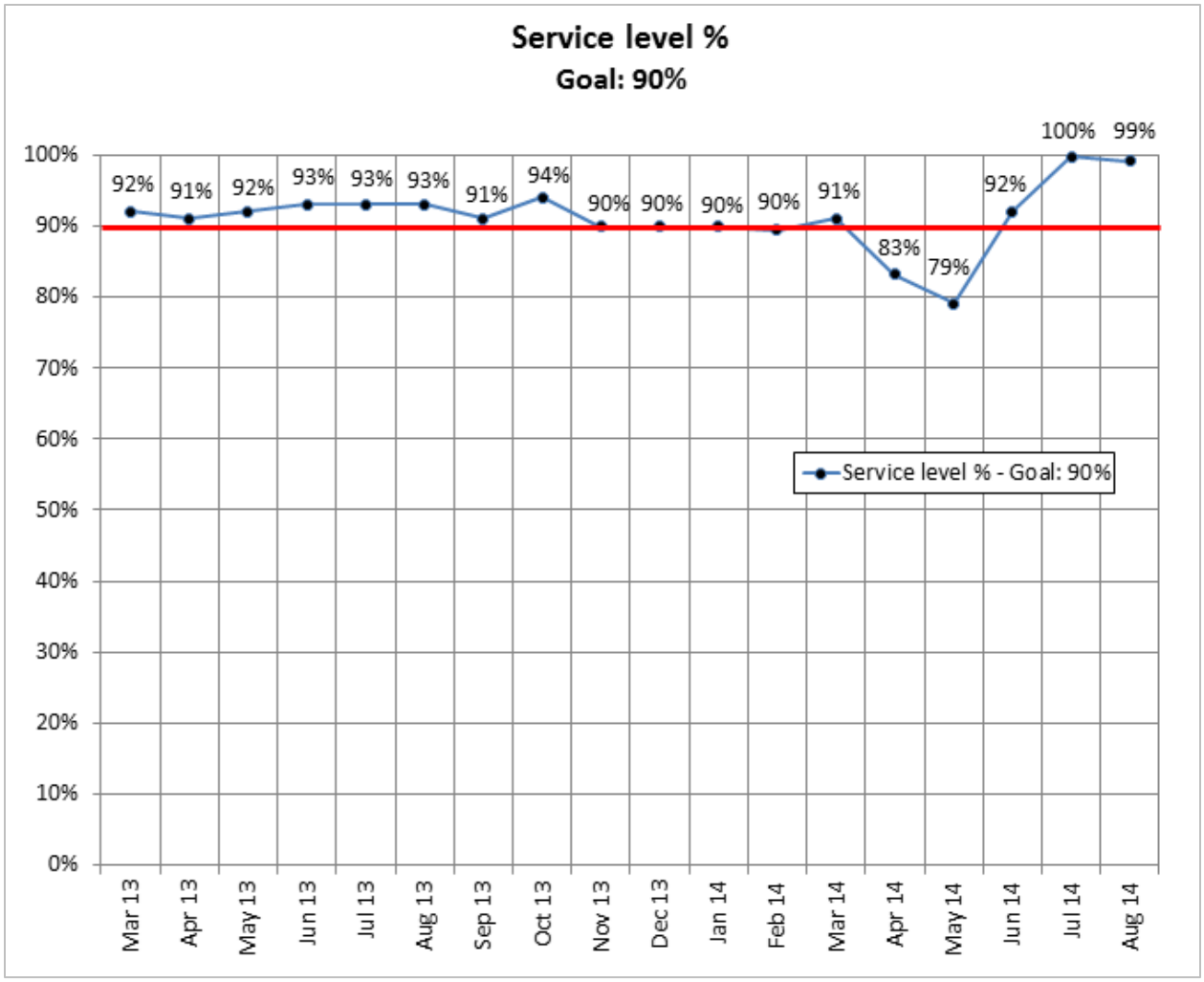

Exhibit P.1-2: Contact Center Service Level Monitoring

Monitoring Contact Center Staff

Vendor management is responsible for monitoring Contact Center staff for proper performance and duty execution, and is available to answer any questions or solve any problems. In addition, ACLA audits performance through both a live and recorded call monitoring review process to assess:

- Accuracy of trip scheduling.
- Accuracy of information acquired during intake.
- Timeliness of answering and completing calls.
- Call Center staff professionalism, sensitivity, courtesy, and responsiveness to member needs.

Meeting Limited English Proficiency (LEP) Needs

ACLA's vendor provides contact center staff with the training necessary to handle culturally diverse, limited English proficiency (LEP) populations with sensitivity and active listening. Reflecting ACLA's practices, the vendor abides by Culturally and Linguistically Appropriate Services standards, hires bilingual employees, and utilizes a certified language line service for all languages not spoken by the call center staff.

CLAS Standards Govern Cultural Sensitivity

The transportation vendor ensures high-quality service is provided to LEP individuals by educating Contact Center staff in cultural competency. The U.S. Department of Health and Human Services Office of Minority Health has issued standards for CLAS to improve access to health care services, while promoting sensitivity and communication styles that respect cultural diversity. In general, CLAS standards address:

- Training.
- Initial and ongoing organizational self-assessments.
- Management accountability and oversight mechanisms to provide culturally and linguistically appropriate services.

Hiring Bilingual Employees to Meet LEP Needs

The vendor seeks to hire bilingual Contact Center staff to improve communication with LEP members. To meet the varying language needs of members in this service area, the vendor hires Call Center staff with language skills in all the required languages specified by DHH.

Using Language Line Services to Meet Additional LEP Needs

To meet the needs of LEP individuals, ACLA utilizes a certified language line service with interpreters to accommodate more than 200 languages.

TTY/TDD Services for the Hearing and Speech Impaired

In addition to meeting LEP needs, the vendor has capabilities to meet the needs of other populations who experience communication barriers, including processing calls for hearing or speech impaired members through TTY (teletype) and TDD (Telecommunication Device for the Deaf) services. By using these services, we can effectively remove communication barriers from all populations regardless of their specific needs.

NEMT Quality Assurance Program

ACLA's goal is to achieve high performance standards in the delivery of NEMT services. To ensure this goal is met, ACLA requires the vendor to develop a comprehensive quality management program. The quality management program features performance metrics and thresholds to evaluate compliance with relevant standards, DHH requirements, and ACLA and

vendor protocols. The vendor collects data from the various operational departments and then compares the data to established goals and thresholds. The vendor's Quality Management Committee receives and trends each threshold or predetermined level of performance.

Vendor Quality Management Committee

The vendor's Quality Management Committee is central to quality assurance efforts. The Quality Management Committee meets quarterly to evaluate reports with the goal of operational excellence and quality assurance for all NEMT services. It serves as an advisory committee and is responsible for:

- Recommending policy decisions.
- Analyzing and evaluating the results of quality management activities.
- Ensuring the integrity of the vendor's quality management program through planning, designing, implementing, reviewing, and approving corrective actions.
- Ensuring follow-up to quality improvement initiatives.

As illustrated by the following graph, the number of ambulatory trips has grown steadily over the past 18 months. (Other modes of travel held steady over that period with the exception of Mileage Reimbursement, which is likely due to seasonal variation.) Through a robust NEMT transportation network, quality oversight program, and capabilities to respond to utilization fluctuations, ACLA and the transportation vendor demonstrate capabilities to meet Louisiana requirements.

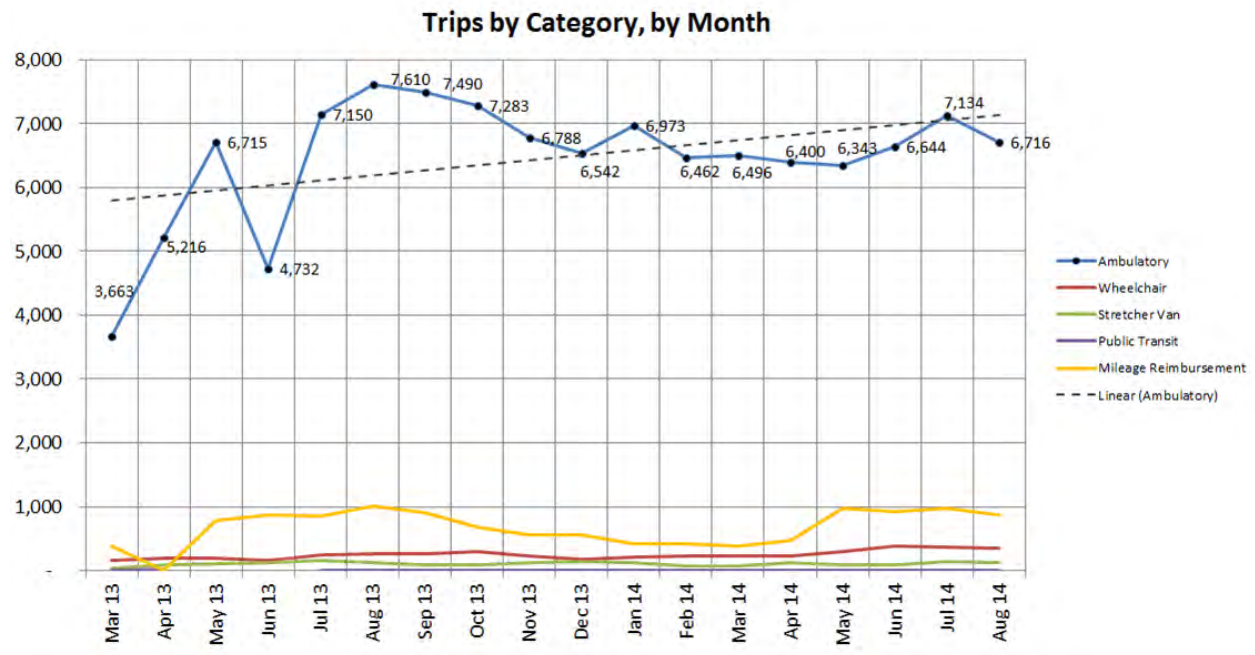

Exhibit P.1-3: Trips by Category by Month

Transportation-related complaints from members are taken very seriously. The process to resolve member complaints is a particularly important measure of the overall effectiveness of delegation

oversight. Despite the increased trip volume, member complaints dropped significantly from an average of about nine per month (July 13) to four per month (July 2014).

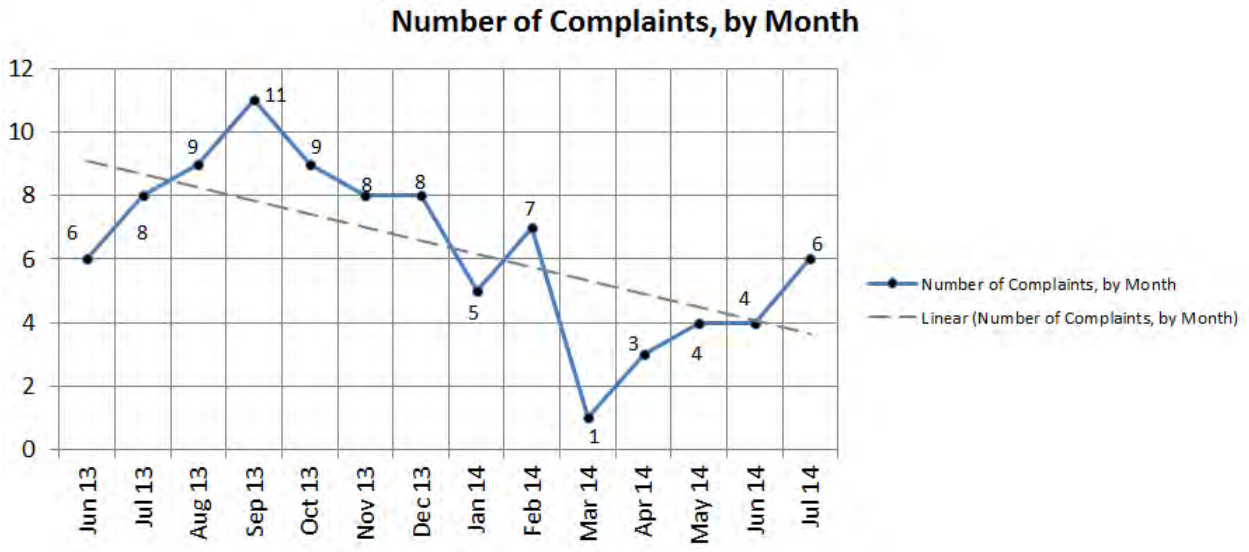

Exhibit P.1-4: Number of Complaints by Month

Recent satisfaction survey results for NEMT services in Louisiana are included below. Member satisfaction is measured every month and includes a minimum of 30 riders from the universe of unique rider/members in the month being evaluated. In the table below, the overall average satisfaction rate for May 2014 was 98.75 percent. Most measures received a 100 percent satisfaction rating, and the lowest average satisfaction rate was 81.25 percent.

Call Center Operator Assessment	Yes	No	Excellent	Good	Poor	Don't Know / NA	Total =32	% Satisfied
Was your call answered promptly when you set up your trip?	30	0				2	32	100.00%
Was the operator courteous and helpful?	30	0				2	32	100.00%
Did the operator review your trip to ensure it was entered correctly?	30	0				2	32	100.00%
Did the operator provide you with a reference number to confirm your reservation?	30	0				2	32	100.00%
Driver Assessment	**Yes**	**No**	**Excellent**	**Good**	**Poor**	**Don't Know / NA**	**Total =32**	**% Satisfied**
Was your driver courteous and helpful?	32	0				0	32	100.00%
Did the driver have visible ID, such as a name badge?	23	0				9	32	100.00%
Do you know the name of the transportation provider who transported you?	23	4				5	32	87.50%
How would you rate the driver's appearance?			16	16	0	0	32	100.00%
How would you rate the driver's driving ability and your safety?			16	16	0	0	32	100.00%
Did the driver obey speed limit and traffic rules?	32	0				0	32	100.00%
Vehicle Assessment	**Yes**	**No**	**Excellent**	**Good**	**Poor**	**Don't Know / NA**	**Total =32**	**% Satisfied**
How would you rate the appearance of the vehicle?			19	13	0	0	32	100.00%
Was the vehicle clean inside?	31	0				1	32	100.00%
Did the vehicle have signage on the outside?	29	0				3	32	100.00%
Did the vehicle have working seat belts?	31	1				0	32	96.88%
Please rate the overall condition of the vehicle.			20	12	0	0	32	100.00%
Service Assessment	**Yes**	**No**	**Excellent**	**Good**	**Poor**	**Don't Know / NA**	**Total =32**	**% Satisfied**
Did the driver call you before your trip?	26	6				0	32	81.25%
Did the driver arrive on time?	30	2				0	32	93.75%

Did you arrive for your appointment on time?	30	2				0	32	93.75%
Were you picked up within 1 hour of your return pick-up call?	30	2				0	32	93.75%
Did you request a car seat?	0	32				0	N/A	N/A
If answer is yes, was one provided for you?	0	0				32	N/A	N/A
Did the driver secure your wheelchair properly?	0	0				32	32	100.00%
How was your overall experience?			18	13	1	0	32	96.88%
Regional Office(WMR line)	Yes	No	Excellent	Good	Poor	Don't Know / NA	Total =32	% Satisfied
During this transportation appointment, did you call the "Where's My Ride Line"?	2	0				30	32	100.00%
Was your call answered promptly?	2	0				30	32	100.00%
Was the operator courteous and helpful?	2	0				30	32	100.00%
Was your issue resolved at the time of the call?	2	0				30	32	100.00%
Were you satisfied with the response to your transportation issue?	2	0				30	32	100.00%
Overall Customer Satisfaction								98.75%

Exhibit P.1-5: LA NEMT Services Satisfaction Survey

URAC Accreditation Shows Quality Commitment

The Utilization Review Accreditation Committee (URAC) accreditation process reviews the operations of a company to ensure that the company meets established national standards and promotes quality improvement. This accreditation covers a broad range of health care industries. As a demonstration of our commitment to ensuring high quality service, ACLA has selected and has been providing transportation services in Louisiana through a transportation vendor that has received URAC Core Accreditation.

AmeriHealth Caritas Louisiana

Q.1. Pharmacy

Q.1 Identify your current or proposed PBM, specifying any corporate relationship to the bidder. (If subcontracting this function, the subcontractor information must be provided in response to item F.4)

Overview

Our pharmacy benefit manager (PBM) is Perform Rx, based out of Philadelphia, PA. PerformRx is a clinician-led PBM that provides breakthrough, cost-reducing services to improve patient outcomes and financial performance. PerformRx partners with AmeriHealth Caritas Louisiana (ACLA) through a clinical focus that is driven by real-time, proprietary technology and more complete integration of health and pharmacy data for better patient outcomes, more collaborative care, and cost reductions that benefit all. PerformRx was one of the first PBMs to achieve URAC accreditation, and has been awarded this designation for the past three years.

Corporate Relationship to Bidder

The AmeriHealth Caritas Family of Companies (ACFC), which includes ACLA and PerformRx, is owned by two of the country's largest nonprofit Blue plans—Independence Blue Cross and Blue Cross Blue Shield of Michigan.

PerformRx is a wholly-owned subsidiary of AmeriHealth Caritas Health Plan (ACHP), formerly known as AmeriHealth Mercy Health Plan. ACHP is a Pennsylvania general partnership that is wholly owned by subsidiaries of BMH, LLC. BMH, LLC itself is owned by Independence Blue Cross (61.26 percent) and Blue Cross Blue Shield of Michigan (38.74 percent). Perform Rx maintains a separate but integrated business operation with separate management structures.

PerformRx has been contracted by ACLA to assign, develop, and manage the pharmacy network and ensure that the plan meets CMS and Louisiana DHH requirements. PerformRx has also been contracted to provide PBM services to members.

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Q.2. Pharmacy

Q.2 Describe the MCOs flexibility to customize PBM policies and procedures to meet Louisiana specific needs and program goals.

Overview

ACLA has a unique, symbiotic relationship with our PBM, PerformRx. ACLA and PerformRx have created departments in their respective companies to act as liaisons between the two companies. The use of the liaisons has helped to facilitate communication and transparency of information between the two entities. ACLA meets with PerformRx to discuss the creation and revision of PBM policies and procedures. If it is necessary, both ACLA and PerformRx have processes in place to alter existing policies and procedures in order to reflect Louisiana needs.

Process for Creation or Revision of Policies and Procedures

ACLA works with PerformRx, and other stakeholders, to create and update pharmacy policies and procedures for our members. Our close relationship with our PBM has allowed us to customize our policies and procedures to respond to state needs. ACLA is also able to quickly and efficiently implement the policies and procedures in place within the company and PerformRx.

Identification of Need

ACLA continually assesses its activities, responsibilities, and the external environment in order to identify the need for policies and procedures. Policies and procedures are necessary to ensure that the material guidelines, standards, and protocols governing the operations of ACLA are clearly documented, updated, communicated, and followed. The need for a written ACLA PBM Policy and Procedure may be identified by:

1. ACLA management.
2. State regulators.
3. Internal or external auditors.
4. Federal or state laws and/or regulations.
5. Accrediting agency guidelines (e.g. NCQA, URAC).
6. Contractual requirements.

Provider Feedback

Additionally, ACLA may change policies and procedures based on provider feedback. For example, we have based our formulary additions on provider response. Since February 2013, ACLA and PerformRx have added more than 200 drugs to the ACLA formulary and streamlined utilization management processes and edits in response to Louisiana provider feedback. We recognize the value that local Louisiana providers and pharmacies have in the

evolution of pharmacy programs. To encourage this type of feedback, we have several open channels that allow and encourage provider comments on current programs:

- ACLA pharmacist visits to providers and pharmacies.
- Participation at Pharmaceutical and Therapeutics (P&T) Committee meetings.
- Announcement of P&T Committee dates and open participation.
- Committee request form, which can be accessed on our website.

AmeriHealth Caritas Louisiana

P&T Committee Request Form for a Formulary Addition, Deletion or Modification

Note: ALL components (2 pages) of this form must be completed by the requestor for a review.

Date of Request:	**Requestor's Email Address:**
Requestor's Name:	**Requestor's Phone Number:**
Requestor's Specialty:	**Requestor's Fax Number:**
Requestor's Mailing Address:	**Requestor's Affiliation with Health Plan (*e.g. physician or network pharmacy*):**

Drug Requested to Review (Brand Name):	**Drug Requested to Review (Generic Name):**
Dosage Form:	**Strength:**
FDA approved Indications for use:	
Other indications for which this agent is being used and/or studied (Describe the role of this agent in the management of these indications):	
Is there a similar drug on the Formulary? Yes____No _____If yes, please include the name of the medication_____	

Exhibit Q.2-1: P&T Committee Request Form

Providers can also access meeting dates and agendas on the ACLA website.

State or Legislative Requirements

ACLA and PerformRx understand the importance of developing and, when necessary, modifying current policies and processes to respond quickly to state requirements. We recognize that is all requirements and specific needs set forth by the State of Louisiana and DHH must be addressed and implemented timely.

As an example of flexibility in systems to meet state requirements, ACLA and PerformRx worked together to ensure that, through our policies and procedures, we could meet Louisiana's specific needs and program goals in response to ACT No. 312, which required Medicaid health plan acceptance of standardized prior authorization forms and outlined step therapy requirements.

ACLA and PerformRx worked very quickly to make the Bayou Health universal pharmacy prior authorization form available to providers online and incorporate it into PerformRx's prior authorization process. To present providers with a streamlined authorization process, ACLA also has a program in place, E-Telligent, that allows providers the ability to submit prior authorizations on certain specialized medications online. Presently the list is limited with anticipation of adding more products in the future.

Based on Louisiana requirements, ACLA and PerformRx have amended current policies and procedures and completed training to acknowledge additional requirements of Act 312 with regards to step therapy and first fail protocols. Our plan will allow any provider to request an override for a specific request concerning our members. Specific factors must be addressed in order to complete this process as addressed in legislative statute.

Policy Owner

The ACLA department that will be the most impacted by, or has the most responsibility for, the policy and procedure, should be considered the policy owner. For example, if the policy or procedure required changes in prior authorizations, our Utilization Management department would be the policy owner. Additionally, because PBM policies and procedures require ongoing participation from PerformRx, a formal policy and procedure is indicated. PerformRx will also be identified as a stakeholder in the policy and procedure.

Development of Policies and Procedures

ACLA involves PerformRx, and other stakeholders when necessary, in the development of its policies and procedures. Greater information and broader experiences make it easier to develop and implement realistic policies and plans.

Consultation with PerformRx

Once the need for a new policy, or a revision of a current policy, is identified, the policy owner meets with the PerformRx Account Management team and the ACLA Pharmacy department to discuss the implications of the policy or procedure.

PerformRx Account Management Team

The PerformRx Account Management team consists of a Regional Account Executive, an Account Executive, and a Customer Solutions team. The Customer Solutions team consists of members from ACLA functional areas including clinical, operational, finance, and compliance departments to provide immediate support for any existing or emerging issues and projects.

ACLA Pharmacy Department

ACLA's Pharmacy department also acts as a direct link between ACLA and PerformRx. The Pharmacy department ensures that the P&T Committee decisions are implemented, benefits are set up appropriately, call center metrics are met, and complaints and grievances are being addressed. They also monitor PerformRx to ensure that policies and procedures are being followed, and that NCQA and state requirements are met.

ACLA Pharmacist Liaison

ACLA has an in-state, Louisiana-licensed pharmacist employed full time as a liaison between ACLA and pharmacists in its network, to improve relationships and to communicate and educate the needs and requirements of the Pharmacy department and Louisiana DHH. In any addition to addressing and resolving those issues brought to ACLA, our Pharmacist Liaison has accompanied the Medical Director to on-site meetings with network providers as a subject matter expert and resource to address pharmacy issues and concerns.

Team Meetings

In an effort to support ACLA's Pharmacy department, the PerformRx Account Management team works with the ACLA Pharmacy Director and the ACLA Pharmacy department on a daily basis to assist with managing the pharmacy benefit. In addition, the Account Management team meets biweekly with ACLA's Pharmacy team to review open projects and requests, including policies and procedures.

Pharmaceutical and Therapeutics Committee

ACLA established a P&T Committee for the development of the Formulary and the Preferred Drug List (PDL), as well as other policies and procedures. The P&T Committee represents the needs of all our members, including those with special needs. Louisiana in-network and out-of-network physicians, including a network behavioral health specialist, participate in the development of the Formulary, PDL, and clinical drug policies. Other practice specialists are invited to participate on an ad-hoc basis when there is a need for review of highly specialized drug products specific to that specialist's area of expertise. Prior to any changes to the Formulary or PDL, the P&T Committee reviews, considers, and comments on proposed changes. P&T Committee meetings are open to the public.

Our P&T Committee meets at least quarterly to consider products in categories recommended for consideration for inclusion/exclusion on Formulary or PDL. In developing recommendations for a Formulary and PDL, we consider the clinical efficacy, safety, cost-effectiveness, and any program benefit associated with the product.

ACLA developed policies governing the conduct of P&T Committee meetings, including procedures by which it makes its Formulary and PDL recommendations. For example, in order to address the rising concerns voiced at meetings with Louisiana Medicaid and other state Medicaid agencies over the use of central nervous system stimulant drugs in the pediatric population, a subcommittee of the P&T Committee held an ad hoc meeting this past January. The subcommittee was comprised of the ACLA Medical Director, network behavioral health specialists, and pharmacists from ACLA and PerformRx.

After review of utilization of drugs to treat Attention Deficit Hyperactivity Disorders (ADHD) in children, in both Louisiana and South Carolina, the subcommittee reached consensus on the following:

- Drugs to be listed on Plan Formulary/Drug Lists.
- Drug specific age limitations.
- Protocols to be used in overrides.

As of the end of July 2014, 77 requests for ADHD medications below these age limits were denied. Pharmacy and medical management reached out to the prescribers to discuss and recommend non-pharmacologic treatment options.

The trend in ADHD medication usage in children between the ages of 0–6 has been positively affected. The following grid shows the reduction in the number of children utilizing these drugs between January and July 2014.

Month	JAN	FEB	MAR	APR	MAY	JUN	JUL
Total Members Ages 0-6	614	611	614	572	525	426	422

Exhibit Q.2-2: Children Using ADHD Drugs

Compliance and Regulatory Affairs Review

The policy owner consults with Compliance and Regulatory Affairs (Compliance) during the development of the document, as well as during the review phase to verify the completeness and accuracy of incorporation of legal, state, federal, and other regulatory requirements into the document. Compliance must sign off on the draft policy and procedure prior to execution. Compliance will also review to ensure communication standards, such as formatting, are met.

Submission of Draft to DHH

The ACLA Regulatory Affairs department submits necessary policies and procedures to DHH to review and approve. Policies are submitted to DHH in draft form after completion of the Internal Department Review and Development process but before execution of the final policy and procedure. ACLA will submit drafted policies and procedures that are to be submitted to outside entities to our Communications department for review to ensure that the policy and procedure complies with ACLA communication standards. Outside entities (e.g., State

Medicaid Agency) are contacted to review and approve applicable policies and procedures that require such approval and other feedback, prior to being finalized.

Approval of the Draft Policy and Procedure

ACLA provides PerformRx, and any other stakeholders, with a hard copy of the drafted policy and procedure to solicit their comments and/or revisions and ask that the stakeholder document relevant comments and/or approval. ACLA will review each stakeholder's questions, comments, and/or revisions, revising the policy and procedure as appropriate. Although the feedback may recommend changes to the policy and procedure, not all changes may be necessary and/or appropriate. A collaborative decision between ACLA and one or more of the stakeholders may be reached to resolve the issue and/or problem.

ACLA contacts DHH again, forwarding them a revised copy of the policy and procedure, which captures the suggested and/or required changes that they or the stakeholders have specified. After all appropriate revisions have been incorporated, the policy and procedure is forwarded to the Senior Vice President (or department head) to sign the policy. Signatures of all stakeholders identified in the policy and procedure are obtained.

Implementation of Policies and Procedures

Based on the topics and processes addressed, training may be warranted by ACLA or PerformRx. ACLA is responsible for ensuring that training sessions on the processes addressed in the policy and procedure are held. ACLA is responsible for use and retention of training sign-in-sheets, identifying the training date, training topics, and the names of attendees.

If a copy of a policy and procedure is requested by outside entities, associates must seek management's approval prior to the release of any company information, including any description of operational processes within ACLA.

Changes to PerformRx Policies and Procedures

As a PBM, PerformRx creates its own company-wide policies that are used to govern the business. However, through its desktop review process, PerformRx is able to customize its policies to address the needs of Louisiana. PerformRx drafts regulatory addendums to its policies and procedures for Louisiana based on state guidelines as published by the state.

PerformRx Change Request

Upon receipt of approval, PerformRx will immediately submit the request to the appropriate department and notify any other department affected by the change. Programming turnaround times will start once the change order request form is approved by the client and any applicable charges are approved by ACLA and PerformRx. The target date will be communicated to ACLA and affected internal departments.

PerformRx determines how it will implement what the state is expecting to occur within system capabilities. Once updated, the policy and procedure is sent to all subject matter experts as it

relates for review and adjustments. The policy and procedure is then updated with suggested changes that are applicable. Upon completion of the update, all policies and procedures are reviewed and approved by the Compliance Committee to ensure they meet all CMS and DHH regulations and internal policies and procedures.

Distribution and Communication

After the policy and procedure has been approved and signed by the appropriate parties, it is distributed and communicated to ACLA, and PerformRx staff, if applicable. Department web coordinators are provided with an electronic copy of the policy and procedure and attachments, so that it may be placed on ACLA's policy and procedure website. Depending on the policy and its content, it is at the discretion of the policy owner to determine whether the policy should be distributed with a special announcement to all associates, supervisor(s) and above, or only to members of the Leadership Team. PerformRx and other stakeholders are provided with a copy of the signed policy and procedure and any attachments.

Provider Education

PerformRx supports, coordinates, and provides live continuing education programs for network pharmacists and pharmacy technicians. For example, ACLA and PerformRx held a program in April 2014 in Shreveport. Additionally, we held another program in Baton Rouge in June 2014. Not only did PerformRx provide clinical education on key treatments, but it was also an opportunity to engage network providers in dialogue regarding the relationship with ACLA and PerformRx.

Policy and Procedure Review Plan

ACLA reviews existing policies and procedures on an annual and as-needed basis. We review and revise, as necessary, all policies and procedures on an annual basis, i.e., within one year from the date identified as the Current Effective Date, as required by law, regulation, contract, or as otherwise determined by the Senior Vice President or department head. All policies and procedures are reviewed at least once every three years. The Review Cycle is specifically indicated on the first page of the policy and procedure (annual, every other year, etc.). The Senior Vice President (or department head) of the policy owner department maintains a signed, paper copy of the policy and procedure at all times. This policy and procedure is retained after the policy is retired or streamlined.

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Q.3. Pharmacy

Q.3 Submit a preliminary plan for MCO oversight of the PBM's performance.

Overview

Oversight of our PBM, PerformRx is important because PerformRx interacts with members on behalf of ACLA. We monitor the performance of our PBM through a formal contract-based quality oversight program and through ongoing day-to-day oversight and monitoring performed by ACLA staff dedicated to this function. Our PBM agreement includes performance measures which are monitored through monthly reports and are also presented to the quality committees for review. In addition, annual onsite audits are conducted for the PBM where regulatory compliance and performance measures are reviewed.

Oversight Plan of PBM Performance

ACLA retains full accountability and responsibility for the provision of services delivered to its members through our relationship with PerformRx. ACLA also retains the right to require PerformRx to initiate and complete corrective action plans (CAPs), implement increased monitoring, to revoke the subcontract, and to impose sanctions if performance is inadequate or fails to meet the applicable standards; including (but not limited to) standards established by ACLA, the requirements of the Bayou Health MCO RFP, Federal or State regulatory authorities, or applicable accrediting agencies. Our agreement with PerformRx also contains provisions permitting us to terminate the agreement for non-performance of contract requirements and/or the inability of the subcontractor to meet established performance standards. As described below, we will assure that all tasks are performed in accordance with the terms of our contract as well as the Scope of Work listed in the Bayou Health MCO RFP.

Monitoring of PBM

ACLA monitors PerformRx's performance on an ongoing basis and performs a formal review each quarter. If at any time ACLA identifies any deficiencies or areas for improvement, we will take corrective action immediately.

Subcontractor Oversight Coordinator

PerformRx reports on a day-to-day basis to the Subcontractor Oversight Coordinator, as well as ACLA's Pharmacy Department. The Subcontractor Oversight Coordinator works in partnership with the Pharmacy Department to monitor PerformRx's performance and conducts a formal review each quarter, according to a periodic schedule established by ACLA. Based on the results, PerformRx is approved or disapproved for continued operation. If a CAP is imposed, the results of the corrective action and subsequent monitoring are brought back to the appropriate quality committee.

Regional Pharmacy Department

ACLA's Pharmacy Department conducts monitoring of PerformRx, and also acts as a liaison between ACLA and PerformRx's Account Management Team. The Pharmacy Department supports corporate, regional and local medical management and pharmacy goals in implementation of pharmacy related clinical program initiatives.

The Pharmacy Department attends all pharmacy-related meetings and committees as representative of ACLA, and participates on ACLA's P&T Committee. The members of this department also participate on the ACLA's quality committees including, but not limited to, the Quality of Service Committee (QSC) and Quality of Clinical Care Committees (QCCC) and report on Pharmacy agenda items. The role of this department also includes participation in meetings with state agencies as the health plan pharmacy representative, as well as responding and/or resolving identified regulatory issues.

This department provides on-site education and training for regional providers and pharmacists on Formulary and pharmacy procedures using ACLA utilization data, trends and new product details. The members of this department act as resources for physicians, pharmacists, and plan staff who are experiencing problems with the pharmacy program. Furthermore, the Pharmacy department works closely with PerformRx to make sure appropriate provider/member outreach is made at the local level to improve overall program quality. They will also work with PerformRx to identify and resolve any operational issues.

PBM Account Management Team

The PerformRx Account Management Team acts as another liaison between PerformRx and ACLA. The Regional Account Management Team establishes strategic plans to manage all ACLA account issues and identify utilization trends in collaboration with Perform Rx clinical programs and operations division. They also facilitate and manage executive interactions and formal meetings between ACLA and PerformRx.

The Account Management Team leads and directs regional cross-functional clinical and operational teams to manage customer accounts and provide solutions. To further this endeavor, they create and maintain documentation for all services provided to ACLA under a report tracking and evaluation plan. They also develop, maintain, and deploy reporting tools and metrics to ensure transparent views of current activity, track progress with account strategies, and provide early identification of business opportunities.

Quality of Service Committee

In addition to the Subcontractor Oversight Coordinator's monitoring, the QSC will review PerformRx's performance on a quarterly basis. QSC provides oversight of many services, including reviewing, approving, and monitoring the activities of PerformRx and delegating activities associated with service standards, access, and availability. The QSC is chaired by the Director of Plan Operations and Administration. Its members include the following individuals:

- Director, Quality Management.
- Director, Utilization Management.
- Director, Integrated Case Management.
- Director, Network Management.
- Director, Rapid Response.
- Director, Regulatory Affairs.
- Manager, Network Service Operations.
- Manager, Appeals.
- Director/Manager, Member Services.
- Director/Manager, Claims Unit.
- Director/Manager, Contact Center.
- Delegate Oversight Analyst.

The QSC meets quarterly. Key PBM metrics that are presented to the QSC Committee include:

- Call Center and Pharmacy Member Call Center Statistics: Call volume and performance to increase overall customer service satisfaction by maintaining or exceeding the goal of less than 5 percent abandonment rate, average hold time of 3 minutes or less, and an average speed of answering calls in 45 seconds or less with a service level of 90 percent or greater for Pharmacy Services and Pharmacy Member Services call center.
- Pharmacy Decision Timeliness: ACLA and the Regional Pharmacy Department monitors the PBM to ensure that the performance guarantee is met 95 percent of the time for review and decision on pharmacy prior authorization requests. The guarantee is that PerformRx will review all pharmacy prior authorizations in a 24 hour turn-around timeframe.
- Pharmacy Services Appeal Service Standards: Pharmacy Services, in coordination with Pharmacy Member Services, works the health plan's Medical Directors on reviewing and completing medication appeal requests within the required timeframe. Our goal is to ensure members receive needed medications in a timely manner. Members and providers have the right to appeal any limitations or restrictions placed on medications. Louisiana Department of Health and Hospitals (DHH) appeals department is charged with protecting these rights by adhering to Louisiana DHH regulations governing the appeals process. The turnaround time for a standard appeal is within 30 calendar days. An expedited appeal may be requested if the limitations/denial of the medication could result in harm to the member; these appeals must be processed within 72 hours from initial receipt of the appeal request. Our goal is 95 percent compliance with the appeal turnaround time requirements.

Pharmacy and Therapeutics Committee (P&T)

With the assistance of PerformRx, the Regional Pharmacy Department conducts quarterly meetings to monitor drug utilization patterns, develop pharmacy benefit management procedures, address quality concerns, and identify opportunities for provider education. The P&T selects medications for the plan formulary, reviews and approves prior authorization criteria, and establishes step therapy protocols. The Regional Pharmacy Department ensures

that PerformRx has implemented all P&T decisions and that the posted formularies are correct and up-to-date.

P&T Meetings are open to the public. Meeting agendas are posted to the website in advance of each meeting, and copies of the minutes of each meeting are subsequently posted once finalized and approved by committee at each ensuing meeting. Providers, pharmacists and members are encouraged to submit comments and requests for changes to the formulary. All requests are brought to the committee for consideration and possible approval. As a result of inquiries received since the formulary was created a significant number of unique drug products and additional dosage forms of existing products have been added to the list.

Appeals and Grievances

ACLA has established policies and procedures that ensure compliance with the requirements of the Bayou Health MCO RFP related to the grievance and appeals process. PerformRx is responsible for initial coverage determinations in accordance with the provisions of the Bayou Health MCO RFP. Policies employed by ACLA which are used to oversee PerformRx—along with regularly scheduled and/or ad hoc audits of PerformRx's policies, procedures, and files—ensure that initial determinations and initial coverage decisions are handled in a manner consistent with the policies of ACLA and the requirements of DHH and the RFP. PerformRx is required to provide to ACLA all necessary data to comply with the reporting requirements of or as such requirements may be amended by DHH in the future. If a need for corrective action or follow-up is identified, ACLA sends a written notice to the subcontractor identifying specific actions or information required. If audits identify non-compliance, PerformRx is required to prepare and implement a CAP. ACLA retains the right to review and overturn any appeal determination made by a PerformRx.

The Pharmacy Department, who works in direct coordination with our Utilization Management (UM) Medical Directors, is responsible for supporting all member and provider appeals. During the appeals process, the reviewing Medical Director reviews the initial denial rationale to ensure that PerformRx made an appropriate decision. The Medical Directors also performs spot checks at random to verify that the criteria were met. This is conducted in addition to PerformRx internal audits.

Annual PBM Oversight Process

ACLA completes a full assessment of the PerformRx's activities annually. During the annual assessment, policies and procedures, program descriptions and evaluations, work processes and a variety of other supporting documents are reviewed. In addition, file audits may be performed.

Audit Procedure

PerformRx is notified of the upcoming audit and the requested information and a mutually agreed upon annual audit date is arranged. In an effort to allow PerformRx the opportunity to clarify any outstanding issues or questions, discussion of the preliminary findings takes place at

the time of the audit between the ACLA representative and a representative from the PerformRx. The audit consists of a desktop review of the required evidence, and an on-site visit, if necessary. In addition to the annual delegation audit, ACLA reserves the right to conduct ad hoc audits.

All corresponding audit documentation, which includes auditing tools (with scoring methology), evidence supporting each requirement, audit results, and the executive summary are stored and available for review, upon request.

2014 Delegation Audit Scoring for PerformRx

All annual delegation audits are completed within a 14-month annual auditing cycle. A score of 95 percent or greater is required for all areas. The annual audit was completed May, 2014 in accordance with the ACLA Delegation Oversight Policy No: 277.010.

The results are as follows:

Audit Category	Score
File Review: Score for Denials	100%
File Review: Score for Approvals	100%
Quality of Care	100%
Quality of Service	100%
Document Review Score	100%
Contact Center Policy Review	100%

Corrective Action Plans

ACLA analyzes and scores the annual audit; and a CAP will be required for any items that fall below ACLA standards, as defined on the Oversight Tool, including elements identified as "Must Pass." The CAP identifies the action required, accountable parties, a resolution to the action, and a completion date. The Stakeholder Department is responsible for updating the oversight committee and soliciting feedback from the committee as necessary until the CAP is resolved. Performance measures will be monitored per reporting requirements.

As outlined in the ACLA Delegation Oversight Policy No: 277.010, a CAP will be required for all performance/reporting measures failing to meet goals for three consecutive months and/or reporting cycles, or for demonstrating a pattern of failing to meet performance/reporting measures in the majority of a six months and/or reporting cycle. For example, PerformRx did not meet the required service levels for the 1st quarter of 2014. A CAP requirement was imposed to determine root cause, actions needed to correct the deficiency, and follow-up monitoring to insure compliance. As of result of this oversight and actions taken by PerformRx, they have been in compliance since April.

In the event that a CAP is indicated, ACLA will provide consultation to PerformRx to help complete any outstanding issues identified in the CAP. ACLA is responsible for ensuring that appropriate updates are prepared as necessary for internal and external committees, governing bodies, State Medicaid Agencies and other regulatory authorities, and for coordinating with relevant departments for the delivery of such updates.

Upon satisfactory completion of the outstanding items in the CAP, the information is presented to all internal/external committees, as required for approval. Once approved by all necessary internal ACLA committees, approval is sought from applicable external reviewers, such as regulatory authorities where review and approval of the Delegation relationship is required.

If all outstanding items on a CAP are not complete within the agreed upon time frame, the audit results and CAP are presented to the Oversight Committee, with a recommendation to terminate the subcontract. The decision may be reviewed by the appropriate governing boards, and may be subject to prior regulatory notification and/or approval.

Termination

If ACLA decides at any point in time that the PBM relationship should be terminated, PerformRx will be notified of the decision in writing. ACLA is responsible for working with the corporate Legal Affairs Department to prepare the necessary correspondence. The letter will include the reason(s) for termination of the subcontract and the procedure(s) PerformRx must follow to return the subcontractor function(s) back to the Plan.

PBM Reporting Requirements

The reporting requirements, including content and frequency, are defined within the subcontractor contract, but shall be no less than at least semiannually. Report(s) are received by ACLA on a mutually agreed upon date/frequency. ACLA reviews, records, and presents this information to the responsible committee. ACLA is responsible for indicating PerformRx's compliance or non-compliance based on the reporting information received. ACLA is responsible for maintaining any and all information pertaining to PerformRx. Pertinent information pertaining to the PBM is shared with the appropriate governing body.

Q.4. Pharmacy

Q.4 The drug file for both retail and specialty drugs, including price, must be updated at a minimum every seven (7) calendar days, at the MCO's discretion they may update the file more frequently. Provide a brief summary of your policy, process and frequency for drug file updates.

Overview

PerformRx provides Drug Information Updates, supports ACLA's Pharmacy & Therapeutics (P&T) Committee, maintains the ACLA formularies, and conducts daily maintenance for both retail and specialty drugs.

Drug Information Update Policy

PerformRx updates the drug file for both retail and specialty drugs at least every seven days, and as often as daily. We update as frequently as the changes are available from third-party data sources. We maintain a series of National Drug Code (NDC) databases that contain drug information from each nationally recognized third-party drug price source utilized by PerformRx: First Databank (FDB), Micromedex, and MediSpan.

These files contain records for the drugs recognized by the NDC system. Both daily and weekly files include addition of new drugs, deletion of drugs no longer recognized by the NDC, and changes to existing drugs. For daily files, only drug updates denoted as a "price change" are considered for loading. This means that prices for new drugs that have just come to market will not be loaded prior to receiving clinical information required for patient safety edits, and drugs no longer being actively sold by manufacturers will not be immediately deactivated as is consistent with standard industry practice.

Drug Information Update Process

PerformRx will provide a Drug Information Update containing information on new drugs on a monthly basis to ACLA Leadership and Pharmacy department staff. Each Drug Information Update will typically contain the following sections:

New Generics to Market

The New Generics to Market section contains a chart with the generic drug name, strength and dosage form, generic manufacturer, brand name, and the approval date for each new generic.

New Drug Entities

The New Drug Entities section contains a chart with the description of the medication, brand name, generic name, strength, and notes. In the notes area, the clinical team describes the change to the drug entity. For example, the clinical team may note that there is a new dosage form, a new entity, or a new combination.

New Indications

The New Indications section provides updates on existing drugs, such as new approved uses. Each update includes the source website, a link to the article further explaining the update, and the date the article was published.

FDA News/Bulletins/Advisories/Safety Alerts

Each article summary includes original articles and updates if applicable. PerformRx presents the issue, date issue was identified, background information, links to the article and source, and recommendations if necessary.

Studies

The Studies section provides relevant and interesting studies to clients. These studies range from medication adherence to research indicating potential side effects of medications. Each synopsis includes the date published, article link, and source website for further reading.

Recalls

The Recalls section comprises a chart with all current recalls. Information includes product type, product description, code information, class, reason for recall, and recalling firm.

Current Drug Shortages

The Current Drug Shortages section updates the client on the specific shortage, date discovered, and the reason for the shortage, as well as a link to both the article and source website for further research. At the end of the shortages list, PerformRx directs the clients to American Society of Health-System Pharmacists (ASHP) for more information and provides the link for ease of access.

Drug Information Update Frequency

Weekly Updates

PerformRx's formulary pharmacists monitor the First DataBank (FDB) weekly for drug updates, such as new drugs or new strengths. PerformRx's formulary recommendations are based on scientific and economic considerations that achieve appropriate, safe, and cost-effective drug therapies as well as established standards of practice, as described below:

- Assessing peer-reviewed medical literature, pharmacoeconomic studies, and outcomes research data.
- Employing published practice guidelines, developed by an acceptable, evidence-based process.
- Comparing the efficacy as well as the type and frequency of side effects and potential drug interactions among alternative drug products.

- Assessing the likely impact of a drug product on patient compliance when compared to alternative products.
- Basing formulary system decisions on a thorough evaluation of the benefits, risks, and potential outcomes for patients.

Economic factors are also carefully weighted:

- Basing formulary system decisions on cost factors only after the safety, efficacy, and therapeutic need have been established.
- Evaluating drug products and therapies in terms of their impact on total health care costs.
- Permitting financial incentives only when they promote cost management as part of the delivery of quality medical care. Financial incentives or pressures on practitioners that may interfere with the delivery of medically necessary care are unacceptable.

Daily Maintenance

The formulary staff will continually receive updates affecting the formulary. To ensure that all formulary changes are processing correctly at the point of sale, all formulary claim processing programming requests are claim tested immediately upon completion. These include but are not limited to P&T changes, drug additions, drug removals, formulary requirement additions and/or removals, and DUR edits.

Formulary Availability

PerformRx provides ACLA with a link to the searchable formulary and a PDF version of the formulary to post on the pharmacy section of their website or provide in printed form upon request of members and providers. The searchable formulary is maintained by a clinical lead and is updated immediately as soon as any changes are implemented.

The online searchable formulary identifies:

- Alternatives using the drugs' Therapeutic-Class and Sub-Class hyperlinks.
- Formulary/Non-Formulary drugs.
- OTC drugs.
- Available generic equivalent when a brand name drug is searched.
- The online searchable formulary provides coverage restriction icons in the search results.

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Q.5. Pharmacy

Q.5 Submit a summary report of three (3) pharmacy utilization management efforts which demonstrated successful outcomes for three (3) separate disease states.

Overview

PerformRx has demonstrated proven success with client collaboration and pharmacist integration into the pharmacy utilization management efforts. We have found that a collaborative model incorporating education and communication among prescribers, members, care managers, and pharmacists optimizes medication therapy, addresses medication-related problems, and encourages appropriate medication utilization. Accordingly, we incorporate these elements into our utilization management efforts. Below are descriptions of three utilization management programs at ACLA.

Hepatitis C Virus (HCV) Drug Utilization

Sovaldi and Olysio were released in December 2013 to treat HCV. They were approved by the FDA at the beginning of 2014 and chosen in federal guidelines as the two acceptable agents to treat HCV. In accordance with these guidelines, ACLA implemented updated Pharmacy & Therapeutics Committee approved treatment guidelines to address the latest practice standards and the need for greater member education and direct intervention. Members qualified for treatment through the program are required to comply with the regimen. Care managers reach out to members to encourage this compliance. Members who do not adhere to medication guidelines by not refilling prescriptions or missing more than two doses are terminated from the program.

Key Criteria Changes

Key criteria for the HCV utilization program include a required attestation of abstinence from drug and alcohol, and program participation as documented by a copy of the note in the member's medical record. Nurse care managers are engaged to contact, educate, and follow up with every member approved for treatment to help ensure that the member receives the full benefit of these drug regimens through full compliance with the program. Additionally, the program requires testing in the following measures, as verified by a copy of the testing results:

- ALT/AST, albumin, bilirubin, total and direct, prothrombin time.
- CBC, ferritin, iron saturation.
- TSH, ANA.
- Serum creatinine, glucose, uric acid.
- ECG, echo cardiogram, stress test in the presence of heart disease.
- Urine drug screen.
- Blood alcohol level.
- Pregnancy test in women of childbearing age.
- Serum HBsAg, anti-HBc, anti-HBs, anti-HAV.

- HIV serology (CD4+ T cell count and HIV RNA required for HIV co-infection.
- Liver biopsy showing advanced to severe fibrosis (Ishak Stage > 3 OR Metavir Score > 2) OR non-invasive testing, Fibroscan or Acoustic Radiation Force Impulse (ARFI), to identify severe liver fibrosis.

These efforts have ensured clinical and fiscal oversight, as well as compliance to treatment regimens, for the best positive outcomes. Prior to the implementation of stringent criteria and direct patient intervention, 31.5 percent of prior authorization requests were approved. Subsequent to the implementation of stringent criteria, 10.5 percent of prior authorization requests were approved. Of the 14 members who received either Sovaldi or Olysio HCV therapy following the above new guidelines and interventions, all but two members have been fully compliant with, and successfully completed, treatment.

Attention Deficit Hyperactivity Disorder (ADHD) Pharmacy Utilization in Children

The incidence of ADHD in children continues to rise in prevalence in the U.S. Children ages 4–17 with an ADHD diagnosis by a health care provider, as reported by parents, has increased an average of 5 percent per year since 2003, according to the Centers for Disease Control and Prevention (*from Trends in the Parent-Report of Health Care Provider-Diagnosed and Medicated ADHD: United States, 2003–2011*).

ADHD in children is particularly prevalent in Louisiana. The same report shows that 13.3 percent of children in Louisiana are currently diagnosed with ADHD (as of 2011). Among all U.S. states, Louisiana ranked third highest for ADHD diagnosis in children. Louisiana ranks highest among U.S. states for diagnosed children taking medication to treat ADHD, at 10.4 percent.

To ensure that ADHD medication was being used as intended and according to usage instructions, we implemented drug-specific age limits for the treatment of ADHD in children, approved by our Southern Region P&T Committee in May 2014. The new limits imposed restrictive drug approval for certain ADHD medication to ages ≥ 3 and ≥ 6 respectively. As of the end of July 2014, 77 requests to fill ADHD medications below these age limits were returned to prescribers in our affiliate plan. Local Pharmacy and Medical Management teams contacted the prescribers to discuss and recommend non-pharmacologic treatment options. We are in the process of implementing this ADHD initiative in Louisiana.

The trend in ADHD medication usage in children between the ages of 0–6 has been positively affected. The grid below shows the reduction in the number of children utilizing these drugs between January and July 2014.

Month	Jan	Feb	Mar	Apr	May	Jun	Jul
Total Members Ages 0–6	614	611	614	572	525	426	422

Exhibit Q.5-1: Children Using ADHD Drugs

Medication Adherence for the Treatment of Hypertension, Diabetes, High Cholesterol, and Asthma

In 2013, ACLA implemented several initiatives to improve medication adherence in the treatment of four chronic conditions, as measured by drug possession ratio. Initiatives included:

- Monthly reporting on members in Integrated Care Management identified as high risk: Care managers contacted members from this report to educate the member on compliance.
- Completion of a member survey in June 2013 to solicit member concerns about medications and understand barriers to getting their prescriptions filled timely.
- Interdepartmental collaboration to initiate and implement a program to visit members at home who were at high risk and unable to be contacted.
- Member and provider education via newsletters and direct intervention including member refill reminders.
- Allowing 90-day-supply prescription refills for most medications to treat these conditions in an effort to address the barriers that members face in getting to the pharmacy to fill and refill their medication.

As a result of these interventions, we saw an increase in the number of days members adhered to their medication regimen by the percentages shown in the table below.

Drug Class	Overall Improvement in Patient Medication Adherence as measured by the change in the proportion of days covered
Antihypertensives	24.1%
Asthma Controllers	5.2%
Hypoglycemics	22.4%
Statins	25.5%
Overall	18.4%

Exhibit Q.5-2: Portion of Days Covered Rates (%) Percentage Changes 2013 vs. 2012 Baseline

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Q.6. Pharmacy

Q.6 Describe at least 2 and no more than 4 existing or proposed educational initiatives the PBM or MCO will take regarding the use of Behavioral Health Medications (including ADD/ADHD), treatment of infectious diseases, and the treatment and control of diabetes or asthma

Overview

PerformRx has demonstrated proven success with client collaboration and pharmacist integration into the disease management efforts. PerformRx's URAC-accredited Drug Therapy Management (DTM) Program is a member-centric pharmacist outreach program designed to optimize therapeutic member outcomes, and improve HEDIS scores while decreasing overall health care costs.

PerformRx builds DTM programs to fit the needs of the client's member population. For ACLA, PerformRx has developed and will implement in September 2014 a foster care DTM program that builds from successes in pyschotropic programs.

PerformRx was awarded the URAC Silver Award for Best Practices in Health Care Consumer Engagement and Protection during the 2013 Best Practices Awards Gala as part of URAC's Annual Quality Summit, held September 30–October 2, 2013 in Washington, D.C. This award recognizes the achievements of organizations that are effectively advancing the role of consumers as active participants in health care through care coordination and clinical integration best practices.

Medication Management Program on Asthma using Health® Tablet

Our PBM, PerformRx, has partnered to create an asthma medication management program designed to increase adherence and reduce overall health care costs associated with the treatment of members with asthma. This program is designed to determine the impact of the Health® Tablet system when incorporated into the ACLA program for moderate to severely persistent asthmatic patients.

The overall objective of this program is to positively impact medication adherence by incorporating this novel program into the patient medication routine.

Identification and Enrollment of Members

Members included in the program will be starting or will have started an asthma medication regimen. Members must be actively insured with ACLA and not have a coverage termination date within 180 days. Inclusion criteria will be as follows:

- Member has been diagnosed with asthma.
- Member has active eligibility at the time of selection.
- Member is aged 5 through 18 years old.

Process

ACLA will identify members for tablet delivery and training. The staff will utilize the Health® Tablet to deliver targeted educational interventions for the child's primary caregiver and other relatives. Selected members will receive a Wi-Fi and cellular capable Health® Tablet. The tablet incorporates several tools to measure and improve intervention adherence and improve general and health literacy. Tools include the following:

Patient Tools

- Daily Health Survey.
- Daily Tips.
- Biometric Tracking (Peak Flow).
- Care Plans (specific instructions for each patient).
- Medication Management Tool.
- Asthma Symptom Tracker.
- Emergency Medication Tracker.

Provider Tools

- Early warning reports that quickly identify members with potential problems.
- Medication reminders & scheduling tool allows provider to set a reminder schedule for members, which is downloaded to the patient's tablet, and to view the patient's compliance.
- Care plan writer.
- Portal to view patient survey responses and biometric tracking.

Clinic Tools

- Clinic Manager Portal that can manage access to the system for providers and members. This is an optional item that can be turned on/off for each clinic.
- National Institute of Health Literacy content adapted for eBooks. Speaks content to members in English or Spanish.
- Asthma – Tips to Control Your Asthma.
- Veterans Administration Health Literacy content adapted for eBooks. Speaks content to members in English or Spanish.
- Children's Asthma educational content. Speaks content to members in English.
- HealthEworks content adapted for eBooks. Speaks content to members in English.
- eBooks to improve literacy.

Drug Therapy Management (DTM) Program

PerformRx can build DTM programs to fit the needs of the Bayou Health population. Currently utilized DTM programs and initiatives by PerformRx clients include:

- Gaps in Care.
- Integration with case management.

- Asthma Adherence.
- Diabetes Treatment Initiative.
- Diabetes Dosing Initiative.
- Member Medication Self-Management Opportunities.
- Diabetes Polypharmacy.

ADHD Drug Therapy Management Program

ACLA is in initial steps of implementation of a program designed 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 program is designed for our members between the ages of 6 and 12 years who are newly prescribed an ADHD medication. Since implementation of this program, our South Carolina affiliate's reported 2014 HEDIS results exceeded the 50 percent benchmark, at 54.4 percent.

Successful medication therapy for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) is directly related to follow-up care. After the initial evaluation and diagnosis of ADHD, a medication recheck visit should be scheduled in two to three weeks to discuss how things are going and address any immediate problems or concerns. Additional office visits may be necessary until the member's parent and doctor feel that the child is doing well on the medication prescribed. Two additional visits should be completed in the 270 days following the medication recheck visit, if the child remains on the medication for at least 210 days. Large prescribing volumes in the plan pediatric population validate the need for additional, more proactive outreach. The 30-day window only allows a short time period to outreach to member and allow enough time for an appointment to be scheduled to meet the 30-day follow-up timeline.

Working together, our Quality and Rapid Response departments, in partnership with PerformRx, seek to improve the percentage of members who are receiving a follow-up visit with their health care provider within 30 days after initial dispensing of ADHD medication.

Members will complete an initial physician visit, in addition to completing two additional follow-up visits, in order to meet the continuation and maintenance phase of the program. As seen in South Carolina, we anticipate a positive impact to the initiation phase that will ultimately result in a similar increase in rate for the continuation and maintenance phase.

A summary ADHD clinical practice guideline has been developed and is being reviewed by our quality committees for approval and distribution to providers. Outreach will be provided to the members with new starts/ADHD prescriptions in order to facilitate the required follow-up visits with their prescriber. Members identified with special health needs will be referred to complex case management for further evaluation and follow up for 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.

Foster Care Drug Therapy Management (DTM) Program

Scope & Identification of Members

A report issued by the Government Accountability Office found that children in foster care are 4.5 times more likely to receive psychotropic drugs, and often multiple drugs, than children who remain with their families. These drugs may be prescribed by practitioners who do not specialize in the care of children, or in the treatment of depression or anxiety, and the children may have no one with the time and knowledge to watch for adverse side effects.

PerformRx's DTM program is focused on optimizing medication regimens for members enrolled in foster care. The expansion of the DTM program to other "at risk" populations will be mutually determined by PerformRx and ACLA guided by experience of this DTM program.

The following is the suggested criteria for enrollment for members in foster care with at least one of the following two conditions:

- A unique drug count of four or more in the previous 90 days.
- A behavioral health medication filled in the previous 90 days.

When members are prescribed multiple medications, the likelihood of adverse drug reactions and the risk of drug-drug interactions increases. This can result in the use of medications solely to treat the side effects from other medication combinations. Therefore, these populations have a high likelihood of having numerous medication-related problems and, subsequently, a high likelihood of benefiting from both DTM interventions and case management services.

Process

DTM interventions are identified by pharmacist review of member profiles. Interventions are documented in PerformRx's proprietary integrated drug therapy management tool, PerformPRO, as well as in ACLA's clinical care management application, ZeOmega Jiva. The path that an intervention follows from identification to completion is dependent on whether the intervention is directed to the member or the provider, as determined at the discretion of the reviewing pharmacist. Prescriber interventions are addressed directly with the prescriber by the pharmacist, while member interventions are forwarded to case management. Case managed members' legal representatives are counseled by their respective case managers, thereby leveraging existing case manager-member relationships, streamlining member contact efforts and resulting in a seamless managed care experience from the member perspective. Non-case managed members are triaged by an integrated case management supervisor to a health plan case manager, which expands the resources available to these members as they are now receiving both DTM and case management services.

At any time, a pharmacist is available to assist in the member counseling and communication. This can be conducted via a conversation between the pharmacist and case manager prior to outreach; a three-way conference call with the member's legal representative, pharmacist, and case manager; or a conversation between the pharmacist and the member's legal representative.

After no more than 20 days from the date the member intervention was identified, the pharmacist reviews case manager notes made pursuant to the member outreach. If additional outreach is needed to the provider, pharmacy, or member, the pharmacist triages those recommendations according to the established workflow. After no more than 90 days from the date the provider intervention was identified, the technician or pharmacist, depending on the nature of the outreach, follows up on the identified intervention using claims data to determine outcomes.

Outcomes

This DTM program targets the following three primary goals:

- Optimized medication regimens.
- Improved member outcomes.
- Decreased overall health plan expenditures.

On a more targeted level, improved member outcomes are evidenced by reduced frequency and severity of drug interactions and adverse reactions, improved laboratory measures, and closing gaps in care. Subsequently, improved member outcomes result in improved health plan cost savings.

ACLA Offered Pharmacy Continuing Education

ACLA has created pharmacy continuing education (CE) programs offering pharmacist education on current trends and guidelines in diabetes pharmaceutical care and management. Recognizing that continuing education is important to network pharmacists across Louisiana, ACLA partnered with PerformRx to sponsor CE programs. Our first CE program was held in April 2014 in the Shreveport area. Based on the support and attendance to this program, ACLA has expanded the program, and has initiated similar programs in Baton Rouge and Lafayette to begin in November 2014. In total, 43 pharmacists and pharmacist technicians have participated in these CE programs to date.

ACLA and PerformRx intend to present three more CE Programs in 2015, once again addressing clinical topics relevant to Louisiana that are important to our professional providers. Presently, we offer the CE program to pharmacists and pharmacy technicians only. We are actively exploring opportunities to present at least one CE program for our participating prescribing providers in 2015.

A sample course offering is included as Exhibit Q.6-1.

AmeriHealth Caritas Louisiana

ACPE

You're invited to our

"Updates in Diabetes Management"

UAN: 0133-9999-14-002-L04-P/T

AmeriHealth Caritas Louisiana invites your pharmacy staff to join us for a CEU Program, followed by a dinner and roundtable in the Baton Rouge area.

Date: Tuesday, June 17, 2014

Time: 6:00 PM to 6:15 PM – Registration and Welcome
6:15 PM to 7:15 PM - CEU Program
7:15 PM to 8:00 PM – Enjoy a Ralph & Kacoo's Dinner
8:00 PM to 8:45 PM – Roundtable with AmeriHealth Caritas Louisiana and PerformRx Pharmacy Teams
8:45 PM to 9:00 PM – Wrap-up and raffle for 8in. Android Netbook Tablet *(All attendees are eligible to enter the drawing)*

Location: Ralph & Kacoo's, 6110 Bluebonnet Blvd, Baton Rouge, LA 70809

CEU Program Presented By: Jeffery D. Evans, PharmD – Associate Professor of Pharmacy Practice at School of Pharmacy Monroe

CEU: Each attendee who participates by attending, signing in and completing the required course and paperwork will receive (1) CEU. Information on obtaining the CEU through Louisiana Pharmacists Association will be provided at end of session. This is a knowledge based activity. The Louisiana Pharmacists Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

Fee: "There are no fees associated with this program"

As dinner will be provided to all attendees and seating may be limited, so please do not forward and please RSVP by June 10th to:

Wayne Camp, R.Ph.
Email: wcamp@amerihealthcaritasla.com
Phone: (225) 300-9173
Fax: (225) 757-8629

_____ **YES,** I will attend. (*Please list names of all attendees below. Pharmacists and Pharmacy Technicians are welcome*) or _____ **NO,** we are unable to attend.

1. _____ 2. _____ 3. _____

☐ *Pharmacist* ☐ *Tech* ☐ *Pharmacist* ☐ *Tech* ☐ *Pharmacist* ☐ *Tech*

Place of Employment: _____ Contact #: _____

We look forward to seeing you there!

Sponsored by PERFORMRx

Exhibit Q.6-1: Pharmacy Continuing Education Flyer

R.1. Customer Service

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

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

Overview

Hearing and helping our members is of paramount importance to ACLA. To make every member contact count, ACLA provides industry-leading customer service any time of day or night through the enterprise's state-of-the-art Contact Center of Excellence (CCOE). Trained Customer Services Representatives staff our CCOE 24 hours per day/7 days per week/365 days per year, and thus, are always available to answer member inquiries, whether telephonic, written, or web-generated. Our technology systems afford employees immediate access to member or provider information, and our automated call distribution (ACD) system quickly routes calls throughout the organization so that any type of inquiry is addressed quickly and efficiently.

Contact Center of Excellence

ACLA has access to the ACFC state of the art CCOE. This solution enables highly effective customer interactions with efficient use of resources. Our technology allows our representatives to have access to all member information so they are able to handle every member concern, from general questions about benefits to scheduling reminders for follow up doctor appointments. The ready availability of data allows us to take advantage of opportunities to maximize the dissemination of information about important benefits and support services when we talk with a member, as well as better serve the member without having to transfer the call to different departments of the company.

The CCOE is the product of the identification and deployment of industry best-practices and strictly monitored internal practices. The CCOE distinguishes itself through the use of best-in-class technology, industry best-practices, and constant organizational improvement. Designed to manage any inbound and outbound contacts with members, the CCOE accommodates the

queuing of calls, e-mails, text messages, and web chat to maximize member contact, enhance the member's experience, and improve member satisfaction.

The Bayou Health Transparency report ranked ACLA first in customer service among all prepaid plans serving the Bayou Health programs, as measured by adult and child member satisfaction.

	AmeriHealth Caritas	Louisiana Healthcare Connections	Amerigroup
Customer Service (adult members)	87%	84%	86%
Customer Service (child members)	89%	85%	87%

Exhibit R.1-1: Bayou Health Transparency Report Customer Service Survey Results

ACFC has also made significant investment in quality monitoring capabilities. By utilizing the Verint Impact 360 Suite, the CCOE records calls while simultaneously recording the desktop screens that are accessed during the call. The analytic capabilities of the suite rapidly identify representatives with skill sets that need improvement. Since the suite is integrated with the representative's desktop, required eLearning courses can be automatically sent and scheduled for the representative to access directly.

Highlights of the CCOE's technology include:

- Avaya Aura Contact Center and Verint Impact 360 Workforce Optimization Suites. These are configured with the Critical Reliability architecture to ensure optimum performance and up time of all telephony systems and services needed to support our 24/7/365 CCOE;
- Interactive Voice Response (IVR) for self-service capabilities that include eligibility inquiry, form faxback, requests for identification cards, and provider directory requests;
- 100 percent call logging ;
- Simultaneous recording of call and desktop screen activity for quality auditing purposes
- Telephonic responses to provider claim status inquiries;
- Primary Care Physician selections based on multi-point geographic location, preferences for gender, languages spoken, and affiliations; and
- Automatic Call Distribution (ACD) System, which features:
  - Messaging that notifies callers that the call may be monitored for quality control purposes.
  - Effective management of all calls received and assignment of incoming calls to available staff using a skill set hierarchy.
  - Transfers of calls to other telephone lines or departments as necessary.
  - Detailed analysis for the reporting requirements, including the quantity, length and types of calls received; elapsed time before the calls are answered; number of calls

transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume.

- Measurement of the number of calls in the queue at all times, including peak hours; the length of time callers are on hold; the total number of calls and average calls handled per day/week/month; and the average hours of use per day.
- Assessment of the busiest times and days by number of calls.
- Messaging to inform the member to dial 911 if there is an emergency.

In addition, ACLA's telephony infrastructure has a comprehensive back-up system with full redundancy capabilities. ACLA utilizes the Avaya Single Image Switch architecture, a fully distributed IP-based phone system. This system provides feature transparency across the ACFC infrastructure and also extends Contact Center and other applications throughout the enterprise. The main Avaya Communication Manager server resides in Philadelphia, Pennsylvania and supports all ACFC locations, including our data center and all affiliates. The secondary standby server is located in a separate location to ensure continuity of service. The Avaya single image switch platform renders all sites fully capable of providing 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 the ACLA site were to lose connectivity to the main Avaya server, the local Avaya gateway(s) at the affiliate site would register to the local Avaya Communication Manager standby server. In essence this site would function as a standalone PBX and would be fully capable of servicing calls.

In the event of a shutdown of the ACLA site, full phone system functionality can be achieved by the Philadelphia corporate site or any other affiliate location. Calls would be redirected by our phone providers to such a location as to provide seamless transition of call handling during any event of impact. This functionality includes mitigating multiple emergency scenarios—including floods and hurricanes—to maintain the uninterrupted function of member services.

Training of Customer Service Representatives

Initial Training

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

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

Examples of Training Topics:

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

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

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

Ongoing Training

Our seasoned representatives strengthen their skills through our well-rounded ongoing training program. All ACLA employees, including representatives, are required to attend a series of training sessions per year to meet their individual and departmental goals. The training courses can be related to specific issues in their department or other professional and career development training. Continuous learning is also supported through feedback sessions with supervisors and our quality assurance department on a daily, weekly, and monthly basis.

Cultural training includes demographic and geographical overviews. This training is regularly conducted by Louisiana staff who have firsthand knowledge of regional nuances. Cultural training includes a Louisiana language guide that helps with pronunciation of common words unique to that region.

The following is a list of some of the training classes that representatives attended in 2013:

- Caring for Customers.
- Creative Decision Making and Problem Solving.
- Cultivating Winning Attitudes and Countering Negativity.
- Defusing Emotionally Charged Situations.
- Handling Difficult People.
- Handling Conflict with Tact & Finesse.
- Team Grammar – The Essentials of English Grammar for Business.
- Helping Your Team Work.
- Reaching for Stellar Service.
- Write Better, Quicker Clearer.

All employees are required to take annual compliance training regarding the Code of Conduct, fraud, waste and abuse, and HIPAA. Additionally, all ACLA employees are required to complete a cultural competency training program upon hire and annually thereafter.

Employees also avail themselves of courses offered online to be followed at their convenience through Anytime Learning, a self-paced, online instruction program. Illustrated in Exhibit R.1-2, Anytime Learning provides access to online reference materials and training on skills in many different areas. Modules include topics such as systems software skills, assorted business and accounting skills, and various personal/professional effectiveness skills. It is aptly named Anytime Learning because it can be accessed anytime, from any location, for all our employees, 24 hours a day, 7 days a week.

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

Customer Service
Self-paced Courses
Customer Services Representative Professionalism
Listening to your Customers
Identifying and Managing Customer Expectations
Frontline Call Center Skills
Customer Services Fundamentals
Customer Focus
Dealing with Challenging Customer Interactions: Establishing a Solid Customer Relationship (Includes Simulation)
Dealing with Challenging Customer Interactions: Overcoming Communication Issues (Includes Simulation)
Dealing with Challenging Customer Interactions: Resolving Challenging Situations (Includes Simulation)
Client Relationship Management
Self-paced Courses
Client Relationship Management 1: Managing Relationships during Initiation and Planning (Includes Simulation)
Client Relationship Management 2: Managing Relationships during Execution and Close-out (Includes Simulation)
Client Relationship Management 3: Managing Interaction-based Causes for Project Failure (Includes Simulation)
Customer Service via Phone and Email (Includes Simulation)
Customer Service: Customer Care (Includes Simulation)
Customer Service: Customer Relationship Management (Includes Simulation)
Customer Service: Increasing Sales via Service (Includes Simulation)
Customer Service: Making a Difference with Customers (Includes Simulation)
Customer Service: Positive Outcomes (Includes Simulation)
Excellence in Technical Customer Service (Includes Simulation)
Fundamentals of Customer Service

Exhibit R.1-2: Examples of Anytime Learning Courses

Routing Calls Appropriately

The CCOE uses Automated Call Distribution (ACD) technology to route calls and ensure timely response to member inquiries. Members are presented with a series of prompts that begin with the selection of the preferred language. Depending upon the option selected (member vs. provider) and agent skill set, ACD routes the call directly to either a representative or one of several internal departments as selected by the caller.

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

The CCOE management team also has access to real-time data, refreshing every three seconds, which is used to determine staffing needs in 30-minute intervals throughout the day. Accurate staff forecasting is another critical component to ensure that the appropriate number of staff are available based on the types of calls received. Call load balancing will be critical during the open enrollment period when a very high volume of calls is anticipated.

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

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

Escalated Call Process

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

- The representative will utilize all available tools to service the member or provider.
- If the representative is not able to provide the service, or if a supervisor is requested, the representative will immediately contact a supervisor.

- The supervisor will accept the member or provider call by either taking the call at the representative's desk or having the call transferred directly to the supervisor.
- The supervisor will complete the call and document the call as required.
- The supervisors are physically located alongside of the representatives for easy access.

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

Information Available to Member Services Staff

ACLA's "Online Benefits Directory" and resource materials are available for representatives. The web-based Online Benefits Directory (Online Help), pictured in Exhibit R.1-3, is a comprehensive reference guide explaining benefits and services and will serve as the primary resource to representatives for reference information.

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

These Help Files function as centralized resource tools for employees in various business units throughout our multiple locations. The Online Help Files contain line of business specific benefit and policy information, daily operational and procedural information, and key updates and important notifications. These files ensure the consistent delivery of accurate information to internal and external customers.

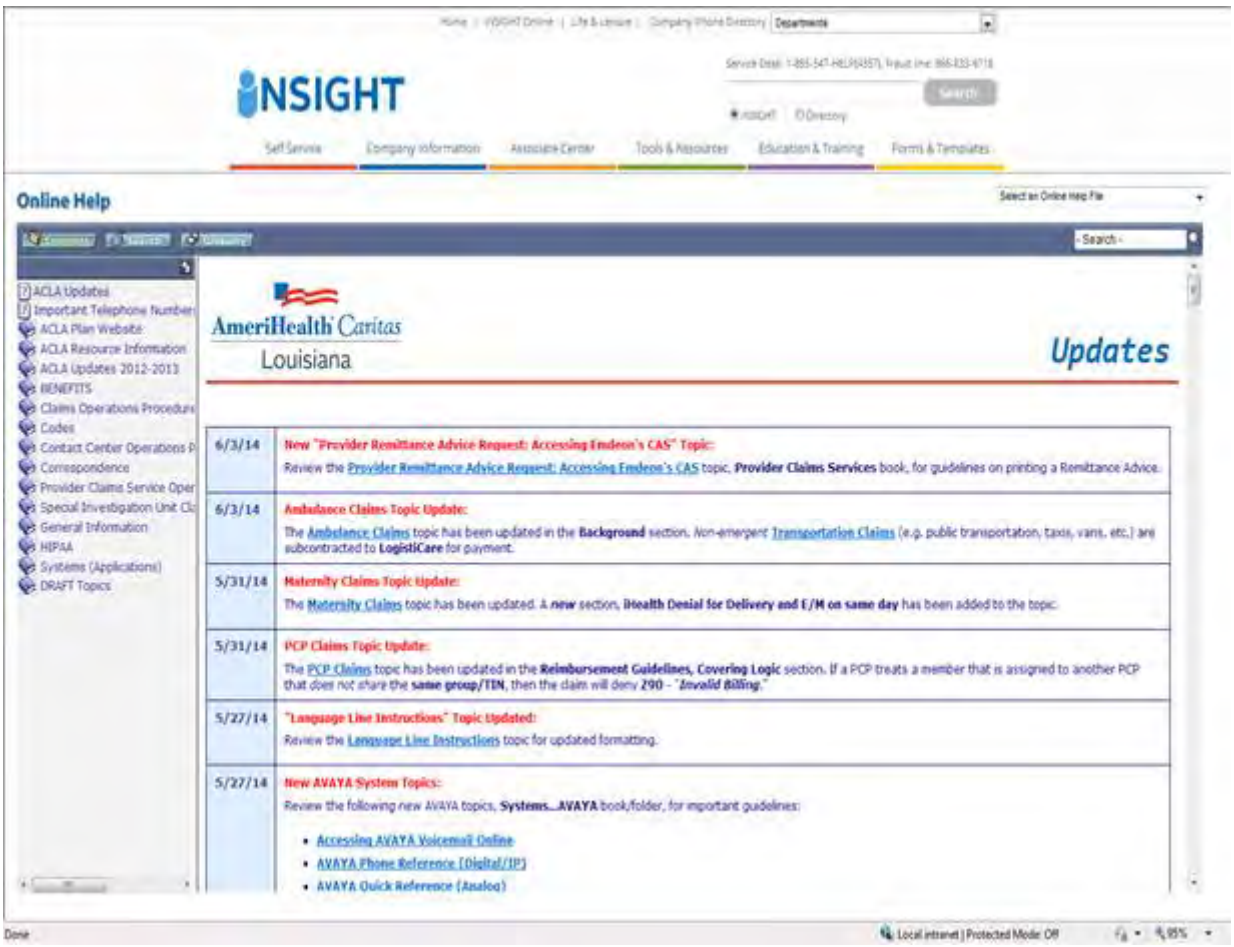

Exhibit R.1-3: Online Help Tool

Process for Handling Calls from Members with Limited English Proficiency and Persons Who Are Hearing Impaired

ACLA recognizes the importance of communicating effectively with members who have very limited English skills or who are hearing impaired. In addition to representatives communicating in English, we also provide bilingual services for Spanish and Russian in-house. To meet the needs of members in Louisiana with limited English proficiency, we employ representatives that speak Vietnamese. Additional languages are added as needs are identified.

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

The CCOE has the technology to respond to teletypewriter/telecommunication device for the deaf (TTY/TDD) calls. A desktop application is loaded on the representative's desktop, where the representative logs in to a TTY/TDD server. This allows for sharing central TTY modems over a network. When a call is received, an alert appears on the desktop to notify the representative that a call is waiting. This optimizes call-handling procedures, because the representative is equipped to handle an incoming TTY/TDD call without the need for additional equipment.

Monitoring Process for Ensuring the Quality and Accuracy of Information Provided to Members

Monitoring of representatives is necessary to assess whether there are areas of concern regarding courtesy, accuracy, consistency, and completeness. Every supervisor is required to monitor calls for representatives on a monthly basis. Each supervisor has the capability through their desk phone to listen in on calls throughout the day. This allows the supervisor to provide real-time feedback and coach representatives as needed, all while ensuring optimal attention for the member and avoiding frustration or escalation.

In addition, on a monthly basis the CCOE and ACLA executive staff complete call sample calibration monitoring. This monthly activity provides the local executive staff the opportunity to monitor a random selection of sample member calls. The calibration exercise allows the CCOE and ACLA staff to provide feedback on call quality and the accuracy of information provided by representatives, and also to inflect Louisiana background and information. This collaborative activity also provides ACLA team opportunity to hear firsthand drivers and concerns expressed by members to the CCOE. This information has been valuable to ACLA in order that programs and written material are developed with the actual needs of members considered.

Quality Assurance

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

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

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

Based on the quality scores, the supervisor will create an individual action plan for the representative. If trends are identified, the training department is engaged to provide refresher training. Quality grades are part of the customer service representative's monthly feedback as well as their annual appraisal. The supervisor meets with every representative at least three times a month or as needed to review their quality scores and address any issues. ACLA will submit member services quality criteria and protocols to DHH for review and approval annually.

Quality is also checked and assured through surveys conducted with members by a third-party. These random-sample surveys capture the topic discussed on the call, the member's level of satisfaction with the results of the call, and any additional comments the member gives. Our recent survey ran from January through early September 2014 and involved a sample size of 353 callers. Of the members surveyed, 88 percent reported that their call was resolved, and 82 percent expressed being very satisfied with the CCOE representative. We also saw a high percentage (73 percent) of World Class Calls. These calls result in members being very satisfied with their CCOE experience, the representative who handled their call, and the way in which their call was resolved. Some comments offered by Louisiana members in this survey are included below.

Call Topic: Member Inquiry
Rated: Very Satisfied
Member Feedback: "It was something that was medically necessary for my husband and I could not find anything on my own. So I called them and they looked it up, they gave me the proper information, and after being done with them I made one phone call to one of the companies and that was it. Everything was handled and settled and the person was very polite, very helpful."

Call Topic: Provider Search
Rated: Very Satisfied
Member Feedback: "He helped me in an area that I needed and the things that I was asking him. He went straight to the point and pulled up everything that I needed with my benefits, and he gave me the contact numbers and the people to talk to for copays and all of that. So, I'm very satisfied with the work that he did.

Call Topic: Member Inquiry
Rated: Very Satisfied
Member Feedback: "I didn't have to put forth any effort for her to take care of the situation. She asked questions to associate all the information she needed to take care of the situation that I was calling about. And I didn't feel like I was being pacified."

Call Topic: Provider Search
Rated: Very Satisfied
Member Feedback: "She was very nice, very polite."

Monitoring Process for Ensuring Adherence to Performance Standards

The CCOE Management team has an extensive list of real-time and historical reports that are used to manage performance. The Avaya system comes with the suite of standard reports as well as customizable reports that will allow ACFC to monitor specifically defined performance requirements, such as those dictated in the Bayou Health MCO RFP Section 12.16.14. As needed, reports are modified based on the specific service level expectations for Louisiana. Alert thresholds will be set to ensure performance expectations are achieved. Multiple processes and systems are used to manage performance:

Workforce Management

Performance management begins with the appropriate forecasting and staffing to meet the expected call volumes. The CCOE has a sophisticated staffing model that utilizes the following assumptions to determine general staffing needs: Calls per 1,000 members; membership; total average handle time goals; Off the Phone Time (OPT); shrinkage rate; average hold time; and days per month. In addition, we utilize Pipkins technology to determine hourly and daily staff needs according to historical information and service goals. This data is critical to allow for quick staffing adjustments to meet call standards during high call volume. We benefit from our service center being located in multiple geographic locations. As a result, we are able to leverage additional staff in other geographical areas to address unexpected increases in call volume resulting from emergency situations, as well as unexpected staffing deficiencies. Further, we partner with a third-party vendor who has the ability to ramp up quickly to address new business, new initiatives, and unexpected increases in membership.

Additionally, in the event of unexpected increases in call volume that may result from emergency situations, we are able to leverage resources from our affiliate locations so that members can continue to reach us in accordance with established access standards.

Performance Monitoring

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

- Individual Goals.
  - Real-time adherence.
  - Total average handle time.
  - Average hold time.
  - Off-the-phone time.
- Department Goals.
  - Answer 95 percent of calls within 30 seconds or an automatic call pickup system.
  - No more than one percent of incoming calls receive a busy signal.
  - Maintain an average hold time of three minutes or less.
  - Maintain abandoned rate of calls of not more than five percent.

The metrics yielded from this monitoring process are favorable. Statistics for year-to-date performance for the CCOE show an average speed of answer for ACLA member calls of 9 seconds and an average abandon rate for ACLA member-related calls of 1.3 percent. Independent auditors have assessed calls to Member Services at a year-to-date score of 98.4 percent for quality and accuracy. This performance demonstrates our success in meeting our goals and outperforming state requirements.

Our processes, technology, and experience give us the ability and agility to meet and exceed all contractual service level goals, as is evidenced by our performance chart included in R.2. Member Hotline Reports of this proposal. These processes allow us to identify and quickly correct service performance issues using intraday performance reports (30-minute interval). For example, when call volume exceeds the forecast and available staff capacity, overflow calls are routed to additional member services centers.

Daily, Weekly, and Monthly Historical Reports

Historical reporting is used to help forecast and track call trends as well as monitor the performance of staff. A sample Daily Summary Report is included as Exhibit R.1-4.

Split/Skill Summary Interval - LaCare MS English

Report Edit Format Tools Options Help

Date: **7/17/2014**

Split/Skill: **LaCare MS English**

Time	Avg Speed Ans	Avg Aban Time	ACD Calls	Avg ACD Time	Avg ACW Time	Aban Calls	Max Delay	Flow In	Flow Out	Extn Out Calls	Avg Extn Out Time	Dequeued Calls	Avg Time to Dequeue	% ACD Time	% Ans Calls	Avg Pos Staff	Calls Per Pos
Totals	**:08**	**:00**	**252**	**5:36**	**:56**	**1**	**1:56**	**1**	**1**	**50**	**1:10**	**0**		**3.38**	**99.21**	**33.8**	**7**
4:00 - 4:30AM			0			0	:00	0	0	0		0		.00		8.0	0
4:30 - 5:00AM			0			0	:00	0	0	0		0		.00		8.0	0
5:00 - 5:30AM			0			0	:00	0	0	0		0		.00		8.0	0
5:30 - 6:00AM			0			0	:00	0	0	0		0		.00		8.0	0
6:00 - 6:30AM			0			0	:00	0	0	0		0		.00		8.0	0
6:30 - 7:00AM			0			0	:00	0	0	0		0		.00		8.0	0
7:00 - 7:30AM			0			0	:00	0	0	0		0		.00		8.0	0
7:30 - 8:00AM			0			0	:00	0	0	0		0		.00		8.0	0
8:00 - 8:30AM	:05		2	4:46	1:41	0	:05	0	0	0		0		2.91	100.00	20.4	0
8:30 - 9:00AM	:05		2	6:09	1:22	0	:05	0	0	0		0		1.21	100.00	35.5	0
9:00 - 9:30AM	:09		8	3:28	:27	0	:17	0	0	3	1:16	0		2.77	100.00	54.8	0
9:30 - 10:00AM	:07		9	4:35	:54	0	:20	0	0	2	2:24	0		1.60	100.00	68.9	0
10:00 - 10:30AM	:05		7	4:23	:59	0	:06	0	0	1	2:07	0		2.66	100.00	71.0	0
10:30 - 11:00AM	:07		16	5:00	:37	0	:15	0	0	3	:59	0		4.25	100.00	78.0	0
11:00 - 11:30AM	:07		14	8:08	:26	0	:17	0	0	4	1:15	0		4.26	100.00	79.8	0
11:30 - 12:00PM	:07		16	3:43	:46	0	:23	0	0	6	1:42	0		2.92	100.00	80.0	0
12:00 - 12:30PM	:06		21	4:39	:51	0	:17	0	0	5	:43	0		4.40	100.00	80.8	0
12:30 - 1:00PM	:09		10	4:58	:40	0	:19	0	0	1	:50	0		3.23	100.00	81.0	0
1:00 - 1:30PM	:06		13	6:36	1:07	0	:10	0	0	3	2:33	0		3.20	100.00	81.0	0
1:30 - 2:00PM	:05		5	4:13	:54	0	:06	0	0	1	1:16	0		2.05	100.00	80.5	0
2:00 - 2:30PM	:07		17	5:03	:51	0	:12	0	0	2	1:03	0		4.62	100.00	80.0	0
2:30 - 3:00PM	:09		16	7:33	1:10	0	:32	0	0	3	:05	0		5.71	100.00	80.0	0
3:00 - 3:30PM	:11		21	6:00	1:48	0	:59	1	1	5	1:14	0		6.03	95.45	80.0	0
3:30 - 4:00PM	:06		12	7:25	1:09	0	:11	0	0	2	:43	0		4.10	100.00	80.0	0
4:00 - 4:30PM	:06		11	4:44	:35	0	:11	0	0	0		0		3.86	100.00	79.0	0
4:30 - 5:00PM	:08		14	6:22	:56	0	:21	0	0	2	1:18	0		4.01	100.00	65.4	0
5:00 - 5:30PM	:07	:00	8	6:22	:50	1	:12	0	0	2	:50	0		4.07	88.89	52.1	0
5:30 - 6:00PM	:06		14	6:15	1:20	0	:12	0	0	3	:31	0		8.47	100.00	33.8	0
6:00 - 6:30PM	:09		8	5:00	:04	0	:17	0	0	2	:03	0		9.85	100.00	18.7	0
6:30 - 7:00PM	:12		3	7:12	2:12	0	:14	0	0	0		0		2.64	100.00	15.4	0
7:00 - 7:30PM	:41		3	4:15	:48	0	1:56	0	0	0		0		3.74	100.00	14.5	0
7:30 - 8:00PM	:05		2	2:16	:08	0	:05	0	0	0		0		1.03	100.00	12.0	0
8:00 - 8:30PM			0			0	:00	0	0	0		0		.00		12.6	0
8:30 - 9:00PM			0			0	:00	0	0	0		0		.00		12.0	0
9:00 - 9:30PM			0			0	:00	0	0	0		0		.00		9.5	0
9:30 - 10:00PM			0			0	:00	0	0	0		0		.00		9.2	0
10:00 - 10:30PM			0			0	:00	0	0	0		0		.00		4.8	0
10:30 - 11:00PM			0			0	:00	0	0	0		0		.00		5.0	0
11:00 - 11:30PM			0			0	:00	0	0	0		0		.00		2.1	0
11:30 - 12:00AM			0			0	:00	0	0	0		0		.00		5.0	0

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Exhibit R.1-4: Avaya Daily Summary Report

Interacting with Other Customer Service Lines Maintained by Community Organizations

ACLA maintains the telephone numbers for critical state, parish, or city organizations under the "Important Telephone Number" section in the Online Benefits Directory. Some of these organizations include Partners for Healthy Babies, WIC, Protective Services, and Safe Kids Louisiana, as well as organizations providing utility assistance, housing assistance, and homeless shelters. We work with state, parish, and city agencies to incorporate the information specific to their programs into our training program. If a member needs assistance in accessing other services during a call, the representative performs a warm transfer to the specific agency to help advocate for the member. For example, if we are talking with a member who needs information about programs to prevent domestic violence, we can transfer them to the appropriate agency and/or our Rapid Response team. Rapid Response, our dedicated unit of staff trained in how to access social services in a particular region, will be engaged to provide in-depth assistance to the member. For example, the Rapid Response team has helped members access utility assistance programs, housing assistance, community support agencies, and crisis hotlines. Notably, ACLA collaborated with community support agencies effectively when Hurricane Isaac hit Louisiana in 2012: ACLA's service center was open 24/7 to help members find shelter, assist them in finding providers that were still operational, and help answer questions related to out-of-state care.

ACLA recognizes the importance of integrating medical and social services to address all of the needs of its members. It is our goal to continue working with DHH to provide truly integrated

care. ACLA intends to integrate critical social and community support data and information into the system to enable interfaces with community systems to truly make each member contact count. Indeed, when a member calls, the representative would receive a screen alert that includes all of the member's key information, care gaps, health initiatives, and even services offered by local agencies. This type of system integration would greatly enhance the customer experience as well as provide critical information to impact the member's health outcomes and quality of life. For example, a contact with a member would not only prompt them to choose a PCP, but might also inform them of other services and supports for which they may be eligible or which are available in their local community.

After-Hours Procedures

Being able to reach a live representative after hours can effect better results than those achieved when these calls are handled by an answering service. Members receive better access to care and services, enhanced coordination between behavioral and physical health, and better coordination with the Nurse 24/7 Hotline. Ultimately, this leads to higher member satisfaction. Accordingly, we exceed state requirements by offering a CCOE that is staffed 24 hours a day/7 days a week/365 days a year.

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

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R.2. Customer Service

R.2 Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2014 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the abandonment rate. Affiliates should be included when determining the largest contract.

Overview

Ensuring access to health care includes providing the means for members to contact us for answers to questions and resolution of issues. ACLA benefits from the years of experience and state-of-the-art technology deployed in the ACFC CCOE. We monitor call volume and trends to make every contact count.

Understanding the drivers and having a system with the flexibility to scale up or down to meet capacity is critical. Identifying and managing call trends are key to meeting the expected service levels. To perform trend analysis, it is necessary to understand the following drivers:

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

Accordingly, we conduct ongoing quality assurance to measure performance. We have exceeded performance expectations in our CCOE by having:

- State of the art workforce management tool in Verint.
- Real-time reporting, which is used to shift resources.
- Online self-services capabilities.
- Individual performance goals that drive departmental performance.
- Experienced management team.

Hotline Telephone Reports

Exhibit R.2-1 shows our Member Services contact center performance for the ACLA plan, which currently serves more than 140,000 Medicaid members in Louisiana. The trend of number of calls received is consistent with our historical experience. Our Average Speed of Answer is consistently less than 15 seconds, and our Abandon Rate at its highest was only 2 percent, well below the DHH-mandated threshold of 5 percent.

	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014
Total Calls	10,034	9,000	8,515	9,636	8,733	8,771	9,227	6,912	7,438	7,655	6,797	7,120
Average Speed of Answer	0:14	0:11	0:13	0:09	0:10	0:11	0:14	0:11	0:10	0:09	0:09	0:10
Abandon Rate	2%	1%	1%	1%	1%	1%	2%	1%	1%	1%	1%	1%
Total Average Handle Time	8:18	8:29	7:29	7:01	7:08	6:50	7:18	7:41	9:40	10:14	8:48	8:24
Call Accuracy Rate	99.3%	98.7%	98.6%	98.6%	99.0%	98.5%	99.3%	98.4%	98.2%	98.9%	97.7%	96.4%

Exhibit R.2-1: CCOE Performance (ACLA)

R.3. Customer Service

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

- *A member has received a bill for payment of covered services from a network provider or out-of-network provider;*
- *A member is unable to reach her PCP after normal business hours;*
- *A Member is having difficulty scheduling an appointment/finding a specialist.*
- *How do you explain to a member why a particular prescription is not covered?*

Overview

Our CCOE is staffed with Member Services representatives trained in how to answer questions, direct members to services, and resolve issues. Responsive customer service is available any time of day or night through associates trained in handling inquiries in a timely, professional, and culturally competent manner. Our Member Services representatives are equipped with thorough training and supported by technology systems that allow easy navigation to information. Each scenario presented would be handled as described below.

Receiving a Bill for Payment of Covered Services

If a member receives a bill, we have specially trained representatives who can help members specifically with billing issues. The representative will reach out to the provider to resolve the payment issue. All billing issues are tracked and trended via internal routing systems which CCOE representatives can access. All ACLA Member & Provider Services CCOE staff report through the same management team and can easily coordinate research efforts. If a trend is identified, the Provider Network Management (PNM) department is notified, and they conduct further provider education regarding appropriate billing processes. Provider education generally prevents recurrence of the issue.

The Member Services representative will also contact the Billing Agency or the Collections Department on behalf of the member and will follow up with the member to inform them of the outcome. If the representative is not able to resolve the billing issue, the member will be instructed of their rights to file a formal complaint or grievance.

Inability to Reach PCP After-Hours

Members can get assistance reaching their PCP by calling the CCOE any time of the day and any day of the week. In this scenario, the representative will immediately call the PCP to ascertain whether there is a recorded message on the line with instructions or an answering service responsible for calls received after normal business hours.

Members with non-emergent issues will be referred to the Nurse Hotline for advice and symptom counseling if their PCP could not be immediately reached after hours. Urgent care

centers are an option presented to members when PCPs are not available. Members with emergent medical needs are instructed to hang up and immediately dial 911 or to go to the nearest emergency room for services.

The representative will document the contact and inform PNM of the situation. PNM will reach out to the PCP to educate them on contractual requirements for physician coverage after normal business hours. Provider access monitoring, standards, and follow up processes would be followed. The member will also be notified of her right to file a formal complaint or grievance.

Difficulty Scheduling an Appointment or Finding a Specialist

The representative will guide the member through the available specialists, according to the member's preference for location, language spoken, office hours, gender, certification, and hospital or practice affiliation. Upon the member's selection of a specialist, the representative will contact the specialist on behalf of the member to assist with appointment scheduling. We often use three-way calling, so that the representative can help to advocate for the member during the call. If necessary, the representative will educate the specialist on contractual requirements for appointment scheduling time frames. ACLA has written policies and procedures for educating providers about appointment time requirements. Appointment standards are included in the Provider Manual and the provider contract. If the specialist fails to adhere to those policies and procedures, the member will be notified of their right to file a formal complaint or grievance, and the representative will help the member select an alternate specialist. The representative will send a communication to the PNM department to follow up with the specialist. If needed, the PNM representative will work with the specialist to develop a corrective action plan.

Prescription Coverage Concerns

Members who have questions about their prescription can contact Member Services for more information from our trained representatives. For questions regarding the formulary, the representative will discuss with the member the formulary drug list, step therapy, and the prior authorization process to obtain non-covered medications. In most cases when a particular medication is not covered, the formulary includes an appropriate alternative medication. The representative will share this information with the member and then direct the member to their physician to seek guidance in considering the alternative medications. With the member's input, the physician can choose an alternative that is in the formulary list. If no appropriate alternative can be identified, or if the member has already tried the alternative medications, the physician can submit a prior authorization requesting the medication. Any medication can be covered if the prior authorization process deems it life sustaining. If the prescription is not covered for reasons unrelated to formulary, the representative will transfer the member to our pharmacy benefit manager call center for a detailed explanation. The member will also be notified of her right to file a formal complaint or grievance.

AmeriHealth Caritas Louisiana

S.1. Member Grievances and Appeals

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

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

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

Overview

AmeriHealth Caritas Louisiana's (ACLA's) Grievance and Appeals (G&A) System is based on proven and rigorous processes utilized by other AmeriHealth Caritas Family of Companies (ACFC) lines of business. ACLA's procedures are customized to meet Louisiana requirements. ACLA has a system in place that includes a grievance process, an appeals process, and access to the State Fair Hearing system, once the internal appeals process has been exhausted. The G&A System quickly and successfully resolves member issues.

Employees handling reviews of any grievances or appeals are extensively trained, to ensure that necessary care is not hindered or interrupted as a result of the process. We also ensure that members fully understand the process every step of the way—regardless of primary language or any other possible communication barriers. Through our continuous review of data and trends, we strive to improve our program. Since the implementation of Bayou Health, ACLA has been party to only one State Fair Hearing, in which our initial decision was upheld. This is evidence of our practice of approving medically necessary services and resolving appeals in a timely and fair manner.

ACLA's G&A System is easily accessible to all members regardless of primary language or other potential barriers. We support ease of access through:

- Member information and education about the G&A System that is easily understood, and that accommodates language or other communication barriers.
- Member assistance with each step of the process when requested.
- Clear and timely communication to members, families, or providers, as applicable, of notifications, decisions, enrollee options, and timeframes throughout the process.
- Continuation of benefits during appeal process.
- Expedited grievance processes when necessary to avoid jeopardizing the member's life or health or ability to attain, maintain, or regain maximum function.
- Improving performance through data gathering.

Chart C-Grievance and Appeal Flow Chart

We have attached a flowchart below (Chart C) indicating the ease in which members or their representatives can access ACLA's G&A System.

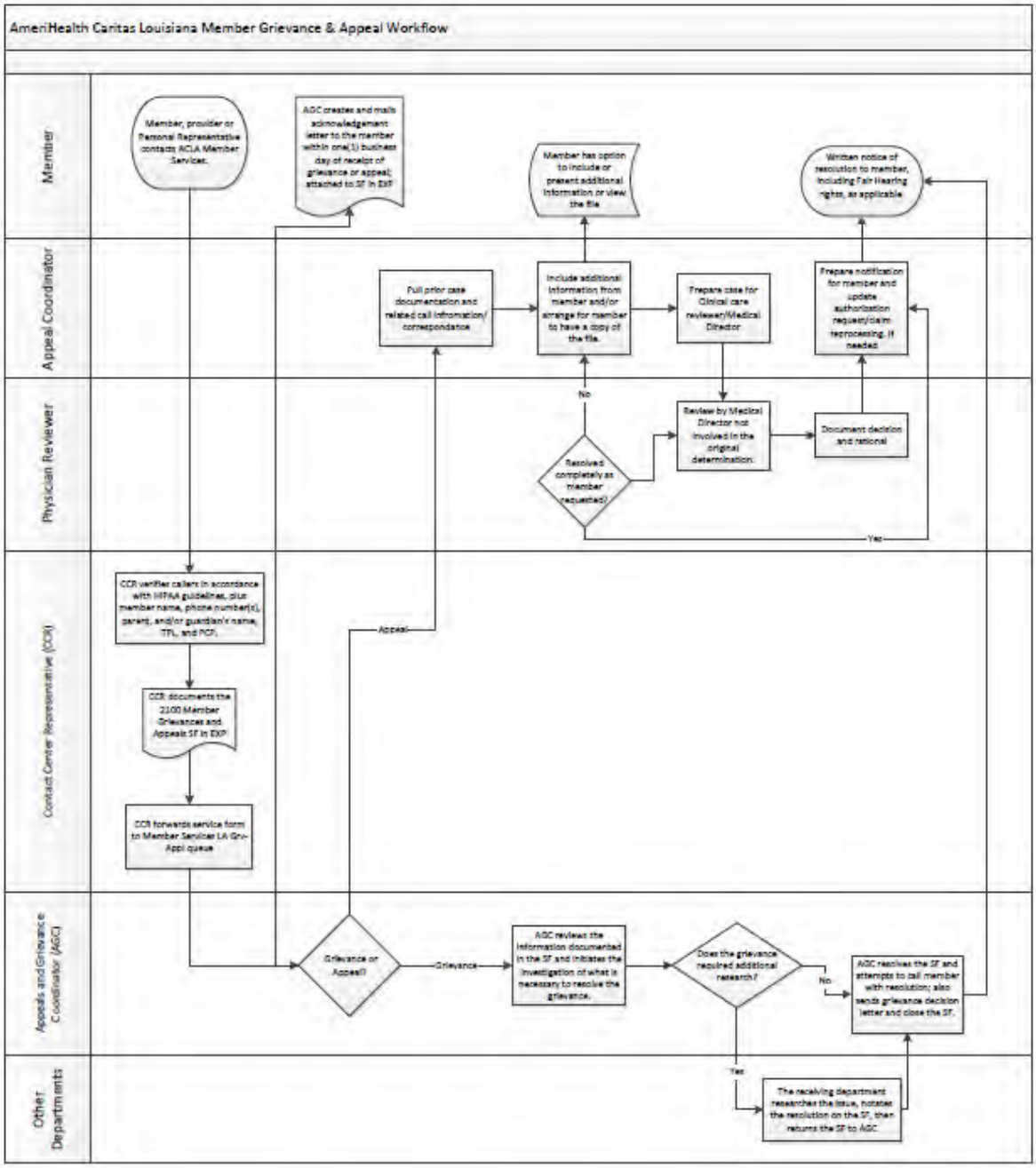

Chart C: Grievance and Appeal Workflow

Grievance and Appeals Process

ACLA's G&A processes ensure that members have access to full and fair filing processes and that they receive ample help from employees through every step of any grievance or appeal. The G&A System complies with all applicable state and federal laws and regulations. All policies and procedures relating to the G&A System are in writing and approved by DHH. Member materials related to filing grievance and appeals with ACLA are available in members' primary languages.

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

During ACLA's current contract with DHH, the average resolution time was 18.16 days for member grievances and 10.99 days for member appeals. The average turnaround times demonstrate ACLA's commitment to resolving member grievances and appeals as expeditiously as possible.

Definitions

ACLA's G&A system operates using the following definitions:

Appeal

An Appeal is a request for a review of an action.

Grievance

A Grievance is an expression of member/provider dissatisfaction about any matter other than an action, as action is defined. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee, and network administration practices.

Administrative Grievance

Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

Action

An Action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service;

the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner.

Member Information and Education

Members may file a grievance or appeal either orally or in writing, including by phone or mail. Network providers may act on behalf of the member's behalf with the member's written consent. ACLA maintains a toll-free number for members who want to access the G&A system. Members may use any form to submit the grievance or appeal in writing. However, ACLA also has forms they may use to file grievances and appeals.

ACLA informs members plainly and clearly and through various means of their rights to file, as well as how to file grievances, appeals, and State Fair Hearings. Information on how to access the G&A system may be found in the Member Handbook, on the ACLA website, and in each Notice of Action letter. The Member Handbook, which is provided in English, Spanish, and Vietnamese, includes information on how to file a grievance or appeal and how to reach an ACLA associate to assist with the process. Assistance includes, but is not limited to, interpreter services, toll-free calling, and teletypewriter/telecommunication device for the deaf/ (TTY/TDD) capability.

Information on the appeal process is also included in ACLA's Notice of Action, which is mailed to members and providers following any determination to deny or limit authorization of a requested service; reduce, suspend, or terminate a previously authorized service; or deny in whole or in part payment for a service.

Assistance with the Grievance and Appeals Process

Members filing grievances and appeals will receive all available assistance from our employees, and those employees who make decisions on the matters will not have had any involvement in any previous adverse decision affecting the member. As needed, ACLA's staff will help members complete and file their grievances and appeals, including providing interpreter services and materials in alternative media, as indicated by member need.

ACLA provides assistance to the member with completing forms and following the procedures for filing a grievance or appeal or requesting a State Fair Hearing. This includes, but is not limited to, interpreter services, toll-free calling, and teletypewriter/telecommunication device for the deaf (TTY/TDD) capability.

Oral requests will be committed to writing and provided to the member and authorized member representative within 10 days (unless an expedited appeal is required) for signature through an acknowledgement letter. The signature may be obtained at any time during the appeal process. The process will not be delayed if the signature of the member or their representative is not received.

In addition, members and/or their representatives will be given the opportunity, both before and during the appeals process, to examine the member's case file for documents and records

that need to be considered during the appeals process. These documents would include, but would not be limited to, the member's medical records.

Eliminating Language Barriers

ACLA provides foreign language interpreter services, including toll-free telephone numbers with interpreter capabilities, at no cost to members who are identified as having Limited English Proficiency. Translated materials in the member's preferred language are also offered to these members. ACLA also provides services and materials translated in alternative media to members with low literacy proficiency and/or sensory impairments.

Grievances and appeals from individuals with disabilities are also accepted by ACLA in alternative formats, including TTY/TDD for telephone inquiries and appeals and grievances from members who are hearing impaired, Braille, audio tape, computer disk, and other commonly accepted alternative forms of communication.

ACLA proactively attempts to anticipate the special needs of any member accessing the G&A System by identifying any speech limitations or disabilities of the requesting member from the information stored in the electronic member file and gathered from state eligibility data, prior disclosure by the member, or the documented historical use of TTY/TDD features.

ACLA helps members file their grievances and appeals, and if they have language issues, ACLA will provide foreign language interpreter services at no cost. Translated materials in the member's preferred language are offered to members who are identified as having Limited English Proficiency. ACLA also provides services and materials translated in alternative mediums to members with low literacy proficiency and/or sensory impairments.

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

To promote understanding of written materials, ACLA maintains information on the member's preferred language as part of our member demographic data set. For members where a language other than English is identified as the preferred language, written notices and materials related to the grievance and appeal process are translated into the member's preferred language. ACLA also provides services and materials translated in alternative mediums for members with sensory impairments.

Appropriate Expertise and Impartiality

ACLA'S G&A policies and processes require that, for both grievances and appeals, an employee be appointed who was not involved in the prior adverse decision and is not a subordinate of the person who made the prior adverse decision. As with initial utilization management decisions involving medical necessity or clinical issues, a physician or other appropriate clinical peer must evaluate medical necessity decisions for adverse appeal decisions. For appeals involving

specialty care, input to the appeal determination will be obtained from a clinician in the same or similar specialty as the care being requested.

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

Grievance and Appeal Processes

ACLA recognizes the importance of a G&A System that is easy to use and responsive to the needs and concerns of members and providers. We use the following processes to ensure that members and families can easily access the G&A System and to ensure they are aware of their rights and responsibilities to use the complaint and/or grievance process.

Member Grievances

The grievance system provides a full and fair process for promptly resolving member disputes and responding to their requests to reconsider a decision they find unacceptable regarding their care and service. As outlined above, ACLA refers all members who are dissatisfied with ACLA or any of its providers or subcontractors in any respect to the designated Grievance and Appeal Coordinator (GAC), who is authorized to review and respond to grievances and appeals. The GAC acknowledges all grievances in writing within one business day of receipt. The GAC coordinates resolution of the member grievance with other departmental stakeholders and sends a resolution letter to the member within 90 days of receipt of the grievance.

Expedited Process

Expedited appeal reviews may be requested verbally or in writing by the member or the member's authorized representative or provider acting on behalf of the member if they believe the member's life, health, or ability to attain, maintain, or regain maximum function would be in jeopardy by following the standard process. No additional member follow-up is required. If the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the request will automatically be handled as an expedited review. ACLA ensures that no punitive action is taken against a provider who requests or supports a request for an expedited appeal.

Members and their authorized representatives are advised of their right to provide written comments, documents, or other information relating to their appeal. Upon receipt of a request for appeal, ACLA will provide written documentation acknowledging receipt of appeal to the appeal requestor and member. Acknowledgment of appeal request is forwarded within 24 hours of receipt. ACLA reviews the appeal request to verify all necessary/pertinent documentation is available, and informs the member of the limited time available for the

member to present evidence and allegations of fact or law, in person, and in writing, when filing an expedited appeal.

ACLA completes all expedited appeals as expeditiously as the member's health condition requires but not more than 72 hours after the request. ACLA provides a verbal resolution notice for expedited requests, which is followed by written notification of the determination.

State Fair Hearing

A member, or authorized representative acting on the member's behalf, may file a State Fair Hearing request with Louisiana's Division of Administrative Law, once ACLA's internal appeals process has been exhausted. If a member requests a State Fair Hearing, parties to the hearing will include ACLA and the member or the member's authorized representative. ACLA will continue the member's benefits during the appeal and State Fair Hearing process if the request meets the requirements outlined below.

Continuation of Benefits

ACLA continues the member's benefits if:

- The member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely (within the latter of 10 days of the mailing of the notice of action or the intended effective date of the proposed action);
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The member requests an extension of benefits.

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

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

Written Notice

Notice of Action

ACLA mails a written Notice of Action to members within the following timeframes:

- For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action, except the period of advance notice is

shortened to 5 days if probable member form fraud has been verified or by the date of action for the following:
  - the death of a member;
  - a signed written member statement requesting service termination or giving information requiring termination or reduction of services (where the member understands that this must be the result of supplying that information);
  - the member's admission to an institution where they are eligible for further services;
  - the member's address is unknown and there is no forwarding address;
  - the member has been accepted for Medicaid services by another local jurisdiction;
  - the member's physician prescribes the change in the level of medical care; or
  - as otherwise permitted under 42 CFR §431.213.
- For denial of payment, at the time of any action affecting the claim.
- If ACLA extends the timeframe in accordance with termination, suspension, reduction, or denial of payments, we will:
  - Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and
  - Issue and carry out the determination as expeditiously as the member's health condition requires and not later than the date the extension expires.
- For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within 14 calendar days following receipt of the request for service. There may be a possible extension of up to fourteen 14 additional calendar days if:
  - The member, or the provider acting on behalf of the member and with the member's written consent, requests extension; or
  - ACLA justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

Notice will also be given on the date that this timeframe expires.

Notice of Appeal

ACLA also provides written notice of disposition for all appeals, including expedited appeals. The Notice of Appeal includes the following:

- The results of the resolution process and the date completed.
- For an appeal not resolved wholly in favor of the member:
  - The right to request a State Fair Hearing within 30 days of receipt of the final determination and how to file the request with Louisiana's Division of Administrative Law;
  - The right to request benefits while the hearing is pending, and how to make the request; and

  - An explanation of the circumstances under which the member may be held liable for the cost of those benefits if the hearing decision upholds ACLA's Action.
- A reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal determination was based, as well as notification that the member, upon request and free of charge, may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the appeal determination was based.
- Notification that the member is entitled to receive upon request and free of charge, reasonable access to and copies of all documents relevant to the appeal.

Timeframes

ACLA adheres to the following timeframes for responding to grievances and appeals:

- Filing: The member is allowed at least 30 calendar days from the date of notice on the action or inaction to file a grievance or appeal.
- Grievances; Standard disposition of grievances and notice to the affected parties are done no later than 90 days from the date of receipt of the grievance.
- Appeals: Standard resolution of an appeal and notice to the affected parties are done no later than 30 calendar days from the day of receipt of the appeal.
- Expedited Appeals: Expedited resolution of an appeal and written notice to the affected parties occurs within 72 hours of ACLA receiving the appeal, or as expeditiously as the member's health condition requires. ACLA will also make reasonable efforts to provide oral notice of the resolution to the member.
- Extensions: Extensions may be provided for filing of grievances, appeals, and expedited appeals up to 14 calendar days if the member requests the extension or ACLA shows to the satisfaction of the DHH, upon its request, that there is need for additional information and how the delay is in the member's best interest. If ACLA extends the timeframe without the member's request, ACLA will provide the member with written notice of the reason for delay and the right to file a grievance if the member disagrees with that decision. In the event of an extension, ACLA will carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

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

Records and Reports

ACLA maintains records of all grievances and appeals. A copy of grievances logs and records of disposition of appeals are retained for six years, or for a longer period if required for matters

involving litigation, claim negotiation, audit, or other actions involving the applicable documents. ACLA electronically provides DHH with a monthly grievances and appeals report in accordance with the requirements outlined in the Bayou Health MCO RFP. The report includes, but is not limited to, members' names and Medicaid numbers, summaries of grievances and appeals, filing dates, current status, and resolutions and resulting corrective actions. ACLA is responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the member.

The G&A process incorporates input from the locally-based Provider Network Management staff and Provider Claims Educator to facilitate the exchange of information between the G&A system and the provider community.

All providers and contractors are provided the information required by 42 CFR 438.10(g)(1) about the G&A System at the time they enter into a contract with ACLA.

Improving Performance through Data Gathering

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

Once grievance and appeals data is gathered, recommendations for improvements in operational performance will be made to the Quality Committee as part of the Quality Management Program Evaluation. The Member Appeals Committee also monitors the data for timeliness, identification of trends and root causes, and recommendation of actions or corrective action plans.

The information we receive assists us in improving our performance. For example, during ACLA's current contract term, the Member Appeals Committee identified an appeal trend regarding wearable cardiac defibrillators. In response, ACLA revised its prior authorization policy surrounding wearable cardiac defibrillators and worked with DHH to have the appropriate code added to the Medicaid fee schedule. ACLA uses grievance and appeal data to evaluate operational performance and propose improvements where needed. Through the monitoring of appeal and dispute data, as well as member/provider communication, ACLA identified services that were incorrectly configured to require prior authorization. Once edits were overridden and claims were correctly processed, the service configuration was corrected to ensure claims were processed without the prior authorization requirement. The analysis and review process allows ACLA to ensure that the correct information is given to the member and/or provider, and claims are paid without delay. Monitoring the appeal and dispute data allows ACLA to better analyze the process and prior authorization expectations to better serve member and providers.

T.1. Marketing and Member Materials

T.1 Describe proposed content for your member educational and marketing materials and attach examples used with Medicaid or CHIP populations in other states. Describe innovative ways that you have engaged in member education.

Describe how you will provide equitable marketing throughout the state. Provide examples or descriptions of how your member education and marketing materials will be used to improve service coordination including:

- *The coordination of carved out and behavioral health services.*
- *Supporting MCO efforts toward EPSDT compliance, appropriate ED utilization, STI education, encouraging the use of prenatal services and prematurity prevention*
- *The use of technological tools, including social media and mobile technology, to engage members.*
- *Partnering with community-based organizations for education and outreach.*

Overview

ACLA is dedicated to reaching out to Medicaid members with information that educates and empowers them as active participants in their health. Our educational and member materials are developed following a process designed to meet cultural competency and literacy requirements. Written materials do not exceed a 6.9 grade reading level and meet style and quality requirements.

ACLA strives to improve health outcomes by empowering and educating our members and potential members to make healthy choices and living a healthier lifestyle for the well-being of self and their family. We use many points of contact to present health information to members. From the information we include in enrollment materials to the newsletters and flyers we distribute at health events, we strive to make every member contact count by facilitating equitable access to high-quality care. Our high-touch, local outreach teams are hired from within the communities they serve; this equips them well to engage members in understanding how to access appropriate care as well as overcome barriers and connect with social supports.

New Enrollment Materials

ACLA will meet all the requirements for new enrollment materials. Welcome Packets will initially be made available in English, Spanish, and Vietnamese, and in additional languages as requested.

Welcome Packets include, at minimum, a welcome letter, the Notice of Privacy Practices, and the Member Handbook. The welcome letter introduces the new member to ACLA and encourages them to call Member Services with any questions. It also lets them know to expect a welcome call, as well as providing a brief checklist reminding the member to read the Member Handbook, select a primary care provider (PCP) if they have not already done so, and make an appointment with their PCP within 90 days of enrollment.

The Member Handbook contains, among other information, a general description of how managed care organizations operate, a summary of benefits and prior authorization requirements, information on the member's rights and freedoms (including the right to change providers and disenroll), and all of the components listed in in Section 12.12.2 of the Bayou Health MCO RFP.

ACLA reaches out to new members with welcome calls. These contacts are intended to initiate a relationship with the member and provide them information in a friendly manner. The representative confirms the member's identity by verifying full name, address, phone number, and birth date, and then proceeds with a full new member orientation. Topics presented include a brief explanation of the program, a statement of confidentiality, an explanation of the availability of and ways to access oral interpretation and written translation services, a description of PCPs and patient-centered medical homes, and instruction on the role of the PCP. Members are asked to confirm their receipt of their ID card and their choice of PCP. If they have not selected a PCP, the representative assists them in selecting one during the call. Other information includes what to do during the transition period, how to utilize services, what to do in an emergency, and how to file a grievance and appeal. A discussion is also facilitated to discover whether the member is pregnant, has a chronic condition, or has any other special health care needs; identified needs are communicated to the Integrated Care Management (ICM) team for further evaluation and outreach. Members are encouraged to contact Member Services with any follow-up questions.

Recertification Education and Assistance

ACFC has experience administering programs intended to assist state agencies with Medicaid renewal efforts. Our affiliate Select Health of South Carolina (SHSC) has been supporting South Carolina Department of Health and Hospitals (SCDHHS) for several years in reaching out to members to remind and assist them in completing necessary Medicaid recertification requirements. This program, administered through the Member Services outbound call department, utilizes annual eligibility review data provided via the member enrollment file. Members who are within 60 days of annual eligibility review date are identified. The contact center then utilizes a mail and phone outreach campaign to contact members about returning annual review forms. In order that no member contacts are missed, recertification dates are loaded into the plan's Care Gap system. This makes every member contact count by allowing any associate or provider who is in contact with the member to provide recertification information. The efforts of the contact center are also supported by in-house SCDHHS-sponsored case workers who are available to answer questions that members may have regarding recertification. This program has demonstrated successful member retention; of the members contacted by the plan, 53% remained eligible 60 days post annual renewal date. With DHH approval, ACLA is equipped to bring this program to Louisiana and looks forward to similar successful results.

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Educational Materials

ACLA develops materials designed to educate members about specific health issues, equip them with strategies for improved wellness, and encourage them to take responsibility for their health. Example topics include asthma control, diabetes management, stress management, high blood pressure, and healthy living. Members are provided educational materials that:

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

ACLA makes information available to members through various communications channels. We develop and maintain a comprehensive library of useful and relevant educational materials, which include, but are not limited to:

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

ACLA develops educational materials with the needs of the members in mind and in conformance to all DHH requirements. Materials that we share with members to increase their understanding of managed care include, but are not limited to:

- Members' Bill of Rights.
- Member notices including notices of provider termination.
- Notification of any change that DHH defines as significant at least 30 calendar days before the intended effective date.

In addition, our ICM and Rapid Response teams send educational materials targeted to members in our ICM program through an evidence-based software program. Topics for education are specifically selected based on members' identified Nursing Assessment needs as well as individualized care plans goals. ACLA provides these materials to our members through our medical management programs and upon request.

Throughout the year we mail disease state information to a specific segment of the membership that has been identified as having symptoms and/or diagnosis with a condition through our aggressive case management programs. For instance, a member with diabetes may be sent a letter or other form of communication to encourage HbA1C testing.

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

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

We also send outreach materials that feature tips for healthy living, educate on illness prevention, and encourage appropriate utilization of services. Some examples of these types of material include:

- What is Health Literacy?
- Knowledge Is Power.
- Nutrition Facts and Labels.
- Fruit and Vegetables.
- Avoid Portion Size Pitfalls.

Samples

Samples of materials that ACLA has developed and were approved by DHH are included as attachments at the end of Section T. These include health education brochures and flyers, member newsletters, and welcome materials.

Providing Equitable Marketing throughout the State

ACLA is proud of our close ties to, and active presence in, the communities we serve throughout the state. Collaboration with local partners in rural and urban areas throughout every region of the state helps us to reach members. We support many causes that promote healthy lifestyles through partnerships with organizations such as the YMCA, Kiwanis, 4-H, Catholic Charities, local parks and recreation departments, school boards, and statewide coalitions.

ACLA hires Community Health Educators from within the community to provide high-touch interaction with members throughout the state, in both rural and urban areas. As members of the communities they serve, Community Health Educators establish trusting relationships with members and are thus able to bridge any gaps and address barriers that members face in accessing care.

Exhibit T.1-1: ACLA Community Health Educator Team

In addition to helping members on an individual basis, Community Health Educators can educate community groups about the importance of preventive health services like vaccines and cancer screening tests. They can recommend ways to improve diet and increase exercise that are based on knowledge of an individual's unique personal situation. For example, Community Health Educators can provide information to members with chronic illnesses like diabetes that require sustained, comprehensive care.

Our Community Health Educators establish and maintain a presence throughout the community. One priority of the Community Health Educator team is to maintain an active presence in provider offices throughout the state by hosting an average of 8–10 informational tables per week. This collaboration is important to ACLA and to our providers. For example, we have informational tables in area Community Health Clinics, such as in multiple locations of Teche Action Clinics and Mooretown Family Clinic in Shreveport. We also actively support several of our providers by scheduling appointments for our members with care gaps. For every 10 member calls we attempt, we schedule an average of two appointments. The numbers may be small, but every member we successfully refer to their PCP will get the care they need. Our providers are pleased with the added service we provide to them, as shown in the comment below.

Valentine Medical Center benefitted a great deal with the help of Kim (ACLA Community Health Educator). Kim has gone over and above for our AmeriHealth Caritas patients by either coming into our office to call patients to help them schedule an appointment or by going out to their home.

Kim has been coming to Valentine Medical Center for two years to help educate the public about AmeriHealth Caritas. We have found this type of service shown by AmeriHealth Caritas and Kim has been very beneficial to our patients and the public in general.

Valentine Medical Center is looking forward to a long relationship with both Kim and AmeriHealth Caritas.

Office Manager
Valentine Medical Center

We aim to reach members at their point of need with relevant solutions. For example, a member who cannot effectively communicate in English may hesitate to take preventive health steps such as scheduling needed appointments or screenings because of the language barrier. Our goal is to make these members aware of the interpretation services available to them, as well as the providers who speak their native language, so that nothing stands in the way of appropriate care. Our Rapid Response team includes bilingual staff who are readily available to assist our Spanish speaking members. Our Community Health Educator team also includes Vietnamese and Spanish speaking individuals.

Member outreach and incentives are designed based on member populations identified as missing certain screenings or interventions, or as experiencing certain chronic conditions. While concentration of need may vary by geographical areas, we seek to reach out to members throughout the state on the importance of preventive measures in maintaining optimal health.

To ensure that ACLA delivers a community education program that supports equitable practices in the marketplace, all associates receive training that equips them to reach members and to adhere to our policy of non-discrimination against any individual for any reason, including but not limited to health condition, disability, race, ethnicity, or geographic location. Our aim is to distribute marketing and educational materials to the Medicaid population throughout the state while targeting areas of high need. This factor influences the design and location of our materials, as well as the concentration of Community Health Educators and provider recruitment efforts.

Using Member Education and Marketing Materials To Improve Service Coordination

Carved-out and Behavioral Health Services

ACLA works collaboratively with service providers across the continuum of care to facilitate holistic care for members. We provide information about covered services in member materials including the Member Handbook and website, and through contact with our Member Services, ICM, and Rapid Response teams. In accordance with requirements, our member ID cards will

include name and contact information for the Louisiana Behavioral Health Partnership. For members who need carved-out services, the ICM team serves as a resource for accessing these services and coordinating the scheduling of needed care.

Currently, the ICM team has an active outreach process to manage care for members receiving Home and Community Based Services (HCBS). As early as the inception of the HCBS carve-in, ICM developed a process to manage and reach out to this special population. A designated Rapid Response care manager is assigned to review and connect with each of the members. The care manager conducts a screening survey to assess any immediate barriers, service participation, caregiver availability, medical needs, etc. If the member needs assistance seeking other waiver services, the care manager provides information about those services and connects the member to the appropriate waiver coordinator and/or explains the application process. Similar internal infrastructure processes will be developed to refer and manage other carved-out services. The process will constantly be evaluated for improvement. We are working with DHH to ensure care for these members, as well as providing training and education for our care managers.

Providers are an important resource in sharing information with members. We develop partnerships with in- and out-of-network care providers to support them in educating members about services available to them. We have reached out to staff of personal care agencies to encourage frequent communication in support of our members receiving waiver services. We also present educational sessions to support groups, advocacy organizations, schools, and drop-in centers.

Our network providers receive initial orientation and ongoing training in helping members navigate the health care system. This training includes information about the basic behavioral health services in the program. We have also developed a series of educational materials about depression for primary care providers to share with members. Our Community Education Outreach Team regularly includes these materials for distribution at community events and in provider offices.

- What is Depression?
- Help Yourself (to target adolescent depression).
- Managing Depression.
- Recovering from Depression.
- Antidepressants and Their Side Effects.

Our care managers educate members in behavioral health within our ICM program. Care managers provide this education through one-on-one interaction as well as by sharing information on topics such as Post-traumatic Stress Disorder, anger management, and bipolar disorder.

Supporting MCO efforts toward EPSDT compliance, appropriate ED utilization, STI education, encouraging the use of prenatal services and prematurity prevention

EPSDT Compliance

Regularly scheduled pediatric wellness appointments are important for tracking healthy development and detecting physical or developmental issues early. ACLA outreaches to members about the importance of making and keeping these appointments for their children. Every month we send out Birthday Cards to children ages 1–21 with EPSDT reminders, as well as basic information about development markers.

Our Rapid Response team is also engaged in encouraging members to follow care guidelines for their children. To support the EPSDT program and well-child visit compliance, we produced magnets listing milestones and timelines for well visits from birth through age 21. Introduced by a cover letter that explains the importance of wellness checks, these magnets were targeted to members ages 3–6 who were due for wellness checks. The mailing went out 3 months before the member's birthday to allow adequate time for appointment scheduling. ACLA will repeat this mailing to the target group of members in large provider groups with this highest non-compliance rate for well visits for ages 3–4 and the adolescent population. Images of the magnet, both in English and Spanish, are featured below.

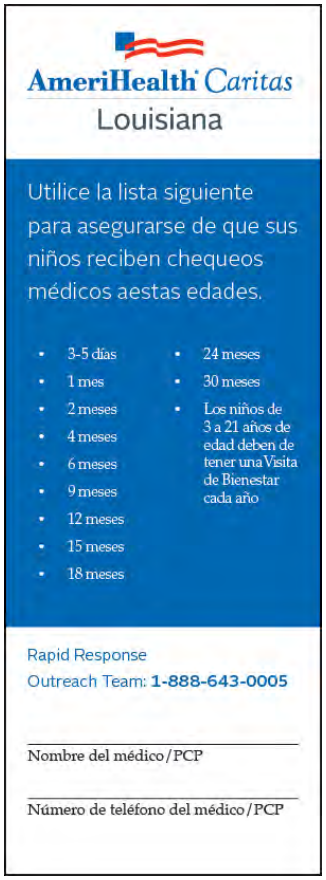

Exhibit T.1-2: Child Well-Visit Magnet

The Rapid Response team also uses soundbites to reach out to members. Monthly automated telephone messages are sent three months before their birthday to members who are now due or past due for wellness visits. Automated outreach continues until appointment can be verified, via claims submission. This ensures that members are reminded to catch up on needed services. Recorded by our local Medical Director, the message is a friendly reminder of the importance of wellness visits for the early identification of health care needs through a comprehensive assessment. For an extra personalized approach, ACLA is exploring interest on the part of providers of recording messages in their own voice for their members.

The message concludes by giving the member or parent/guardian the opportunity to be connected with the Rapid Response team for assistance scheduling the appointment. Once connected with the member, the Rapid Response representative would also elicit information on any barriers to care, such as lack of transportation and resolve the issue. Rapid Response also looks at any other care gaps and for the member or others in the family while on the phone. Information about special needs, including diabetes and asthma, trigger a referral by warm transfer to the Integrated Care Management team or a nurse.

Appropriate ED Utilization

ACLA encourages members to get care in the most appropriate manner. Our "How and Where to Get Care" flyer helps members differentiate between symptoms that require emergency treatment and those that can safely wait for treatment during regular office hours. The flyer, along with an introductory cover letter, is sent to high-tier (those who have had 4 or more ED visits in a month) and medium-tier (those who have had 4 or more ED visits in 90 days) ED utilizers; our plan is to repeat this mailing on a quarterly basis. Low-tier utilizers receive a letter with educational content on appropriate levels of care to help prevent escalation of ED utilization. This information is often reviewed in our Member Newsletter as well. We also notify the providers of high-tier utilizers when their patients have been seeking frequent care through the ED.

Monthly phone calls help to reinforce this information. Through an automated messaging process targeted to high-tier ED utilizers, these members are connected to a Rapid Response representative, who coaches on the importance of being established with a PCP and alternative levels of service to the emergency room. The Rapid Response representative engages the member to elicit information on barriers to care and resolve the issues; any clinical or medical needs trigger a warm transfer to the Rapid Response Care Manager or the Integrated Care Management Team.

Face-to-face engagement is yet another facet of our outreach and education in appropriate utilization. Community Health Educators or Community Health Workers make home visits to members to establish member barriers to seeking primary care and connect them back to ACLA. Community Health Workers let members know that they are available to accompany them to doctor visits, and they often make follow-up home visits

STI Education

Recognizing the importance of member education and information in combatting the increase in STIs, ACLA provides members educational materials reflecting current standards for the prevention, diagnosis, and treatment of STIs. We have featured information on chlamydia in the Member Newsletter; see a sample article from the Summer 2014 issue below. ACLA has also produced an informational brochure about cervical cancer that includes statistics on chlamydia by ethnicity background. This brochure is available in English and Spanish, and in versions targeted to the needs of female members and African-Americans.

ACLA has developed a flyer emphasizing the importance of scheduling regular pap tests for the early detection of STIs or other potential health issues. Moving forward, ACLA will develop a brochure with information targeting chlamydia, gonorrhea, syphilis, HIV, Hepatitis B, and Hepatitis C. The brochure will inform members that screenings to detect STIs are covered services. It will go on to explain the importance of getting screened, define who should undergo screening, and provide information on obtaining the screening. As with all of our educational materials, the brochure will be available in the languages required to effectively serve our members. Our intention is to supply this information to members through various vehicles, including through their providers, at community health fairs, in the Member Newsletter, and directly from ACLA.

All About Chlamydia

Chlamydia is a disease caused by an infection from bacteria. It is most common among young women. It is likely that 1 in 15 women between ages 14 and 19 who are having sex has chlamydia. It is passed on from one sexual partner to another.

Most people don't have symptoms of the infection. However, it can cause big problems. Chlamydia that is not treated can cause damage to a woman's reproductive system, such as the uterus and fallopian tubes. In pregnant women it can cause early delivery. It can also cause pneumonia (infection in the lungs) in newborns. In both men and women, a chlamydia infection that's not treated can cause reactive arthritis (or pain in the joints).

But there is good news. It is easy to get tested and treated for chlamydia. Women can get tested with a vaginal swab when they go in for a regular Pap test or well-woman exam. Both men and women can also get tested using a simple urine sample. Young women ages 16 through 24 who are having sex should get tested every year.

The treatment for chlamydia is antibiotics. If you are prescribed antibiotics for chlamydia:

- Take all the medication as directed. This can help make sure that the infection goes away.
- Stop sexual activity for at least 7 days to prevent spreading the infection.
- Tell recent partners that you have chlamydia. They will also need to see a doctor to get treated.

If you have any questions about chlamydia, you can call our 24-hour Nurse Call Line at **1-888-632-0009**. *If you have questions about visiting the doctor, feel free to call Member Services at* **1-888-756-0004**. *Remember AmeriHealth Caritas Louisiana cares.*

Healthy Now 6 Summer 2014

Member Services 1-888-756-0004
TTY 1-866-428-7588

Exhibit T.1-3: Chlamydia Article from Member Newsletter

Prenatal Services and Prematurity Prevention

To target our goal to reduce prematurity and low birth weights, and increase healthy outcomes for our babies and moms, we send many educational materials to pregnant mothers that encourage proper care during and post-delivery. Some examples include:

- Prenatal Fact Sheet (included in the Member Welcome packet).
- Prevention of SIDS Brochure (sent to new mothers).
- Signs of Preterm Labor.
- March of Dimes: Healthy Babies Are Worth the Wait.
- Centering Pregnancy: A better Way to Get Prenatal Care.
- Text4Baby.
- When You Need to Know about Progesterone Treatment (17P) and Preventing Preterm Birth.
- Well-baby Check-up.
- Postnatal: When to Call the Doctor.
- Pregnancy: Your First Trimester Changes.
- The Benefits of Breastfeeding.
- Kick Counts.
- Asthma and Pregnancy.
- Smoking.
- Anemia during Pregnancy.
- Nutrition during Pregnancy.

Additionally, we frequently feature articles on prenatal and postnatal issues in our Member Newsletter.

Built on the Prenatal Care guidelines from the Institute for Clinical Systems Improvement, the Bright Start program provides maternity management by promoting healthy behaviors and controlling risk factors during pregnancy, with the goal of delivering a healthy, full-term infant. The Bright Start Program is managed by a dedicated team of care managers and Community Care Connectors who reach out to educate and assist expectant members throughout their pregnancy and postpartum period, addressing various issues including dental care and depression screenings. Our Bright Start maternity program is fully described in a brochure made available in English, Spanish, and Vietnamese. Preterm labor and 17-P injections are among the topics explained in the brochure. Our Integrated Care Management team uses Soundbite automated messages to survey postpartum mothers about their experience in our Bright Start program.

ACLA uses a variety of mechanisms, including internal and external assessments, to identify and promptly engage members who are pregnant as early as possible in their pregnancy. All new female members are asked about their pregnancy status as part of the new member assessment and during every call made to or by the Rapid Response team. Current and historical claims data is also reviewed weekly to identify newly pregnant members.

Engaging Members through Technological Tools

ACLA recognizes the importance of reaching members through multiple methods: print, face-to-face contact, and technological tools that promote virtual engagement. Members may read articles, but it often takes more steps and multiple encounters with the information before it becomes actionable and memorable.

ACLA thus seeks to supplement passive reading with member interaction by incorporating technology. For example, when we featured an article in the Member Newsletter about BMI, we made further information available via a BMI calculator that we hosted on our website. Members were able to read about BMI, its importance, and the range for healthy BMI. They could then take the next step in making the information personal and meaningful: the article directed members to visit the site to calculate their own BMI.

Additionally, because many members rely on smart phones increasingly to meet their information needs and manage their daily lives, we are integrating interaction capabilities into our printed materials on an ongoing basis. Our Member Newsletters include QR codes so that members seeking additional information on a topic can scan the code in the article and be directly connected to the associated website.

Our website is constructed with searchable tools including the provider directory, pharmacy directory, and formulary. These tools put members and providers in quick touch with up-to-date information.

ACLA is currently developing a program to provide members free cell phones for easy access to the plan and their Care Managers. The phones will be programmed with the txt4health module to send texts with education information, reminders about general health and screenings, and recommendations of activities to improve health.

Targeted to pregnant women and mothers of newborns, the text messages encourage members to make and keep appointments; take vitamins and eat healthful foods; avoid alcohol, drugs, and smoking; and consult with the doctor before taking any new medications during pregnancy. Information would continue into the postpartum period to support moms in caring for themselves and their newborns during this vulnerable time. The texts include the opportunity for follow-up action, such as phone numbers or links to more information. Messages can be presented in English or Spanish and will allow members to offer feedback on the program. The txt4kids program would offer similar information to members with young children; texts would include reminders to schedule vaccinations, dental appointments, and follow-up PCP visits.

Our marketing strategy is multimodal, and, in addition to written materials and online tools, also features audio components. ACLA uses Soundbite messaging and automated telephonic tools to provide preventive care reminders, request member feedback, and connect members to the Rapid Response or Member Services teams. Targeted members are contacted via telephone through the automated system that plays a recorded message designed for them. For example, our CLAS Coordinator uses Soundbite messages to survey Spanish-speaking members in Spanish about their experience with our interpretation services. If a member is identified as needing a particular screening, a Soundbite message can be sent that is configured to connect the member at the end of the call with the Rapid Response team to schedule the appointment.

Partnering with Community-based Organizations for Education and Outreach

An integral part of the ACLA strategy is to strengthen current relationships with community-based organizations aligned with our mission, while building new relationships throughout the state to continue our grassroots efforts to reach members with holistic care. The Community Education team has developed strong relationships with organizations including local YMCAs, Recreation and Park Commission for the Parish of East Baton Rouge (BREC), Family Road of Greater Baton Rouge, HOPE Ministries, Sickle Cell Associations, David Raines Community Health Centers, Southeast Community Health Systems, MLK Community Center in Alexandria, Urban League of Greater New Orleans, Habitat for Humanity, and many school boards and schools. Because many members are challenged by transportation barriers, we strive to provide face-to-face support. ACLA partners with housing authorities in all of the large cities in Louisiana to establish a presence that facilitates building a rapport with residents and educating them on healthy living.

ACLA is present in the community to offer screenings and chronic condition management activities at school health fairs, faith-based collaborative health events, and local fairs and festivals. Health screenings can include glucose, hemoglobin A1C, and blood pressure.

ACLA collaborates with our corporate affiliate ACFC to offer the Health Ministry Program in Louisiana. The Health Ministry Program is a faith-based health education program designed to educate participants on important health topics, including breast cancer, diabetes, obesity, stroke and hypertension, medication adherence, heart disease awareness and prevention, stress, depression, and emotional and mental well-being. Offered through collaboration with church and ministry leadership of all faiths and denominations, the programs take place in local faith-based settings, such as churches, synagogues, and mosques.

Because diabetes is a prevalent health issue in Louisiana ACLA hosted a Health Ministry event that was a diabetic outreach day at Household of Faith in New Orleans in November 2012. Plan members, as well as the community at large, attended the event. Glucose screenings were available, and a chef prepared gumbo in a healthy cooking demonstration. Diabetic educators were on hand to present topics including:

- Diabetes Overview.
  - Definition and disease process.
  - Types of diabetes and treatment options.
  - Identification of self-care behaviors.
- Eating Healthy.
  - Food groups and carbohydrate counting.
  - Portion sizes, meal-timing, and food labels.
  - Meal plan.
- Being Active.
  - Benefits of exercise.
  - Effects of exercise on blood glucose levels.
  - Increasing activity and exercise.
  - Personal exercise plan.

- Monitoring.
  - Blood glucose monitoring and goals.
  - A1c.
  - Ketones.
  - Utilizing results.
- Taking Medication.
  - Oral medications.
  - Injectable medications.
  - Medication management.
- Problem Solving.
  - Goal-setting.
  - Strategies for making behavior changes.
  - Plans for travel, sick days, and other non-routine situations.
- Reducing Risks.
  - Hypoglycemia & Hyperglycemia.
  - Microvascular & Macrovascular.
  - Immunizations.
  - Foot, eye, skin, and dental care.
- Healthy Coping.
  - Managing stress and emotional adjustments.
  - Support resources.
- Individualized Strategies.
  - Preconception and pregnancy management.
  - Insulin treatment plan.
  - Smoking cessation.

ACLA also held a Diabetes Boot Camp in Baton Rouge in September 2013 as part of the Health Ministry Program. A team of diabetes educators presented participants strategies for fighting diabetes based on curriculum approved by the American Association of Diabetes Educators. Attendees also received free A1C screenings, learned healthy cooking techniques, and participated in a line-dancing class. To continue this important educational outreach, we are currently confirming diabetes education classes to take place in New Orleans, Shreveport, and Lake Charles.

Our Community Health Educators are in close contact with Family Road Healthy Start of Greater Baton Rouge. We have presented 4 Mommy lunch and learn sessions to educate pregnant mothers on improved health and wellness. We also have plans to work in partnership with Healthy Start New Orleans to develop and present reproductive information to members, and to refer women who are pregnant or have a child under two to Healthy Start New Orleans for outreach, health education, and case management. Additionally, we will participate in bi-monthly Community Action Network meetings.

ACLA is committed to promoting health by encouraging physical activity. When children understand and adopt the importance of healthy activity, they bring this behavior to their families and help to promote a lifestyle of wellness. Unfortunately safe places to play are not

always available to children. Accordingly, ACLA has worked with our parent organization to bring safe playgrounds to areas most in need in Louisiana. Safe playgrounds help promote healthy lifestyles by decreasing childhood obesity and preventing injuries that can result from obsolete or dangerous equipment. The Safe Playground Build program brings community members and ACLA employees together to build a new playground structure from the ground up, paint murals, and clean the surrounding areas—all in one day. Professional contractors are on hand during the day to supervise construction. In October 2012, ACLA completed a Safe Playground build at Pierre Capdau Charter School in New Orleans. The project included building a playground, a children's outdoor fitness center, and two basketball courts, as well as incorporating a beautification program; it was the largest build to date. ACLA completed another Safe Playground Build in October 2013 at Park Elementary School in Baton Rouge. ACLA plans to continue this program by targeting elementary schools in Louisiana with a 90–100% poverty rate that need a playground. The next site selected for a Safe Playground Build is Queensborough Elementary in Shreveport scheduled for November 2014.

Exhibit T.1-4: Playground Build at Park Elementary School in Baton Rouge

Exhibit T.1-5: Playground Build at Pierre Capdau School in New Orleans

ACLA is committed to promoting both health and general literacy through partnerships with libraries and K–12 schools. Our Community Health Educators have already partnered with the East Baton Rouge Parish School System to participate in various activities throughout the year. We will continue this strategy by developing relationships with other school systems. We also set up presentations at summer reading program events, local book fairs, and Louisiana Book Festivals. Our Community Health Educators volunteer with local Head Start programs and schools and participate in literacy programs, parent nights, field days, and as volunteers in public schools. Additionally, we fully support our members obtaining basic education. We are committed to helping provide our members with an opportunity to earn a high school equivalency credential and pursue goals of college, training, and jobs. ACLA will reimburse the test fee for members without a high school diploma who complete the GED exam. We will continue to develop relationships with organizations offering GED programs and to educate our members on how they can enroll and participate.

ACLA strives to be present in the lives of members throughout the age continuum. Because of the high rate of premature births in Louisiana, ACLA partnered with the March of Dimes' Louisiana Chapter to support "Healthy Babies are Worth the Wait," a campaign to reduce premature births. Sometimes late, preterm births—those occurring between 34 and 36 weeks—are the result of the mother's choice to be induced or undergo a C-section because she is feeling

uncomfortable in the last weeks of pregnancy. The program urges expectant mothers to do everything they can to carry their babies through at least 39 weeks to ensure full development.

We have also joined with the March of Dimes to help the Cancer Association of Greater New Orleans implement a "Baby & Me — Tobacco Free" program. The first program of its kind in Louisiana and in the southern region of the United States, Baby & Me – Tobacco Free is an evidenced-based, incentive smoking cessation program that helps pregnant women quit smoking and remain smoke-free postpartum. Participants in the program meet monthly with a tobacco cessation counselor and receive free diaper vouchers at each visit for up to 12 months.

Additionally, ACLA will serve as the March of Dimes Prematurity Prevention Sponsor for the 2014 Provider Education Lecture Series on the 17-P Initiative to Improve Birth Outcomes and Reduce Preterm Births. The lecture series is presented to increase physician awareness of the use of 17-P and Vaginal Progesterone to help high-risk patients. DHH has reported that the lowest utilization of 17-P and highest preterm deliveries occur in Geographic Service Area C; accordingly, several lecture series will be delivered in this area, with the possibility of expanding the program through a webinar.

Our partnership with the community also includes sponsorship of and participation in local events, including:

Organization	Event
Louisiana Food Bank Association	Golf Tournament August 2014
Volunteers of America	Family Wellness Health Expo April 2014 Celebration for Change May 2014 Under the Tree campaign (upcoming in December 2014
American Heart Association	Go Red for Women & Heart Walk April 2014
American Cancer Society	Relay for Life Events in Shreveport and Bossier City area
Sickle Cell Disease Association of America	Sickle Cell Walks Annual Golf Tournament May 2014
Urban League of Greater New Orleans	Schools Expo February 2014 Annual Awards Gala July 2012, July 2013, and July 2014
NAMI LA:	NAMIWalks New Orleans October 2014
Daughters of Charity	Annual Gala
Salvation Army, Louisiana Division	Monthly site visits from Community Health Educators Annual luncheons Angel Tree and Toy Drive

YMCA	Achievers Scholarship Banquet sponsor Darkness to Light Thanksgiving with the New Orleans Saints Turkey Give-a-way

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T.2. Marketing and Member Materials

T.2 Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated. How will this information be available to members and the public?

Overview

Members who are informed about their options for health care delivery are better able to participate in their care planning and treatment. ACLA will communicate the options available within our provider network so that members have all the information they need to make choices suited to their needs. Our provider directory includes the names of PCPs, hospitals, urgent care centers, specialists (both pediatric and adult), and ancillary service providers in a designated service area. Each listing includes the provider name, location, telephone number, office hours, accepted age range, languages spoken, special needs accessibility, and whether the provider is accepting new patients. We ensure the accuracy of information in the provider directory through regular reviews and audits, quarterly data validation, and annual validation by providers themselves. Additionally, subcontractors who maintain networks are required to have directory processes that meet DHH and ACLA requirements. Directory links are available on our website for members searching for pharmacy and dental providers.

Provider Directory Contents

Up-to-date and accurate provider information is important to members, providers, the state's Enrollment Broker, and plan operations. Accordingly, ACLA maintains up-to-date information on providers such as name, gender, specialty, hospital affiliation group affiliation, board certification, new patient status, languages spoken, and office locations. We include all of these elements in the hard copy and electronic provider directories to give members the information they need when choosing a provider. Network Operations ensures that the following data elements are captured, updated, and stored in the provider database for all PCPs, specialists, ancillary, and hospital providers and practitioners.

Group Practice Name	Office Address (including City and Zip Code)
Provider's/Practitioner's Name	Additional Office locations (if applicable)
Specialty(s)	Office Phone Number
Type of Medical Degree	Languages spoken by the provider
Board Certification(s) (if any)	Wheelchair Accessibility
Hospital Affiliation (s)	Age Limitations
Accepting New Patients	Gender
Medical Group Affiliations	Physical address, telephone, county, day/hours of operation

Exhibit T.2-1: Data Elements Captured in the Provider Directory

Ensuring Accuracy of the Provider Directory

Frequency of Monitoring Activities and Directory Updates

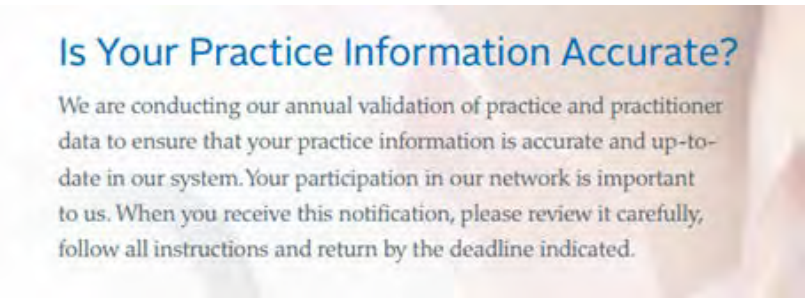
We ensure that our Provider Directory is accurate by regularly updating, reviewing, and auditing the information. The Provider Directory is pulled directly from our core claims administration system, which serves as the official source for all provider data. Written and/or electronic correspondence indicating a change in provider information is forwarded to the Provider Maintenance department for updating in the database. These changes are made on a daily basis and uploaded nightly to the online provider directory.

We regularly review and audit the provider information on file. The accuracy of our provider database is monitored regularly through a quality auditing process that evaluates transactional activity associated with updating and maintaining the provider database. We conduct a daily audit of five pieces of work per employee to assess the accuracy of their work. Real-time results are available to the Provider Maintenance Management team and are used to correct identified errors and coach employees. Additionally, queries are run against the provider database on a regular basis to identify errors, and discrepancies are corrected by the Provider Maintenance team.

Ad-hoc reviews of provider data are conducted if warranted by the need for a supplemental directory, hospital contingency purposes, or DHH-related initiatives. All necessary data changes are documented and forwarded for execution to the Provider Maintenance department.

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

Lastly, on an annual basis, ACLA performs a Provider Panel Roster Validation. Through this process, all providers are required to validate and edit the data stored in our provider database. This process has proven to be a very effective means for ensuring accuracy.


Is Your Practice Information Accurate?

We are conducting our annual validation of practice and practitioner data to ensure that your practice information is accurate and up-to-date in our system. Your participation in our network is important to us. When you receive this notification, please review it carefully, follow all instructions and return by the deadline indicated.

Exhibit T.2-2: Ensuring Accuracy of the Provider Directory through Annual Roster Validation in Provider Newsletter December 2013

Information Availability to Members and the Public

ACLA maintains a Provider Directory in four formats:

- A hard copy (paper), supplied on request, for members and potential members.
- A web-based, searchable online directory for members and the public.
- An electronic file of the directory for the Enrollment Broker.

- A hard copy (paper), abbreviated version for the Enrollment Broker.

Members and providers may also contact Member or Provider Services to obtain provider information.

ACLA produces an updated hard copy of the Provider Directory on an as-needed basis but no less than annually. After internal data teams have finalized their review and approval of the draft provider directory, the document is submitted to DHH for review and approval. Upon approval, our communications department designs and prints hard-copy directories. These directories are distributed between ACLA and the Enrollment Broker and are available to providers or members upon request.

Our online provider directory can be accessed on the members section of our website. This web-based directory presents provider information in a convenient, searchable format. Users can search for providers by type and within a distance they choose to their specified location. Information can be synthesized through the compare feature, which allows the user to choose three providers and compare their information to find the best match for their circumstances and needs. Results can be further customized with built-in filters that allow the user to choose to see providers according to their language spoken, gender, certification, group practice, and hospital affiliation. Any limitations to choosing that provider are also displayed. For added convenience, users can click a link to find a map and directions from their specified location. This web-based version of the provider directory is updated in real time and no less than weekly.

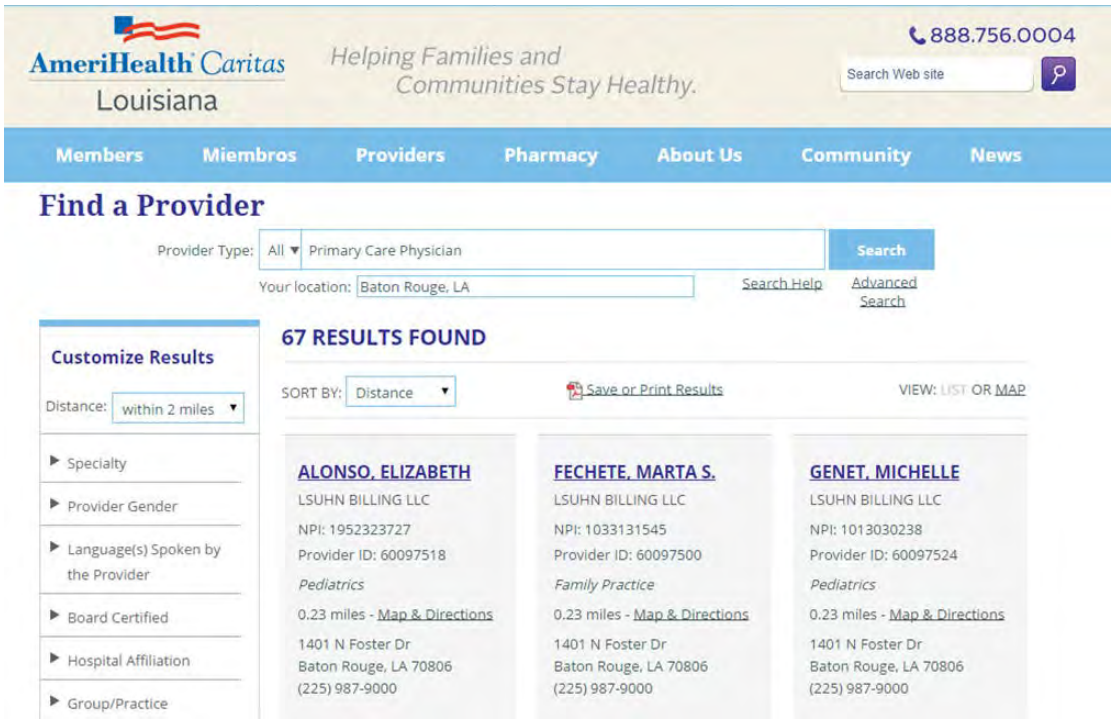


Exhibit T.2-3: Example of Searchable Provider Directory

The electronic version is updated prior to each submission to the Enrollment Broker within the time frames required by DHH. The abbreviated hard copy version is provided to the Enrollment Broker for distribution to new Medicaid enrollees upon request.

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T.3. Marketing and Member Materials

T.3 Describe how you will fulfill Internet presence and Web site requirements, as well as any social media components.

Overview

ACLA shares information with members to promote their engagement in their own health; their understanding of health care services; and their general education on preventive care, wellness, and health issues. Digital presentation on our website is one means by which we make this type of information easily available to members. Our website is a resource for health-related articles, a library of health information, reminders, information on community events (such as baby showers, health screenings, and vaccinations), or warnings about potential pandemics. Our Member Web Portal is a secure resource for a member's personal health information on care gaps, prescription drugs, and health care visits.

Internet Presence

ACLA recognizes the importance of electronic communication, and we have built our Internet presence carefully and purposefully, with measures to ensure compliance with HIPAA requirements and secure information exchange. We are constantly working to ensure that the ACLA website has convenient access to information is available in a fresh and current format. Both members and providers can engage through the website as described below.

Plan Website

The ACLA plan website provides members, providers, and the general community with valuable plan related information without requiring them to log in. ACLA website users can access valuable health plan information, including the member and provider handbooks, plan benefits, health and wellness materials, emergency weather tips, and grievance and appeal filing details. Members and providers are also able to access their respective portal for personalized information via the ACLA website. Additional details on ACLA's member and provider portals are outlined below.

Members and providers can also access tools such as a BMI calculator, searchable provider directory, searchable pharmacy directory, and searchable formulary. The searchable tools allow members and providers to find up-to-date information on network providers, pharmacies, and covered medication.

ACLA regularly reviews the website with the Member Advisory Committee to ensure that web content is displayed in a manner easily understood, navigable, and contains content that addresses member needs. This committee, comprised of members and community partners, is an excellent source of feedback that can shape web site content.

The member section is available in Spanish via the Miembros tab, which includes links to the applicable documents, including the Member Handbook, in Spanish translation.

The provider section of our website connects providers with prior authorization instructions, training webinars, quick reference guides, and the toll-free number for Provider Services, as well as for Provider Network Management (PNM) Account Executives.

A screen shot of the home page for the ACLA website follows.

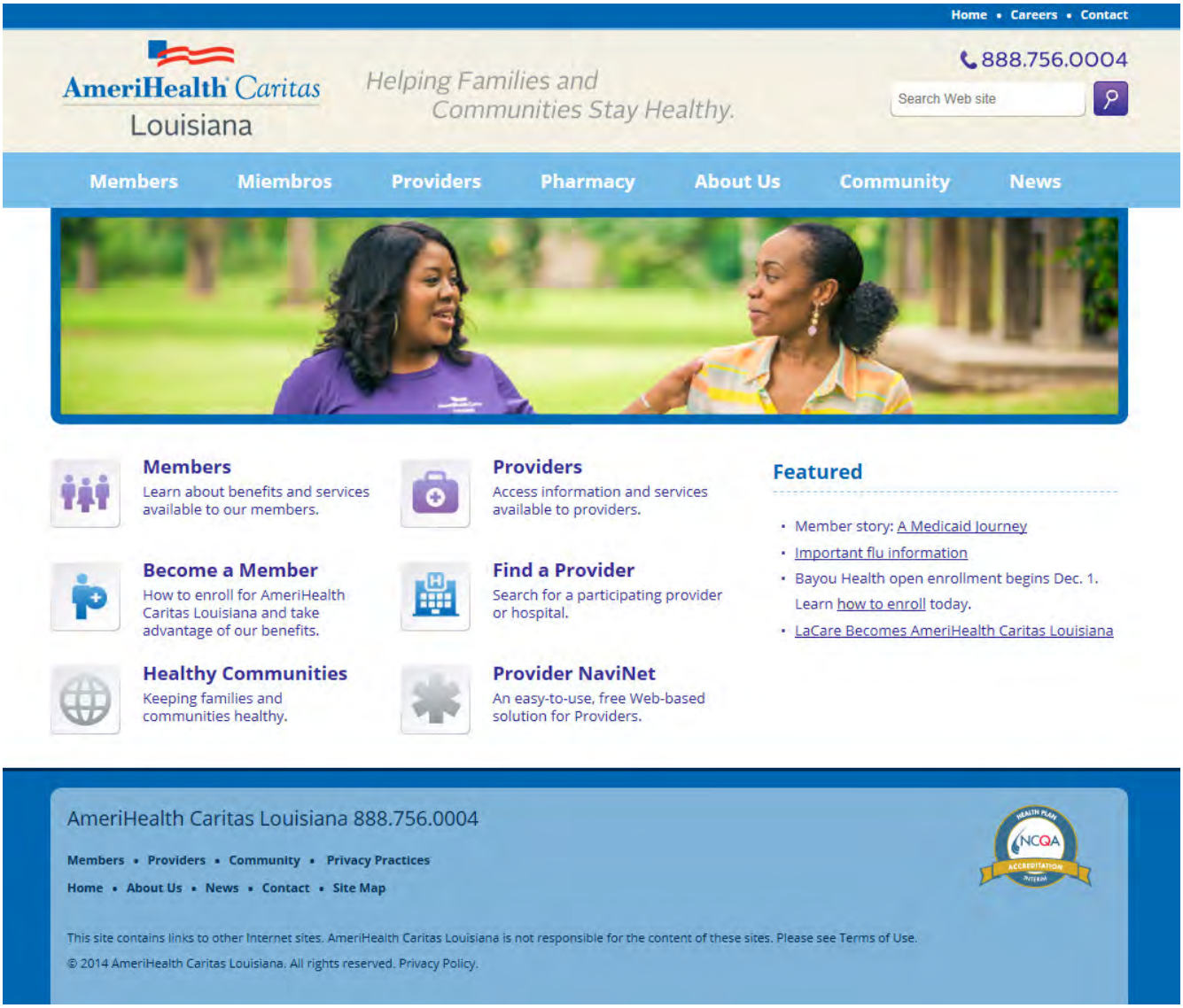

Exhibit T.3-1: ACLA Homepage

Member Portal

The Member Portal provides members with interactive tools to perform self-service for specific activities. For example, the portal gives members the ability to view demographic information about their doctor or find a new PCP using a link to the online Provider Directory. Detailed information about medical and prescription benefits is available. Members are also able to see, medications they have been prescribed within the past six months including the date prescribed, medication name, dosage, and prescribing physician. Members can view their recent

visits to the doctor, hospital, and emergency room and link to the Health and Wellness Section of the ACLA website. Finally, members have the opportunity to submit questions and comments to ACLA and receive responses back via a secure contact form.

The objective of the secure portal is to maintain or increase member satisfaction by offering user-friendly capabilities and to provide members with secure tools and a full picture of their medical care. By giving members added access, clinical outcomes can be improved through better medication adherence and reduced gaps in care. A screen shot of the Member Portal landing page is included below.

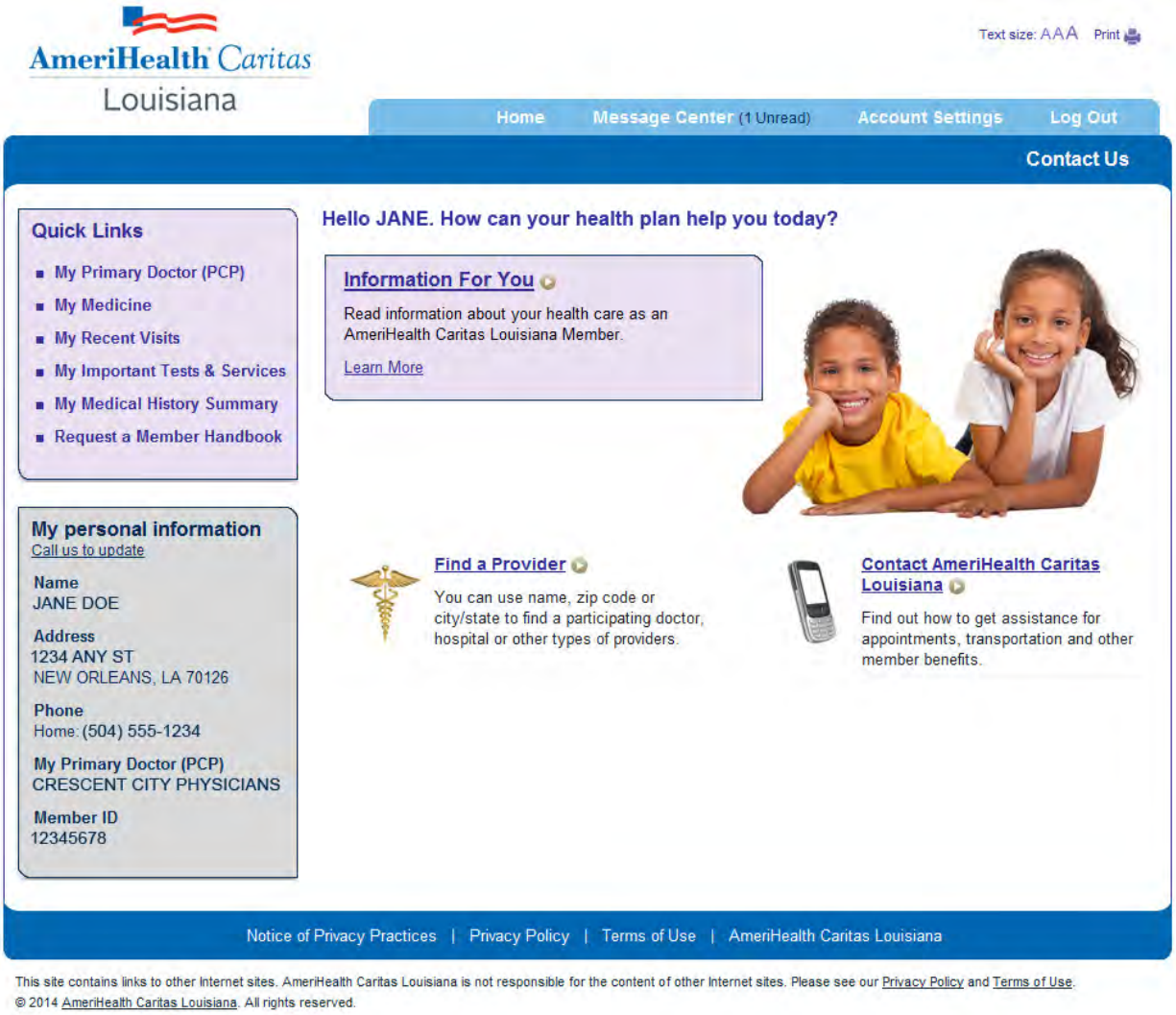

Exhibit T.3-2: Member Portal Landing Page

Provider Portal

Our Provider Portal, NaviNet, enables easy access to information, maximizing efficiency, and encouraging collaboration among our providers. In addition, the system links our caregivers to ensure our physicians have the vital information they need to provide the best, coordinated care for our members. A screen shot of the NaviNet home page is included below.

AmeriHealth Caritas Louisiana

Welcome to NaviNet

This easy-to-use portal provides you with plan updates and information that will help you care for our members. Use the links below to search our provider directory, view prior authorization criteria, download forms, and more.

- NaviNet User Guide
  NaviNet User Guide for providers
- Prior Authorization
  Prior authorization instructions and forms
- Billing information
  Electronic Funds Transfer (EFT)
- Submitting a claim
  Emdeon, paper and electronic claim submission, EDI
- Searchable provider directory
  Find a doctor in the provider directory
- Resources
  Prior authorization, forms, referrals, clinical information
- Provider communications
  Provider newsletters, fax blasts, DHH information

LATEST UPDATES

- The new and improved **Online Provider Directory.**

- Read our **"Connections" newsletter**.

Need support?
Contact your account executive.

Important phone numbers

Provider Services: 1-888-922-0007

Verfiy Member Eligibility: 1-888-922-0007

Check Claims Status: 1-888-922-0007, prompt 2

Prior Authorizations: 1-888-913-0350

See other important phone numbers

Exhibit T.3-3: NaviNet Home Page

Bayou Health

To help members gain a general understanding about the Louisiana Medicaid Program, the ACLA website includes a page on the Bayou Health program. This page presents an overview of what Bayou Health means for members and their families. Links to more specific information are also included.

Best Practices

The ACLA website is tested for cross-browser compatibility, which allows it to display and behave consistently in the following browsers: Internet Explorer, Firefox, Safari, and Google Chrome. No items requiring the use of a specific browser are included. The website is optimized to support mobile devices so that members and providers can view information easily whether they use a desktop, tablet, or mobile phone.

ACLA ensures the website follows all written guidelines included in Section 12.10 of the Bayou Health MCO RFP. For example, the website includes a link to the Member Handbook, as well as to the large-print version and the Spanish and Vietnamese translations. General customer service information, including the toll-free Member Services number, is prominently displayed, along with a Telecommunications Device for the DFF (TDD) number. There is also an NCQA-compliant searchable list of network providers with their contact information, and a designation of open versus closed panels that is updated in real-time. Contact information and links for DHH and Bayou Health are included for members to resolve eligibility and enrollment questions. Information about how to file grievances and appeals is also included.

Additionally, the website meets all coding standards set by the World Wide Web Consortium for markup language, link validation, and CSS. We follow best practice designs based on the US Government's Web Guidelines on usability to ensure that members and providers can easily find information and services that ACLA provides. All of the features and offerings on the website meet or exceed requirement in Section 508 of the Americans with Disabilities Act and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern, including the Web Content Accessibility Guidelines (WCAG) 1.0 "Triple A" Conformance Level.

Updating Information on the Website

After DHH approval, new and updated content is managed through a workflow process to allow for any required internal reviews from a legal and technical prospective. Content and information for the ACLA website is updated and managed via an enterprise Content Management System, Autonomy TeamSite. TeamSite also provides content version management and control. A committee of member, provider, and digital experts meets monthly to review the website content for accuracy and timeliness.

Tracking Website Activity

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

All inquiries are responded to within two business days. Responses to email inquiries are audited for accuracy and timeliness using the same audit process that is used for phone inquiries. ACLA web properties, both internal and external, are monitored using HP OpenView software. HP OpenView alerts ACLA management if there are response time and availability issues in responding to emails.

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

All activity on the website is measured and analyzed through standard web server logging through IIS 6.0, web server software. ACLA leverages Google Analytics for tracking interaction and transactions. Google Analytics is a web-based solution that tracks visitor information related to visits, browser and operating system types, screen resolutions, and traffic sources such as search engines. Data generated through the program provide summary metrics as well as detailed drill-down reports. This data provides insight into the trends and traffic of activity in the member and provider sections of the website. Our website averages 4,000 visits per month to the member section and 8,000 visits per month to the provider section.

Social Media Components

ACLA recognizes that social media has become an important part of engaging and communicating with members and providers. We also recognize that effective policies and procedures are necessary to succeed, in addition to selecting the appropriate platforms and topics. We will be conducting an evaluation during the last quarter of 2014. This evaluation will be used to develop a social media strategy that will be executed during 2015 and 2016. The strategy and material will be provided to DHH for review prior to execution.

T.4. Marketing and Member Materials

T.4 Describe how you will ensure culturally-competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each, including description how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.

Overview

ACLA fully recognizes the importance of addressing the needs of members in a culturally competent and linguistically appropriate manner from a philosophy of promoting health equity. This is an integral part of our overarching strategy to deliver person-centered care and reduce health disparities. Accordingly, ACLA agrees to continue our successful practice of ensuring that services are provided to all members in a manner that values, affirms, and respects their worth and protects and preserves their dignity.

ACLA promotes diversity and inclusion in our efforts to help the underserved and chronically ill stay well and build healthy communities. In fact, among our eight defined organizational values are advocacy, dignity, and diversity, elements that are critical in culturally competent care.

All ACLA associates are trained upon hire and annually thereafter in Culturally and Linguistically Appropriate Services (CLAS) standards and health equity. This helps engrain our philosophy throughout the organization so that all associates are empowered to help members receive equal access to care.

The Health Equities Council

Background

ACFC operates an enterprise-wide Health Equities Council that promotes health plan accountability for reducing racial, ethnic, language, poverty, and educational disparities in its member population. The Health Equities Council is a multidisciplinary team including representatives from ACLA's CLAS department. This enterprise-wide approach has full executive support and implements the following activities:

- Analysis of clinical quality and member satisfaction data.
- Community health and outreach disparities initiatives.
- New hire and annual Health Equity and Cultural Competency training in partnership with human resources.
- Year-round staff awareness and education efforts.

Collectively, these initiatives have raised the internal dialogue around health disparities through formal staff education and a series of presentations by industry thought leaders, while

establishing a systematic approach to increasing the quality and access of care delivered to our vulnerable communities. In Louisiana, we have hosted several educational forums that address social determinants of health, health equity, and health disparities. External speakers from Louisiana State University have offered presentations to associates to better understand how to serve ACLA members in a culturally competent and culturally relevant manner. In addition, the ACLA CLAS coordinator provides leadership as the Communications Sub-committee Chair for the Council. She has provided leadership in this capacity for two years and has led the following efforts:

- Identified and secured national and local thought leaders to provide education and training activities to all ACLA associates.
- Provided subject matter expertise to revise the enterprise-wide Health Equity and Cultural Competency annual training.
- Created a Health Equities Council webpage, including a resource library, that all associates can access to obtain updated information about the Health Equities Council's activities and disparities data.
- Supported the National Minority Health Month Campaign and coordinated a brown bag Lunch-and-Learn event at ACLA for associates to share their experience addressing health disparities through community outreach.
- Created and distributed a Multicultural Resource Guide that provides detailed information about understanding diverse sub-populations, cultures, and languages in Louisiana.

Health Equities Council History

The Health Equities Council was formed in 2011 to increase awareness of health equity and reduce health disparities in the health plan membership of ACFC. The Health Equities Council provides a coordinated organizational approach and a body of members to oversee existing internal and external efforts to address health and related social disparities while creating an opportunity to innovatively and collaboratively implement new efforts.

This structure allows multiple teams of subject-matter experts to review data and effectively design targeted interventions that will reach high-risk targeted members. In addition, this structure allows ACFC health plans to identify stakeholders and partners to increase cultural competency among new and existing staff. Through a mixed internal and external approach of utilizing disparities data analysis, specific interventions, and educational forums and trainings, the Health Equities Council is also increasing interdepartmental communication and creating an explicit focus on health disparities. The Health Equities Council operates in Louisiana, Pennsylvania, New Jersey, South Carolina, Florida, Nebraska, Indiana, and Washington, D.C. Ultimately, the Health Equities Council will provide a consistent framework for addressing disparities for members within health plans across the enterprise.

Disparities Focus

The Health Equities Council focuses on various issues for the racial and ethnic member population. In addition, the Health Equities Council engages associates by providing educational, awareness, and training opportunities on issues concerning health disparities.

In 2013–2014, the Health Equities Council led the following actions:

- Staff awareness and education: Through the ACLA CLAS coordinator and Health Equities Council Communications sub-committee leadership, 10 speakers provided educational forums on various clinical and minority health topics. Forums presented are listed below.
    - Advancing Diabetes Care in the Latino Population presented by Dr. Glen Hamilton and Dr. Edgardo Maldonado.
    - The Role of Community Health Workers in Patient Empowerment presented by Barbara Schneider.
    - Breast and Cervical Cancer among African-Americans in South Carolina presented by Dr. Heather Brandt and the SC Witness Project.
    - Health Promotion Strategies for Reducing Health Disparities presented by Dr. Dawn Wilson.
    - Diabetes Disparities in American Indians presented by Dr. Ronny A. Bell.
    - Diabetes — "Jeans"… "Genes" presented by Dr. Gayenell Magwood.
    - Poverty: Might Not Be What You Think presented by Joe Ostrander.
    - *Unnatural Causes* video presentation, "In Sickness and in Wealth."
    - Fostering Health Equity through Culturally and Linguistically Appropriate Service Delivery presented by Dr. Robert Like.
    - The Geography of U.S. Poverty: Space, Place, and Implications for Health presented by Dr. Tim Slack (from Louisiana State University).
    - *In Development*: Internal associate presentation about personal experiences in the health care setting related to Health Equity and Cultural Competency. Associates from ACLA will be invited to give presentations.
- Participation in the DHH Office of Minority Health's National Minority Health Month Campaign: ACFC led an internal campaign that offered a community-staff-led educational panel on how it delivers care to the underserved. In ACLA, associates from the Community Health Outreach department shared first-hand accounts of their work in the community delivering high quality, culturally competent care.
- Staff training: A training module on cultural competency and health equity was offered to all new hires and existing associates. This mandatory training is now offered on an annual basis.
- Data analysis: Member satisfaction and clinical performance data was reviewed, monitored, and analyzed by race, ethnicity, and language.

- National recognition: ACLA was featured in the America's Health Insurance Plans Health Literacy Compendium in 2012.

AmeriHealth Caritas Louisiana

National Health Plan Collaborative 10-YEAR ANNIVERSARY

AmeriHealth Caritas Louisiana | Health Literacy

When and how did you get started?

AmeriHealth Caritas Louisiana, a part of AmeriHealth Caritas, launched as a Medicaid Managed Service Provider in February of 2012. Even before the plan began taking members, there was one full time staff member who focused on promoting and creating a plan that had Culturally and Linguistically Appropriate Services (CLAS) for all members, as well as a CLAS workgroup, for which health literacy is a significant component. Incorporating appropriate processes and fostering an environment that promotes health literacy is important for the entire AmeriHealth Caritas enterprise.

What are the current components of your program?

In addition to grade level testing of all member materials and mandatory AmeriHealth Caritas Louisiana-wide health literacy training in July 2012 for all associates, the plan thought it would be a good idea to begin its first year with the AHIP Health Literacy Assessment developed in conjunction with Emory University. AmeriHealth Caritas used the assessment to find areas for opportunity and improvement. As a result, the plan learned that they needed to implement a verbal health literacy toolkit, or guide, for all associates with member contact. AmeriHealth Caritas has set that goal for this year, and they plan on using the AHIP verbal health literacy guidebook. AmeriHealth Caritas will also be conducting website navigation tests using a sample of people that mirrors its membership population. Over time, AmeriHealth Caritas hopes to build on this momentum with larger goals.

How have you made the case internally for your work?

AmeriHealth Caritas has made these components integral to the company since its inception. It is the culture and modus operandi of the company. It is something that is expected.

What have you learned?

AmeriHealth Caritas has learned that health literacy is a continual process and there are always new goals to set.

What is next?

AmeriHealth Caritas' mission is helping people get care, stay well, and build healthy communities. The plan also follows the AmeriHealth Caritas vision to lead America in health care solutions for the underserved. AmeriHealth Caritas understands that in order to excel in these goals, they have to provide care in a way people can understand and take an active role in their health. Health literacy is an integral part of these goals and the plan will continue to expand its health literacy efforts to achieve this.

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4 America's Health Insurance Plans | Health Literacy and America's Health Insurance Plans' Laying the Foundation and Beyond

Exhibit T.4-1: America's Health Insurance Plans Health Literacy Compendium, 2012

In addition, a director of health disparities was hired to lead enterprise-wide efforts to address health disparities and to support the work of the Health Equities Council. This organizational commitment demonstrates our focus and continued success in supporting the mission to help people get care, stay well, and build healthy communities.

Results

Overall, the activities of the Health Equities Council have proven to be a success:

- Over 83 percent of staff reported that content learned during an educational forum was informative.
- One hundred percent of staff who participated in an educational forum reported interest in learning more about health equities and the impact on ACFC's member population.
- Overall, staff also expressed satisfaction with the awareness and education forums hosted throughout the year.
- Over 50 associates at ACLA participated in the National Minority Health Month Campaign that increased visibility of minority health issues.
- ACLA had over 97 percent completion rate for the Health Equity and Cultural Competency Training in 2014.

Cultural and Linguistically Appropriate Services (CLAS)

ACLA complies with the DHH Office of Minority Health's CLAS Standards. CLAS Standards are federal guidelines that impact members, providers, and employees in two key areas:

- Cultural competence, such as language assistance and an awareness of cultural differences between the health care provider and member.
- Health literacy, including the ability to communicate with members in clear, concise language they can understand, no matter what language they speak.

Embracing CLAS Standards can advance health equity, improve quality of care, and make strides toward eliminating health care disparities by providing a blueprint for delivering appropriate services. These standards form the basis of our CLAS Committee, and our strategic plan is updated annually with goals based on these standards.

Our CLAS Committee meets quarterly to review successes and consider improvements in helping members receive the care they need. Committee members review every CLAS-related member complaint each quarter to consider whether systemic adjustments are necessary. The committee also sets goals. Supporting program descriptions, strategic plans, and evaluation criteria are adopted annually to steer initiatives that improve our cultural competence. This year, the CLAS Committee plans to begin reviewing member HEDIS data; the data will be stratified by race, ethnicity, and language to reveal any disparities that need to be addressed.

Identifying and Addressing Member Needs

ACLA maintains a current demographic and cultural profile of our members. We use this to profile plan services. ACLA continually monitors the special needs of our members by reviewing monthly demographic reports that include racial, ethnic, and preferred language information.

In Louisiana, there are four federally recognized Native American tribes. Although these Native Americans comprise only 0.7 percent of Louisiana's total population, their numbers have risen 20 percent since 2000, according to U.S. Census figures. ACLA serves about 500 Native Americans members and providers. Our CLAS coordinator educates and informs employees on the most effective and considerate manner of relating to these members and helping them to manage their health services. For example, in this culture it is especially important not to interrupt the speaker; listening and silence are highly valued.

In serving the Louisiana Medicaid population since 2012, we have found that most of our members speak English, Spanish, or Vietnamese. Accordingly, all welcome packet components are made available in at least these languages initially. We have hired certified bilingual community health educators to communicate with members in Spanish and Vietnamese. We also solicit and respond to member requests. In fact, in response to member concerns, we created an expanded language tagline for inclusion in the Member Newsletter once a year; in addition to Spanish and Vietnamese, we mention the availability of translations to Arabic, Brazilian, Portuguese, French, Nepali, and Burmese. For any population meeting the standard Medicaid threshold (at least 5 percent of members speak the language), we will translate all written member materials into the language spoken and add taglines to materials in the appropriate language informing members of their right to free interpretation and translation services. Even for language needs in less than .01 percent of our member populations, members can call and request material in their preferred language.

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

In 2013, Member Services handled 1,456 calls from members with limited English proficiency. The list below shows the languages spoken by members who contacted and were assisted by Member Services.

- Amharic.
- Arabic.
- Bengali.
- Burmese.
- Cambodian.

- Cantonese.
- Farsi.
- Haitian Creole.
- Hindi.
- Korean.
- Laotian.
- Mandarin.
- Nepali.
- Portuguese.
- Russian.
- Somali.
- Spanish.
- Vietnamese.

Ensuring Cultural Competence in Written Materials

Members who understand health care information—medication directions, guidance from their providers, benefits, and instructions provided over nurse advice lines and websites—benefit in improved health status as a result. Conversely, a lack of understanding has significant implications for both the cost and quality of health care, particularly for members who have chronic conditions and need to carefully follow the treatment regimens prescribed by their physicians.

ACLA seeks to provide information that empowers our members to be participants in their health care. To foster this understanding and empowerment, we follow a documented process to produce all communication materials in accordance with cultural competency and literacy requirements. Materials are reviewed by staff trained in CLAS standards to ensure they are clear, understandable, compliant with reading requirements, and available in alternative formats to members with specialized needs. Strategies that help us accomplish this include:

- Using simple vocabulary to convey information and minimizing the use of medical jargon.
- Using language that is at or below a 6th grade reading level.
- Choosing appropriate design formats that maximize white space and include easy-to-read fonts and layouts.
- Translating materials into Spanish, Vietnamese, and other alternate languages.
- Making materials available in alternate formats (large print, Braille, compact disc, audiotape).
- Testing our materials with member focus groups.
- Using diverse graphics on materials to engage members.

ACLA's member materials are developed by associates who undergo annual training in cultural competency and are instructed in health literacy and reading-level requirements. Our writers use a toolkit adopted from the work of the Partnership for Clear Health Communication at the

National Patient Safety Foundation to ensure that our communications to members are easy to understand and culturally competent.

Review of Materials

All draft member materials are edited for readability and are reviewed through a two-step internal review process prior to submission for state approval. Materials are first reviewed by our Editorial Review Committee—an internal team consisting of representatives from Media Relations, National Plan Communications, Medical Management, Operations, and Internal Communications. The Editorial Review Committee verifies that all materials meet our own strict standards for cultural competency and health literacy. The second review is conducted by representatives of our regulatory team and Legal Affairs. The regulatory and legal teams verify compliance with regulatory and state contract requirements. Our internal material production management system ensures materials have the required approvals from internal stakeholders as well as from DHH before they are printed or distributed. Our process incudes documenting reviews and approvals before final production can commence.

Alternative Formats

Member materials are available in alternative formats—Braille, large print, compact disc, or audio tape—to accommodate those members with sensory impairments. Members with a hearing impairment can call ACLA's toll-free teletypewriter/telecommunication device for the deaf (TTY/TDD) number to request materials in an alternative medium. This line is accessible 24 hours per day, 7 days per week. Member Handbooks, mailing materials, and other material that communicates plan benefits information all include a "tagline" that advises a member who has a visual or hearing impairment to contact Member Services when s/he wishes to request something in an alternative medium.

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

Ensuring a Culturally Competent Provider Network

ACLA recognizes that our efforts to serve members in a culturally competent manner must involve providers. Our recruitment strategy includes recruiting providers who reflect the cultural needs of our membership; speak languages other than English; are of different racial, ethnic, and cultural backgrounds; and are experienced in serving those living with disabilities and chronic conditions.

Rooted in our recognition that provider-member interaction affords a unique opportunity to fundamentally change the health of an individual—and potentially an entire family—ACLA routinely educates providers on cultural competency during initial provider orientation, as well as at a minimum annually, as part of ongoing provider training. ACLA offers web-based

resources for all providers to access at their own convenience. ACLA also posts and updates related information on the Provider Portal and will be available to assist providers in addressing any cultural competency issue. To ensure that members with disabilities have access to providers, we survey all primary care and OB/GYN providers upon contracting for compliance with the American Disabilities Act requirements; we monitor this compliance through regular provider office visits and member complaints and grievances.

Our Network Management account executives are local liaisons who interact frequently with providers, often through face-to-face visits. Account executives are instrumental in coaching providers in the provision of culturally competent services. Providers receive ongoing training through regular interactions with account executives and can request additional trainings at any time. ACLA also produces informational brochures for providers focusing on CLAS and language standards. Account executives distribute these materials at on-site visits and provider training sessions.

To ensure that members can access care from doctors who speak their language, we review provider language reports to identify language concentration by members. When these reports reveal a member need that is not sufficiently being met, we engage Provider Network Management to recruit providers who speak the needed languages. We provide in-person American Sign Language interpretation to members who are hearing impaired to facilitate communication with their providers.

Success Story: Meeting a Member's Language Needs

Our Care Manager reached out on behalf of "Mariam," an ACLA member who was pregnant. The only contact number available belonged to "Mariam's" husband. After the care manager attempted several times to contact the member's husband without success, he called back when he was with the "Mariam." The care manager got permission from "Mariam" to speak with her husband about her care. The care manager learned that "Mariam" speaks only Urdu, but her husband speaks English.

The husband related that he was having trouble getting "Mariam's" progesterone prescription refilled. The care manager related that prior authorization may be needed from "Mariam's" doctor. The care manager called PerformRx, our prescription benefits manager, and, after confirming that prior authorization was needed, reached out and left a message with "Mariam's" doctor.

The care manager then followed up with "Mariam's" husband to let him know the status. He informed her that "Mariam" was seeing a different doctor as a result of a complication with her pregnancy. He provided the name of the new doctor. The care manager indicated that she would call the doctor, inform him of the need for prior authorization of the prescription, and get back in touch with "Mariam's" husband.

During this conversation, "Mariam's" husband expressed his concerns about interpreting for his wife. The care manager reassured him that she would use the services of an interpreter. Satisfied that "Mariam" would be able to communicate her needs to the care manager through this means, her husband gave the care manager "Mariam's" personal cell phone number.

The care manager called the doctor's office to provide prior authorization instructions and followed up once more with "Mariam's" husband. She let him know that he could call the doctor's office for further instructions or reach out again to the care manager with any problems. He expressed his gratitude for all of the assistance in getting the medication refilled.

Utilizing the Urdu language line, the care manager then reached out to "Mariam" directly to engage her in her care and learn of any other needs she had. "Mariam" agreed to have educational materials mailed to her In Urdu. The case manager reached out to ACLA's CLAS coordinator to request translation of materials into Urdu for "Mariam." The team arranged for the translation into Urdu of the Welcome Packet, as well as educational materials targeted to "Mariam's" needs, including "Fetal Kick Count" and "Understanding Pre-term Labor." They mailed these materials to "Mariam."

The care manager reached out to "Mariam" again after she delivered her baby. "Mariam" confirmed that she had received the translated materials and offered her thanks.

AmeriHealth Caritas Louisiana

U.1. Quality Management

U.1 Declare whether or not the proposer submitted HEDIS measures in measurement year 2013. Indicate whether the measures were reported for a State Medicaid, CHIP, and/or Commercial product line. Five points will be awarded to proposers with this experience reporting HEDIS measures.

Overview

AmeriHealth Caritas Louisiana (ACLA) reported HEDIS data in 2014, to reflect the services provided during the 2013 measurement year. ACLA serves the Medicaid and CHIP population, and HEDIS data was submitted to the Louisiana DHH in June 2014. HEDIS data for the Medicaid Plan was also submitted in June 2014 to NCQA.

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U.2. Quality Management

U.2 Complete Appendix WW, HEDIS Scoring Tool by submitting the Proposer's results for the HEDIS measures specified below for measurement year 2013, for each of your State Medicaid contracts.

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

Include the Proposer's legal business name, as defined by L.R.S.12:23, AND the product line name or dba.

If the average of seven or more measures for state Medicaid contracts is above the 2013 NCQA HMO National 50th Percentile for Medicaid Product Lines, ten points will be awarded.

If the average of all measures for state Medicaid contracts is above the 2013 NCQA HMO National 25th Percentile for Medicaid Product Lines, five points will be awarded. No points will be awarded if all measures do not meet at least the 2013 NCQA HMO National 25th Percentile for Medicaid Product Lines.

DHH Reserves the right to independently verify all information provided in Appendix WW.

Appendix WW

The completed Appendix WW is provided on the following pages.

2014 NCQA ACFC - Medicaid Product Lines (1)	Keystone First	AmeriHealth Caritas Pennsylvania	Select Health	MDWise Hoosier Alliance (2)	AmeriHealth Caritas Louisiana (3)	Arbor Health (4)	Average of Scores	Does Average Score Exceed 2013 NCQA HMO National 25th Percentile for Medicaid Product Lines?	Does Average Score Exceed 2013 NCQA HMO National 50th Percentile for Medicaid Product Lines?
Adults' Access to Preventive/Ambulatory Health Services	85.57%	86.55%	87.70%	N/A	83.16%	88.72%	**86.34%**	Y (79.93%)	Y (84.35%)
Comprehensive Diabetes Care- HgbA1C component	82.51%	84.83%	82.85%	77.33%	79.87%	80.50%	**81.32%**	Y (79.21%)	N (83.16%)
Chlamydia Screening in Women	63.27%	53.45%	54.48%	45.04%	55.84%	30.50%	**50.43%**	N (50.97%)	N (57.30%)
Well-Child Visits in the 3,4,5,6 years of life	80.80%	76.50%	64.05%	68.78%	57.17%	57.40%	**67.45%**	Y (67.40%)	N (72.26%)
Adolescent Well-Care.	62.42%	62.70%	48.66%	49.40%	43.49%	41.94%	**51.44%**	Y (41.72%	Y (48.18%)
Ambulatory Care - ER utilization	68.60%	85.21%	59.42%	N/A	76.85%	42.85%	**66.59%**	Y (75.53%)	N (65.65%)
Childhood Immunization status	81.90%	79.91%	74.45%	N/A	43.71%	64.86%	**68.97%**	N (70.44%)	N (76.89%)

2014 NCQA ACFC - Medicaid Product Lines (1)	Keystone First	AmeriHealth Caritas Pennsylvania	Select Health	MDWise Hoosier Alliance (2)	AmeriHealth Caritas Louisiana (3)	Arbor Health (4)	Average of Scores	Does Average Score Exceed 2013 NCQA HMO National 25th Percentile for Medicaid Product Lines?	Does Average Score Exceed 2013 NCQA HMO National 50th Percentile for Medicaid Product Lines?
Breast Cancer Screening	66.19%	68.72%	63.81%	40.94%	N/A	66.25%	**61.18%**	Y (46.51%)	Y (51.32%)
Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents	69.78%	74.54%	25.06%	N/A	1.43%	57.84%	**45.73%**	Y (37.96%)	N (52.31%)
Follow-Up Care for Children Prescribed ADHD Medication	15.68%	19.54%	41.59%	N/A	31.85%	N/A	**27.17%**	N (31.40%)	N (39.76%)

NOTES

(1) HEDIS scores were not provided for the following markets due to the following factors : a) AmeriHealth District of Columbia & AmeriHealth Northeast were not in place as a plan for the entire measurement year & b) Florida True Health - Low overall plan enrollment impacted measure denominators resulting in N/A results.

(2) Only rates reported are those that are available for plan through administrative data. Part of consortium of plans, MDWise, which holds the accreditation and completes single submission of HEDIS rates on behalf of all subsidiaries as documented on IDSS,

(3) Some measures are NA due to low denominators/ not meeting continuous enrollment.

(4) Low overall plan enrollment impacted measure denominators resulting in NA measures.

*Arbor Health plan was only eligible to report on 13 measures due to low continuous enrollment.

** N/A= Measure not eligible due to low continuous enrollment/ denominator.

Immediately following this section, please find included as Attachments the Audit Review Tables for each of the six (6) lines of business outlined above. In addition, we have provided a copy on CD of the files that are imported into NCQA's Interactive Data Submission System (IDSS) for each of the lines of business above, plus a subsidiary breakdown report from MDWise.

U.3. Quality Management

U.3 Document experience in other States or previous Louisiana Medicaid managed care experience. Describe experience in using results of performance measures, member satisfaction surveys, and other data will be used to drive changes and to positively impact the healthcare status of Medicaid and or CHIP populations. Provide an example of changes implemented as a result of data collection to improve the health outcomes of your membership in Louisiana or another state Medicaid program. Examples of areas of interest include, but are not limited to the following:

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

Overview

ACLA believes that solid, actionable data drives good decision-making. This philosophy has been the backbone of our Quality Program in Louisiana since 2012. 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. Under the Bayou Health program, ACLA is experienced in using the results of performance measures, including HEDIS, member satisfaction surveys, Consumer Assessment of Healthcare Providers and Systems (CAHPS), and state data to effect program changes that have positive impact on the health care status of our members.

Data Sources

ACLA'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:

- **HEDIS/CHIPRA Results:** We use Inovalon's Quality Spectrum Insight, an NCQA HEDIS-certified product to create a HEDIS/CHIPRA reporting repository that allows us to run monthly reports on progress toward HEDIS goals, identify low performing measures, and drill down to the member and provider level. This dataset serves as the

backbone for our care gap infrastructure, allowing us to provide alerts and reports on overdue or missing recommended services to providers and ACLA staff working with members. Provider-level data from this system also feeds our provider performance programs.

- **CAHPS Results (adult and child versions):** We partner with NCQA-certified vendors to collect and analyze member satisfaction using the CAHPS survey tools. Results are analyzed at the individual question level and at the composite score levels. Annually, we add approved questions to the survey to collect data on special areas of focus.
- **DHH Quality University of Louisiana at Monroe (ULM) Reports:** We incorporate quality data created by ULM on behalf of DHH to provide insight into ACLA performance on areas of focus for DHH.
- **Provider Satisfaction Survey Results:** We use an outside vendor to objectively collect and analyze data on practitioner and provider satisfaction with our utilization management, care management, quality, credentialing, and provider service programs. The data collection tool is refined each year to collect data on areas of importance to the provider network.
- **Medical and Pharmacy Claim Data:** Data from medical and pharmacy claim transactions are fed from our TriZetto Facets® claim/eligibility system to ACLA's data warehouse. We use data from ACLA claim transactions, as well as historical claim data provided by DHH, as a starting point in our analyses of utilization rates, chronic care and maternity incidence and outcomes, clinical guideline performance and gaps, and health outcome measurement.
- **Care Management Assessment Data:** Data collected through the care management process is stored in our ZeOmega Jiva® care management system. Specific elements, including new member assessment responses, comprehensive and condition-focused assessments, and barrier identification 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 Service team are entered into our Facets® claim/eligibility system. Member race, ethnicity, language, and zip code/census block data is used to identify important subpopulations and geographic pockets with specific needs. Information on Medicaid category and length of enrollment with ACLA is used to augment clinical risk score analysis.
- **Member Disenrollment Surveys:** The reason for disenrollment, along with specific question response for members who disenroll voluntarily, is collected by the Service Operations department. Information from member disenrollment surveys is used to identify potential areas of dissatisfaction and/or gaps in plan services.
- **Utilization Data:** Utilization data is collected through our clinical care management system Jiva® and through analysis of claim information. Data on requested and incurred services is used as the basis for analysis of utilization management processes, such as prior authorization, as well as in evaluating health outcomes and clinical guideline adherence.

- **Provider Access and Availability Data:** We use GeoAccess reporting tools and data collected from provider assessments to evaluate network adequacy and provider adherence to appointment and availability standards.
- **Internal Service Data:** ACLA's systems and processes are set up to enable collection of performance data for all key service areas. Data related to ACLA service levels, including phone performance (speed of answer, abandonment rate, hold time); transaction time (authorization and claim timeliness); and performance quality (claim accuracy, encounter acceptance, denial processing) is used to identify areas of weakness and opportunities to improve performance.
- **Delegate Subcontractor Reports:** Monthly subcontractor report data is reviewed by staff overseeing delegate performance and aggregated to identify trends and potential areas for service improvement. Key areas of focus, as appropriate to the subcontractor's scope of service, include phone performance (speed of answer, abandonment rate, hold time); transaction time (authorization and claim timeliness); and performance quality (claim accuracy, encounter acceptance, denial processing, trip timeliness).
- **Clinical Risk Groups:** ACLA licenses Clinical Risk Groups (CRGs) algorithms from 3M. CRGs are a risk-adjustment tool and clinically-based classification system used to measure a population's burden of illness through longitudinal analysis of medical and pharmacy claim data. Each individual is assigned to a single, mutually exclusive risk group. CRGs use the historical, clinical, and demographic characteristics of the member to predict the amount and type of health care resources that the member will use in the future.
- **Potentially Preventable Events:** ACLA also licenses algorithms and software to identify and measure Potentially Preventable Events (PPEs) from 3M. PPE analysis is used to allow ACLA the ability to target interventions to members whose utilization patterns are most likely to be positively impacted through improved access and coordination of health care services. Conversely, a reduction in the level and number of PPEs indicates more appropriate utilization of health care services and a member's ability to better manage their condition.
- **Member Medical Records:** ACLA collects data directly from member medical records to support analysis of health outcomes.

Within these data sources, ACLA identifies key measures and results for ongoing monitoring. Performance goals and benchmarks, where available, are identified for each measure based on performance targets, industry trends, state experience, and quality committee recommendations. Using SAS and other analytical tools, the ACLA medical economics team performs a more detailed drilldown analysis to understand the drivers of different results.

We incorporate internal performance targets, standards, and external benchmarks into our internal key indicator monitoring and reporting as we work with the state and provider partners to identify areas for additional analysis and, as necessary, implement quality improvement activities and corrective actions.

Using Data to Drive Program Changes

ACLA and its corporate affiliates have a strong track record of data-driven program improvements. The examples in the following section outline the data used and actions taken related to key areas of focus for the Medicaid beneficiaries our health plans serve.

Perinatal Care and Birth Outcomes

Birth outcome data is a key area of focus for ACLA and its affiliate 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, ACLA'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.[1] From 2009–2011, 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 pre-term deliveries was 12.2 percent in 2012, with 7.7 percent in the low birth weight category. Despite the fact that the plan's rates for pre-term 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.

Further analysis, including consultation with a national obstetrical medicine specialist, identified that pregnant members with a history of pre-term birth, a risk factor for a subsequent pre-term 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 pre-term birth. Educational materials, including clinical guidelines on appropriate use and safety were developed with input from network obstetricians. The plan leveraged their strong partnership with the March of Dimes to increase awareness of the issues. They 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.

[1] National Center for Health Statistics, final natality data. From March of Dimes: Peristats, 2014. https://www.marchofdimes.com/peristats/Peristats.aspx; accessed on 3/5/2014.

The home care 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.

Results:

Measure	2012	2013	% change
Low Birthweight (total)	7.70%	5.51%	3.19% decrease
Preterm Births	12.65%	12.60%	0.05% increase

While these results and activities are specific to the Select Health Plan, ACLA has mirrored these activities and through detailed analysis of its own data developed plans and activities that target the needs of the membership in that state. Some of the activities 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 member demographic data, ACLA's Pennsylvania affiliate identified 3 geographical areas with high volumes of pregnant women who did not attend needed postpartum visits. As a result of this analysis, the plan's Bright Start (maternity) staff is collaborating with high volume hospitals and pediatrician offices in each of the areas to track births and encourage new moms to have a postpartum visit.

ACLA's analysis of post-partum visit rate data identified the provider reimbursement mechanism used for maternity services as a potential barrier. Obstetrical providers are paid one fee that includes post-partum services. To align incentives for providers and ACLA, ACLA is considering the implementation of an additional payment, above the global maternity care payment, for the post partum visit. This method creates an additional incentive for obstetricians to ensure that the member receives timely post-partum care.

Planned Early Deliveries

ACLA is currently analyzing data on delivery dates, focusing on elective deliveries (induction or C-section) that occur prior to 39 weeks. C-section deliveries are a major driver of the early delivery volume. The plan's C-section rates (39 percent in 2012 and 38 percent in 2013) mirror the overall state C-section rates of 40.2 percent and 38.9 percent, respectively. Louisiana is rated by www.cesareanrates.com as the state with the most C-sections (#1 in the country). Interventions are now in development to eliminate elective deliveries prior to 39 weeks unless there is a clinical reason for the procedure. In addition to member education campaigns, ACLA is partnering with Louisiana DHH to require providers to submit information through Vital Records supporting the medical necessity for any delivery performed before 39 weeks. Provider education on this initiative and the resultant medical necessity review activity is incorporated into ACLA's Bright Start Maternity program.

Planned Early Delivery Section

ACLA's South Carolina affiliate also implemented initiatives in response to non-medically necessary elective inductions prior to 39 weeks, which then contributed to high C-section rates. In partnership with the state's Birth Outcomes Initiative, the plan conducted state-wide provider education campaigns and worked with in partnership with the March of Dimes to educate members on the importance of waiting for labor. The affiliate implemented non-payment for all elective deliveries prior to 39 weeks that were not medically necessary.

Sickle Cell Anemia

Telemedicine Program

Ongoing analysis of utilization data, including emergency room and inpatient events, led to the implementation of telemedicine services to support members with Sickle Cell Disease who live in rural areas of the state. ACLA identified 987 members who have been diagnosed with Sickle Cell Disease. This small number of members has a significantly higher incidence of ER visits and hospital admissions than other ACLA chronic illness populations. In performing data analysis and drill down, ACLA identified that the highest incidence of ER visits and admissions/readmissions were concentrated in rural areas where members did not have easy access to hematologists for needed care.

With the goal of decreasing ER visits and hospital admissions and providing improved specialty care for our members with sickle cell, ACLA partnered with LSU Shreveport to provide telemedicine services. Access to the LSU medical specialist occurs through a live interactive consultation by video link. For members located in the designated rural locations and in need of a specialist, ACLA Care Managers link them to the program and assist them with obtaining an appointment. Specifically, LSU Shreveport offers Hematological and Specialty Services for members with sickle cell anemia. The telemedicine program began in April 2014 and a few members have used the program to date. Care Managers are actively referring members to the existing 24 hospitals, hematologists and other specialists engaged in the program.

Hydroxyurea Utilization

Through analysis of pharmacy and medical claim data, ACLA and several of its affiliates identified low utilization of hydroxyurea among members with Sickle Cell Disease. Hydroxyurea can reduce the number of pain events experienced by an individual with Sickle Cell Disease. Pain crises are disruptive to the member's life, and often result in emergency room use and inpatient admission.

To improve appropriate utilization of Hydroxyurea in the Sickle Cell Disease population, ACLA and several affiliates are developing a data-driven member and physician outreach program. Ongoing data pulls will identify members with Sickle Cell Disease who have not been prescribed hydroxyurea and those who have a prescription, but have not received their refill.

Providers will receive educational information on the use of hydroxyurea to treat Sickle Cell Disease and information on their members who may be candidates for the medication. The physician education material will also include information on pharmacies that can compound and deliver the medication in liquid form (required for children who need the medication). The ACLA Rapid Response outreach team will contact members missing medication refills to identify barriers, assist in getting follow-up physician appointments and/or laboratory testing, and connect the member to ongoing care management, as appropriate.

Reducing Childhood Obesity

Using a combination of benchmark data, plan demographics and HEDIS results, ACFC identified pediatric obesity as an area of need and implemented a focused program to improve practitioner 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. Since 1980, obesity prevalence among children and adolescents has almost tripled. One of three children is obese or overweight before their 5th 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 tracking of body mass index (BMI) 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.[3] 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 ACFC as all of our health plans have a high volume pediatric membership. In ACLA, the pediatric population (ages 3 through 17) totals 72,402, with 45,016 of those being ages 3 through 11.

The ACFC results for the three components of the HEDIS 2013 Weight Assessment and Counseling for Nutritional and Physical Activity for Children/Adolescents (WCC) measure were below the NCQA 10th percentile. Analysis of the data revealed opportunities to improve the documentation by PCPs of BMI percentile, nutritional, and activity counseling. All ACFC 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 the member and family to make small, meaningful changes, and includes access to a library of educational and referral resources for the care manager, parents and the provider network.

2 Centers for Disease Control, www.CDC.gov, 2011

3 Centers for Disease Control, www.CDC.gov, 2011

In addition, ACLA implemented the Make Every Calorie Count program in 2014, targeting members who have a diagnosis of obesity with other co-morbidities such as diabetes, hypertension, depression, asthma, and sleep disorders. The goal of the program is to see modest, sustainable weight loss. The initial goal for a member is to lose 7- 10 percent of body weight as tracked and reported from initial obesity assessment and reassessment. The Make Every Calorie Count program involves care managers for both children and adults in helping the member to establish personal health goals. The care managers not only coordinate care, they also serve as a motivator for these members. All members undergo a disease and age- specific Health Risk Assessment that addresses lifestyle, activity, nutrition, medication changes, and other areas impacting weight, culminating in the development of an individualized plan of care based on the member-identified goals. Members also receive educational materials on calorie counting, portion sizes, and nutritional guidelines.

Additionally, ACLA has a weight management welcome packet tool kit that is used to help members fulfill their weight management plan. The packet contains a pedometer, measuring tape, calorie count log book, and an informational packet with healthy habit information addressing various areas such as exercise, nutrition, and activity. In addition to aiding the member, the toolkit helps the care manager to obtain patient reported data during follow-up calls, such as how many steps the member took since the last call and how much caloric intake the member has had. This information helps to drive the care plan and monitor progress towards meeting goals.

ACLA also added coverage for one-to-one nutritional counseling with a registered dietitian, a service not currently available through Louisiana Medicaid benefits, for members enrolled in the ACLA obesity program.

ACLA's Pennsylvania affiliates collaborated with the American Academy of Pediatrics, to conduct onsite training on all practices that treat children. BMI toolkits were distributed, which included BMI wheels and information about calculating and documenting BMI percentile, nutrition, and physical activity counseling in the patient's chart, as well as tips for communicating with the parents and/or caregiver.

In keeping with AmeriHealth Caritas' mission to build healthier communities, the AmeriHealth Caritas' Safe Playground program provides new playgrounds at schools that lack safe play areas. Since 2007, the ACFC's associates helped build over 20 playgrounds, including two in Louisiana with one more planned for November 2014. Besides preventing injuries, safe play areas help address the issue of childhood obesity. Play has also been shown to have other powerful benefits for children, including increasing academic performance, reducing youth violence, and enhancing social development.

Reduction of Inappropriate Utilization of Emergency Services

Use of hospital emergency departments (EDs) for non-emergent conditions is a drain on national health care resources, resulting in medically and financially ineffective patient care, unnecessary testing and treatment, and missed opportunities for primary care provider (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 study focusing on 9,240 Head Start families found hospital ED 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.

Pediatric Non-Urgent Emergency Room Use

Like many Medicaid MCOs, ACFC's Medicaid health plans have a high percentage of pediatric membership, as well as a high volume of pediatric members receiving care for common childhood illnesses at hospital emergency departments.

Based in the urban market of Philadelphia, PA, ACLA's affiliate Keystone First identified Infants (< 1 year old) as the most frequent utilizers of ER services, accounting for over 90 visits 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 response to the data findings, the 4 Your Kids Care program was designed and implemented. The program's goal is to address the high rate of non-urgent visits to hospital EDs by pediatric Keystone First members (0–5 years of age) by providing their parents/caregivers with hands-on training and education on how to provide care for common childhood illnesses at home.

The educational program focuses on informing parents/caregivers on caring for common pediatric conditions. The entire curriculum is 4 hours in length, consisting of two sessions. The first session, titled First Response to Your Child's Illness, helps parents/caregivers understand that they are the first line of defense in their child's health care. The learning outcomes include: 1) identifying non-emergent childhood issues; 2) exploring available health care resources; and 3) understanding the importance of primary care physicians (PCPs). The second session, titled Common Childhood Ailments, helps parents/caregivers understand the common issues associated with non-emergent childhood earaches, colds, and flu, and includes becoming familiar with several common over-the counter medications, such as children's acetaminophen and nasal spray, and recognizing when to call a PCP.

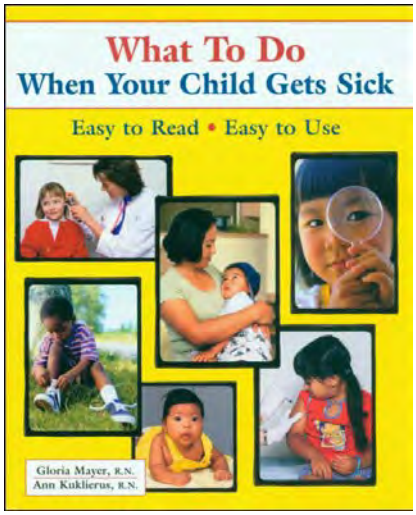

Exhibit U.3-1: 4 Your Kids Care Book

The materials provided to the participant include handouts that discuss specific common childhood illnesses; a free thermometer; educational materials related to taking their child's temperature; and handouts that describe what constitutes an emergency, as well as situations that advise a member to call a doctor. Additionally, participants receive the book titled "What

to Do When Your Child Gets Sick", an easy-to-read, easy-to-use reference designed for people of all reading levels available in English and Spanish, which was developed by two nurses. The book contains information for managing over 50 common childhood conditions, including earaches, fever, vomiting, and nosebleeds. The book describes the illness, what can be done to manage the condition at home, and when to call a healthcare provider. The evaluation tools available to the 4 Your Care trainers included pre- and post-assessments, program evaluations, behavioral cues, and informal interviews.

In matched control evaluation of the program (geography, race, ethnicity, language, and risk score), Keystone First showed a statistically significant drop in emergency room visits for non-urgent conditions for members whose parent/guardian attended the class. To assess knowledge gained from the program, the study group completed a six-point questionnaire before and after attending the educational sessions. Results showed statistically significant improvements in all six questions asked ($p<.01$).[4]

Heart Failure and Diabetes High Utilizers

Analysis of claim and medical record data for members with diabetes and heart failure identified a cohort of members with multiple emergency room visits and inpatient admissions. Many of these ER and inpatient events could be prevented if the symptoms were identified and treated before resulting in a trip to the emergency room. To better meet the needs of these members, ACLA partnered with a vendor for in-home monitoring services starting October 2014. Enrolled members will receive a combination of daily monitoring, provider coordination, and clinical assessment. Objective measures obtained include blood pressure monitoring, glucose monitoring, and daily weights. ACLA care managers will refer members to this program as one of the interventions within ACLA's chronic care/disease management programs. Network providers will be educated on the benefit for members, including how to make referrals for this in-home monitoring service through the ACLA care manager.

This program has been in place in ACLA's South Carolina affiliate for over 4 years. Recent outcome reports assessing members who had received service over 10 months from January 2013 through May 2014 demonstrated significant decreases in inpatient and emergency room utilization and total cost for those members stratified as high risk. [4]

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4 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.

Community Education and Outreach Team (CEOT)

Analysis of claim data focusing on low level (non-urgent) ER utilization identified that only 45% of adult and 40% of children with low level ER use had an established relationship with their PCP (indicated by a PCP visit with in the previous six months). In response, ACLA added outreach to members without a PCP visit in the past 6 months to the services provided by the CEOT. ACLA also implemented a member incentive program providing a gift card to members who see their PCP within 90 days of becoming eligible with ACLA, and annually. ACLA's Quality Enhancement Program (QEP) also rewards PCP practices for well child and adult access to care measures.

Dental-Related ED Visits

In addition to the above findings on members who were not engaged with their PCP, ACLA's analysis of ED claim activity identified disorders of teeth as a driver of low level ED use. To improve access to routine dental care and decrease dental-related ED visits, ACLA is expanding its current enhanced adult dental benefit in 2015 to include x-rays, fillings, and extraction (with a $250 annual maximum), in addition to the examination and cleaning already covered.

Children with Special Needs

Foster Care Children

Through review of pharmacy data and member eligibility files, ACLA identified that many children in the foster care population were prescribed behavioral health medications. A significant portion of those members were in foster care living arrangements, placing them at risk for uncoordinated care. The physician treating the member may not be the physician who originally prescribed the medication and may not be skilled managing a child on a behavioral health drug.

As the result of this data analysis, ACLA is launching a Drug Therapy Management (DTM) program focusing on foster children. The DTM program targets foster care children with at least one of the following conditions: (1) A unique drug count of 4 or more in the previous 90 days, and/or (2) A behavioral health medication (including medication for ADHD) filled in the previous 90 days. ACLA 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

ACLA also conducted an analysis of pediatric members with Behavioral Health / Physician Health co-morbidities.

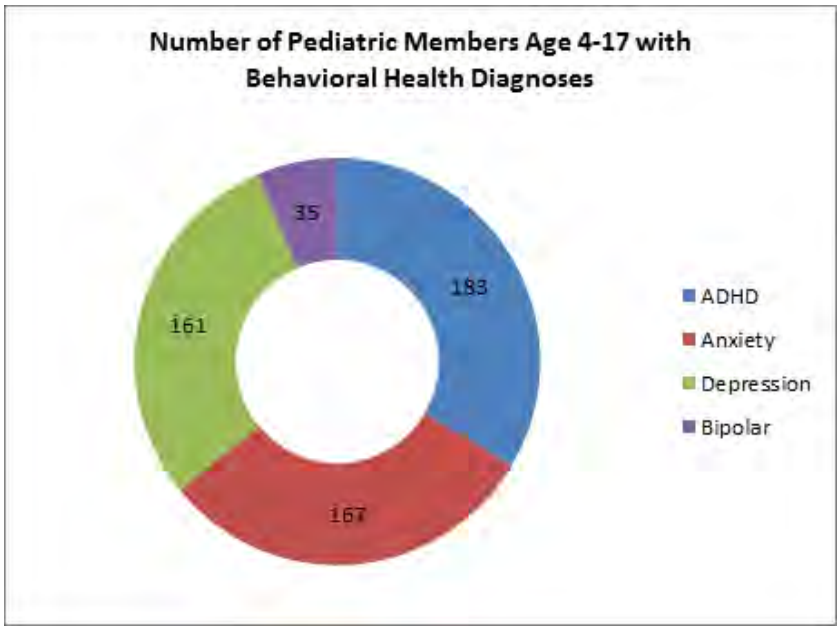

Exhibit U.3-2: Number of Pediatric Members Age 4-17 with Behavioral Health Diagnoses

The children were placed into groups by number and similar diagnoses of comorbidities. The members were further triaged into four groups in order to treat the most sick:

- Significant identified care gaps;
- Immediate referral/case management;
- Behavioral or physical health diagnoses with untreated behavioral health problems;
- Stable but had behavioral or physical health diagnoses.

The results identified 338 children with an unexpectedly high number of comorbidities. These children are being assessed by ACLA care managers for ongoing coordination and management. This methodology is now a routine part of our population analysis, used to trigger a care management assessment.

ADHD Drug Therapy Management

In 2011 the U.S. Centers for Disease Control (CDC) published a study that found nearly 1 in 10 children in the U.S have been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). An analysis of ACLA 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. In addition, ACLA identified a large number of children under age six who were receiving ADD/ADHD medication that was not FDA-approved for their age group.

To address these issues, ACLA implemented clinical guidelines for ADD/ADHD medication and is exploring the implementation of an outreach program designed 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 are newly prescribed an ADHD medication.

Inappropriate Utilization

To address the high volume of ADHD/ADD prescriptions and use of non-FDA approved medication and dosages in children under age six, ACLA and PerformRx (ACLA's pharmacy benefit manager) worked together to draft, present, and implement clinical guidelines and approval edits for CNS Stimulants and Related Agents used to treat ADHD/ADD. The guidelines enforce drug specific age limits. ACLA also implemented a medical review process which allows physicians to present information requesting coverage for medications outside of the recommended guidelines.

Appropriate Follow-Up

ACLA's South Carolina affiliate reported nationally 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 South Carolina affiliate's data and recognition that 80% of their members were less than 18 years of age led to the implementation of a program to increase follow up care for children prescribed ADHD Medication. The program includes physician education and direct member outreach for members started on a CNS Stimulant or related medication to treat ADHD.

ACLA's data analysis and reporting also identified low rates of follow-up for children newly prescribed medication to treat ADHD. To address this opportunity, ACLA's Quality and Rapid Response departments, in partnership with PerformRx (ACLA's pharmacy benefit manager), developed a summary ADHD clinical practice guideline that is currently being reviewed by the ACLA Quality committees for approval and distribution to providers. Outreach, through the Rapid Response team, will be provided to the members with new ADHD prescriptions in order to facilitate the required follow-up visits with their prescriber. 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.

Asthma Management

Asthma is a leading chronic illness in the pediatric population, and a significant driver of health care service utilization for organizations managing Medicaid beneficiaries. ACLA and its affiliate plans continually look for ways to improve health outcomes for this population.

Medication Adherence

Using a combination of medical and pharmacy claim analysis, ACLA, working as part of an ACFC 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. ACLA asthmatic members prescribed an asthma controller medication had a PDC rate of 47 percent for February through December 2012. Through focused outreach and use of specifically designed education materials, ACLA improved medication adherence for asthma controller medications by 6.2 percent from 2012 to 2013.

Every day matters.

Dear Mom

And you don't want to miss one moment of it.

But you have asthma. That can slow you down. It can make the things you do harder.

What can you do to make sure you are there for all of the important things to come in life? **Take your medicine.**

- Talk to your doctor. Make sure you know about your medicine. Talk about how to take it and when to take it. If you take more than one medicine, talk to your doctor about the best and safest way to take them.
- Have an Asthma Action Plan. This will help you know what medicine to take when you feel certain symptoms.
- Talk with your family or a close friend. If you sometimes forget to take your medicine, they can help remind you. Make sure they know where your medicine is if you ever need help.
- Call AmeriHealth Caritas. We are here for you 24 hours a day, 7 days a week.

AmeriHealth Caritas Louisiana Nurse Call Line: 888-632-0009

Member Services: 888-756-0004

Member Services TTY: 866-428-7588

Always call 9-1-1 if you have an emergency.

Every day matters.
Don't miss one moment of it.

AmeriHealth Caritas Louisiana

Exhibit U.3-3: Medication Adherence Fact Sheet Excerpt – Asthma

Health® Tablet Computer System

ACLA is also partnering with our corporate pharmacy affiliate, PerformRx, to create an asthma medication management program designed to increase adherence and reduce overall costs. The program uses a Wi-Fi/Cellular-enabled tablet device given to the member that provides two-way communication between members and the ACLA 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 with poor literacy skills, the tablet provides both audio and visual delivery of educational material. ACLA is the first ACFC affiliate to pilot this program. Program results will be evaluated to determine other ACFC markets for program expansion.

Breathe Easy Start Today (B.E.S.T.) Program

ACLA's Philadelphia-based affiliate is piloting an additional program based on its analysis of asthma medication adherence data. The B.E.S.T. program is a collaborative program, established by the ACLA affiliate, Keystone First. It targets the asthmatic member by combining a teach-back method of patient education with asthma medications and supplies dispensed directly at their point of service in the member's participating provider offices. Asthma medications and supplies are supplied at the expense of the plan to provider practices by a contracted Pharmacy Service. By having medication and supplies available at the point of service, patients do not need to go to the pharmacy to fill the prescription. Instead they leave the providers office with the medication and all supplies in hand and all billing is handled by the plan.

Diabetes Care

Using a combination of benchmark data and ACLA member outcomes, ACLA strengthened their diabetic management program through the addition of a Diabetic Boot Camp.

In 2012, 12.3 percent of the Louisiana adult population, aged 18 years and older, was told by a doctor that they have diabetes.[5] In 2009–2010, only 71.1 percent and 68.5 percent of Louisiana adults diagnosed with diabetes had at least one prior-year foot examination and dilated eye examination, respectively; 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.[6]

5 America's Health Rankings. United Health Foundation. http://www.americashealthrankings.org; accessed on 3/3/2014.

6 Age-adjusted; Centers for Disease Control and Prevention: National Diabetes Surveillance System. http://apps.nccd.cdc.gov/DDTSTRS/default.aspx; accessed on 3/3/2014.

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.[7] In 2010, the total cost of hospital discharges for people with diabetes in Louisiana was approximately $231 million.[8] Based on an analysis of Louisiana Medicaid SFY13 data, diabetes of all types affected approximately 32,541 managed care recipients, roughly 4% of the Louisiana Medicaid managed care population.

Over 4,700 ACLA 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 their diabetic population, ACLA evaluated their current program offerings and went a step further, holding a Diabetes Boot Camp in collaboration with the AmeriHealth Caritas Partnership. Using a curriculum approved by the American Diabetes Association, the Diabetes Boot Camp program educated members on how to win the fight against the disease.

Anchored by a team of diabetes educators, attendees were rotated through four, 50-minute health workshops. Topics included healthy eating, being active, monitoring and taking medication, reducing risks and health and healthy coping. Members also 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 proved to be 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.

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

ACFC's goal is to deliver care that respects the uniqueness of each member and directly benefits the communities we serve. Each ACFC health plan has a distinct composition of member race, ethnicity and language (R/E/L). Review of the R/E/L data for each plan confirmed that within our diverse population, many members in linguistic, racial, and ethnic minority groups continue to have poorer health and lower quality health care.

7 ADA 2008. Referenced in 2010 Louisiana Health Report Card. LA Department of Health and Hospitals. 2012. http://dhh.louisiana.gov/assets/oph/Center-RS/healthstats/HlthRprtCrd2010.pdf; accessed on 3/3/2014.

8 Louisiana Hospital Inpatient Discharge Data (LaHIDD), 2010.

Health Equities Council

To ensure that culturally competent care is reflected in the vision, goals and mission of our company, ACFC created a Health Equities Council (HEC). The Health Equities Council implemented several programs to improve awareness and knowledge for all ACFC associates. Training on CLAS and Health Equity topics were added to the mandatory annual training received by every associate. The HEC schedules regular, nationally recognized speakers to keep the topic current in the organization.

In celebration of National Minority Health Month, the Health Equities Council hosted Robert C. Like, MD, MS on fostering health equity through Culturally and Linguistically Appropriate Service (CLAS) delivery. Dr. Like is a nationally recognized thought leader and advisor to the DHHS Office of Minority Health's CLAS Standards National Project Advisory Committee. In addition, ACFC employees learned about national and local challenges of poverty, geography, and health implications from Dr. Tim Slack, Director of Undergraduate Studies and Associate Professor in the Department of Sociology at Louisiana State University (LSU). Dr. Slack is a national researcher and is locally affiliated with Louisiana Center for Rural Initiatives (LCRI), at LSU.

Race, Ethnicity, Language Data Collection

Each plan routinely analyzes health outcomes for race, language and ethnic subpopulations. Through this analysis, we identified that both member and provider R/E/L data in our systems was insufficient. Most of our data used the Office of Budget Management (OMB) classifications for race and ethnicity, which do not adequately address many populations. For example, using the OMB classification, a recent immigrant from Jordan is in the same "Asian" category as a second-generation Chinese-American. Accurate R/E/L data is necessary to understand the composition of the membership and network and helps to identify actionable healthcare disparities.

To improve this deficiency, ACFC invested in system enhancements and changes to staff protocols to allow for independent and specific R/E/L data capture, storage and retrieval. Since a high percentage of members' R/E/L data found on the states' enrollment files are incomplete and or inaccurate, it was determined that a mechanism was needed to obtain R/E/L data directly from the member and provider.

During the new plan orientation call, and at other touch points with the Member Service and Care Management team, members are directly asked about what languages they prefer to use in medical contexts (for reading and speaking), as well as their race and ethnicity. Data obtained directly from the member is added to our information systems so that it is accessible for ongoing communication with the member, as well as reporting. While the updated information takes precedence in our future contacts with the member, we do not overwrite the data received from the state.

Annually, providers are surveyed for their R/E/L data to determine the network's cultural responsiveness as culturally competency is a necessary component of high quality health care system. Provider network language capacity is analyzed by parish against our membership in

each area annually, in order to ensure we are meeting the language needs of our members. In areas with opportunities, Provider Network Management puts a plan in place to address any gaps or identified needs.

Plan-based Initiatives

The following additional programs and initiatives were implemented to address health disparity findings:

Keystone First

African American females were identified as having statistically significantly lower breast cancer screening rates than their Caucasian counterparts. The plan implemented focused member outreach and mobile mammography screenings centered in African American communities. The "Gift of Life" program was created to offer block scheduling for screenings at local hospitals with transportation provided. A Keystone First outreach associate attends the screening events to provide direct support for those members who are fearful or hesitant of the test.

AmeriHealth Caritas Pennsylvania

Prenatal care utilization (including the timeliness of care and frequency of prenatal visits) for African Americans is statistically significantly lower than for other health plan populations. Program changes included developing culturally specific maternity care member materials and the implementation of educational workshops for targeted communities in seven counties with high African American populations. Particular attention is paid to WIC, Head Start, and other child-oriented sites. The education workshop, entitled "Steps to a Healthy Pregnancy," provides materials and information on a wide variety of topics, including materials on information including the Text4Baby program, the importance of prenatal care and contact information for our Bright Start (maternity) program.

The African American population of AmeriHealth Caritas Pennsylvania is concentrated in 7 counties. To date in 2014, we have provided 18 education workshops and presented maternity materials at more than 60 community events in the targeted counties.

Select Health of South Carolina

Cervical cancer screening was identified as a disparity for African American and Hispanic/Latina women in South Carolina. To provide a more focused interaction with each member, ACFC's Select Health developed customized print materials for each subpopulation. Strong post-assessment results revealed that tailored materials caught members' attention and were easy to read, and that recipients related to and responded favorably to culturally competent images.

Hospital Readmissions and Avoidable Hospitalizations

Preventable hospital readmissions are a significant avoidable cost in the health care 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 also have the potential to drive up health care costs.

Analysis of claim data, incorporating the classifications used in the 3M Clinical Resource Group 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 1000 members across ACFC health plans). In response, all ACFC health plans, including ACLA, implemented initiatives to decrease readmissions for these chronically ill members. Program changes implemented in support of 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
- 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 practitioner 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 Primary Care Provider 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 member education 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 of 2014, readmission rates for members with a dominant Chronic Condition or Asthma in all ACFC plans have decreased by 11.5 percent, with the ACLA rate decreasing by 7 percent.

Additional Data-Driven Program Changes

Other examples of program changes are summarized in the below table:

Data Source and Findings	Action Taken	Health Plan
Pharmacy Claim Data: low medication adherence rates (Proportion of Days Covered: PDC) for oral hypoglycemic, anti-hypertensive and cholesterol-lowering (statin) medication	Implemented 90-day refill program, allowing member to receive a 90-day supply of the targeted medication classes Members incurred a single copay (where copay applied) and pharmacies were paid 2 dispensing fees as an incentive (the health plan saved by reimbursing 2 dispensing fees versus what would have been 3 30-day supply fees).	AmeriHealth Caritas LA AmeriHealth Caritas PA 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 educate treating providers, as needed	AmeriHealth Caritas LA
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 SC
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 LA
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 LA AmeriHealth Caritas PA AmeriHealth Caritas DC Keystone First

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U.4. Quality Management

U.4 Submit a preliminary description of your Quality Assessment and Performance Improvement Program (QAPI), as described in Section 14.1 of the RFP. Such description should address the following. Proposers may submit information from another state Medicaid program showing proposed adaptations to be made for the Louisiana population.

- *1. Proposed membership of the QAPI Committee including roles and responsibilities*
- *2. Proposed QAPI Work plan including a detailed descriptions of how the QAPI Committee will work with the MCO leadership to monitor quality improvement work, specifically:*
  - *performance improvement projects;*
  - *medical record audits;*
  - *performance measures;*
  - *Plan-Do-Study-Act cycles or continuous quality improvement activities;*
  - *member and/or provider surveys; and*
  - *activities that address health disparities identified through data collection.*
- *3. Work the QAPI will undergo to improve the health care status of the Louisiana Medicaid population.*
- *4. Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.*
- *5. How the proposer will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner.*
- *6. How the proposed QAPIs may include, but is not necessarily, limited to the following:*
  - *New innovative programs and processes.*
  - *Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics or other non-traditional health care settings.*

Introduction

The AmeriHealth Caritas Louisiana's Quality Assessment and Performance Improvement (QAPI) program provides a framework for the evaluation of the delivery of health care and services provided to members. The QAPI Program Description describes the quality improvement structure, function, scope, and goals defined for AmeriHealth Caritas Louisiana (ACLA). The Board of Directors for AmeriHealth Caritas Family of Companies approves the QAPI program annually.

ACLA's practitioners form a network of independent health care providers that includes primary care providers (PCPs), hospitals, ancillary providers, and specialists. PCPs are defined as individual practitioners who provide primary care services and manage routine health care needs, including family practice, pediatrics, internal medicine, and general practice.

Purpose

The purpose of the Quality Assessment and Performance Improvement Program is to provide a formal process to systematically monitor and objectively evaluate the quality, appropriateness, efficiency, effectiveness, and safety of the care and service provided to AmeriHealth Caritas Louisiana (ACLA) members in accordance with the following organizational mission statement:

We help people: Get Care, Stay well, Build healthy communities. We have a special concern for those who are poor.

The Quality Assurance Performance Improvement Program also provides oversight and guidance for the following:

- Determining practice guidelines and standards on which the program's success will be measured.
- Complying with all applicable laws and regulatory requirements, including but not limited to, the Louisiana Department of Health and Hospitals, other applicable state and federal regulations, and NCQA accreditation standards.
- Providing oversight of all delegated services.
- Ensuring that a qualified network of providers and practitioners is available to provide care and service to members through the credentialing/re-credentialing process.
- Conducting member and practitioner satisfaction surveys to identify opportunities for improvement.
- Reducing health care disparities by measuring, analyzing and redesign of services and programs to meet the healthcare needs of our diverse membership.
- Evaluating and mitigating member safety issues through the credentialing and re-credentialing process, quality of care concern investigation, risk management program, pharmaceutical management program, and monitoring of member complaints and grievances.
- Access the quality and appropriateness of care furnished to enrollees with special health care needs.

Goals

The overall goal of the Quality Assessment and Performance Improvement Program is to improve the quality and safety of clinical care and services provided to members by establishing a comprehensive quality management structure and program that:

- Efficiently collects, analyzes and reports data
- Implements strategies to manage risk
- Addresses clinical, psychosocial and functional needs of the membership
- Improves access to care and quality of services provided to members and those with special health care needs.
- Reduces healthcare disparities.

ACLA develops goals and strategies considering applicable state and federal laws and regulations, NCQA accreditation standards, evidence-based guidelines that are established by medical specialty boards and societies, public health goals, and national medical criteria.

Objectives

The objectives of the Quality Assessment and Performance Improvement Program are to systematically develop, monitor, assess, and take action to improve access to care and quality of services through the following activities:

- Maximizing utilization of collected information about the quality of clinical care, health outcomes and quality of service..
- Identifying clinical and service improvement initiatives for targeted interventions.
- Ensuring adequate physical health practitioner and provider availability and accessibility to effectively serve the membership.
- Maintaining credentialing/re-credentialing processes to assure that AmeriHealth Caritas Louisiana's network is comprised of qualified practitioners.
- Overseeing the provision of services by delegated entities.
- Communicating performance to participating practitioners through provider profiling and information dissemination.
- Coordinating services between various levels of care, network practitioners, and community resources to assure continuity of care and promote optimal physical, psychosocial, and functional wellness.
- Designing and implementing programs to coordinate care and maximize health outcomes for members with complex health needs.
- Optimizing utilization management to assure that care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards.
- Ensuring that member benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate, overutilization or underutilization.
- Utilizing results of member and practitioner/provider satisfaction measures when identifying and prioritizing quality activities.
- Implementing and evaluating condition management programs to effectively address chronic illnesses affecting the membership.
- Designing and implementing outreach and health education activities.
- Provide mechanisms for members to have input into the quality improvement activities by monitoring complaints, grievances, appeals, quality of care concerns, satisfaction surveys, integrated care management and member service encounters and community member advisory participation.
- Maintaining compliance with evolving NCQA accreditation standards.
- Communicating results of clinical and service measures and quality initiatives to practitioners, providers, and members.
- Identifying and implementing activities that promote member safety.

- Documenting and reporting monitoring activities to appropriate committees.
- Facilitating the delivery of culturally competent healthcare to reduce health care disparities.

Program Scope

The scope of the QAPI Program encompasses members, providers, and health care delivery systems across all dimensions of quality. The program includes all care management processes, performance monitoring activities, clinical and service improvement activities, clinical outcome measures, satisfaction assessments, NCQA, and applicable laws and regulatory requirements.

The scope of the QAPI Program includes the following areas:

- Identification of the Member profile.
- Accessibility and availability of care.
- Member, provider, and practitioner satisfaction.
- Member grievance and appeal processes and trends.
- Maternity and chronic condition management.
- Development, implementation, and adherence assessment of clinical and preventive health practice guidelines.
- Continuity and coordination of care.
- Member safety.
- Clinical quality initiatives.
- Review of quality of care incidents.
- Assessment of quality of care across practice for treatment of chronic conditions.
- Assessment of care coordination and continuity of care.
- Monitoring of utilization including over, under and misutilization.
- Quality of service.
- Credentialing/Re-credentialing activities.
- Preventive health care services.
- Medical record documentation.
- Oversight of delegated activities.
- Activities to reduce health care disparities.
- Activities to improve linguistic and cultural competence.

The scope of the QAPI Program encompasses processes to promote access and availability of health care services, activities to improve health outcomes and initiatives to improve satisfaction for members and providers. The QAPI Program is implemented using a comprehensive and integrated systematic process of collecting information, analyzing the information, identifying opportunities to improve care and service, acting upon such opportunities and monitoring the effectiveness of interventions.

Program Structure Governing Body Accountability

The Board of Directors for AmeriHealth Caritas Louisiana (ACLA) provides strategic direction for the Quality Assessment Performance Improvement (QAPI) Program and retains ultimate responsibility for ensuring that the QAPI Program is incorporated into ACLA's operations.

Operational responsibility for the development, implementation, monitoring, and evaluation of the QAPI Program are delegated by the Board of Directors through the Regional President to the Executive Director and Quality Assessment Performance Improvement Committee.

The QAPIC, ACLA's Medical Director, and Director of Quality Management have responsibility for planning, designing, implementing, and coordinating quality improvement activities.

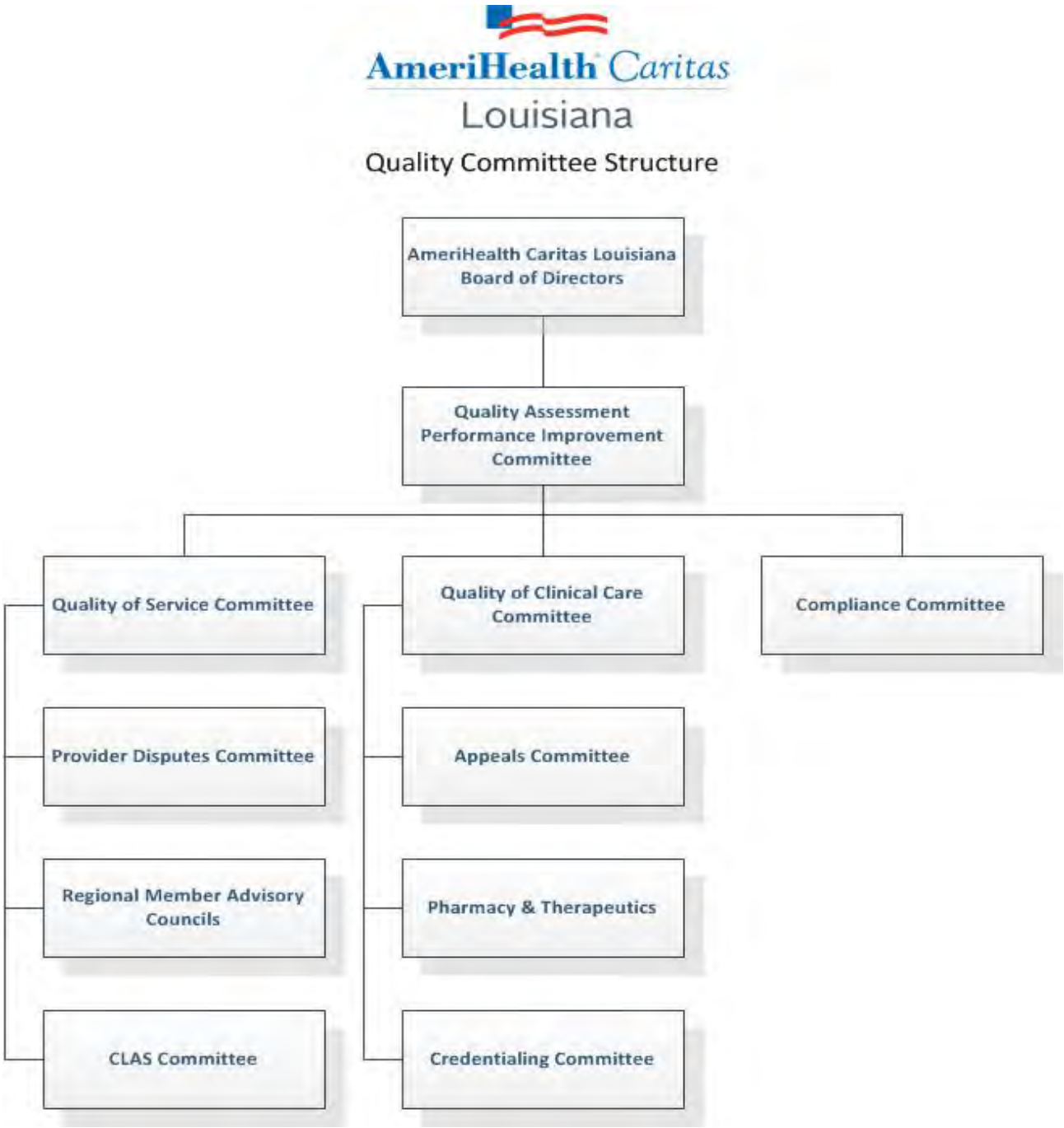

Exhibit U.4-1: Quality Committee Structure

Quality Assessment Performance Improvement Committee

The Quality Assessment Performance Improvement Committee (QAPIC) oversees AmeriHealth Caritas Louisiana's (ACLA) efforts to measure, manage, and improve quality of care and services delivered to ACLA members, and evaluate the effectiveness of the QAPI Program. The QAPIC directs and reviews AmeriHealth Caritas Louisiana's Quality Improvement (QI), and Utilization Management (UM) activities and has the authority to create and provide direction to work groups, committees, and departments within the Plan to assess, investigate, and take action related to the health care services received by the ACLA members. The QAPIC report through the AmeriHealth Caritas Louisiana's Executive Director to the Regional President and, ultimately up to the Board of Directors of AmeriHealth Caritas Family of Companies.

The QAPIC provides oversight for Quality Assessment Performance Improvement QAPI and Utilization Management (UM) activities. The primary responsibilities of the QAPIC include:

- Assuring integration of QAPI activities throughout the plan, including providing direction to committees and work teams to review areas of concern.
- Reviewing the effectiveness of the ICM, UM and QAPI programs and processes and make changes as needed.
- Review and approve results of the plan's service initiatives from the Compliance Committee, Quality of Service Committee and the Quality Clinical Care Committee
- Review the QAPI program description, QAPI program evaluation, combined QAPI/UM work plan, ICM and UM program descriptions and UM program evaluations.
- Reviewing and suggesting new and/or improved QI activities.
- Identifying and approving evaluation and study-design procedures.
- Reviewing and approving clinical and preventive practice guidelines used by the plans.
- Assessing the effectiveness of the plan's health management and chronic care improvement programs.
- Monitoring and evaluating utilization of health services (including over- and underutilization and outliers) and the effectiveness of utilization management activities.
- Monitoring and reviewing individual practitioner and provider performance with respect to quality and utilization outcomes and application of clinical practice guidelines.
- Assessing the effectiveness of performance-improvement projects (PIP's) through analysis and evaluation of results, initiation of needed action, and follow up, as appropriate.
- Reviewing and approving program policies and procedures related to QAPI, UM and Integrated Care Management (ICM) processes and committee infrastructure.
- Monitor and review the practitioner network access reports, after hours and availability compliance.
- Monitoring and evaluating performance related to credentialing/recredentialing activity, appeal processing, and service indicators.
- Reviewing program peer-review activity and recommending any appropriate actions.
- Reviewing results of program clinical outcome collection, including Healthcare Effectiveness Data and Information Set (HEDIS) and other metrics defined by the DHH;

clinical practice guideline adherence and utilization results to identify opportunities for improvement; and overseeing related improvement plans.
- Monitoring and evaluating consistent application of medical necessity criteria and overseeing related improvement plans.
- Reviewing results of member satisfaction, grievances and appeal data to identify opportunities for improvement.
- Reviewing results of provider satisfaction, complaint and appeal data to identify opportunities for improvement.
- Reviewing and approving results of service initiatives.
- Monitoring performance of program delegates and vendors and recommending interventions, as appropriate.

Chairperson and Membership

The chairperson of the QAPIC is the ACLA's Executive Director, who has the tie-breaking vote. The Plan's Medical Director serves as the co-chairperson for QAPIC.

Membership: Voting

- Six to eight practicing Practitioners (Specialists and Primary Care Practitioners).
- Executive Director, chair.
- Medical Director, co-chair.
- Regional Chief Medical Officer.
- Regional Clinical Director, Medical Services.
- Director, Quality Management.
- Director, Utilization Management.
- Director, Integrated Case Management.
- Director, Provider Network Management.
- Director, Compliance.
- Director, Plan Operations and Administration.
- Director, Community Outreach, and/or a designee serve as a Member Advocate representative to this committee.

The QAPIC meets quarterly. A quorum is established upon attendance of at least 50% of voting members. Committee minutes are recorded at each meeting and reflect key discussion points, decisions made, rationale, planned actions, responsible person and follow-up. Minutes from the quarterly meeting are submitted to DHH by the 30th of the month following the end of the quarter (April 30th, July 30th, October 30th, and January 30th).

Compliance Committee

The AmeriHealth Caritas Louisiana's Compliance Committee is a subcommittee of QAPIC. The as committee serves in an oversight role to ensure that AmeriHealth Caritas Louisiana is in compliance with all contractual requirements and all applicable laws, rules and regulations. The Compliance Committee also oversees and addresses potential fraud, waste and abuse concerns. This committee reports up to the QAPI Committee.

The primary responsibilities of the Compliance Committee include:

- Review and approve ACLA's annual Compliance Work Plan.
- Ongoing monitoring of the Compliance Work Plan to ensure that compliance activities are carried out in a timely manner.
- Monitor updates at state and federal levels and respond as necessary to ensure plan compliance.
- Addressing, researching and responding to any and all issues regarding compliance with Federal and State regulations, as well as specific Medicaid program rules and requirements.
- Monitoring and tracking of ongoing compliance-related activities and education.
- Effectively identify and manage potentially fraudulent and/or wasteful activity within the plan.
- The oversight of compliance with the State contract.

Chairperson and Membership

The chairperson of the Compliance Committee is the ACLA's Compliance Director and Regulatory Affairs.

Membership: Voting

- Director, Compliance.
- Executive Director.
- Director, Integrated Care Management.
- Director, Quality Management.
- Director, Provider Network Management.
- Director, Plan Operations and Administration.
- Director, Finance.
- Director, Community Education.
- Medical Director.
- VP, Corporate Compliance & Privacy Officer (ACFC).
- Membership: Non -Voting Compliance Specialist.
- Director, Corporate Audit ((ACFC).
- Human Resource Business Partner.
- Director, Special Investigations Unit.

ACLA's Compliance Committee meets at least quarterly, or at a minimum of three times a year. A quorum is established upon attendance of at least fifty percent (50 percent) of the voting membership. The committee maintains its minutes in the same manner as QAPIC minutes. Compliance Committee minutes, recommendations and actions are submitted to QAPIC for its review and approval. The Compliance Committee reports to the QAPI Committee.

Quality of Clinical Care Committee

The Quality Clinical Care Committee (QCCC) is a subcommittee of QAPIC. The responsibility of the committee is provide direction and oversight of the clinical quality and appeals,

utilization management, integrated case management, chronic case management, pharmacy and credentials programs. The committees reporting to QCCC include the Pharmacy and Therapeutics (P&T), Credentialing and Appeals.

The primary responsibilities of the QCCC committee are to:

- Review results of program clinical outcome collection, including HEDIS and other metrics defined by the DHH, clinical practice guidelines adherence and utilization results to identify opportunities for improvement and oversee related improvement plans.
- Creating better system for identification, screening, and evaluation health outcomes for members with special health needs.
- Collect provider feedback and committee approval of practice and preventive health guidelines and utilization management criteria used to determine medical necessity.
- Monitor and evaluate performance related to credentialing/re-credentialing activity.
- Review and recommend annual program descriptions and program evaluations for utilization management and integration case management.
- Review results of member and provider satisfaction results that impact clinical services and recommend necessary actions.
- Monitor and evaluate consistent application of medical necessity criteria to include oversight of the nursing/physician inter-rater reliability testing results and related improvement plans.
- Monitor outcomes of grievance, complaint and appeal processes and recommend interventions as appropriate.
- Monitor performance and outcomes for integrated case management and chronic condition improvement programs.
- Provide leadership and oversight to develop effective clinical Performance Improvement Projects.
- Evaluate quality concern events (resulting in adverse outcomes).
- Monitoring the medical appropriateness and necessity of healthcare services provided to the plan's members utilizing provider quality and utilization profiling.
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed.
- Monitoring over- and underutilization.
- Monitor ACLA's review of member medical records to ensure that PCPs provide high quality health care that is documented according to established standards.

Chairperson and Membership

The chairperson of the QCCC is the ACLA's Medical Director.

Membership: Voting

- Two to four practicing Practitioners (Specialists and Primary Care Practitioners).
- Regional Medical Director, Medical Affairs.
- Regional Clinical Lead, Medical Affairs.
- Manager, Appeals.

- Director, Utilization Management.
- Director, Integrated Case Management.
- Director, Quality Management.
- Director, Provider Network Management.
- Director, Operations Services.

The QCCC meets quarterly or a minimum of four times a year. A quorum is established upon attendance of at least 50 percent of voting members. The committee maintains its minutes in the same manner as QAPIC minutes. The QCCC minutes, recommendations and actions of the committee are submitted to QAPIC for its review and approval. Minutes from the quarterly meeting are submitted to DHH by the 30th of the month following the end of the quarter (April 30th, July 30th, October 30th, and January 30th).

Quality of Service Committee

The Quality of Service Committee (QSC) is a subcommittee of the QAPIC. The purpose of the QSC is to assure that performance and quality improvement activities related to ACLA'S services are reviewed, coordinated and effective. The QSC reviews, approves, and monitors action plans created in response to any identified variance. The committees reporting to the QSC includes; Provider Dispute, CLAS and the Member Advisory Council.

QSC provides oversight of the following services:

- Access and availability.
- Annual review of membership demographics and utilization of services.
- Appeal and grievance processing.
- Decision making timeliness for Utilization Management.
- Member, practitioner and provider satisfaction surveys.
- Service standard compliance.
- Practitioner/provider complaints.
- Member orientation calls.
- Review, approval and monitoring of Subcontractor and Delegate activities associated with service standards, access and availability.
- Member communication.
- Race, Ethnicity and Language utilization, access/availability and timeliness.

Chairperson and Membership

The chairperson of the QSC is ACLA's Director Plan Operations and Administration. The Plan's Director of Quality serves as the co-chairperson for QSC.

Membership: Voting

- Director, Quality Management.
- Director, Utilization Management.
- Director, Integrated Case Management.
- Director, Network Management.

- Director, Rapid Response.
- Director, Regulatory Affairs.
- Manager, Network Service Operations.
- Manager, Appeals.
- Director/Manager, Member Services.
- Director/Manager, Claims Unit.
- Director/Manager, Contact Center.
- Delegate Oversight Analyst.

The QSC meets quarterly or four times a year. A quorum is established upon attendance of at least 50% of voting members. The committee maintains its minutes in the same manner as QAPIC minutes. The QSC minutes, recommendations and actions are submitted to QAPIC for its review and approval.

Practitioner Participation

Several channels exist to encourage provider participation in QAPI Program initiatives.

Committee Participation

Practitioners from the plan's network are invited to participate as voting members on the QAPIC, QCCC, and Credentialing Committees. QAPIC and QCCC members play an active role in shaping the direction and specific initiatives that comprise the QAPI Program. Credentialing Committee members have the final say on which practitioners and providers participate in the ACLA's network. There are currently 16 physicians who sit on the committee, from across the state of Louisiana.

Physician Feedback Mechanisms

AmeriHealth Caritas Louisiana introduced an incentive program for Primary Care Providers (PCP). The incentive program, Quality Enhancement Program (QEP) provides incentives to PCP for high-quality and cost-effective care, member service and convenience and for submission of accurate and complete health data. Quality performance is the most important determinant of this additional incentive. The five performance components are as follows.

- Quality Performance.
- Severity of Illness.
- Cost Efficiency Management.
- Non- Emergent Emergency Room Utilization.
- Improvement Incentive.

The QEP provides financial incentives over and above the practice's base compensation. Offices with few than 500 members on their panels are not eligible for participation as well as those practices that have alternate incentive arrangements or risk-sharing arrangements with AmeriHealth Caritas Louisiana are also not eligible for participation in the QEP.

Beginning in 2015, Primary Care Physician (PCP) will begin to receive report cards that will provide direct feedback on the practitioner's performance. The report will incorporate quality measures that the practitioner will be compared to a peer group within the AmeriHealth Caritas Louisiana's network, on key quality measures. Adjusted for acuity, these report cards engage practitioners in the quality program by providing direct feedback. Additionally, PCPs can pull reports on their assigned members that provide member-level data on key quality metrics.

Additionally, providers entering the member's ID number into the Provider Web Portal are able to see an alert notifying them that the member's record indicates a Care Gap. Care Gaps fall into two categories:

- Recommended services for which there is no evidence that the member received the service
- Conditions that indicate a possible need for physician intervention.

Clicking on the alert displays a member-specific care gap worksheet that identifies the care gap, along with a list of up-to-date services for the provider's reference. The Care Gap Worksheet is formatted to allow for easy printing and inclusion in the member's chart. The identification and dissemination of care gaps at the point of service engages providers in the provision of quality, evidence-based care.

QAPI Work Plan

The goals, objectives, and related measures used to monitor and evaluate performance are incorporated into the QAPI Work Plan. The work plan identifies objectives for the current year, program scope, quality improvements and monitoring activities for the coming year, planned monitoring of previously identified issues and the plan's scheduled annual QAPI program evaluation.

The work plan also identifies the responsible party and a time frame for completion for all activities. The work plan activities are assigned to the plan's staff person with responsibility for the specific plan department who will perform most of the work related to the planned activity. The work plan is revised as necessary to add new initiatives and services. ACLA submits the QAPI Work Plan to DHH on an annual basis and prior to implementation of revisions.

An overview of the full proposed QAPI Work Plan is detailed below:

AmeriHealth Caritas Louisiana

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT WORK PLAN

	Activity	Responsible Dept(s)/Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Comments
A	**Quality Assessment Performance Improvement Committee (QAPIC)**														
XX	**QAPI Deliverables to Board of Directors** - QAPI Program Description /Work plan and Evaluation **Goal**: To provide an annual evaluation, review, and report on the overall effectiveness/opportunities for improvement of the quality program with regard to Amerihealth Caritas Louisiana's (ACLA) Mission and contractual/accreditation obligations. Monitoring- QAPIC- Quarterly	**Quality (L)** Rebecca Engelman, Executive Director													
XX	**Quality Assessment and Improvement (QAPI) Program** – Annual review and approval of the Plan's Quality Improvement Program. **Goal**: To provide an annual review and update of the QAPI Program that is consistent with achieving ACLAs mission of improving the health and quality of life of our members. Monitoring: QAPIC- Annually	**Quality (L)** Debra Auclair, Director QM				X									
XX	**2013 Annual Evaluation of the Quality Improvement Program** **Goal**: To provide an annual evaluation and report on the overall effectiveness of the quality program, identifying opportunities for inclusion in the upcoming QAPI Program and Work Plan. Monitoring: QAPIC – Annually	**Quality (L)** Debra Auclair, Director QM **ALL (S)**				X									
XX	**QAPI Work Plan-** Quarterly review and update of ACLA's Quality Assessment and Performance Improvement Work Plan. **Goal**: To provide a quarterly review and update of the work plan for prioritization of contractual and accreditation obligations Monitoring: QAPIC- Quarterly	**Quality (L)** Debra Auclair, Director QM **ALL (S)**				X			X			X		X	
XX	Maintain **NCQA's Accreditation for Health Plans -** Ongoing monitoring and implementation of those activities identified to maintain the Plan's NCQA accreditation due for renewal in 2015. **Goal**: Review the NCQA Health Plan Standards, implementing activities to address gaps in effort to ensure compliance with NCQA standards. Monitoring: QAPIC- Quarterly	**Quality (L)** Debra Auclair, Director QM **ALL (S)**				X			X			X		X	

Responsible Person: (L) Lead (S) Support

AmeriHealth Caritas Louisiana

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT WORK PLAN

Activity		Responsible Dept(s)/Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Comments
B	**Quality of Service Committee (QSC)**														
XX	Monitor customer service performance within **Member Services for call center service standards** including ASA & Abandonment rates. **Goal:**: Meet or exceed the following performance standards for Member Services ASA ≤ 0:30 seconds Abandonment rate ≤ 5.0% Monitoring: QSC – Quarterly	**Member Services (L)** Tanika Stokes Manager, Contact Center; Cristhiane Diana Manager, Member Services (L)	X			X			X			X			
XX	Monitor, analyze and report **Member Grievances** received by the Plan per the DHH contract and NCQA Accreditation. Annual assessment of the member grievances are evaluated on the following five categories; Quality of Care, Access, Attitudes/Service, Billing/Financial and Quality of Practitioner Office Sites. **Goal:** Improve operational processes and educational practices in order to maintain or reduce the number of member grievances received by the Plan. Monitoring: QSC – Annually	**Member Services (L)** Tanika Stokes Manager, Contact Center; Cristhiane Diana Manager, Member Services (L)										X			
XX	Assess the **availability of ACLA's provider network through Geo Access** for the following provider types: PCP's, Hospitals, Specialists, Lab/Radiology and Pharmacy **Goal:** Meet or exceed the following established network availability standards • PCP's – within 30 miles for mbrs living in rural parishes Within 20 miles for mbrs living in urban parishes • Hospitals - within 30 miles for mbrs living in rural within 30 minutes for mbrs living in urban parishes • Specialists –within 60 miles for at least 75% of members and 90 miles for all members • Lab/Radiology – within 30 minutes or 30 miles Monitoring: QSC – Annually	**Network Mgmt (L)** Sherry Wilkerson, Director Provider Network Management				X									

Responsible Person: (L) Lead (S) Support

AmeriHealth Caritas Louisiana

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT WORK PLAN

Activity		Responsible Dept(s)/Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Comments
XX	Monitor and report **Practitioner after hour performance** against established access standards, implement corrective actions as necessary **Goal:**: Meet or exceed practitioner accessibility standards for after hours accessibility (24 hr a day, 7 days a week, personally or through coverage) Monitoring: QSC- Annually	**Network Mgmt (L)** Sherry Wilkerson, Director Provider Network Management				X									
XX	Report results of ACLA's annual **Provider Satisfaction Survey**. Identify and prioritize activities to improve network provider's satisfaction with services provided by ACLA **Goal:** To improve the provider's satisfaction of the Plan's services by monitoring and responding to identified opportunities within the Provider Satisfaction Survey. Monitoring: QSC – Annually	**Network Mgmt (L)** Sherry Wilkerson, Director Provider Network Management **Quality (S)**										X			
XX	**Monitor and report the plan's PCSU Client/Claims Report**: to include call center stats (i.e. ASA and AR) and claim statistics, denials and claim accuracy. **Goal:** To ensure PCSU call center standards and claim payment requirements and accuracy meet the following goals: ASA ≤ 0:30 seconds - AR ≤ 5.0% Ensure 90% of all clean claims are paid to provider within 15 business days of receipt of the claim. Plan shall process and pay within 30 calendar days -99% of all clean claims. Claim accuracy≥ XX% Monitoring: QSC – Bi-Annually	Renee Simmons **Operations – (L)**				X								X	
XX	Collect, analyze and implement activities as necessary in response to identified trends from **Informal Provider Grievances** received by the Plan. **Goal:** Improve operational processes and educational practices in order to maintain or reduce provider grievances received by the plan. Monitoring: QSC – Annually	**Provider Services (L)** Renee Simons, Director Operations										X			
XX	Report **CAHPS – Satisfaction Survey results for Child, Child with CCC and Adult populations**. Identify and prioritize activities to improve member satisfaction. **Goal:** Improve upon identified areas and processes within ACLA to improve the services proved to plan members. Monitoring: QSC – Annually	**Quality (L)** Debra Auclair, QM Director **All (S)**										X			

Responsible Person: (L) Lead (S) Support

AmeriHealth Caritas Louisiana

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT WORK PLAN

Activity		Responsible Dept(s)/Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Comments
XX	Collect, analyze and implement activities as necessary, based on information from **Provider Satisfaction with the UM/ICM processes** **Goal:** To identify and improve upon areas within the UM/CM processes that are negatively impacting results received from ACLA's provider satisfaction survey. Monitoring: QSC- Annually	**UM (L)** Kathy Kiester, UM Director **ICM (S)** Rachel Weary, ICM Director										X			
XX	Collect, analyze and implement activities, if necessary, based on information from **Member Satisfaction with the UM/ICM processes.** **Goal:** To identify and improve upon areas within the CM processes that are negatively impacting results received from ACLA's member satisfaction survey. Monitoring: QSC- Annually	**UM (L)** Kathy Kiester, UM Director **ICM (S)** Rachel Weary, ICM Director										X			

AmeriHealth Caritas Louisiana

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT WORK PLAN

	Activity	Responsible Dept(s)/Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Comments
C	**CLAS Committee**														
1	Annual review and approval of the plan's **Culturally and Linguistically Appropriate Services (CLAS) Program Description.** **Goal:** To provide an annual review and update of the plan's CLAS Initiative and Strategic Plan. Ensuring that all activities for members are consistent with the 15 national CLAS standards guaranteeing that plan members are serviced in a way that tis responsive to their culture and linguistic needs while addressing member healthcare disparities. Monitoring: CLAS - Annually	**QM (L)** Erin Hawley, CLAS Coordinator				X									
2	Annual review and approval of the **Culturally and Linguistically Appropriate Services (CLAS) Program Evaluation** **Goal:** To provide an annual evaluation and report on the overall effectiveness of the CLAS Program, identifying opportunities to include and address of cultural needs of the plan's membership in the upcoming annual CLAS Program Description.. Monitoring: CLAS – Annually	**QM (L)** Erin Hawley, CLAS Coordinator				X									
3	Monitor the ethnic, racial and linguistic needs of the plan's membership. **Goal:** To identify opportunities and implement actions that will address the cultures needs of the plan's membership. Evaluate disparities in **HEDIS performance measures and implement at least** one culturally competent intervention to address at least one member healthcare disparity. Monitoring: CLAS - Annually	**QM (L)** Erin Hawley, CLAS Coordinator **Medical Economics (S)**										X			
4	Develop the **CLAS Strategic Plan that will address the plan's cultural competency needs.** . **Goal:** To provide a quarterly review and update of the strategic plan to determine progress cultural competency goals, Monitoring: CLAS – Annually	**QM (L)** Erin Hawley, CLAS Coordinator				X									

Responsible Person: (L) Lead (S) Support

AmeriHealth Caritas Louisiana

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT WORK PLAN

	Activity	Responsible Dept(s)/Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Comments
D	**Quality of Clinical Care Committee (QCCC)**														
XX	**Integrated Case Management (ICM) Program Description –** Annual review and approval **Goal:** To provide an annual review of the ICM Program that is consistent with achieving ACLA's mission of improving the health and quality of life for our members. Monitoring: QCCC- Annually	**ICM (L)** Rachel Weary, Director ICM			X										
XX	**Annual Integrated Case Management Evaluation** - **Goal:** To provide an annual evaluation and report on the overall effectiveness of the Complex Case Management and Chronic Condition Management activities, identifying opportunities for inclusion in the Program Description. Monitoring: QCCC – Annually	**ICM (L)** Rachel Weary, Director ICM			X										
XX	Develop and maintain **Clinical Practice Guidelines** relative to the needs of the population – Evaluation and approval of guidelines. **Goal:** Develop, adopt, revise and distribute clinical practice guidelines as necessary to support the population. Monitoring: QCCC - Annually	**Medical Affairs (L)** Dr. Burnham, Region UM Director			X										
XX	Maintain Preventive Health Guidelines relative to the needs of the population - **Evaluation and approval of guidelines for Adults, Children, Pregnant Women** **Goal:** Review and revise preventive health guidelines as necessary to support the population. Monitoring: QCCC - Annually	**Medical Affairs (L)** Dr. Burnham Region UM Director			X										
XX	**Performance Improvement Project (PIP): Emergency Room Utilization** Implement a structured Performance Improvement Project to address Emergency Room Utilization Goal: Decrease inappropriate emergency room utilization Monitoring: QCCC – Annually	**Quality (L)** Debra Auclair, Director QM										X			
XX	**Performance Improvement Project (PIP): Cervical Cancer Screening** Implement a structured Performance Improvement Project to address Cervical Cancer Screening **Goal:** Increase cervical cancer screenings Monitoring: QCCC – Annually	**Quality (L)** Debra Auclair, Director QM										X			

Responsible Person: (L) Lead (S) Support

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QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT WORK PLAN

	Activity	Responsible Dept(s)/Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Comments
XX	**Quality Improvement Activity (QIA): Bright Start** Identify and implement Prenatal activities to improve prenatal outcomes and HEDIS measures. **Goal:** Increase the timeliness and frequency of prenatal care and postpartum visits for pregnant members; decrease the incidence of preterm births and delivery of low birth weight infants. Monitoring: QCCC – Annually	**Bright Start/ICM (L)** Ann Morell, Manager Bright Start **Quality (S)**										X			
XX	**Quality Improvement Activity (QIA): Diabetes, ICM Chronic Condition Program** Identify and implement Diabetes activities to improve the health and quality of life for members with diabetes, increasing the use of national standards of care. **Goal:** To increase ACLA's rate of diabetic testing and improve management of glucose and lipid levels related to the following: • LDL-L C • HbA1c • Nephropathy monitoring • Eye exams Monitoring: QCCC – Annually	**ICM (L)** Rachel Weary, Director ICM **Quality (S)**										X			
XX	Provide member and provider outreach activities that are centered on advising members the importance of why and how to quit smoking, While **promoting smoking cessation options** to the providers to discuss with plan members. **Goal:** To increase awareness and knowledge on smoking cessation options to plan members. Measure through Adult CAHPS Survey Monitoring: Preventive– Quarterly	**ICM (L)** Rachel Weary, Director ICM **Quality (S)**										X			

Responsible Person: (L) Lead (S) Support

AmeriHealth Caritas Louisiana

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT WORK PLAN

Activity		Responsible Dept(s)/Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Comments
XX	**Quality Improvement Activity (QIA): Chlamydia Screenings Quality Management** Identify and implement member and practitioner outreach **activities** for Chlamydia Screenings to initiate interventions as appropriate. **Goal**: Increase Chlamydia screening as measured through HEDIS annually. Monitoring: QCCC – Annually	**Quality (L)** FeLisa Carpenter, Quality Performance Specialist-Clinical										X			
XX	**Quality Improvement Activity (QIA): Well Visits Quality Management** Identify and implement member and practitioner outreach activities to increase Well Visits and HEDIS preventive care rates associated with children and adolescents. **Goal**: To increase the well visits annually for the following age groups: • Children in first 15 months of life (six or more visits) • Children ages 3 to 6 years • Adolescent well care visits Monitoring: QCCC – Annually	**Quality (L)** FeLisa Carpenter, Quality Performance Specialist-Clinical										X			
XX	Evaluate collective **Annual HEDIS summary report**, conduct analysis and make recommendations to QCCC. **Goal**: Presentation of HEDIS reported measures in the plan's annual Health Outcomes Report for evaluation and discussion of current/future opportunities. Monitoring: QCCC – Annually	**Quality (L)** FeLisa Carpenter, Quality Performance Specialist-Clinical										X			

Responsible Person: (L) Lead (S) Support

AmeriHealth Caritas Louisiana

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT WORK PLAN

	Activity	Responsible Dept(s)/Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Comments
XX	Develop and implement plan initiatives and activities to members and providers to **Increase Obesity Awareness.** Identify and implement member and practitioner outreach activities to improve self-management skills related to nutrition and physical activity for plan members who have been identified as being obese or at a risk of becoming obese. **Goal:** To decrease obesity among AmeriHealth Caritas Louisiana plan members. Monitoring: QCCC- Annually	**ICM (L)** Rachael Weary, Director ICM										X			
XX	Monitor compliance with **Medical Record Review** standards, to assess and improve medical record keeping practices of participating practitioners. **Goal:** To maintain rates at 90% or greater adherence to ACLA medical record standards. Monitoring: QCCC – quarterly	**Quality (L)** Agnes Robins, Quality Performance Specialist-Clinical **Operations (S)**			X			X			X			X	
XX	Identification, investigation and tracking identified **Quality of Care** (QOC) issues and Never Events/Preventable Serious Adverse Events received by the Plan through clinical events/member concerns. **Goal:** Analysis and trending of quality of care issues and Never Events / Preventable Serious Adverse Events to identify opportunities for improvement. Monitoring: QCCC – Quarterly	**Quality (L)** Agnes Robins, Quality Performance Specialist-Clinical **Operations (S)**			X			X			X			X	
XX	**Utilization Management (UM) Program Description** – Annual review and approval **Goal:** Annual review and update of the UM Program that is consistent with achieving ACLA's mission of improving the health and quality of life of our members. Monitoring: QCCC – Annually	**UM (L)** Kathy Kiester, Regional Dir. UM			X										
XX	Annual **Utilization Management Program Evaluation,** to include monitoring and evaluation of utilization of health services (including over- and under-utilization and outliers) and the effectiveness of utilization management activities **Goal:** To provide an annual evaluation and report on the overall effectiveness of the utilization management activities, identifying opportunities for inclusion in the UM Program Monitoring: QCCC – Annually	**UM (L)** Kathy Kiester, Regional Director UM			X										

Responsible Person: (L) Lead (S) Support

AmeriHealth Caritas Louisiana

- QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT WORK PLAN

Activity		Responsible Dept(s)/Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Comments
XX	Develop and implement plan initiatives and activities to parents/caregivers and providers that addresses **ADHD Follow Up Care for Children prescribed ADHD Medication** **Goal**: Increase follow up visits with prescribing practitioner within 30 days of prescription initially dispensed. And increase follow up visits for children who stayed on prescription (at least 210 days) with at least two f/u visits after initiation phase ended. Monitoring: QCCC – annually	**ICM (L)** Rachel Weary, Director ICM										X			

Responsible Person: (L) Lead (S) Support

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Exhibit U.4-2: QAPI Work Plan

Medical Record Audits

AmeriHealth Caritas Louisiana conducts medical record audits to assess the provision and documentation of high quality primary care according to established standards. PCP sites with fifty or more linked members undergo a Medical Record Review (MRR) at least once every two years. A PCP practice may include both an individual office and a large group facility site. Ad-hoc reviews of Ob-Gyn's and Specialists may also be conducted, as needed, using the same process.

A minimum of five records are reviewed for each site. Records are selected using a random number methodology among members assigned to the PCP for a minimum of 6 months.

All office sites surveyed are notified of their practice-specific performance scores. Practice sites that fall below the expected performance benchmark are notified of the deficiency and that a re-review will be scheduled in six months from date of notification. After re-review, if a practice site/group continues to fall below the expected benchmark a Corrective Action Plan is developed with the practice group and a follow up review scheduled. Practitioners who fail to comply with the Corrective Action Plan or continue to fall below benchmark are referred to the AmeriHealth Caritas Louisiana Medical Director/designee and/or Credentialing Committee for further review and action. The medical record performance scores and any resultant Corrective Action Plans are placed in the practitioners' credentialing file. An annual summary of performance is presented to the QAPIC for their review and recommendations.

Plan-Do-Check-Act/Continuous Improvement

The QAPI Program is designed to monitor and evaluate the quality of care and service provided to members. QAPI Program activities are conducted using the Plan-Do-Check-Act (PDCA) methodology:

Plan – Establish objectives and processes necessary to meet performance or outcome goals.

Do – Implement the plan and processes; collect data for further analysis.

Check – Evaluate and compare the results to the performance/outcome goal; identify differences between the actual/expected/target outcomes.

Act – Develop and implement corrective action to address significant differences between the actual and planned results; conduct root cause analysis; as necessary, return to the Plan step.

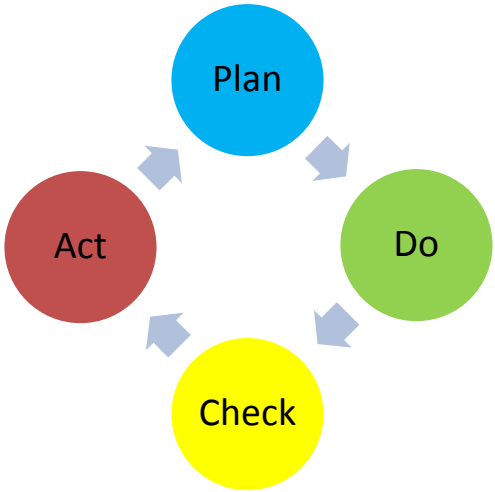

Exhibit U.4-3: PDCA Quality Process

Data is collected at least annually to evaluate clinical and financial aspects of care and service and to identify opportunities for improvement. Every effort is made to collect and use timely, complete and accurate data. Some of the data used for evaluating performance includes:

- Access and availability data.
- CAHPS®.
- Claim Data.
- Clinical guideline performance studies.
- Cultural and Linguistically Appropriate Service data.
- Focused reviews.
- Health Risk Assessment and Screening responses.
- HEDIS® and other metrics defined by DHH.
- Member dissatisfaction data.
- Member opt-out data.
- Performance Improvement Project/Outcome study analysis.
- Pharmacy utilization data.
- Provider and Practitioner Satisfaction survey results.
- Physician office medical record reviews.
- Quality indicator studies.
- Sentinel Condition analysis.
- Utilization data.
- State Specific Requirements.

The QAPIC coordinates the review of data and identification of opportunities for improvement. Cross-functional teams are assigned to conduct barrier analysis and to identify appropriate interventions. Practicing primary care practitioners, specialists, and members participate in improvement initiatives as appropriate. Teams identify both external benchmarks and internal improvement goals. Ongoing initiatives are monitored and evaluated throughout the year and at least annually for re-measurement of barriers, quality of care and/or utilization of services over time. Improvement initiatives are reported through the QAPI committee structure. Program data and results are reported to the DHH and the DHH's External Quality Review Organization (EQRO) in accordance with the Louisiana Medicaid Health Plan Contract.

Measuring Member and Provider Satisfaction

Member satisfaction is measured through the CAHPS Survey. Provider satisfaction is measured through an annual Practitioner/Provider satisfaction survey. ACLA will conduct the CAHPS survey in the spring of 2015. The plan will also complete an annual Provider Satisfaction study. The results, along with analysis and trends on dissatisfactions and member opt-outs are reported to the QAPI for review and identification/prioritization of opportunities for improvement.

Cultural Competency and Health Care Equity

AmeriHealth Caritas Louisiana has a Cultural Competency Plan that promotes the delivery of services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members and protects and preserves the dignity of each. The plan will include mechanisms for assessment of culturally appropriate service delivery, evaluation of healthcare equity across subpopulations and interventions to address identified opportunities.

Activities to assess and promote Cultural Competency and Health Care Equity include the following:

- Collect and analyze practitioner race/ethnicity and language data to determine if the network is responsive to the needs of the Membership.
- Develop a plan to address network race/ethnicity and language gaps.
- Support practitioners in providing appropriate language services.
- Conduct baseline assessment of performance on chronic care and preventive care outcome measures by race and ethnicity subgroups; identify and prioritize opportunities to reduce disparities.

Work the QAPI Will Undergo to Improve the Health Care Status of the Louisiana Medicaid Population

AmeriHealth Caritas Family of Companies ensures each PIP supports the advancement and acceleration of the quality improvement services as identified by well over 28 years of expertise in the Medicaid business. PIP topics are identified using data gathered from activities such as member complaints, HEDIS/CAHPS results, member needs, or regulatory requirements. Every PIP incorporates a sound analysis, considers industry best practices and tested implementation techniques. Plans and interventions are designed to support and complement existing initiatives to increase access to evidence based services and promote awareness and behavior changes. The interventions we implement will be designed to drive robust and sustainable changes for Louisiana Bayou Health members.

The QAPI Program is evaluated annually and as needed to measure its effectiveness.

The evaluation assesses all aspects of the QAPI Program including clinical and service performance improvement projects, quality studies and activities and the rationale, methodology, results and subsequent improvement associated with each study. The QAPI Evaluation is used to determine the annual QAPI Program Description and Work Plan for the following year. The QAPI Program is also revised as needed throughout the year based on the ongoing review and monitoring by the plan and QAPI Committee. Drivers/barriers identified from the qualitative and quantitative analysis are reviewed by the QAPI committee. Goals are developed by the plan, the network providers and by DHH. The 2014 goals include but are not limited to the following:

Clinical Improvement Goals for 2014		
DHH Incentive Based Measures	2013 ACLA Results	2014 Performance Goal
Well Child 3-6 Years of Age (W34)**	46.91%	35.45%
Adolescent Well Care (AWC)**	29.08%	25.16%
Adult Access Ambulatory/Preventive Care**	77.71%	78.39%
Chlamydia Screening**	57.35%	58.68%
HbA1c screening**	73.80%	70.21%
Prenatal and Postpartum Care		
DHH Incentive Based Measures	2013 ACLA Results	2014 Performance Goal
Timeliness of Prenatal Care	84.09%	2.5 % increase (86.19%)
Frequency of Prenatal Care	58.14%	2.5 % increase (59.59%)
Postpartum Care	32.58%	2.5 % increase (33.39%)
Louisiana DHH Required PIP's		
DHH Incentive Based Measures	2013 ACLA Results	2014 Performance Goal
Cervical Cancer Screening	38.99%	5% increase (40.94%)
Emergency Room Utilization	69.95%	1% decrease (69.25%)

Exhibit U.4-4

Additional goals focus on high prevalence conditions that include but not limited to such as diabetes, hypertension, and asthma, HIV, Sickle Cell and other.

Rationale and Development of Performance Improvement Projects

The rationale for selecting the specific programs includes the identification of particular health care problems and issues identified within the Louisiana Medicaid population. Each program will address the underlying cause(s) of such problems and issues. We continually study the profile of the Louisiana population statistics, Louisiana Medicaid results, and national rankings and compare to the ACLA membership in order to target quality improvement programs.

AmeriHealth Caritas Louisiana (ACLA) develops and implements Performance Improvement Projects focusing on areas of concern or low performance both clinical and service related and are identified through internal and external recommendations. The ultimate goal is to define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management. ACLA will monitor, evaluate, and improve the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to enrollees through peer review, Performance Improvement Projects (PIPs), medical record audits, performance measures, surveys, and related activities.

Key performance monitors include collection of data related to areas of clinical priority and quality of care and service. Objective, measurable quality indicators are defined to provide a

consistent means to evaluate internal performance and demonstrate quality of care and service to members and improvements that positively affect the quality of care and services members receive. Internal performance targets, standards, and external benchmarks are incorporated into internal key indicator monitoring and reporting to identify areas for additional analysis and, as necessary, implementation of Performance Improvement Projects and corrective actions.

Focused areas are centered on the identification to be followed by prioritizing to meet the following criteria:

- Clinical importance and scientific validity
- High-risk and/or high volume service or process
- Relevance to the Bayou Health population
- Alignment with Louisiana DHH priorities

The areas targeted for improvement are projects based upon current performance with the greatest impact on member outcomes and health status. AmeriHealth Caritas utilizes evidence - based guidelines as baseline for Performance Improvement Projects (PIPs). Performance goals and benchmarks are identified based on performance targets, industry trends, state experience, and quality committee recommendations.

Completion timeframes are assigned based on the complexity of the activity, any relevant or contractual requirements, and the availability of resources. Activities that are expected to span multiple years are broken into relevant milestones to allow for appropriate interim tracking.

Measurement periods are built into the design of the PIP to allow for systematic and periodic follow-up on the effect of the interventions. Goals are set to reflect demonstrable improvement, and/or achievement of benchmark performance, in the targeted health outcome or service.

Assessing Performance

The quality indicators used to assess performance are based on accepted industry measures, to allow for comparison with external benchmarks and consistency in evaluation across time periods. Where possible, nationally published specifications, including HEDIS and CAHPS, are utilized to measure identified changes in health outcomes, service levels, functional status and satisfaction associated with a PIP.

Evaluation and Reporting

PIPs are monitored and evaluated according to the re-measurement schedule developed as part of the PIP design. Where possible, the same methodology is used to evaluate the program as was used for the baseline measurement. On rare occasions the metrics are altered in response to a change in national specifications, such as a HEDIS® measure or CAHPS® question.

The results of re-measurements are compared to the PIP goal and the identified benchmark. The analysis includes identification of barriers that impacted the interventions. Where possible, strategies are designed to address identified barriers in the next measurement cycle.

All PIPs will achieve, through ongoing measurements and intervention, significant improvement to the quality of care and service delivery, sustained over time, in areas that are expected to have a favorable effect on health outcomes and member satisfaction. Improvement will be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention.

ACLA will submit project data analysis on a monthly basis to DHH and project outcomes on an annual basis to DHH. The QAPIC reviews the prioritization, plans, and results of quality improvement activities and projects. PIP results are also reported to DHH and the EQRO as required.

Corrective Action Plans

Corrective action plans are developed based on findings resulting from medical and/or service reviews. Any quality committee, the executive director, or regional chief medical officer may recommend a corrective action plan.

A corrective action plan may consist of focused instructions to an individual provider, service site, or administrative manager. A plan may address documentation, clinical protocol continuity of care and QIP procedures involving members or other aspects of health care or service administration that impact the delivery of health services to ACLA members. Corrective action plans will include strategies to improve the situation, as well as monitoring of the results in order to fully assess and realize achievable benefits.

All corrective action plans include the following:

- A description of findings to be addressed.
- Specific actions to be taken.
- The individuals responsible for each action.
- A timetable for correction.
- An alternative approach if improvements do not occur.
- Written feedback to the QAPI committee and all parties affected by the action plan.
- Follow-up to re-evaluate the situation and determine the degree to which the corrective action plan was effective.

If the issue requiring correction involves a provider, the CMO meets with the appropriate provider as necessary to discuss the nature of the problem and the recommended solution. The CMO offers technical assistance in support of the provider's effort to resolve the problem. The CMO also stipulates the frequency with which the provider formally assesses the implementation process. The CMO is responsible for monitoring the effectiveness of the corrective action plan, including a follow-up visit to reevaluate the situation. The CMO reports this activity to the QAPI committee and determines whether plan provisions are warranted.

If a corrective action plan involves an administrative issue, the executive director or his/her designee meets with the appropriate managers and staff. The executive director or the designee is involved in the discussion and resolution phase of the corrective action plan, and also stipulates a plan of action moving forward.

Keeping DHH Informed

An important piece of the QAPI Program keeping DHH informed. The ongoing progress of the PIP's is monitored through the Plan's QAPI Work Plan under the direction of the Quality Assessment Performance Improvement Committee. ACLA will work with DHH to ensure timely reporting of the QAPI program, PIPs, Performance Measures, Surveys, and Access Studies through a comprehensive annual QAPI Program Evaluation.

ACLA's Medical Director (or a representative) participates on the Medicaid Quality Committee previously known as the Bayou Health Quality Committee. Membership includes participants from each of the managed care plans. Communication is able to flow back and forth between the plan and DHH.

In addition, in 2015 a DHH representative will be participating on the QAPI Committee. Committee participation will allow DHH to be more informed on the QAPI program activities, to also include committees reporting up to QAPIC.

New Innovative Programs and Processes

ACLA and the AmeriHealth Family of Companies are continually exploring innovative programs and collaborative partnerships with organizations, such as national and local community resources, vendors, and network providers to improve health outcomes for our members.

Additionally, ideas and feedback are solicited from quality committee members, plan members, as well as stakeholders across the organization. Relevance, validity, and importance of the proposed interventions and initiatives are reviewed within the quality committees, interdepartmental workgroups, and organizational leadership.

AHFC's Quality Directors across organization communicate regularly to share best practices, brainstorm and craft interventions to impact access to quality health care and improve services.

AHFC shares best practices by submitting every year to the Medicaid Health Plans of America (MHPA) Best Practices Compendium. Recognizing the importance that shared knowledge plays in improving health outcomes and containing costs, MHPA has established the Center for Best Practices to identify, gather and disseminate innovative practices in Medicaid that demonstrate improvements in health care delivery.

In 2013–2014, a total of 10 innovative initiatives were submitted, by the AmeriHealth Family of Companies, and selected for publication in the MHPA's Best Practice Compendium. Topics included: improving birth outcomes, child and adolescent care, reducing health care disparities and unnecessary ER utilization, and improving integration of physical and behavior health.

In addition to the MHPA published programs, there are a number of other ACLA partnerships and program examples;

Pregnancy Alere 17P Program

AmeriHealth Caritas partners with Alere to offer OB Homecare Nursing Services to Bright Start program members. Patients experiencing high-risk pregnancies receive additional OB nursing services and support in coordination with the plan of care. The OB Homecare maternity program improves patient outcomes and compliance, and provides additional resources to members for risk condition information, support, and education.

The services include:

- 17P Administration Nursing and Care Management Service with in-home administration of weekly injections.
- Nausea and Vomiting of Pregnancy with nurse administration of continuous antiemetic therapy.
- Preterm Labor Management.
- Diabetes in Pregnancy Program.
- Hypertensive Disorders in Pregnancy service.
- Coagulation Disorders in Pregnancy with home-based treatment.

Community Education and Outreach Teams

Our Community Education and Outreach Teams (CEOT) perform community education services by partnering with community organizations for events and educational offerings. They develop and maintain community relationships, collaborate with internal departments, and outside organizations to obtain and use data for health promotion projects.

As part of their member outreach activities, the Community Outreach Teams establish connections with members and act as primary contact for targeted members. The team assists with follow-up care management tasks, provides education and facilitates connections to address gaps in care, and performs in-person outreach to locate/connect members to care management services.

An example of this at work in Louisiana was our Diabetes Boot Camp program in which ACLA partnered with Healthcare Education and Case Management Services, Inc. to conduct a boot camp for our members with a diagnosis of diabetes. Several diabetes management clinical topics were addressed with the members during interactive group sessions by trained RNs and Diabetic Educators. The group sessions encouraged members to ask questions and engage with the presenting nurses. The one-day “boot camp” also included a live cooking demonstration and A1C diabetes screenings were completed. The boot camp was closed out with a line dance, which promoted increasing activity and fun exercise.

Topics included:

- An overview of Diabetes.
- Healthy eating – covering portion size, reading food labels and meal planning.
- Being Active.
- Monitoring – how to monitor blood glucose, understanding HgA1c, ketones.

- Taking Medications – how to administer injectable and management of diabetic medications.
- Problem Solving.
- Reducing Risks.
- Healthy Coping.
- Individualized Strategies: preconception and pregnancy management, insulin treatment plan and smoking cessation.

Community-Based Care Management Team (CCMT): Innovations on the Ground

ACLA has also implemented an innovative program in July 2014 for our members with complex chronic conditions who receive the majority of their care in the ER and inpatient setting. These "super-utilizer" members, as described more fully above, are most in need of intervention. The goal of this program is to implement an industry- leading model that is a community-based, high-touch individualized care management program that will lead to greater quality outcomes, reduced medical costs, and more effective utilization.

Community Care Management teams (CCMT) are currently active in Baton Rouge, LA, in addition to ACFC partner states in Charleston, SC; Philadelphia, PA; and Chester, PA. ACLA currently has enrolled 14 members in this program to date; actively looking for another 20 identified as potential participants through our screening processes:

Professional care managers, community care connectors under medical direction will engage members in the field through continuous, high-touch, in-person interaction and follow up to connect members to services to meet physical, behavioral, and environmental needs.

Target high-risk members (super utilizers) with highest utilization patterns to foster behavioral change and promote access and appropriate utilization of services with outcomes that improve the members overall disposition and lower their PMPM.

The key to the success of the CCMT program is the relationship between the member and the Community Care Connector (CCC). CCCs are hired from within the community and share language and life experiences of members served. CCCs are able to develop a critical trustworthy link between the medical delivery system and individuals in the communities where they live.

CCCs become knowledgeable about the local ecosystem for social services, and help members sort through complex and competing needs (many of which are not medical). CCCs are passionate about helping others and become anchors in a chaotic life.

Cell Phone Program – VOXIVA

ACLA is currently developing a program to provide members free cell phones for easy access to the plan and their Care Managers. The phones would be programmed with the txt4health, text4kids and text4baby modules to send texts with education information, reminders about general health and screenings, health surveys and recommendations of activities to improve health.

In August 2013, the Centers for Medicare and Medicaid Services (CMS) awarded a three-year contract to Voxiva to support the implementation of the Text4baby service in four states in collaboration with state Medicaid agencies.

Under the contract, Text4baby founding partners Voxiva and the National Healthy Mothers, Healthy Babies Coalition (HMHB) are working with CMS and the state Medicaid agencies (California, Louisiana, Oklahoma and Ohio) to expand efforts to enroll Medicaid beneficiaries in the service, customize Text4baby messages to include state-specific information and assess txt4baby's impact on improving health outcomes. The project is focused on improving a range of specific health quality measures including rates of pre- and post-partum care and well-baby visit attendance and smoking cessation.

In Louisiana, the project is being implemented under a formal partnership with the Louisiana Department of Health and Hospitals - Medicaid and with the support and guidance of Dr. Rebekah Gee, Louisiana's Medicaid Medical Director.

One of the project's core strategies is to work with ACLA to (a) customize Text4baby's content to include MCO specific information; (b) enroll their pregnant and new parent members in the service on a systematic basis; (c) provide real-time data to the MCOs about the members who have enrolled; and (d) collaborate with the MCOs to understand the impact the service has on key quality measures.

Historically, MCOs have promoted the public version of Text4baby. Under this model, Voxiva is able to enroll specific members on an identified basis. This allows for the delivery of health plan specific content and allows Voxiva to provide the MCO with member specific information on their utilization of the service.

Asthma Health® Tablet

ACLA's PBM, PerformRx, has created an asthma medication management program designed to increase medication adherence and reduce overall health care costs in treating moderate to severely persistent asthmatic members. The program was recently implemented in our D.C. affiliate market, which has one of the country's highest asthma rates.

The Health Tablet features tools that able to measure and increase adherence, as well as improve general and health literacy. These tools include a daily health survey, daily tips, biometric tracking (peak flow), individualized care plan instructions, medication management tool, asthma symptom tracker, and emergency medication tracker. Tools to help the provider manage member care include early warning reports that identify patients with potential problems, a tool that allows the provider to set medication reminder schedule and track member compliance, a portal to view patient survey responses and biometric tracking, and an individualized care plan writer. Additionally, the tablet is programmed with e-books to promote health literacy, health-related games, tutorials on using asthma inhalers, and content that can be spoken in English or Spanish.

ACLA plans to implement the Breathe program to offer identified members with a Wi-Fi and cellular capable Health Tablet computer through which we can deliver educational interventions

for the child's primary caregiver and other relatives. The program includes a home assessment, providing what is necessary to prevent asthma attacks (e.g., air filter, dehumidifier).

The mission of the program is to ensure that every breathe counts by promoting health lifestyles and preventing lung disease through advocacy education and program services, especially in communities affect by health disparities.

Telemonitoring Pilot Program

ACLA has partnered with a vendor for in-home monitoring services starting October 2014. The targeted members will have a diagnosis of diabetes or congestive heart failure as well as multiple emergency room visits and/or admissions. The services include a combination of daily monitoring, provider coordination and clinical assessment. Objective measures obtained include blood pressure monitoring, glucose monitoring and daily weights. ACLA Care Managers will refer members to this program as one of the interventions within the disease management programs. Network providers will be educated on the benefit for members, including how to make referrals for tele monitoring to the care managers.

Sickle Cell Telemedicine Program

To provide better care for our members with sickle cell, ACLA has partnered with LSU Shreveport to provide telemedicine services. This program specifically allows ACLA to refer members to facilities located in rural areas. This referral process facilitates care coordination for our members who are in need of specialty services.

BRFHH Shreveport provides access to medical specialties and education through the use of live interactive consultation with a medical specialist by video link. For members located in the designated rural locations and need a specialist, our Care Managers link them to the program and assist with obtaining an appointment. Specifically, LSU Shreveport offers Hematological Services for members with Sickle Cell Disease.

Embedding Case Managers

ACLA is also exploring options to embed care managers in high-volume facilities and primary care practices. We have successfully used this model in other ACFC markets. The embedded care manager works directly with the member and the provider staff to coordinate additional services, initiate follow-up for treatment plan changes and provide direct member education in support of treatment goals.

Partnerships that Enhance the Delivery of Health Care

AmeriHealth Caritas hosts culturally competent programs and health promotion events featuring local providers and community organizations whose focus goes beyond health care and nutrition to include, housing, immigration, legal services, counseling, and others.

The Plan develops education and outreach programs targeting community and elected officials, advocates, and faith-based and human service agencies in all of communities in which we operate. The primary purpose of this outreach strategy is to increase awareness of the availability of health care coverage and to assist stakeholders in understanding our programs and how to access available services.

Partnerships with community-based organizations are a valuable resource and a vital link to individuals who face language, cultural, literacy barriers; require additional assistance; or do not trust governmental agencies. Our objective is to provide the resources and education necessary for community-based organizations to serve as an effective and accessible bridge for eligible individuals so that they can be educated and connected to qualifying benefits/choice counselors, as well as assisted with applying for available services. This includes our relationship with the following organizations:

Sample Community and Service Organizations	
Brec Recreation Center	12th Ward Save Our Community
Catholic Charities of Baton Rouge	Kingsley House Adult Services
Catholic Charities of New Orleans	New Orleans Health Corporation
Treme Community Education Program	Pontchartrain Park Community Center
March of Dimes of New Orleans	

Exhibit U.4-5: Community Partnerships

Ryan White Foundation

ACLA actively participates in the Louisiana HIV Medical Care Coordination (MCC) Task Force along with other health plans. The purpose of this task force is to improve quality and effectiveness of HIV medical care coordination/case management services and to avoid duplication of services. Another goal is to align services with meeting the needs of people living with HIV. This task force focused on transition plans, care coordination, care planning to efficiently collaborate and coordinate care for members included in the STD/HIV program, Bayou Health plan and Ryan White Part A & B Community based organizations. A shared network matrix between the health plans and Louisiana Ryan White community based organizations were distributed and ACLA shared this information with Care Managers as use as a resource tool. The task force continues to meet and discuss coordination strategies.

Nurse-Family Partnership

The ACLA Bright Start team collaborates with and refers first-time pregnant members to the Nurse-Family Partnership for additional in-person support. Nurse-Family Partnership staff visits the member's home and provides a follow-up plan of care focused on good health practices, adherence to with prenatal and post-partum care recommendations, and education on how to care for the infant. Partnership staff performs hands-on assessments of the pregnant mother and, after birth, of the child.

Our Lady of the Lake

We routinely partner with local organizations to improve health outcomes. For example we worked with Our Lady of the Lake (OLOL) on the Community Asthma Management Program (CAMP). CAMP targets the pediatric population with moderate to severe persistent asthma who have had multiple ER visits and admissions to OLOL. A respiratory therapist works with the members to train them on the proper use of inhalers and the importance of medication adherence. Our members received additional asthma management, education, and care coordination from ACLA care managers. The partnership allowed our care management staff to reach more members and educate them about asthma and available treatment options.

March of Dimes

To further address the high rate of premature births in Louisiana, ACLA partnered with the March of Dimes' Louisiana Chapter to support "Healthy Babies are Worth the Wait," a campaign to reduce premature births. Sometimes late, preterm births—those occurring between 34 and 36 weeks—are the result of the mother's choice to be induced or undergo a C-section because she is feeling uncomfortable in the last weeks of pregnancy. The program urges expectant mothers to do everything they can to carry their babies through at least 39 weeks to ensure full development. ACLA Bright Start (maternity) care managers incorporate program materials and education in their interactions with pregnant members.

We have also joined with the March of Dimes to help the Cancer Association of Greater New Orleans and Baton Rouge to implement a "Baby & Me — Tobacco Free" program. The first program of its kind in Louisiana and in the southern region of the United States, Baby & Me – Tobacco Free is an evidenced-based, incentive smoking cessation program that helps pregnant women quit smoking and remain smoke-free after delivery. Participants in the program meet monthly with a tobacco cessation counselor and receive free diaper vouchers at each visit for up to 12 months.

ACLA also served as the March of Dimes Prematurity Prevention Sponsor for the 2014 Provider Education Lecture Series. The goal of the presentation is to make provider more aware of progesterone therapy and its use in high-risk eligible patients to prevent preterm births.

School-based Health Clinics (SBHCs)

ACLA collaborates closely with School Based Health Clinics across Louisiana and is a partner of both The Louisiana School-Based Health Alliance, an alliance of individuals and organizations that support the mission of our state's school-based health centers and the Louisiana Office of Public Health and their Adolescent School Health Program.

ACLA is supportive of their combined mission in the following:

- Promoting the delivery of high-quality, comprehensive, accessible and affordable health care to children and adolescents at school sites.
- Providing leadership in the long-term sustainability of school-based health centers.

- Offering technical expertise and assistance to school-based health centers across the state, as well as prospective new partners interested in establishing a school-based health center in their communities.

School aged members spend a significant portion of their day on school grounds. SBHCs are accessible, convenient, encourage family and community involvement, reduce student absenteeism, reduce parental leave from work for doctor visits, and work with school personnel to meet the needs of the students and their families, additionally, with 35 of Louisiana's 64 parishes classified as rural, school-based health clinics is an important statewide resource helping to address the health care needs of underserved and rural children.

ACLA is currently contracted with 65 School-based Health Clinics (SBHCs) across Louisiana. These school-based sites provide preventative, diagnostic and treatment services, including care for acute and chronic illnesses, immunizations, and health education. It is planned for the coming year to be able to work in collaboration with the SBHCs to conduct screenings for sexually transmitted diseases.

ACLA has contractual relationships with Baton Rouge area provider, Health Center's in Schools that allows 8 area school based sites to act as primary care providers to a linked panel of members, allowing for year round access to care in a familiar environment to their school aged patients.

Many SBHCs are also able to provide care for other children in the household, to further increase the convenience for parents/guardians.

Patient Centered Medical Homes

In collaboration with DHH, ACLA has promoted the establishment of the Patient-Centered Medical Homes (PCMH) throughout the state. We have shown our commitment to the use of PCMHs as a best practice to reduce emergency room usage and provide our members with increased ability to integrate all of their care in one location, including their behavioral health needs. ACLA has one PCMH-certified content expert on our network management team and another five who are eligible for certification. The ACLA strategy for the expansion of the PCMH program has three primary goals:

- To improve PCMH access to care for our members and in our members with chronic conditions;
- To incorporate the PCMH model of care as a core component of improving delivery of care and benefits; and
- To reduce unnecessary costs, including ER, avoidable admissions, and readmissions, and by encouraging accountable behaviors in our members.

ACLA is available to provide support and assistance with transformation activities through

- Easy to find and easy to use resources/guides/templates.
- Presentations/staff training.
- Opportunities for sharing of best practices/lessons learned with other practices—both locally and nationally.
- Topic specific assistance and resources based on needs of your practice.

Additionally, ACLA provides access to data from cross-functional departments to ensure that providers have a view of the whole person; this data includes, but is not limited to:

- Access to patient-focused resources/support from AmeriHealth (care management, rapid response teams, behavioral health management, community outreach, and links to community resources, etc.)
- Assistance with resources/support for performance improvement

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U.5. Quality Management

U.5 Describe the process that will be utilized to develop the performance improvement projects (PIPs) identified in Appendix DD of the RFP. Include a preliminary plan for at least one (1) required PIP including the following:

- *The study question;*
- *The study population;*
- *The quantifiable measures to be used;*
- *Baseline methodology;*
- *Data sources;*
- *Data collection methodology and plan;*
- *Data collection plan and cycle;*

Overview

AmeriHealth Caritas Louisiana (ACLA) will focus its Performance Improvement Project (PIP) program on conditions found to have a high impact on the Bayou Health population and of importance to DHH. This includes premature births and childhood obesity, as found in Appendix DD of this RFP.

PIP Development Process

ACLA develops and implements PIPs focusing on areas of concern or low performance, both clinical and services related, and are identified through internal and external recommendations. The ultimate goal is to define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management. ACLA will monitor, evaluate, and improve the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to enrollees through peer review, PIPs, medical record audits, performance measures, surveys, and related activities.

Key performance monitors include collection of data related to areas of clinical priority and quality of care and service. Objective, measurable quality indicators are defined to provide a consistent means to evaluate internal performance and demonstrate quality of care and service to members and improvements that positively affect the quality of care and services members receive. Internal performance targets, standards, and external benchmarks are incorporated into internal key indicator monitoring and reporting to identify areas for additional analysis and, as necessary, implementation of PIPs and corrective actions.

Focused areas are centered on the identification to be followed by prioritizing to meet the following criteria:

- Clinical importance and scientific validity.
- High-risk and/or high volume service or process.
- Relevance to the Bayou Health population.

- Alignment with Louisiana DHH priorities.

The areas targeted for improvement are projects based upon current performance with the greatest impact on member outcomes and health status. ACLA utilizes evidence-based guidelines as baseline for PIPs. Performance goals and benchmarks are identified based on performance targets, industry trends, state experience, and quality committee recommendations.

Completion timeframes are assigned based on the complexity of the activity, any relevant or contractual requirements, and the availability of resources. Activities that are expected to span multiple years are broken into relevant milestones to allow for appropriate interim tracking.

Measurement periods are built into the design of the PIP to allow for systematic and periodic follow-up on the effect of the interventions. Goals are set to reflect demonstrable improvement, and/or achievement of benchmark performance, in the targeted health outcome or service.

PIP to Reduce Premature Births

Although ACLA has been working in partnership with DHH to reduce premature births since 2012, the Plan will follow requirements by implementing a formal PIP. The goal for the 2015 to 2017 contract period as defined by DHH is to reduce premature births in the Plan's population by 15 percent. ACLA will build upon the current activities with the following preliminary PIP:

Study Question

Does providing a pregnant member with a previous preterm birth drug 17P, in addition to telephonic outreach services and written prenatal information on the importance of continuous prenatal care, decrease rates of premature birth?

Study Population:

Prematurity is the leading cause of deaths for newborns in the United Sates. According to the March of Dimes, in 2013, 1 in 9 babies were born prematurely in the U.S. (2013).[1] Between 2002 and 2012, the rate of infants born preterm in the United States declined 5 percent. March of Dimes reported the U.S. Preterm rate for 2012 as 11.5 percent. Louisiana's preterm birth rate for 2012 was 15.3 percent.[2]

[1] March of Dimes Peristats, US- Preterm Birth, Retrieved June 10, 2013
http://www.marchofdimes.com/peristats/ViewTopic.aspx?reg=99&top=3&lev=0&slev=1&dv=mt
[2] March of Dimes Foundation, retrieved August 21, 2014.
http://www.marchofdimes.com/Peristats/ViewSummary.aspx?reg=22&stop=60

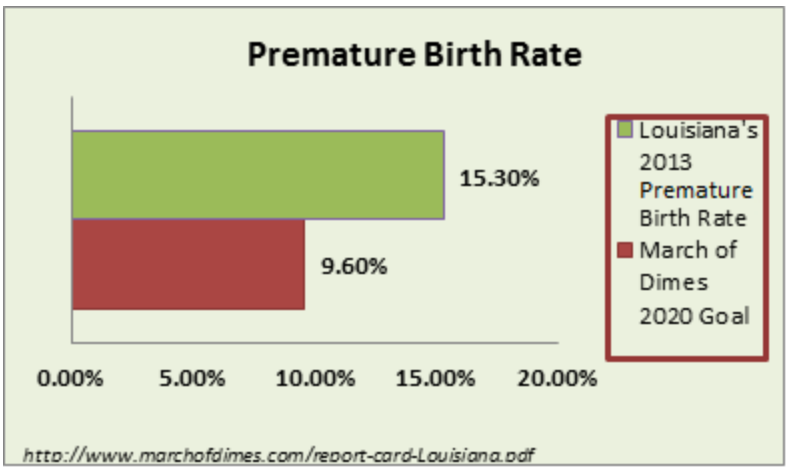
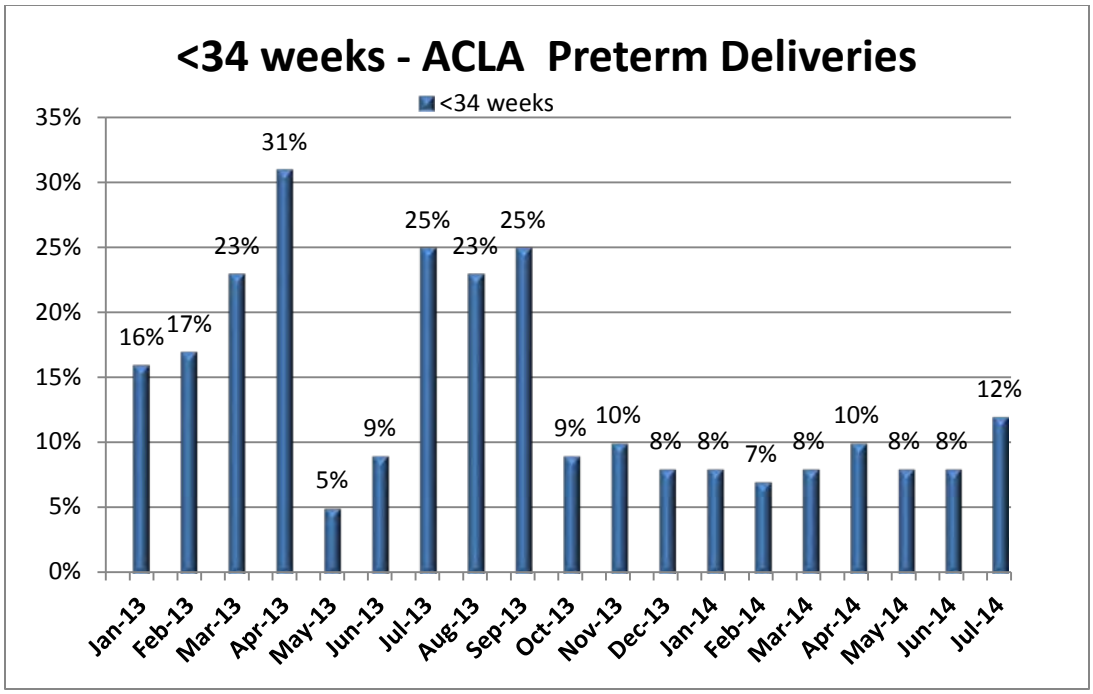
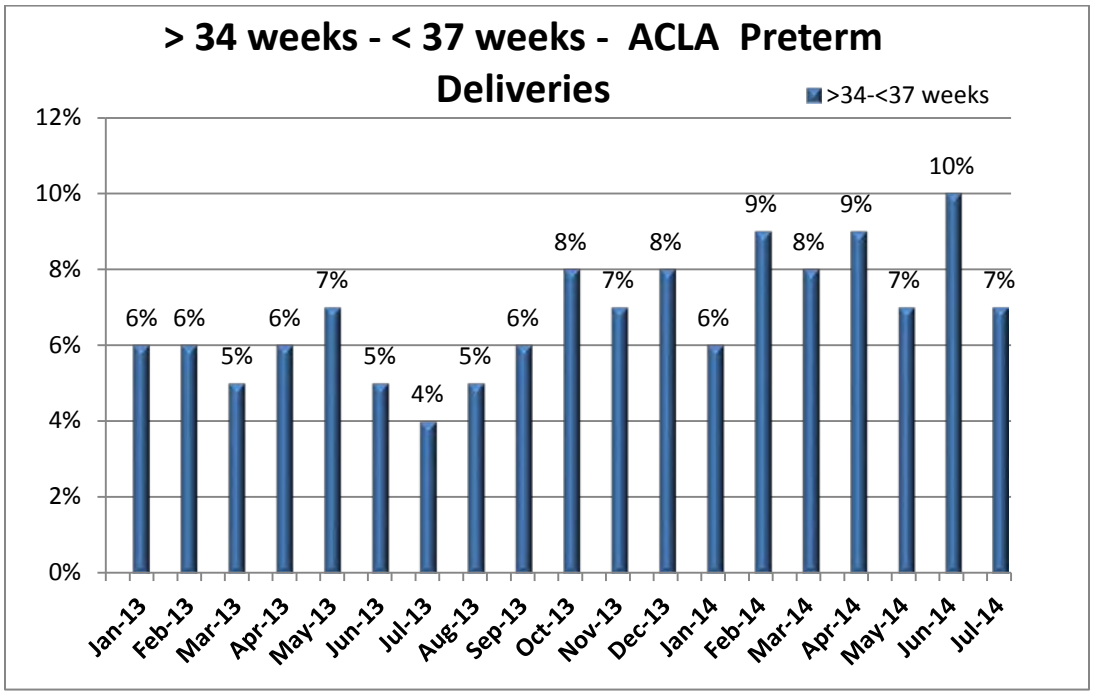


Exhibit U.5-1: Premature Birth Rate in Louisiana

Every year more than half a million babies are born after less than 37 weeks gestation. The cost associated with preterm birth in 2005 was at least $26.2 billion (March of Dimes, Problems of Prematurity). Along that same line, the average first year costs for infants that included inpatient and out-patient care was about $32,325 opposed to a full term infant in the first year of life of $3,325. The March of Dime is leading the Prematurity Campaign to reduce the nation's preterm birth rate to 9.6 percent or less by 2020. According to the March of Dimes, Louisiana received an "F" in regards to birth outcomes and the risk of preterm births.

ACLA is committed to preventing preterm births statewide. The following graphs reveal the plan's preterm deliveries rates from January 2013 to July 2014:





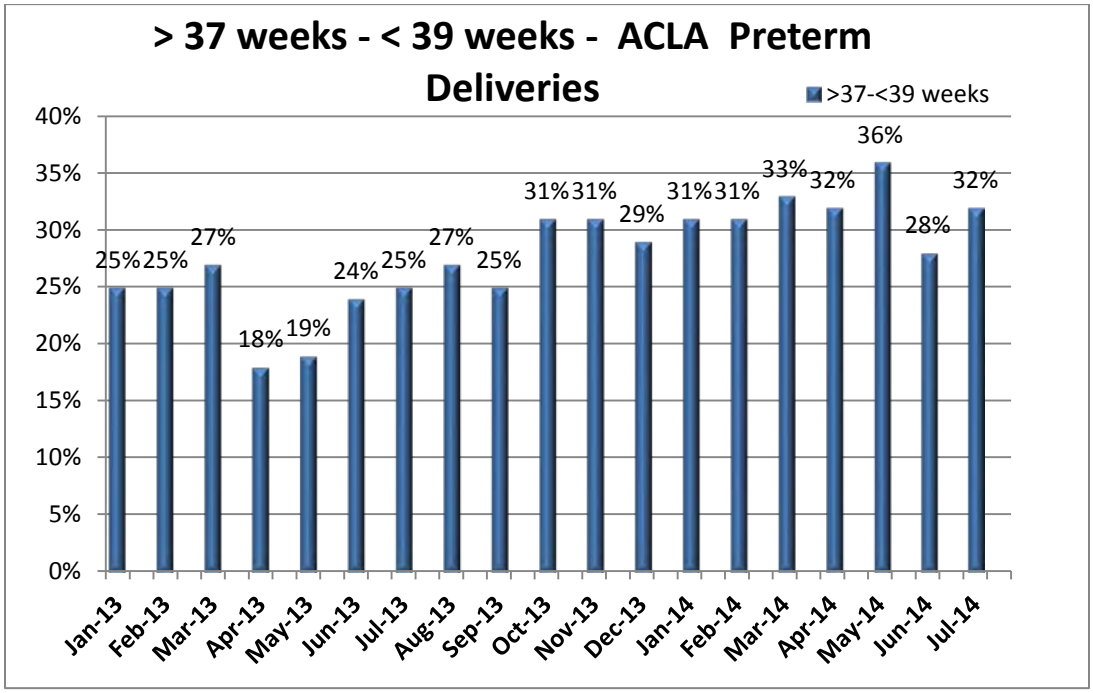


Exhibit U.5-2: Pre-term Birth Rates

Quantitative Measures to be Used

Quantifiable Measures:	Description
Quantifiable Measure # 1A	**Preterm Births (< 37 weeks)**
Numerator:	The total number of all live births less than or equal to 36 weeks during the measurement year
Denominator:	The total number of all live births during the measurement year.
Quantifiable Measure # 1B	**Moderately Preterm Births ≥32 – <36 weeks**
Numerator:	The total number of all live births greater than 32 weeks on up to under 36 weeks during the measurement year.
Denominator:	The total number of all live births during the measurement year.
Quantifiable Measure # 1C	**Very Preterm Births ≤ 31 weeks gestation**
Numerator:	The total number of all preterm live births equal or less than 31 weeks gestation during the measurement year
Denominator:	The total number of all live births during the measurement year.

Exhibit U.5-3: Quantitative Measures to be Used

Baseline Methodology

Baseline Methodology will collect data for HEDIS 2015 measurement period January 1, 2014 to December 31st 2014.

The March of Dimes stratifies preterm birth rates into three categories as indicated below:

Preterm - Live births prior to 37 weeks gestation

Moderately Preterm - Live births delivery between 34 and 36 weeks gestation

Very Preterm - Live births prior to 32 completed weeks of gestation

Gestational age is defined by National Center for Health Statistics (NCHS) to be determined by the first day of the mother's last normal menstrual period and the newborn's date of birth.

Data Sources:

Data collections sources will include administrative data (claims, hospital provided information, third party related data) and supplemental data obtained by AmeriHealth Caritas

Louisiana's medical economics department. ACLA will also utilize LEERs data to accurately identify and report delivery gestational age.

Data Collection Methodology:

Data will be collected from the OB/GYN office for identified pregnant members. Data collected includes estimated due date (EDD), date of last menstrual period, and identified risk factors. Prenatal risk information will additionally be gathered from LEERS data provided to the health plan.

Data Collection Plan and Cycle

- Baseline: January 1, 2014 to December 31, 2014.
- Re-measurement 1: January 1, 2015 to December 31, 2015.
- Re-measurement 2: January 1, 2016 to December 31, 2016.

The program is evaluated as needed and at least annually to measure the effectiveness of the program. The evaluation assesses all aspects of the quality program, including clinical and service quality studies and activities as well as the rationale, methodology, results and subsequent improvements associated with each study. The evaluation includes recommendations for improvement in the quality improvement program, proposes goals and objectives for the following year, and identifies the resources needed to accomplish the proposed goals and objectives.

Alere

TIME MAKES A DIFFERENCE
Encourage your 17P patient to complete her course of therapy.

AmeriHealth Caritas Louisiana

AmeriHealth Caritas Louisana and **Alere** partner together in the management of your high-risk obstetrical patients.

We know 17P administration decreases risk of PTB by 34%.[1]

Studies have shown that stopping 17P administration early increases the risk of preterm birth by up to nearly 50%.[2,3]

Our 17P Administration Nursing and Care Management Service provides:

- Compounded, unit dose 17P* via OB nurse administration, in home or at work
- Weekly intramuscular administration (via Z-track injection)
- Weekly, in-person preterm labor/high-risk assessment by a skilled OB nurse
- Patient education materials related to preterm labor/ pregnancy complications
- Education and encouragement specific to the importance of completing the full course of therapy
- Care management from diagnosis to delivery or 36 weeks and 6 days as ordered by physician
- Compliance management to schedule injections to meet patient needs
- Telephonic OB nurse and clinical pharmacist access
- On demand and scheduled weekly reports to the prescribing physician
- Outcomes reports for health plan populations, total or subsets
- High patient satisfaction (Alere patient satisfaction = 98%)[4]

EVERY WEEK MATTERS...

ACOG has introduced new definitions based on recent research showing that babies born at 39 and 40 weeks do better, but that risks rise again after 41 weeks.[5]

Early term: Between 37 weeks 0 days and 38 weeks, six days

Full term: Between 39 weeks and 40 weeks, six days

Late term: Between 41 weeks and 41 weeks, six days

Post term: 42 weeks and beyond

REFERENCES
1. Meis Paul J, et al. Prevention of recurrent preterm delivery by 17 alpha-hydroxyprogesterone caproate. N Engl J Med 2003.
2. Lucas B, et al. Pregnancy outcomes of managed medicaid members prescribed home administration of 17 α-hydroxyprogesterone caproate. Am J Perinatol 2012.
3. Rebarber A, et al. Increased recurrence of preterm delivery with early cessation of 17-alphahydroxyprogesterone caproate. Am J Obstet Gynecol 2007.
4. IVR survey administered by 3rd party vendor. Data on file 2012.
5. ACOG Committee Opinion 579. Definition of term pregnancy. November 2013.

If you have any questions about program coverage or case-by-case review, please call the **ACLA Bright Start Case Management Department: 888-913-0327**

To make a referral, call **800-999-0225** or visit **alerehealth.com**.

*Delivered by national compounding pharmacy when prescribed by physician based on a patient's individual medical need.

Exhibit U.5-4: Alere Fact Sheet

PIP to Reduce Childhood Obesity

For contract years 2015-2017, DHH has set the goal of reducing and preventing childhood obesity among Medicaid-eligible children (18 and under) through weight-assessment, counseling, and other Preventive Methods. Exact goals include the:

- Reduction by 10% of the number of children who are obese on BMI measurement.
- Increase by 20% of the number of children with a BMI documented during physical exam.

Study Question

Does weight assessment, nutritional, and physical activity counseling by a PCP or OB/GYN provider during an outpatient visit reduce pediatric obesity?

Study Population

Approximately 13 million U.S. children and adolescents are obese, with a body mass index at or above the 95th percentile. During the past 40 years, obesity rates for children aged 6 to 11 nearly tripled—from 5 percent to 14 percent —and more than tripled for adolescents aged 12 to 19—from 5 percent to 17.1 percent. Childhood obesity health expenses are estimated at $14 billion annually.

Good nutrition and physical activity can help prevent obesity, but opportunities for healthy choices may be limited. Wealthy communities have three times as many supermarkets as poor areas, increasing their access to fruits, vegetables, and a wider selection of healthy foods. Poorer areas also often have less access to places to be physically active. Almost 30 percent of U.S. children do not exercise three or more times a week. More than 75 percent of high school students do not eat the recommended servings of fruits and vegetables each day. Obese adolescents have an 80 percent chance of becoming obese adults. An estimated 61 percent of obese young people already have at least one additional health risk factor such as high blood pressure or high cholesterol.

Approximately 1 in 3 Louisiana children is overweight or obese. In Louisiana, the percentage of obese children aged 10-17 was 21.0 percent, ranked 4th in the nation in 2011. The percentage of children ages 6-17 participating in vigorous daily physical activity was 31.1 percent. In 2011, 35.6 percent of Louisiana high school students were overweight or obese. Additionally, only 24.2% of Louisiana high school students were physically active at least 60 minutes per day on all 7 days.[3]

Quantifiable Measures to be used

Quantifiable Measures: NCQA Medicaid HEDIS® Measures	Description
Quantifiable Measure #1a:	**BMI percentile documentation during physical exam**
Numerator:	Number of eligible members with evidence of BMI percentile documentation
Denominator:	Eligible members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN

[3] Ogden, et al. JAMA. 2014; 311(8):806-814. JAMA, 295 (13): 1549-1555 and JAMA, 288 (14): 1728-1732. CDC, Morbidity and Mortality Weekly Report 54, no.8: 203. Pediatrics 103, no.6: 1175-1172. CDC, Preventing Obesity and Chronic Diseases through Good Nutrition and Physical Activity. Interagency Forum on Child and Family Statistics America's Children; Key National Indicators of Well-Being, 2007.

Quantifiable Measure # 1b:	**Counseling for nutrition documentation**
Numerator:	Number of eligible members with evidence of counseling for nutrition documentation
Denominator:	Eligible members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN
Quantifiable Measure #1c:	**Counseling for physical activity documentation**
Numerator:	Number of eligible members with evidence of physical activity documentation
Denominator:	Eligible members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN
Quantifiable Measure 2#: **(Healthy People 2020)**	**Obesity rate**
Numerator:	Number of eligible members who are considered obese (BMI at or above the gender-and age specific 95th percentile from the CDC Growth Charts, U.S.)
Denominator:	Eligible members 2-19 years of age who had an outpatient visit with a PCP or OB/GYN

Exhibit U.5-5: Quantifiable Measures to be Used

Baseline Methodology

ACLA's baseline data will be collected during HEDIS 2015 (measurement year 2014).

Data sources

Data collection sources will include administrative data (claims/encounters) and medical record chart review for all eligible members as defined by the 2015 HEDIS specifications for all measures.

Data collection methodology

The HEDIS sampling methodology for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC) will be utilized.

Data collection plan and cycle

- Baseline: January 1, 2014 to December 31, 2014.
- Re-measurement 1: January 1, 2015 to December 31, 2015.
- Re-measurement 2: January 1, 2016 to December 31, 2016.

The Baseline Measurement Year (2014) and following re-measurement years will follow NCQA HEDIS Technical Specifications of the applicable year. Data collection for the HEDIS measure will initiate in January 2015 for the Baseline Measurement Year 2014.

All provider claims data submitted to ACLA from 1/1/14 through 12/31/14 will be mapped to the certified software. The external NCQA certified HEDIS all provider claims data submitted to ACLA from January 1, 2014 through December 31, 2014. Membership eligibility will be based on state reported membership files of calendar year 2014 and will follow age and enrollment specification of HEDIS 2015 Technical Specifications.

Medical record abstraction will begin on/about March 1, 2015 for provider based medical records included in the denominator. All medical record abstraction must be complete by May 15, 2015. This cycle will repeat through 2017.

Audit Review Table

AmeriHealth Caritas Louisiana (Org ID: 19526, SubID: 10824, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013

The Auditor lock has been applied to this submission.

Measure/Data Element	Report Measure	Benefit Offered	Rotated Measure	Rate	Reportable	Comment
Effectiveness of Care: Prevention and Screening						
Adult BMI Assessment (aba)	Y			10.11%	R	Reportable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y					
BMI Percentile				1.43%	R	Reportable
Counseling for Nutrition				2.86%	R	Reportable
Counseling for Physical Activity				0.26%	R	Reportable
Childhood Immunization Status (cis)	Y					
DTaP				57.98%	R	Reportable
IPV				74.59%	R	Reportable
MMR				81.21%	R	Reportable
HiB				78.37%	R	Reportable
Hepatitis B				58.49%	R	Reportable
VZV				81.02%	R	Reportable
Pneumococcal Conjugate				58.82%	R	Reportable
Hepatitis A				75.88%	R	Reportable
Rotavirus				51.76%	R	Reportable
Influenza				29.66%	R	Reportable
Combination #2				43.71%	R	Reportable
Combination #3				40.73%	R	Reportable
Combination #4				39.02%	R	Reportable
Combination #5				32.66%	R	Reportable
Combination #6				18.07%	R	Reportable
Combination #7				31.53%	R	Reportable
Combination #8				17.57%	R	Reportable
Combination #9				14.99%	R	Reportable
Combination #10				14.71%	R	Reportable
Immunizations for Adolescents (ima)	Y					
Meningococcal				85.97%	R	Reportable
Tdap/Td				86.23%	R	Reportable
Combination #1				84.99%	R	Reportable
Human Papillomavirus Vaccine for Female Adolescents (hpv)	Y			18.48%	R	Reportable
Lead Screening in Children (lsc)	Y			66.61%	R	Reportable
Breast Cancer Screening (bcs)	Y			NA	R	Denominator fewer than 30
Cervical Cancer Screening (ccs)	Y			49.93%	R	Reportable
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	Y			8.15%	R	Reportable
Chlamydia Screening in Women (chl)	Y					
16-20 Years				51.60%	R	Reportable
21-24 Years				66.45%	R	Reportable
Total				55.84%	R	Reportable
Effectiveness of Care: Respiratory Conditions						
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y		50.57%	R	Reportable
Appropriate Treatment for Children With URI (uri)	Y	Y		71.43%	R	Reportable
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y		25.52%	R	Reportable
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y			NA	R	Denominator fewer than 30
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y				
Systemic Corticosteroid				65.22%	R	Reportable
Bronchodilator				85.77%	R	Reportable
Use of Appropriate Medications for People With Asthma (asm)	Y	Y				
5-11 Years				76.71%	R	Reportable
12-18 Years				92.11%	R	Reportable
19-50 Years				NA	R	Denominator fewer than 30
51-64 Years				NA	R	Denominator fewer than 30
Total				81.75%	R	Reportable
Medication Management for People With Asthma (mma)	Y	Y				
5-11 Years - Medication Compliance 50%				47.27%	R	Reportable
5-11 Years - Medication Compliance 75%				29.09%	R	Reportable
12-18 Years - Medication Compliance 50%				54.29%	R	Reportable
12-18 Years - Medication Compliance 75%				22.86%	R	Reportable
19-50 Years - Medication Compliance 50%				NA	R	Denominator fewer than 30

19-50 Years - Medication Compliance 75%				NA	R	Denominator fewer than 30
51-64 Years - Medication Compliance 50%				NA	R	Denominator fewer than 30
51-64 Years - Medication Compliance 75%				NA	R	Denominator fewer than 30
Total - Medication Compliance 50%				52.25%	R	Reportable
Total - Medication Compliance 75%				31.53%	R	Reportable
Asthma Medication Ratio (amr)	Y	Y				
5-11 Years				50.75%	R	Reportable
12-18 Years				57.89%	R	Reportable
19-50 Years				NA	R	Denominator fewer than 30
51-64 Years				NA	R	Denominator fewer than 30
Total				54.20%	R	Reportable
Effectiveness of Care: Cardiovascular						
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y					
LDL-C Screening Performed				78.95%	R	Reportable
LDL-C Control (<100 mg/dL)				6.02%	R	Reportable
Controlling High Blood Pressure (cbp)	Y		N	0.00%	R	Reportable
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y		72.09%	R	Reportable
Effectiveness of Care: Diabetes						
Comprehensive Diabetes Care (cdc)	Y					
Hemoglobin A1c (HbA1c) Testing				79.87%	R	Reportable
HbA1c Poor Control (>9.0%)				64.70%	R	Reportable
HbA1c Control (<8.0%)				30.51%	R	Reportable
HbA1c Control (<7.0%)				22.60%	R	Reportable
Eye Exam (Retinal) Performed				37.86%	R	Reportable
LDL-C Screening Performed				73.96%	R	Reportable
LDL-C Control (<100 mg/dL)				19.81%	R	Reportable
Medical Attention for Nephropathy				81.47%	R	Reportable
Blood Pressure Control (<140/80 mm Hg)				27.16%	R	Reportable
Blood Pressure Control (<140/90 mm Hg)				42.65%	R	Reportable
Effectiveness of Care: Musculoskeletal						
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y		70.00%	R	Reportable
Use of Imaging Studies for Low Back Pain (lbp)	Y			77.94%	R	Reportable
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (amm)	Y	Y				
Effective Acute Phase Treatment				41.87%	R	Reportable
Effective Continuation Phase Treatment				31.82%	R	Reportable
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y				
Initiation Phase				31.85%	R	Reportable
Continuation and Maintenance (C&M) Phase				35.49%	R	Reportable
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	N				
30-Day Follow-Up				NB	R	Required benefit not offered
7-Day Follow-Up				NB	R	Required benefit not offered
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	Y	Y		81.24%	R	Reportable
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	Y			60.74%	R	Reportable
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	Y			NA	R	Denominator fewer than 30
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	Y	Y		58.41%	R	Reportable
Effectiveness of Care: Medication Management						
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y				
ACE Inhibitors or ARBs				88.36%	R	Reportable
Digoxin				92.38%	R	Reportable
Diuretics				88.34%	R	Reportable
Anticonvulsants				69.08%	R	Reportable
Total				86.48%	R	Reportable
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y					
20-44 Years				80.18%	R	Reportable

45-64 Years				87.86%	R	Reportable
65+ Years				73.24%	R	Reportable
Total				83.16%	R	Reportable
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y					
12-24 Months				94.77%	R	Reportable
25 Months - 6 Years				84.83%	R	Reportable
7-11 Years				83.57%	R	Reportable
12-19 Years				80.97%	R	Reportable
Annual Dental Visit (adv)	Y	Y				
2-3 Years				40.85%	R	Reportable
4-6 Years				58.14%	R	Reportable
7-10 Years				59.14%	R	Reportable
11-14 Years				52.30%	R	Reportable
15-18 Years				46.23%	R	Reportable
19-21 Years				30.83%	R	Reportable
Total				51.95%	R	Reportable
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	N				
Initiation of AOD Treatment: 13-17 Years				NB	R	Required benefit not offered
Engagement of AOD Treatment: 13-17 Years				NB	R	Required benefit not offered
Initiation of AOD Treatment: 18+ Years				NB	R	Required benefit not offered
Engagement of AOD Treatment: 18+ Years				NB	R	Required benefit not offered
Initiation of AOD Treatment: Total				NB	R	Required benefit not offered
Engagement of AOD Treatment: Total				NB	R	Required benefit not offered
Prenatal and Postpartum Care (ppc)	Y		N			
Timeliness of Prenatal Care				77.83%	R	Reportable
Postpartum Care				32.44%	R	Reportable
Call Answer Timeliness (cat)	Y			92.12%	R	Reportable
Utilization						
Frequency of Ongoing Prenatal Care (fpc)	Y		N			
<21 Percent				10.36%	R	Reportable
21-40 Percent				5.40%	R	Reportable
41-60 Percent				9.14%	R	Reportable
61-80 Percent				17.35%	R	Reportable
81+ Percent				57.75%	R	Reportable
Well-Child Visits in the First 15 Months of Life (w15)	Y					
0 Visits				4.18%	R	Reportable
1 Visit				4.05%	R	Reportable
2 Visits				7.18%	R	Reportable
3 Visits				10.94%	R	Reportable
4 Visits				15.65%	R	Reportable
5 Visits				21.08%	R	Reportable
6+ Visits				36.92%	R	Reportable
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y			57.17%	R	Reportable
Adolescent Well-Care Visits (awc)	Y			43.49%	R	Reportable
Frequency of Selected Procedures (fsp)	Y				R	Reportable
Ambulatory Care: Total (amba)	Y				R	Reportable
Ambulatory Care: Dual Eligibles (ambb)	Y				R	Reportable
Ambulatory Care: Disabled (ambc)	Y				R	Reportable
Ambulatory Care: Other (ambd)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	Y				R	Reportable
Identification of Alcohol and Other Drug Services: Total (iada)	Y	N			R	Required benefit not offered
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	Y	N			R	Required benefit not offered
Identification of Alcohol and Other Drug Services: Disabled (iadc)	Y	N			R	Required benefit not offered
Identification of Alcohol and Other Drug Services: Other (iadd)	Y	N			R	Required benefit not offered
Mental Health Utilization: Total (mpta)	Y	N			R	Required benefit not offered
Mental Health Utilization: Dual Eligibles (mptb)	Y	N			R	Required benefit not offered
Mental Health Utilization: Disabled (mptc)	Y	N			R	Required benefit not offered
Mental Health Utilization: Other (mptd)	Y	N			R	Required benefit not offered
Antibiotic Utilization: Total (abxa)	Y	Y			R	Reportable
Antibiotic Utilization: Dual Eligibles (abxb)	Y	Y			R	Reportable

Antibiotic Utilization: Disabled (abxc)	Y	Y			R	Reportable
Antibiotic Utilization: Other (abxd)	Y	Y			R	Reportable
Relative Resource Use						
Relative Resource Use for People With Diabetes (rdi)	Y				R	Reportable
Relative Resource Use for People With Asthma (ras)	Y	Y			R	Reportable
Relative Resource Use for People With Cardiovascular Conditions (rca)	Y				R	Reportable
Relative Resource Use for People With Hypertension (rhy)	Y				R	Reportable
Relative Resource Use for People With COPD (rco)	Y				R	Reportable
Health Plan Descriptive Information						
Board Certification (bcr)	Y				R	Reportable
Total Membership (tlm)	Y				R	Reportable
Enrollment by Product Line: Total (enpa)	Y				R	Reportable
Enrollment by Product Line: Dual Eligibles (enpb)	Y				R	Reportable
Enrollment by Product Line: Disabled (enpc)	Y				R	Reportable
Enrollment by Product Line: Other (enpd)	Y				R	Reportable
Enrollment by State (ebs)	Y				R	Reportable
Race/Ethnicity Diversity of Membership (rdm)	Y				R	Reportable
Language Diversity of Membership (ldm)	Y				R	Reportable
Weeks of Pregnancy at Time of Enrollment (wop)	Y		N		R	Reportable

Audit Review Table

AmeriHealth Caritas Pennsylvania (Org ID: 1054, SubID: 4475, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013

The Auditor lock has been applied to this submission.

Measure/Data Element	Report Measure	Benefit Offered	Rotated Measure	Rate	Reportable	Comment
Effectiveness of Care: Prevention and Screening						
Adult BMI Assessment (aba)	Y			87.08%	R	Reportable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y					
BMI Percentile				74.54%	R	Reportable
Counseling for Nutrition				69.91%	R	Reportable
Counseling for Physical Activity				63.43%	R	Reportable
Childhood Immunization Status (cis)	Y					
DTaP				83.22%	R	Reportable
IPV				95.36%	R	Reportable
MMR				93.82%	R	Reportable
HiB				95.36%	R	Reportable
Hepatitis B				94.70%	R	Reportable
VZV				93.60%	R	Reportable
Pneumococcal Conjugate				83.89%	R	Reportable
Hepatitis A				85.65%	R	Reportable
Rotavirus				74.83%	R	Reportable
Influenza				65.56%	R	Reportable
Combination #2				79.91%	R	Reportable
Combination #3				76.38%	R	Reportable
Combination #4				72.63%	R	Reportable
Combination #5				63.80%	R	Reportable
Combination #6				57.62%	R	Reportable
Combination #7				61.59%	R	Reportable
Combination #8				56.51%	R	Reportable
Combination #9				50.33%	R	Reportable
Combination #10				50.11%	R	Reportable
Immunizations for Adolescents (ima)	Y					
Meningococcal				83.82%	R	Reportable
Tdap/Td				88.59%	R	Reportable
Combination #1				81.96%	R	Reportable
Human Papillomavirus Vaccine for Female Adolescents (hpv)	Y			32.96%	R	Reportable
Lead Screening in Children (lsc)	Y			70.42%	R	Reportable
Breast Cancer Screening (bcs)	Y			68.72%	R	Reportable
Cervical Cancer Screening (ccs)	Y			69.04%	R	Reportable
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	Y			3.25%	R	Reportable
Chlamydia Screening in Women (chl)	Y					
16-20 Years				49.73%	R	Reportable
21-24 Years				58.66%	R	Reportable
Total				53.45%	R	Reportable
Effectiveness of Care: Respiratory Conditions						
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y		58.28%	R	Reportable
Appropriate Treatment for Children With URI (uri)	Y	Y		85.90%	R	Reportable
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y		21.48%	R	Reportable
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y			28.52%	R	Reportable
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y				
Systemic Corticosteroid				78.76%	R	Reportable
Bronchodilator				89.87%	R	Reportable
Use of Appropriate Medications for People With Asthma (asm)	Y	Y				
5-11 Years				91.34%	R	Reportable
12-18 Years				86.73%	R	Reportable
19-50 Years				77.95%	R	Reportable
51-64 Years				75.31%	R	Reportable
Total				84.05%	R	Reportable
Medication Management for People With Asthma (mma)	Y	Y				
5-11 Years - Medication Compliance 50%				63.42%	R	Reportable
5-11 Years - Medication Compliance 75%				39.87%	R	Reportable

12-18 Years - Medication Compliance 50%				64.24%	R	Reportable
12-18 Years - Medication Compliance 75%				43.42%	R	Reportable
19-50 Years - Medication Compliance 50%				70.09%	R	Reportable
19-50 Years - Medication Compliance 75%				48.44%	R	Reportable
51-64 Years - Medication Compliance 50%				75.82%	R	Reportable
51-64 Years - Medication Compliance 75%				55.74%	R	Reportable
Total - Medication Compliance 50%				66.96%	R	Reportable
Total - Medication Compliance 75%				44.99%	R	Reportable
Asthma Medication Ratio (amr)	Y	Y				
5-11 Years				76.25%	R	Reportable
12-18 Years				67.07%	R	Reportable
19-50 Years				55.38%	R	Reportable
51-64 Years				54.80%	R	Reportable
Total				64.88%	R	Reportable
Effectiveness of Care: Cardiovascular						
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y					
LDL-C Screening Performed				86.77%	R	Reportable
LDL-C Control (<100 mg/dL)				52.67%	R	Reportable
Controlling High Blood Pressure (cbp)	Y		N	65.59%	R	Reportable
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y		95.12%	R	Reportable
Effectiveness of Care: Diabetes						
Comprehensive Diabetes Care (cdc)	Y					
Hemoglobin A1c (HbA1c) Testing				84.83%	R	Reportable
HbA1c Poor Control (>9.0%)				33.33%	R	Reportable
HbA1c Control (<8.0%)				56.17%	R	Reportable
HbA1c Control (<7.0%)				39.68%	R	Reportable
Eye Exam (Retinal) Performed				65.50%	R	Reportable
LDL-C Screening Performed				77.83%	R	Reportable
LDL-C Control (<100 mg/dL)				39.00%	R	Reportable
Medical Attention for Nephropathy				80.50%	R	Reportable
Blood Pressure Control (<140/80 mm Hg)				45.50%	R	Reportable
Blood Pressure Control (<140/90 mm Hg)				69.50%	R	Reportable
Effectiveness of Care: Musculoskeletal						
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y		77.69%	R	Reportable
Use of Imaging Studies for Low Back Pain (lbp)	Y			73.43%	R	Reportable
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (amm)	Y	Y				
Effective Acute Phase Treatment				53.63%	R	Reportable
Effective Continuation Phase Treatment				40.73%	R	Reportable
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y				
Initiation Phase				19.54%	R	Reportable
Continuation and Maintenance (C&M) Phase				20.25%	R	Reportable
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	N				
30-Day Follow-Up				NB	R	Required benefit not offered
7-Day Follow-Up				NB	R	Required benefit not offered
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	Y	Y		85.12%	R	Reportable
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	Y			74.77%	R	Reportable
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	Y			NA	R	Denominator fewer than 30
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	Y	Y		72.04%	R	Reportable
Effectiveness of Care: Medication Management						
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y				
ACE Inhibitors or ARBs				89.60%	R	Reportable
Digoxin				94.34%	R	Reportable
Diuretics				89.52%	R	Reportable

Anticonvulsants				61.60%	R	Reportable
Total				86.11%	R	Reportable
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y					
20-44 Years				84.10%	R	Reportable
45-64 Years				91.49%	R	Reportable
65+ Years				90.70%	R	Reportable
Total				86.55%	R	Reportable
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y					
12-24 Months				96.43%	R	Reportable
25 Months - 6 Years				87.61%	R	Reportable
7-11 Years				91.94%	R	Reportable
12-19 Years				91.51%	R	Reportable
Annual Dental Visit (adv)	Y	Y				
2-3 Years				34.20%	R	Reportable
4-6 Years				61.20%	R	Reportable
7-10 Years				62.86%	R	Reportable
11-14 Years				58.62%	R	Reportable
15-18 Years				52.68%	R	Reportable
19-21 Years				40.69%	R	Reportable
Total				54.80%	R	Reportable
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	N				
Initiation of AOD Treatment: 13-17 Years				NB	R	Required benefit not offered
Engagement of AOD Treatment: 13-17 Years				NB	R	Required benefit not offered
Initiation of AOD Treatment: 18+ Years				NB	R	Required benefit not offered
Engagement of AOD Treatment: 18+ Years				NB	R	Required benefit not offered
Initiation of AOD Treatment: Total				NB	R	Required benefit not offered
Engagement of AOD Treatment: Total				NB	R	Required benefit not offered
Prenatal and Postpartum Care (ppc)	Y		N			
Timeliness of Prenatal Care				92.22%	R	Reportable
Postpartum Care				68.00%	R	Reportable
Call Answer Timeliness (cat)	Y			89.08%	R	Reportable
Utilization						
Frequency of Ongoing Prenatal Care (fpc)	Y		N			
<21 Percent				1.78%	R	Reportable
21-40 Percent				1.33%	R	Reportable
41-60 Percent				3.33%	R	Reportable
61-80 Percent				10.89%	R	Reportable
81+ Percent				82.67%	R	Reportable
Well-Child Visits in the First 15 Months of Life (w15)	Y					
0 Visits				1.77%	R	Reportable
1 Visit				0.22%	R	Reportable
2 Visits				1.10%	R	Reportable
3 Visits				3.31%	R	Reportable
4 Visits				6.84%	R	Reportable
5 Visits				15.23%	R	Reportable
6+ Visits				71.52%	R	Reportable
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y			76.50%	R	Reportable
Adolescent Well-Care Visits (awc)	Y			62.70%	R	Reportable
Frequency of Selected Procedures (fsp)	Y				R	Reportable
Ambulatory Care: Total (amba)	Y				R	Reportable
Ambulatory Care: Dual Eligibles (ambb)	Y				R	Reportable
Ambulatory Care: Disabled (ambc)	Y				R	Reportable
Ambulatory Care: Other (ambd)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	Y				R	Reportable
Identification of Alcohol and Other Drug Services: Total (iada)	Y	N			R	Required benefit not offered
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	Y	N			R	Required benefit not offered

Identification of Alcohol and Other Drug Services: Disabled (iadc)	Y	N			R	Required benefit not offered
Identification of Alcohol and Other Drug Services: Other (iadd)	Y	N			R	Required benefit not offered
Mental Health Utilization: Total (mpta)	Y	N			R	Required benefit not offered
Mental Health Utilization: Dual Eligibles (mptb)	Y	N			R	Required benefit not offered
Mental Health Utilization: Disabled (mptc)	Y	N			R	Required benefit not offered
Mental Health Utilization: Other (mptd)	Y	N			R	Required benefit not offered
Antibiotic Utilization: Total (abxa)	Y	Y			R	Reportable
Antibiotic Utilization: Dual Eligibles (abxb)	Y	Y			R	Reportable
Antibiotic Utilization: Disabled (abxc)	Y	Y			R	Reportable
Antibiotic Utilization: Other (abxd)	Y	Y			R	Reportable
Relative Resource Use						
Relative Resource Use for People With Diabetes (rdi)	Y				R	Reportable
Relative Resource Use for People With Asthma (ras)	Y	Y			R	Reportable
Relative Resource Use for People With Cardiovascular Conditions (rca)	Y				R	Reportable
Relative Resource Use for People With Hypertension (rhy)	Y				R	Reportable
Relative Resource Use for People With COPD (rco)	Y				R	Reportable
Health Plan Descriptive Information						
Board Certification (bcr)	Y				R	Reportable
Total Membership (tlm)	Y				R	Reportable
Enrollment by Product Line: Total (enpa)	Y				R	Reportable
Enrollment by Product Line: Dual Eligibles (enpb)	Y				R	Reportable
Enrollment by Product Line: Disabled (enpc)	Y				R	Reportable
Enrollment by Product Line: Other (enpd)	Y				R	Reportable
Enrollment by State (ebs)	Y				R	Reportable
Race/Ethnicity Diversity of Membership (rdm)	Y				R	Reportable
Language Diversity of Membership (ldm)	Y				R	Reportable
Weeks of Pregnancy at Time of Enrollment (wop)	Y		N		R	Reportable

Audit Review Table

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013

The Auditor lock has been applied to this submission.

Measure/Data Element	Report Measure	Benefit Offered	Rotated Measure	Rate	Reportable	Comment
Effectiveness of Care: Prevention and Screening						
Adult BMI Assessment (aba)	Y			NA	R	Denominator fewer than 30
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y					
BMI Percentile				57.84%	R	Reportable
Counseling for Nutrition				37.53%	R	Reportable
Counseling for Physical Activity				33.77%	R	Reportable
Childhood Immunization Status (cis)	Y					
DTaP				67.14%	R	Reportable
IPV				86.29%	R	Reportable
MMR				82.86%	R	Reportable
HiB				86.57%	R	Reportable
Hepatitis B				86.29%	R	Reportable
VZV				82.86%	R	Reportable
Pneumococcal Conjugate				70.57%	R	Reportable
Hepatitis A				67.71%	R	Reportable
Rotavirus				58.86%	R	Reportable
Influenza				43.14%	R	Reportable
Combination #2				64.86%	R	Reportable
Combination #3				60.86%	R	Reportable
Combination #4				50.57%	R	Reportable
Combination #5				46.57%	R	Reportable
Combination #6				33.71%	R	Reportable
Combination #7				40.86%	R	Reportable
Combination #8				29.14%	R	Reportable
Combination #9				27.43%	R	Reportable
Combination #10				24.00%	R	Reportable
Immunizations for Adolescents (ima)	Y					
Meningococcal				60.43%	R	Reportable
Tdap/Td				79.14%	R	Reportable
Combination #1				60.12%	R	Reportable
Human Papillomavirus Vaccine for Female Adolescents (hpv)	Y			19.11%	R	Reportable
Lead Screening in Children (lsc)	Y			37.43%	R	Reportable
Breast Cancer Screening (bcs)	Y			NA	R	Denominator fewer than 30
Cervical Cancer Screening (ccs)	Y			44.88%	R	Reportable
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	Y			6.66%	R	Reportable
Chlamydia Screening in Women (chl)	Y					
16-20 Years				26.16%	R	Reportable
21-24 Years				42.03%	R	Reportable
Total				30.50%	R	Reportable
Effectiveness of Care: Respiratory Conditions						
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y		44.68%	R	Reportable
Appropriate Treatment for Children With URI (uri)	Y	Y		64.93%	R	Reportable
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y		42.31%	R	Reportable
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y			NA	R	Denominator fewer than 30
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y				
Systemic Corticosteroid				NA	R	Denominator fewer than 30
Bronchodilator				NA	R	Denominator fewer than 30
Use of Appropriate Medications for People With Asthma (asm)	Y	Y				
5-11 Years				NA	R	Denominator fewer than 30
12-18 Years				NA	R	Denominator fewer than 30
19-50 Years				NA	R	Denominator fewer than 30
51-64 Years				NA	R	Denominator fewer than 30
Total				NA	R	Denominator fewer than 30
Medication Management for People With Asthma (mma)	Y	Y				
5-11 Years - Medication Compliance 50%				NA	R	Denominator fewer than 30
5-11 Years - Medication Compliance 75%				NA	R	Denominator fewer than 30

12-18 Years - Medication Compliance 50%				NA	R	Denominator fewer than 30
12-18 Years - Medication Compliance 75%				NA	R	Denominator fewer than 30
19-50 Years - Medication Compliance 50%				NA	R	Denominator fewer than 30
19-50 Years - Medication Compliance 75%				NA	R	Denominator fewer than 30
51-64 Years - Medication Compliance 50%				NA	R	Denominator fewer than 30
51-64 Years - Medication Compliance 75%				NA	R	Denominator fewer than 30
Total - Medication Compliance 50%				NA	R	Denominator fewer than 30
Total - Medication Compliance 75%				NA	R	Denominator fewer than 30
Asthma Medication Ratio (amr)	Y	Y				
5-11 Years				NA	R	Denominator fewer than 30
12-18 Years				NA	R	Denominator fewer than 30
19-50 Years				NA	R	Denominator fewer than 30
51-64 Years				NA	R	Denominator fewer than 30
Total				NA	R	Denominator fewer than 30
Effectiveness of Care: Cardiovascular						
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y					
LDL-C Screening Performed				NA	R	Denominator fewer than 30
LDL-C Control (<100 mg/dL)				NA	R	Denominator fewer than 30
Controlling High Blood Pressure (cbp)	Y		N	63.27%	R	Reportable
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y		NA	R	Denominator fewer than 30
Effectiveness of Care: Diabetes						
Comprehensive Diabetes Care (cdc)	Y					
Hemoglobin A1c (HbA1c) Testing				80.50%	R	Reportable
HbA1c Poor Control (>9.0%)				55.19%	R	Reportable
HbA1c Control (<8.0%)				36.93%	R	Reportable
HbA1c Control (<7.0%)				24.16%	R	Reportable
Eye Exam (Retinal) Performed				48.55%	R	Reportable
LDL-C Screening Performed				56.02%	R	Reportable
LDL-C Control (<100 mg/dL)				20.75%	R	Reportable
Medical Attention for Nephropathy				67.22%	R	Reportable
Blood Pressure Control (<140/80 mm Hg)				45.23%	R	Reportable
Blood Pressure Control (<140/90 mm Hg)				67.63%	R	Reportable
Effectiveness of Care: Musculoskeletal						
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y		NA	R	Denominator fewer than 30
Use of Imaging Studies for Low Back Pain (lbp)	Y			75.81%	R	Reportable
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (amm)	Y	Y				
Effective Acute Phase Treatment				NA	R	Denominator fewer than 30
Effective Continuation Phase Treatment				NA	R	Denominator fewer than 30
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y				
Initiation Phase				NA	R	Denominator fewer than 30
Continuation and Maintenance (C&M) Phase				NA	R	Denominator fewer than 30
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	N				
30-Day Follow-Up				NB	R	Required benefit not offered
7-Day Follow-Up				NB	R	Required benefit not offered
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	Y	Y		84.31%	R	Reportable
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	Y			NA	R	Denominator fewer than 30
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	Y			NA	R	Denominator fewer than 30
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	Y	Y		NA	R	Denominator fewer than 30
Effectiveness of Care: Medication Management						
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y				
ACE Inhibitors or ARBs				NA	R	Denominator fewer than 30
Digoxin				NA	R	Denominator fewer than 30
Diuretics				NA	R	Denominator fewer than 30

Anticonvulsants				NA	R	Denominator fewer than 30
Total				NA	R	Denominator fewer than 30
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y					
20-44 Years				87.53%	R	Reportable
45-64 Years				90.98%	R	Reportable
65+ Years				91.30%	R	Reportable
Total				88.72%	R	Reportable
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y					
12-24 Months				93.03%	R	Reportable
25 Months - 6 Years				81.54%	R	Reportable
7-11 Years				NA	R	Denominator fewer than 30
12-19 Years				NA	R	Denominator fewer than 30
Annual Dental Visit (adv)	Y	N				
2-3 Years				NB	R	Required benefit not offered
4-6 Years				NB	R	Required benefit not offered
7-10 Years				NB	R	Required benefit not offered
11-14 Years				NB	R	Required benefit not offered
15-18 Years				NB	R	Required benefit not offered
19-21 Years				NB	R	Required benefit not offered
Total				NB	R	Required benefit not offered
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	N				
Initiation of AOD Treatment: 13-17 Years				NB	R	Required benefit not offered
Engagement of AOD Treatment: 13-17 Years				NB	R	Required benefit not offered
Initiation of AOD Treatment: 18+ Years				NB	R	Required benefit not offered
Engagement of AOD Treatment: 18+ Years				NB	R	Required benefit not offered
Initiation of AOD Treatment: Total				NB	R	Required benefit not offered
Engagement of AOD Treatment: Total				NB	R	Required benefit not offered
Prenatal and Postpartum Care (ppc)	Y		N			
Timeliness of Prenatal Care				91.59%	R	Reportable
Postpartum Care				66.81%	R	Reportable
Call Answer Timeliness (cat)	Y			91.85%	R	Reportable
Utilization						
Frequency of Ongoing Prenatal Care (fpc)	Y		N			
<21 Percent				5.31%	R	Reportable
21-40 Percent				3.10%	R	Reportable
41-60 Percent				4.42%	R	Reportable
61-80 Percent				11.73%	R	Reportable
81+ Percent				75.44%	R	Reportable
Well-Child Visits in the First 15 Months of Life (w15)	Y					
0 Visits				4.07%	R	Reportable
1 Visit				2.03%	R	Reportable
2 Visits				2.71%	R	Reportable
3 Visits				7.46%	R	Reportable
4 Visits				12.88%	R	Reportable
5 Visits				21.69%	R	Reportable
6+ Visits				49.15%	R	Reportable
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y			57.40%	R	Reportable
Adolescent Well-Care Visits (awc)	Y			41.94%	R	Reportable
Frequency of Selected Procedures (fsp)	Y				R	Reportable
Ambulatory Care: Total (amba)	Y				R	Reportable
Ambulatory Care: Dual Eligibles (ambb)	Y				R	Reportable
Ambulatory Care: Disabled (ambc)	Y				R	Reportable
Ambulatory Care: Other (ambd)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	Y				R	Reportable
Identification of Alcohol and Other Drug Services: Total (iada)	Y	N			R	Required benefit not offered
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	Y	N			R	Required benefit not offered

Identification of Alcohol and Other Drug Services: Disabled (iadc)	Y	N			R	Required benefit not offered
Identification of Alcohol and Other Drug Services: Other (iadd)	Y	N			R	Required benefit not offered
Mental Health Utilization: Total (mpta)	Y	N			R	Required benefit not offered
Mental Health Utilization: Dual Eligibles (mptb)	Y	N			R	Required benefit not offered
Mental Health Utilization: Disabled (mptc)	Y	N			R	Required benefit not offered
Mental Health Utilization: Other (mptd)	Y	N			R	Required benefit not offered
Antibiotic Utilization: Total (abxa)	Y	Y			R	Reportable
Antibiotic Utilization: Dual Eligibles (abxb)	Y	Y			R	Reportable
Antibiotic Utilization: Disabled (abxc)	Y	Y			R	Reportable
Antibiotic Utilization: Other (abxd)	Y	Y			R	Reportable
Relative Resource Use						
Relative Resource Use for People With Diabetes (rdi)	Y				R	Reportable
Relative Resource Use for People With Asthma (ras)	N	N			NR	Measure Unselected
Relative Resource Use for People With Cardiovascular Conditions (rca)	N				NR	Measure Unselected
Relative Resource Use for People With Hypertension (rhy)	Y				R	Reportable
Relative Resource Use for People With COPD (rco)	N				NR	Measure Unselected
Health Plan Descriptive Information						
Board Certification (bcr)	Y				R	Reportable
Total Membership (tlm)	Y				R	Reportable
Enrollment by Product Line: Total (enpa)	Y				R	Reportable
Enrollment by Product Line: Dual Eligibles (enpb)	Y				R	Reportable
Enrollment by Product Line: Disabled (enpc)	Y				R	Reportable
Enrollment by Product Line: Other (enpd)	Y				R	Reportable
Enrollment by State (ebs)	Y				R	Reportable
Race/Ethnicity Diversity of Membership (rdm)	Y				R	Reportable
Language Diversity of Membership (ldm)	Y				R	Reportable
Weeks of Pregnancy at Time of Enrollment (wop)	Y		N		R	Reportable

Audit Review Table

Keystone First (Org ID: 328, SubID: 4275, Medicaid, Spec Area: None, Spec Proj: PA Medicaid); Measurement Year - 2013

The Auditor lock has been applied to this submission.

Measure/Data Element	Report Measure	Benefit Offered	Rotated Measure	Rate	Reportable	Comment
Effectiveness of Care: Prevention and Screening						
Adult BMI Assessment (aba)	Y			78.44%	R	Reportable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y					
BMI Percentile				69.78%	R	Reportable
Counseling for Nutrition				69.56%	R	Reportable
Counseling for Physical Activity				63.56%	R	Reportable
Childhood Immunization Status (cis)	Y					
DTaP				84.99%	R	Reportable
IPV				95.58%	R	Reportable
MMR				93.82%	R	Reportable
HiB				96.91%	R	Reportable
Hepatitis B				94.92%	R	Reportable
VZV				93.60%	R	Reportable
Pneumococcal Conjugate				84.11%	R	Reportable
Hepatitis A				86.98%	R	Reportable
Rotavirus				75.72%	R	Reportable
Influenza				67.33%	R	Reportable
Combination #2				81.90%	R	Reportable
Combination #3				78.81%	R	Reportable
Combination #4				75.50%	R	Reportable
Combination #5				66.89%	R	Reportable
Combination #6				59.60%	R	Reportable
Combination #7				64.24%	R	Reportable
Combination #8				57.17%	R	Reportable
Combination #9				51.43%	R	Reportable
Combination #10				49.45%	R	Reportable
Immunizations for Adolescents (ima)	Y					
Meningococcal				88.50%	R	Reportable
Tdap/Td				91.15%	R	Reportable
Combination #1				86.73%	R	Reportable
Human Papillomavirus Vaccine for Female Adolescents (hpv)	Y			24.28%	R	Reportable
Lead Screening in Children (lsc)	Y			74.61%	R	Reportable
Breast Cancer Screening (bcs)	Y			66.19%	R	Reportable
Cervical Cancer Screening (ccs)	Y			70.95%	R	Reportable
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	Y			1.84%	R	Reportable
Chlamydia Screening in Women (chl)	Y					
16-20 Years				61.08%	R	Reportable
21-24 Years				66.32%	R	Reportable
Total				63.27%	R	Reportable
Effectiveness of Care: Respiratory Conditions						
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y		64.60%	R	Reportable
Appropriate Treatment for Children With URI (uri)	Y	Y		89.20%	R	Reportable
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y		27.03%	R	Reportable
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y			25.82%	R	Reportable
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y				
Systemic Corticosteroid				78.30%	R	Reportable
Bronchodilator				91.39%	R	Reportable
Use of Appropriate Medications for People With Asthma (asm)	Y	Y				
5-11 Years				92.60%	R	Reportable
12-18 Years				89.35%	R	Reportable
19-50 Years				78.97%	R	Reportable
51-64 Years				75.66%	R	Reportable
Total				86.91%	R	Reportable
Medication Management for People With Asthma (mma)	Y	Y				
5-11 Years - Medication Compliance 50%				55.43%	R	Reportable
5-11 Years - Medication Compliance 75%				32.32%	R	Reportable

12-18 Years - Medication Compliance 50%				57.10%	R	Reportable
12-18 Years - Medication Compliance 75%				35.50%	R	Reportable
19-50 Years - Medication Compliance 50%				62.57%	R	Reportable
19-50 Years - Medication Compliance 75%				42.73%	R	Reportable
51-64 Years - Medication Compliance 50%				78.89%	R	Reportable
51-64 Years - Medication Compliance 75%				59.68%	R	Reportable
Total - Medication Compliance 50%				59.29%	R	Reportable
Total - Medication Compliance 75%				37.59%	R	Reportable
Asthma Medication Ratio (amr)	Y	Y				
5-11 Years				71.26%	R	Reportable
12-18 Years				65.91%	R	Reportable
19-50 Years				50.34%	R	Reportable
51-64 Years				52.51%	R	Reportable
Total				63.12%	R	Reportable
Effectiveness of Care: Cardiovascular						
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y					
LDL-C Screening Performed				79.20%	R	Reportable
LDL-C Control (<100 mg/dL)				43.14%	R	Reportable
Controlling High Blood Pressure (cbp)	Y		N	60.44%	R	Reportable
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y		94.74%	R	Reportable
Effectiveness of Care: Diabetes						
Comprehensive Diabetes Care (cdc)	Y					
Hemoglobin A1c (HbA1c) Testing				82.51%	R	Reportable
HbA1c Poor Control (>9.0%)				36.72%	R	Reportable
HbA1c Control (<8.0%)				55.17%	R	Reportable
HbA1c Control (<7.0%)				39.23%	R	Reportable
Eye Exam (Retinal) Performed				51.67%	R	Reportable
LDL-C Screening Performed				79.81%	R	Reportable
LDL-C Control (<100 mg/dL)				37.68%	R	Reportable
Medical Attention for Nephropathy				80.92%	R	Reportable
Blood Pressure Control (<140/80 mm Hg)				40.22%	R	Reportable
Blood Pressure Control (<140/90 mm Hg)				66.93%	R	Reportable
Effectiveness of Care: Musculoskeletal						
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y		73.94%	R	Reportable
Use of Imaging Studies for Low Back Pain (lbp)	Y			78.53%	R	Reportable
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (amm)	Y	Y				
Effective Acute Phase Treatment				54.75%	R	Reportable
Effective Continuation Phase Treatment				41.25%	R	Reportable
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y				
Initiation Phase				15.68%	R	Reportable
Continuation and Maintenance (C&M) Phase				14.58%	R	Reportable
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	N				
30-Day Follow-Up				NB	R	Required benefit not offered
7-Day Follow-Up				NB	R	Required benefit not offered
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	Y	Y		67.12%	R	Reportable
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	Y			67.04%	R	Reportable
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	Y			74.49%	R	Reportable
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	Y	Y		75.35%	R	Reportable
Effectiveness of Care: Medication Management						
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y				
ACE Inhibitors or ARBs				83.18%	R	Reportable
Digoxin				88.64%	R	Reportable
Diuretics				82.01%	R	Reportable

Anticonvulsants				57.38%	R	Reportable
Total				79.75%	R	Reportable
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y					
20-44 Years				82.38%	R	Reportable
45-64 Years				91.03%	R	Reportable
65+ Years				88.17%	R	Reportable
Total				85.57%	R	Reportable
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y					
12-24 Months				97.35%	R	Reportable
25 Months - 6 Years				88.67%	R	Reportable
7-11 Years				92.29%	R	Reportable
12-19 Years				90.60%	R	Reportable
Annual Dental Visit (adv)	Y	Y				
2-3 Years				53.30%	R	Reportable
4-6 Years				73.25%	R	Reportable
7-10 Years				70.50%	R	Reportable
11-14 Years				64.51%	R	Reportable
15-18 Years				54.52%	R	Reportable
19-21 Years				41.26%	R	Reportable
Total				62.73%	R	Reportable
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	N				
Initiation of AOD Treatment: 13-17 Years				NB	R	Required benefit not offered
Engagement of AOD Treatment: 13-17 Years				NB	R	Required benefit not offered
Initiation of AOD Treatment: 18+ Years				NB	R	Required benefit not offered
Engagement of AOD Treatment: 18+ Years				NB	R	Required benefit not offered
Initiation of AOD Treatment: Total				NB	R	Required benefit not offered
Engagement of AOD Treatment: Total				NB	R	Required benefit not offered
Prenatal and Postpartum Care (ppc)	Y		N			
Timeliness of Prenatal Care				84.00%	R	Reportable
Postpartum Care				58.67%	R	Reportable
Call Answer Timeliness (cat)	Y			90.18%	R	Reportable
Utilization						
Frequency of Ongoing Prenatal Care (fpc)	Y		N			
<21 Percent				5.11%	R	Reportable
21-40 Percent				5.56%	R	Reportable
41-60 Percent				10.44%	R	Reportable
61-80 Percent				15.78%	R	Reportable
81+ Percent				63.11%	R	Reportable
Well-Child Visits in the First 15 Months of Life (w15)	Y					
0 Visits				0.23%	R	Reportable
1 Visit				1.13%	R	Reportable
2 Visits				2.26%	R	Reportable
3 Visits				4.52%	R	Reportable
4 Visits				7.47%	R	Reportable
5 Visits				16.29%	R	Reportable
6+ Visits				68.10%	R	Reportable
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y			80.80%	R	Reportable
Adolescent Well-Care Visits (awc)	Y			62.42%	R	Reportable
Frequency of Selected Procedures (fsp)	Y				R	Reportable
Ambulatory Care: Total (amba)	Y				R	Reportable
Ambulatory Care: Dual Eligibles (ambb)	Y				R	Reportable
Ambulatory Care: Disabled (ambc)	Y				R	Reportable
Ambulatory Care: Other (ambd)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	Y				R	Reportable
Identification of Alcohol and Other Drug Services: Total (iada)	Y	N			R	Required benefit not offered
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	Y	N			R	Required benefit not offered

Identification of Alcohol and Other Drug Services: Disabled (iadc)	Y	N			R	Required benefit not offered
Identification of Alcohol and Other Drug Services: Other (iadd)	Y	N			R	Required benefit not offered
Mental Health Utilization: Total (mpta)	Y	N			R	Required benefit not offered
Mental Health Utilization: Dual Eligibles (mptb)	Y	N			R	Required benefit not offered
Mental Health Utilization: Disabled (mptc)	Y	N			R	Required benefit not offered
Mental Health Utilization: Other (mptd)	Y	N			R	Required benefit not offered
Antibiotic Utilization: Total (abxa)	Y	Y			R	Reportable
Antibiotic Utilization: Dual Eligibles (abxb)	Y	Y			R	Reportable
Antibiotic Utilization: Disabled (abxc)	Y	Y			R	Reportable
Antibiotic Utilization: Other (abxd)	Y	Y			R	Reportable
Relative Resource Use						
Relative Resource Use for People With Diabetes (rdi)	Y				R	Reportable
Relative Resource Use for People With Asthma (ras)	Y	Y			R	Reportable
Relative Resource Use for People With Cardiovascular Conditions (rca)	Y				R	Reportable
Relative Resource Use for People With Hypertension (rhy)	Y				R	Reportable
Relative Resource Use for People With COPD (rco)	Y				R	Reportable
Health Plan Descriptive Information						
Board Certification (bcr)	Y				R	Reportable
Total Membership (tlm)	Y				R	Reportable
Enrollment by Product Line: Total (enpa)	Y				R	Reportable
Enrollment by Product Line: Dual Eligibles (enpb)	Y				R	Reportable
Enrollment by Product Line: Disabled (enpc)	Y				R	Reportable
Enrollment by Product Line: Other (enpd)	Y				R	Reportable
Enrollment by State (ebs)	Y				R	Reportable
Race/Ethnicity Diversity of Membership (rdm)	Y				R	Reportable
Language Diversity of Membership (ldm)	Y				R	Reportable
Weeks of Pregnancy at Time of Enrollment (wop)	Y		N		R	Reportable

Audit Review Table

MDwise, Inc. (Org ID: 2101, SubID: 10884, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013

The Auditor lock has been applied to this submission.

Measure/Data Element	Report Measure	Benefit Offered	Rotated Measure	Rate	Reportable	Comment
Effectiveness of Care: Prevention and Screening						
Adult BMI Assessment (aba)	Y			76.64%	R	Reportable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y					
BMI Percentile				63.50%	R	Reportable
Counseling for Nutrition				63.02%	R	Reportable
Counseling for Physical Activity				48.66%	R	Reportable
Childhood Immunization Status (cis)	Y					
DTaP				74.21%	R	Reportable
IPV				88.81%	R	Reportable
MMR				88.56%	R	Reportable
HiB				89.54%	R	Reportable
Hepatitis B				90.51%	R	Reportable
VZV				88.08%	R	Reportable
Pneumococcal Conjugate				74.94%	R	Reportable
Hepatitis A				76.89%	R	Reportable
Rotavirus				62.77%	R	Reportable
Influenza				47.93%	R	Reportable
Combination #2				72.02%	R	Reportable
Combination #3				68.13%	R	Reportable
Combination #4				62.04%	R	Reportable
Combination #5				52.55%	R	Reportable
Combination #6				41.12%	R	Reportable
Combination #7				50.36%	R	Reportable
Combination #8				40.15%	R	Reportable
Combination #9				33.82%	R	Reportable
Combination #10				33.09%	R	Reportable
Immunizations for Adolescents (ima)	Y					
Meningococcal				89.67%	R	Reportable
Tdap/Td				96.74%	R	Reportable
Combination #1				89.67%	R	Reportable
Human Papillomavirus Vaccine for Female Adolescents (hpv)	Y			11.48%	R	Reportable
Lead Screening in Children (lsc)	Y			53.28%	R	Reportable
Breast Cancer Screening (bcs)	Y			66.20%	R	Reportable
Cervical Cancer Screening (ccs)	Y			61.85%	R	Reportable
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	Y			6.76%	R	Reportable
Chlamydia Screening in Women (chl)	Y					
16-20 Years				47.36%	R	Reportable
21-24 Years				59.05%	R	Reportable
Total				51.33%	R	Reportable
Effectiveness of Care: Respiratory Conditions						
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y		55.35%	R	Reportable
Appropriate Treatment for Children With URI (uri)	Y	Y		81.07%	R	Reportable
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y		23.46%	R	Reportable
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y			35.80%	R	Reportable
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y				
Systemic Corticosteroid				64.55%	R	Reportable
Bronchodilator				80.00%	R	Reportable
Use of Appropriate Medications for People With Asthma (asm)	Y	Y				
5-11 Years				90.22%	R	Reportable
12-18 Years				84.28%	R	Reportable
19-50 Years				71.43%	R	Reportable
51-64 Years				69.23%	R	Reportable
Total				85.76%	R	Reportable
Medication Management for People With Asthma (mma)	Y	Y				
5-11 Years - Medication Compliance 50%				52.38%	R	Reportable

5-11 Years - Medication Compliance 75%				29.15%	R	Reportable
12-18 Years - Medication Compliance 50%				49.68%	R	Reportable
12-18 Years - Medication Compliance 75%				24.07%	R	Reportable
19-50 Years - Medication Compliance 50%				56.25%	R	Reportable
19-50 Years - Medication Compliance 75%				35.63%	R	Reportable
51-64 Years - Medication Compliance 50%				NA	R	Denominator fewer than 30
51-64 Years - Medication Compliance 75%				NA	R	Denominator fewer than 30
Total - Medication Compliance 50%				51.88%	R	Reportable
Total - Medication Compliance 75%				28.08%	R	Reportable
Asthma Medication Ratio (amr)	Y	Y				
5-11 Years				76.11%	R	Reportable
12-18 Years				61.72%	R	Reportable
19-50 Years				49.32%	R	Reportable
51-64 Years				44.74%	R	Reportable
Total				67.60%	R	Reportable
Effectiveness of Care: Cardiovascular						
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y					
LDL-C Screening Performed				80.68%	R	Reportable
LDL-C Control (<100 mg/dL)				43.18%	R	Reportable
Controlling High Blood Pressure (cbp)	Y		Y	59.68%	R	Reportable
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y		NA	R	Denominator fewer than 30
Effectiveness of Care: Diabetes						
Comprehensive Diabetes Care (cdc)	Y					
Hemoglobin A1c (HbA1c) Testing				83.21%	R	Reportable
HbA1c Poor Control (>9.0%)				45.26%	R	Reportable
HbA1c Control (<8.0%)				46.90%	R	Reportable
HbA1c Control (<7.0%)				36.47%	R	Reportable
Eye Exam (Retinal) Performed				50.55%	R	Reportable
LDL-C Screening Performed				71.90%	R	Reportable
LDL-C Control (<100 mg/dL)				31.39%	R	Reportable
Medical Attention for Nephropathy				70.07%	R	Reportable
Blood Pressure Control (<140/80 mm Hg)				39.42%	R	Reportable
Blood Pressure Control (<140/90 mm Hg)				68.43%	R	Reportable
Effectiveness of Care: Musculoskeletal						
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y		77.17%	R	Reportable
Use of Imaging Studies for Low Back Pain (lbp)	Y			77.32%	R	Reportable
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (amm)	Y	Y				
Effective Acute Phase Treatment				54.48%	R	Reportable
Effective Continuation Phase Treatment				34.69%	R	Reportable
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y				
Initiation Phase				50.80%	R	Reportable
Continuation and Maintenance (C&M) Phase				62.97%	R	Reportable
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	Y				
30-Day Follow-Up				75.31%	R	Reportable
7-Day Follow-Up				51.27%	R	Reportable
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	Y	Y		70.43%	R	Reportable
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	Y			NA	R	Denominator fewer than 30
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	Y			NA	R	Denominator fewer than 30
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	Y	Y		40.51%	R	Reportable
Effectiveness of Care: Medication Management						
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y				
ACE Inhibitors or ARBs				98.67%	R	Reportable
Digoxin				NA	R	Denominator fewer than 30

Diuretics				97.94%	R	Reportable
Anticonvulsants				99.12%	R	Reportable
Total				98.36%	R	Reportable
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y					
20-44 Years				84.62%	R	Reportable
45-64 Years				91.15%	R	Reportable
65+ Years				NA	R	Denominator fewer than 30
Total				85.75%	R	Reportable
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y					
12-24 Months				96.67%	R	Reportable
25 Months - 6 Years				88.42%	R	Reportable
7-11 Years				91.26%	R	Reportable
12-19 Years				90.84%	R	Reportable
Annual Dental Visit (adv)	N	N				
2-3 Years				NR	NR	Measure Unselected
4-6 Years				NR	NR	Measure Unselected
7-10 Years				NR	NR	Measure Unselected
11-14 Years				NR	NR	Measure Unselected
15-18 Years				NR	NR	Measure Unselected
19-21 Years				NR	NR	Measure Unselected
Total				NR	NR	Measure Unselected
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	Y				
Initiation of AOD Treatment: 13-17 Years				42.01%	R	Reportable
Engagement of AOD Treatment: 13-17 Years				18.20%	R	Reportable
Initiation of AOD Treatment: 18+ Years				38.72%	R	Reportable
Engagement of AOD Treatment: 18+ Years				11.38%	R	Reportable
Initiation of AOD Treatment: Total				39.42%	R	Reportable
Engagement of AOD Treatment: Total				12.83%	R	Reportable
Prenatal and Postpartum Care (ppc)	Y		N			
Timeliness of Prenatal Care				89.05%	R	Reportable
Postpartum Care				71.53%	R	Reportable
Call Answer Timeliness (cat)	Y			89.69%	R	Reportable
Utilization						
Frequency of Ongoing Prenatal Care (fpc)	Y		N			
<21 Percent				3.65%	R	Reportable
21-40 Percent				0.97%	R	Reportable
41-60 Percent				2.68%	R	Reportable
61-80 Percent				8.76%	R	Reportable
81+ Percent				83.94%	R	Reportable
Well-Child Visits in the First 15 Months of Life (w15)	Y					
0 Visits				1.95%	R	Reportable
1 Visit				1.46%	R	Reportable
2 Visits				1.70%	R	Reportable
3 Visits				5.60%	R	Reportable
4 Visits				8.52%	R	Reportable
5 Visits				9.73%	R	Reportable
6+ Visits				71.05%	R	Reportable
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y			76.89%	R	Reportable
Adolescent Well-Care Visits (awc)	Y			58.88%	R	Reportable
Frequency of Selected Procedures (fsp)	Y				R	Reportable
Ambulatory Care: Total (amba)	Y				R	Reportable
Ambulatory Care: Dual Eligibles (ambb)	N				NR	Measure Unselected
Ambulatory Care: Disabled (ambc)	N				NR	Measure Unselected
Ambulatory Care: Other (ambd)	N				NR	Measure Unselected
Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	N				NR	Measure Unselected
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	N				NR	Measure Unselected
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	N				NR	Measure Unselected
Identification of Alcohol and Other Drug Services: Total (iada)	Y	Y			R	Reportable
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	N	N			NR	Measure Unselected

Identification of Alcohol and Other Drug Services: Disabled (iadc)	N	N			NR	Measure Unselected
Identification of Alcohol and Other Drug Services: Other (iadd)	N	N			NR	Measure Unselected
Mental Health Utilization: Total (mpta)	Y	Y			R	Reportable
Mental Health Utilization: Dual Eligibles (mptb)	N	N			NR	Measure Unselected
Mental Health Utilization: Disabled (mptc)	N	N			NR	Measure Unselected
Mental Health Utilization: Other (mptd)	N	N			NR	Measure Unselected
Antibiotic Utilization: Total (abxa)	Y	Y			R	Reportable
Antibiotic Utilization: Dual Eligibles (abxb)	N	N			NR	Measure Unselected
Antibiotic Utilization: Disabled (abxc)	N	N			NR	Measure Unselected
Antibiotic Utilization: Other (abxd)	N	N			NR	Measure Unselected
Relative Resource Use						
Relative Resource Use for People With Diabetes (rdi)	N				NR	Measure Unselected
Relative Resource Use for People With Asthma (ras)	N	N			NR	Measure Unselected
Relative Resource Use for People With Cardiovascular Conditions (rca)	N				NR	Measure Unselected
Relative Resource Use for People With Hypertension (rhy)	N				NR	Measure Unselected
Relative Resource Use for People With COPD (rco)	N				NR	Measure Unselected
Health Plan Descriptive Information						
Board Certification (bcr)	N				NR	Measure Unselected
Total Membership (tlm)	N				NR	Measure Unselected
Enrollment by Product Line: Total (enpa)	N				NR	Measure Unselected
Enrollment by Product Line: Dual Eligibles (enpb)	N				NR	Measure Unselected
Enrollment by Product Line: Disabled (enpc)	N				NR	Measure Unselected
Enrollment by Product Line: Other (enpd)	N				NR	Measure Unselected
Enrollment by State (ebs)	N				NR	Measure Unselected
Race/Ethnicity Diversity of Membership (rdm)	Y				R	Reportable
Language Diversity of Membership (ldm)	Y				R	Reportable
Weeks of Pregnancy at Time of Enrollment (wop)	Y		N		R	Reportable

Audit Review Table

Select Health of South Carolina, Inc. (Org ID: 832, SubID: 9480, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013

The Auditor lock has been applied to this submission.

Measure/Data Element	Report Measure	Benefit Offered	Rotated Measure	Rate	Reportable	Comment
Effectiveness of Care: Prevention and Screening						
Adult BMI Assessment (aba)	Y			65.84%	R	Reportable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y					
BMI Percentile				25.06%	R	Reportable
Counseling for Nutrition				39.90%	R	Reportable
Counseling for Physical Activity				34.06%	R	Reportable
Childhood Immunization Status (cis)	Y					
DTaP				81.75%	R	Reportable
IPV				89.29%	R	Reportable
MMR				91.00%	R	Reportable
HiB				87.83%	R	Reportable
Hepatitis B				83.21%	R	Reportable
VZV				92.94%	R	Reportable
Pneumococcal Conjugate				82.48%	R	Reportable
Hepatitis A				84.67%	R	Reportable
Rotavirus				68.61%	R	Reportable
Influenza				42.09%	R	Reportable
Combination #2				74.45%	R	Reportable
Combination #3				70.56%	R	Reportable
Combination #4				64.72%	R	Reportable
Combination #5				55.72%	R	Reportable
Combination #6				34.55%	R	Reportable
Combination #7				51.09%	R	Reportable
Combination #8				33.33%	R	Reportable
Combination #9				27.25%	R	Reportable
Combination #10				26.28%	R	Reportable
Immunizations for Adolescents (ima)	Y					
Meningococcal				62.04%	R	Reportable
Tdap/Td				68.13%	R	Reportable
Combination #1				60.83%	R	Reportable
Human Papillomavirus Vaccine for Female Adolescents (hpv)	Y			13.18%	R	Reportable
Lead Screening in Children (lsc)	Y			61.31%	R	Reportable
Breast Cancer Screening (bcs)	Y			63.81%	R	Reportable
Cervical Cancer Screening (ccs)	Y			65.31%	R	Reportable
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	Y			6.15%	R	Reportable
Chlamydia Screening in Women (chl)	Y					
16-20 Years				51.72%	R	Reportable
21-24 Years				62.12%	R	Reportable
Total				54.48%	R	Reportable
Effectiveness of Care: Respiratory Conditions						
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y		73.87%	R	Reportable
Appropriate Treatment for Children With URI (uri)	Y	Y		79.72%	R	Reportable
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y		18.39%	R	Reportable
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y			32.16%	R	Reportable
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y				
Systemic Corticosteroid				57.14%	R	Reportable
Bronchodilator				81.51%	R	Reportable
Use of Appropriate Medications for People With Asthma (asm)	Y	Y				
5-11 Years				93.98%	R	Reportable
12-18 Years				89.53%	R	Reportable
19-50 Years				76.70%	R	Reportable
51-64 Years				63.44%	R	Reportable
Total				90.53%	R	Reportable
Medication Management for People With Asthma (mma)	Y	Y				
5-11 Years - Medication Compliance 50%				59.25%	R	Reportable
5-11 Years - Medication Compliance 75%				32.91%	R	Reportable

12-18 Years - Medication Compliance 50%				52.81%	R	Reportable
12-18 Years - Medication Compliance 75%				26.47%	R	Reportable
19-50 Years - Medication Compliance 50%				54.04%	R	Reportable
19-50 Years - Medication Compliance 75%				35.74%	R	Reportable
51-64 Years - Medication Compliance 50%				74.58%	R	Reportable
51-64 Years - Medication Compliance 75%				57.63%	R	Reportable
Total - Medication Compliance 50%				56.81%	R	Reportable
Total - Medication Compliance 75%				31.06%	R	Reportable
Asthma Medication Ratio (amr)	Y	Y				
5-11 Years				79.45%	R	Reportable
12-18 Years				67.58%	R	Reportable
19-50 Years				55.26%	R	Reportable
51-64 Years				44.09%	R	Reportable
Total				72.67%	R	Reportable
Effectiveness of Care: Cardiovascular						
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y					
LDL-C Screening Performed				80.54%	R	Reportable
LDL-C Control (<100 mg/dL)				31.39%	R	Reportable
Controlling High Blood Pressure (cbp)	Y		N	42.05%	R	Reportable
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y		79.66%	R	Reportable
Effectiveness of Care: Diabetes						
Comprehensive Diabetes Care (cdc)	Y					
Hemoglobin A1c (HbA1c) Testing				82.85%	R	Reportable
HbA1c Poor Control (>9.0%)				56.39%	R	Reportable
HbA1c Control (<8.0%)				35.77%	R	Reportable
HbA1c Control (<7.0%)				25.79%	R	Reportable
Eye Exam (Retinal) Performed				50.73%	R	Reportable
LDL-C Screening Performed				70.62%	R	Reportable
LDL-C Control (<100 mg/dL)				27.74%	R	Reportable
Medical Attention for Nephropathy				79.56%	R	Reportable
Blood Pressure Control (<140/80 mm Hg)				27.55%	R	Reportable
Blood Pressure Control (<140/90 mm Hg)				46.17%	R	Reportable
Effectiveness of Care: Musculoskeletal						
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y		68.67%	R	Reportable
Use of Imaging Studies for Low Back Pain (lbp)	Y			74.77%	R	Reportable
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (amm)	Y	Y				
Effective Acute Phase Treatment				45.65%	R	Reportable
Effective Continuation Phase Treatment				30.53%	R	Reportable
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y				
Initiation Phase				41.59%	R	Reportable
Continuation and Maintenance (C&M) Phase				54.39%	R	Reportable
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	Y				
30-Day Follow-Up				66.32%	R	Reportable
7-Day Follow-Up				46.23%	R	Reportable
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	Y	Y		84.21%	R	Reportable
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	Y			73.45%	R	Reportable
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	Y			NA	R	Denominator fewer than 30
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	Y	Y		73.15%	R	Reportable
Effectiveness of Care: Medication Management						
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y				
ACE Inhibitors or ARBs				89.89%	R	Reportable
Digoxin				93.02%	R	Reportable
Diuretics				89.20%	R	Reportable

Anticonvulsants				66.47%	R	Reportable
Total				87.57%	R	Reportable
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y					
20-44 Years				86.25%	R	Reportable
45-64 Years				91.05%	R	Reportable
65+ Years				NA	R	Denominator fewer than 30
Total				87.70%	R	Reportable
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y					
12-24 Months				98.65%	R	Reportable
25 Months - 6 Years				91.23%	R	Reportable
7-11 Years				92.96%	R	Reportable
12-19 Years				91.24%	R	Reportable
Annual Dental Visit (adv)	Y	N				
2-3 Years				NB	R	Required benefit not offered
4-6 Years				NB	R	Required benefit not offered
7-10 Years				NB	R	Required benefit not offered
11-14 Years				NB	R	Required benefit not offered
15-18 Years				NB	R	Required benefit not offered
19-21 Years				NB	R	Required benefit not offered
Total				NB	R	Required benefit not offered
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	N				
Initiation of AOD Treatment: 13-17 Years				NB	R	Required benefit not offered
Engagement of AOD Treatment: 13-17 Years				NB	R	Required benefit not offered
Initiation of AOD Treatment: 18+ Years				NB	R	Required benefit not offered
Engagement of AOD Treatment: 18+ Years				NB	R	Required benefit not offered
Initiation of AOD Treatment: Total				NB	R	Required benefit not offered
Engagement of AOD Treatment: Total				NB	R	Required benefit not offered
Prenatal and Postpartum Care (ppc)	Y		N			
Timeliness of Prenatal Care				91.04%	R	Reportable
Postpartum Care				74.63%	R	Reportable
Call Answer Timeliness (cat)	Y			82.31%	R	Reportable
Utilization						
Frequency of Ongoing Prenatal Care (fpc)	Y		N			
<21 Percent				7.82%	R	Reportable
21-40 Percent				3.35%	R	Reportable
41-60 Percent				6.47%	R	Reportable
61-80 Percent				14.93%	R	Reportable
81+ Percent				67.44%	R	Reportable
Well-Child Visits in the First 15 Months of Life (w15)	Y					
0 Visits				0.00%	R	Reportable
1 Visit				2.26%	R	Reportable
2 Visits				1.26%	R	Reportable
3 Visits				4.77%	R	Reportable
4 Visits				9.55%	R	Reportable
5 Visits				18.34%	R	Reportable
6+ Visits				63.82%	R	Reportable
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y			64.05%	R	Reportable
Adolescent Well-Care Visits (awc)	Y			48.66%	R	Reportable
Frequency of Selected Procedures (fsp)	Y				R	Reportable
Ambulatory Care: Total (amba)	Y				R	Reportable
Ambulatory Care: Dual Eligibles (ambb)	Y				R	Reportable
Ambulatory Care: Disabled (ambc)	Y				R	Reportable
Ambulatory Care: Other (ambd)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	Y				R	Reportable
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	Y				R	Reportable
Identification of Alcohol and Other Drug Services: Total (iada)	Y	N			R	Required benefit not offered
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	Y	N			R	Required benefit not offered

Identification of Alcohol and Other Drug Services: Disabled (iadc)	Y	N			R	Required benefit not offered
Identification of Alcohol and Other Drug Services: Other (iadd)	Y	N			R	Required benefit not offered
Mental Health Utilization: Total (mpta)	Y	Y			R	Reportable
Mental Health Utilization: Dual Eligibles (mptb)	Y	Y			R	Reportable
Mental Health Utilization: Disabled (mptc)	Y	Y			R	Reportable
Mental Health Utilization: Other (mptd)	Y	Y			R	Reportable
Antibiotic Utilization: Total (abxa)	Y	Y			R	Reportable
Antibiotic Utilization: Dual Eligibles (abxb)	Y	Y			R	Reportable
Antibiotic Utilization: Disabled (abxc)	Y	Y			R	Reportable
Antibiotic Utilization: Other (abxd)	Y	Y			R	Reportable
Relative Resource Use						
Relative Resource Use for People With Diabetes (rdi)	Y				R	Reportable
Relative Resource Use for People With Asthma (ras)	Y	Y			R	Reportable
Relative Resource Use for People With Cardiovascular Conditions (rca)	Y				R	Reportable
Relative Resource Use for People With Hypertension (rhy)	Y				R	Reportable
Relative Resource Use for People With COPD (rco)	Y				R	Reportable
Health Plan Descriptive Information						
Board Certification (bcr)	N				NR	Measure Unselected
Total Membership (tlm)	Y				R	Reportable
Enrollment by Product Line: Total (enpa)	Y				R	Reportable
Enrollment by Product Line: Dual Eligibles (enpb)	Y				R	Reportable
Enrollment by Product Line: Disabled (enpc)	Y				R	Reportable
Enrollment by Product Line: Other (enpd)	Y				R	Reportable
Enrollment by State (ebs)	Y				R	Reportable
Race/Ethnicity Diversity of Membership (rdm)	Y				R	Reportable
Language Diversity of Membership (ldm)	Y				R	Reportable
Weeks of Pregnancy at Time of Enrollment (wop)	Y		N		R	Reportable

Audit Review Table

AmeriHealth Caritas Louisiana (Org ID: 19526, SubID: 10824, Medicaid, Spec Area: None, Spec Pro

The Auditor lock has been applied to this

Measure/Data Element	Report Measure	Benefit Offered	Rotated Measure
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	Y		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y		
BMI Percentile			
Counseling for Nutrition			
Counseling for Physical Activity			
Childhood Immunization Status (cis)	Y		
DTaP			
IPV			
MMR			
HiB			
Hepatitis B			
VZV			
Pneumococcal Conjugate			
Hepatitis A			
Rotavirus			
Influenza			
Combination #2			
Combination #3			
Combination #4			
Combination #5			
Combination #6			
Combination #7			
Combination #8			
Combination #9			
Combination #10			
Immunizations for Adolescents (ima)	Y		
Meningococcal			
Tdap/Td			
Combination #1			
Human Papillomavirus Vaccine for Female Adolescents (hpv)	Y		
Lead Screening in Children (lsc)	Y		
Breast Cancer Screening (bcs)	Y		
Cervical Cancer Screening (ccs)	Y		
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	Y		
Chlamydia Screening in Women (chl)	Y		
16-20 Years			
21-24 Years			
Total			
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y	
Appropriate Treatment for Children With URI (uri)	Y	Y	

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y		
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y	
Systemic Corticosteroid			
Bronchodilator			
Use of Appropriate Medications for People With Asthma (asm)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Medication Management for People With Asthma (mma)	Y	Y	
5-11 Years - Medication Compliance 50%			
5-11 Years - Medication Compliance 75%			
12-18 Years - Medication Compliance 50%			
12-18 Years - Medication Compliance 75%			
19-50 Years - Medication Compliance 50%			
19-50 Years - Medication Compliance 75%			
51-64 Years - Medication Compliance 50%			
51-64 Years - Medication Compliance 75%			
Total - Medication Compliance 50%			
Total - Medication Compliance 75%			
Asthma Medication Ratio (amr)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Effectiveness of Care: Cardiovascular			
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y		
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Controlling High Blood Pressure (cbp)	Y		N
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y	
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)	Y		
Hemoglobin A1c (HbA1c) Testing			
HbA1c Poor Control (>9.0%)			
HbA1c Control (<8.0%)			
HbA1c Control (<7.0%)			
Eye Exam (Retinal) Performed			
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Medical Attention for Nephropathy			

Blood Pressure Control (<140/80 mm Hg)			
Blood Pressure Control (<140/90 mm Hg)			
Effectiveness of Care: Musculoskeletal			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y	
Use of Imaging Studies for Low Back Pain (lbp)	Y		
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)	Y	Y	
Effective Acute Phase Treatment			
Effective Continuation Phase Treatment			
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y	
Initiation Phase			
Continuation and Maintenance (C&M) Phase			
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	N	
30-Day Follow-Up			
7-Day Follow-Up			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	Y	Y	
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	Y		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	Y		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	Y	Y	
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y	
ACE Inhibitors or ARBs			
Digoxin			
Diuretics			
Anticonvulsants			
Total			
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y		
20-44 Years			
45-64 Years			
65+ Years			
Total			
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y		
12-24 Months			
25 Months - 6 Years			
7-11 Years			

12-19 Years			
Annual Dental Visit (adv)	Y	Y	
2-3 Years			
4-6 Years			
7-10 Years			
11-14 Years			
15-18 Years			
19-21 Years			
Total			
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	N	
Initiation of AOD Treatment: 13-17 Years			
Engagement of AOD Treatment: 13-17 Years			
Initiation of AOD Treatment: 18+ Years			
Engagement of AOD Treatment: 18+ Years			
Initiation of AOD Treatment: Total			
Engagement of AOD Treatment: Total			
Prenatal and Postpartum Care (ppc)	Y		N
Timeliness of Prenatal Care			
Postpartum Care			
Call Answer Timeliness (cat)	Y		
Utilization			
Frequency of Ongoing Prenatal Care (fpc)	Y		N
<21 Percent			
21-40 Percent			
41-60 Percent			
61-80 Percent			
81+ Percent			
Well-Child Visits in the First 15 Months of Life (w15)	Y		
0 Visits			
1 Visit			
2 Visits			
3 Visits			
4 Visits			
5 Visits			
6+ Visits			
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y		
Adolescent Well-Care Visits (awc)	Y		
Frequency of Selected Procedures (fsp)	Y		
Ambulatory Care: Total (amba)	Y		
Ambulatory Care: Dual Eligibles (ambb)	Y		
Ambulatory Care: Disabled (ambc)	Y		
Ambulatory Care: Other (ambd)	Y		
Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y		
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	Y		
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	Y		
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	Y		

Identification of Alcohol and Other Drug Services: Total (iada)	Y	N	
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	Y	N	
Identification of Alcohol and Other Drug Services: Disabled (iadc)	Y	N	
Identification of Alcohol and Other Drug Services: Other (iadd)	Y	N	
Mental Health Utilization: Total (mpta)	Y	N	
Mental Health Utilization: Dual Eligibles (mptb)	Y	N	
Mental Health Utilization: Disabled (mptc)	Y	N	
Mental Health Utilization: Other (mptd)	Y	N	
Antibiotic Utilization: Total (abxa)	Y	Y	
Antibiotic Utilization: Dual Eligibles (abxb)	Y	Y	
Antibiotic Utilization: Disabled (abxc)	Y	Y	
Antibiotic Utilization: Other (abxd)	Y	Y	
Relative Resource Use			
Relative Resource Use for People With Diabetes (rdi)	Y		
Relative Resource Use for People With Asthma (ras)	Y	Y	
Relative Resource Use for People With Cardiovascular Conditions (rca)	Y		
Relative Resource Use for People With Hypertension (rhy)	Y		
Relative Resource Use for People With COPD (rco)	Y		
Health Plan Descriptive Information			
Board Certification (bcr)	Y		
Total Membership (tlm)	Y		
Enrollment by Product Line: Total (enpa)	Y		
Enrollment by Product Line: Dual Eligibles (enpb)	Y		
Enrollment by Product Line: Disabled (enpc)	Y		
Enrollment by Product Line: Other (enpd)	Y		
Enrollment by State (ebs)	Y		
Race/Ethnicity Diversity of Membership (rdm)	Y		
Language Diversity of Membership (ldm)	Y		
Weeks of Pregnancy at Time of Enrollment (wop)	Y		N

j: None); Measurement Year - 2013

submission.

Rate	Reportable	Comment
10.11%	R	Reportable
1.43%	R	Reportable
2.86%	R	Reportable
0.26%	R	Reportable
57.98%	R	Reportable
74.59%	R	Reportable
81.21%	R	Reportable
78.37%	R	Reportable
58.49%	R	Reportable
81.02%	R	Reportable
58.82%	R	Reportable
75.88%	R	Reportable
51.76%	R	Reportable
29.66%	R	Reportable
43.71%	R	Reportable
40.73%	R	Reportable
39.02%	R	Reportable
32.66%	R	Reportable
18.07%	R	Reportable
31.53%	R	Reportable
17.57%	R	Reportable
14.99%	R	Reportable
14.71%	R	Reportable
85.97%	R	Reportable
86.23%	R	Reportable
84.99%	R	Reportable
18.48%	R	Reportable
66.61%	R	Reportable
NA	R	Denominator fewer than 30
49.93%	R	Reportable
8.15%	R	Reportable
51.60%	R	Reportable
66.45%	R	Reportable
55.84%	R	Reportable
50.57%	R	Reportable
71.43%	R	Reportable

25.52%	R	Reportable
NA	R	Denominator fewer than 30
65.22%	R	Reportable
85.77%	R	Reportable
76.71%	R	Reportable
92.11%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
81.75%	R	Reportable
47.27%	R	Reportable
29.09%	R	Reportable
54.29%	R	Reportable
22.86%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
52.25%	R	Reportable
31.53%	R	Reportable
50.75%	R	Reportable
57.89%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
54.20%	R	Reportable
78.95%	R	Reportable
6.02%	R	Reportable
0.00%	R	Reportable
72.09%	R	Reportable
79.87%	R	Reportable
64.70%	R	Reportable
30.51%	R	Reportable
22.60%	R	Reportable
37.86%	R	Reportable
73.96%	R	Reportable
19.81%	R	Reportable
81.47%	R	Reportable

27.16%	R	Reportable
42.65%	R	Reportable
70.00%	R	Reportable
77.94%	R	Reportable
41.87%	R	Reportable
31.82%	R	Reportable
31.85%	R	Reportable
35.49%	R	Reportable
NB	R	Required benefit not offered
NB	R	Required benefit not offered
81.24%	R	Reportable
60.74%	R	Reportable
NA	R	Denominator fewer than 30
58.41%	R	Reportable
88.36%	R	Reportable
92.38%	R	Reportable
88.34%	R	Reportable
69.08%	R	Reportable
86.48%	R	Reportable
80.18%	R	Reportable
87.86%	R	Reportable
73.24%	R	Reportable
83.16%	R	Reportable
94.77%	R	Reportable
84.83%	R	Reportable
83.57%	R	Reportable

80.97%	R	Reportable
40.85%	R	Reportable
58.14%	R	Reportable
59.14%	R	Reportable
52.30%	R	Reportable
46.23%	R	Reportable
30.83%	R	Reportable
51.95%	R	Reportable
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
77.83%	R	Reportable
32.44%	R	Reportable
92.12%	R	Reportable
10.36%	R	Reportable
5.40%	R	Reportable
9.14%	R	Reportable
17.35%	R	Reportable
57.75%	R	Reportable
4.18%	R	Reportable
4.05%	R	Reportable
7.18%	R	Reportable
10.94%	R	Reportable
15.65%	R	Reportable
21.08%	R	Reportable
36.92%	R	Reportable
57.17%	R	Reportable
43.49%	R	Reportable
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	R	Reportable
	R	Reportable

Audit Review Table

AmeriHealth Caritas Pennsylvania (Org ID: 1054, SubID: 4475, Medicaid, Spec Area: None, Spec Pr

The Auditor lock has been applied to this

Measure/Data Element	Report Measure	Benefit Offered	Rotated Measure
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	Y		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y		
BMI Percentile			
Counseling for Nutrition			
Counseling for Physical Activity			
Childhood Immunization Status (cis)	Y		
DTaP			
IPV			
MMR			
HiB			
Hepatitis B			
VZV			
Pneumococcal Conjugate			
Hepatitis A			
Rotavirus			
Influenza			
Combination #2			
Combination #3			
Combination #4			
Combination #5			
Combination #6			
Combination #7			
Combination #8			
Combination #9			
Combination #10			
Immunizations for Adolescents (ima)	Y		
Meningococcal			
Tdap/Td			
Combination #1			
Human Papillomavirus Vaccine for Female Adolescents (hpv)	Y		
Lead Screening in Children (lsc)	Y		
Breast Cancer Screening (bcs)	Y		
Cervical Cancer Screening (ccs)	Y		
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	Y		
Chlamydia Screening in Women (chl)	Y		
16-20 Years			
21-24 Years			
Total			
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y	
Appropriate Treatment for Children With URI (uri)	Y	Y	

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y		
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y	
Systemic Corticosteroid			
Bronchodilator			
Use of Appropriate Medications for People With Asthma (asm)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Medication Management for People With Asthma (mma)	Y	Y	
5-11 Years - Medication Compliance 50%			
5-11 Years - Medication Compliance 75%			
12-18 Years - Medication Compliance 50%			
12-18 Years - Medication Compliance 75%			
19-50 Years - Medication Compliance 50%			
19-50 Years - Medication Compliance 75%			
51-64 Years - Medication Compliance 50%			
51-64 Years - Medication Compliance 75%			
Total - Medication Compliance 50%			
Total - Medication Compliance 75%			
Asthma Medication Ratio (amr)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Effectiveness of Care: Cardiovascular			
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y		
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Controlling High Blood Pressure (cbp)	Y		N
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y	
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)	Y		
Hemoglobin A1c (HbA1c) Testing			
HbA1c Poor Control (>9.0%)			
HbA1c Control (<8.0%)			
HbA1c Control (<7.0%)			
Eye Exam (Retinal) Performed			
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Medical Attention for Nephropathy			

Blood Pressure Control (<140/80 mm Hg)			
Blood Pressure Control (<140/90 mm Hg)			
Effectiveness of Care: Musculoskeletal			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y	
Use of Imaging Studies for Low Back Pain (lbp)	Y		
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)	Y	Y	
Effective Acute Phase Treatment			
Effective Continuation Phase Treatment			
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y	
Initiation Phase			
Continuation and Maintenance (C&M) Phase			
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	N	
30-Day Follow-Up			
7-Day Follow-Up			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	Y	Y	
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	Y		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	Y		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	Y	Y	
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y	
ACE Inhibitors or ARBs			
Digoxin			
Diuretics			
Anticonvulsants			
Total			
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y		
20-44 Years			
45-64 Years			
65+ Years			
Total			
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y		
12-24 Months			
25 Months - 6 Years			
7-11 Years			

12-19 Years			
Annual Dental Visit (adv)	Y	Y	
2-3 Years			
4-6 Years			
7-10 Years			
11-14 Years			
15-18 Years			
19-21 Years			
Total			
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	N	
Initiation of AOD Treatment: 13-17 Years			
Engagement of AOD Treatment: 13-17 Years			
Initiation of AOD Treatment: 18+ Years			
Engagement of AOD Treatment: 18+ Years			
Initiation of AOD Treatment: Total			
Engagement of AOD Treatment: Total			
Prenatal and Postpartum Care (ppc)	Y		N
Timeliness of Prenatal Care			
Postpartum Care			
Call Answer Timeliness (cat)	Y		
Utilization			
Frequency of Ongoing Prenatal Care (fpc)	Y		N
<21 Percent			
21-40 Percent			
41-60 Percent			
61-80 Percent			
81+ Percent			
Well-Child Visits in the First 15 Months of Life (w15)	Y		
0 Visits			
1 Visit			
2 Visits			
3 Visits			
4 Visits			
5 Visits			
6+ Visits			
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y		
Adolescent Well-Care Visits (awc)	Y		
Frequency of Selected Procedures (fsp)	Y		
Ambulatory Care: Total (amba)	Y		
Ambulatory Care: Dual Eligibles (ambb)	Y		
Ambulatory Care: Disabled (ambc)	Y		
Ambulatory Care: Other (ambd)	Y		
Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y		
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	Y		
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	Y		
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	Y		

Identification of Alcohol and Other Drug Services: Total (iada)	Y	N	
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	Y	N	
Identification of Alcohol and Other Drug Services: Disabled (iadc)	Y	N	
Identification of Alcohol and Other Drug Services: Other (iadd)	Y	N	
Mental Health Utilization: Total (mpta)	Y	N	
Mental Health Utilization: Dual Eligibles (mptb)	Y	N	
Mental Health Utilization: Disabled (mptc)	Y	N	
Mental Health Utilization: Other (mptd)	Y	N	
Antibiotic Utilization: Total (abxa)	Y	Y	
Antibiotic Utilization: Dual Eligibles (abxb)	Y	Y	
Antibiotic Utilization: Disabled (abxc)	Y	Y	
Antibiotic Utilization: Other (abxd)	Y	Y	
Relative Resource Use			
Relative Resource Use for People With Diabetes (rdi)	Y		
Relative Resource Use for People With Asthma (ras)	Y	Y	
Relative Resource Use for People With Cardiovascular Conditions (rca)	Y		
Relative Resource Use for People With Hypertension (rhy)	Y		
Relative Resource Use for People With COPD (rco)	Y		
Health Plan Descriptive Information			
Board Certification (bcr)	Y		
Total Membership (tlm)	Y		
Enrollment by Product Line: Total (enpa)	Y		
Enrollment by Product Line: Dual Eligibles (enpb)	Y		
Enrollment by Product Line: Disabled (enpc)	Y		
Enrollment by Product Line: Other (enpd)	Y		
Enrollment by State (ebs)	Y		
Race/Ethnicity Diversity of Membership (rdm)	Y		
Language Diversity of Membership (ldm)	Y		
Weeks of Pregnancy at Time of Enrollment (wop)	Y		N

oj: None); Measurement Year - 2013

submission.

Rate	Reportable	Comment
87.08%	R	Reportable
74.54%	R	Reportable
69.91%	R	Reportable
63.43%	R	Reportable
83.22%	R	Reportable
95.36%	R	Reportable
93.82%	R	Reportable
95.36%	R	Reportable
94.70%	R	Reportable
93.60%	R	Reportable
83.89%	R	Reportable
85.65%	R	Reportable
74.83%	R	Reportable
65.56%	R	Reportable
79.91%	R	Reportable
76.38%	R	Reportable
72.63%	R	Reportable
63.80%	R	Reportable
57.62%	R	Reportable
61.59%	R	Reportable
56.51%	R	Reportable
50.33%	R	Reportable
50.11%	R	Reportable
83.82%	R	Reportable
88.59%	R	Reportable
81.96%	R	Reportable
32.96%	R	Reportable
70.42%	R	Reportable
68.72%	R	Reportable
69.04%	R	Reportable
3.25%	R	Reportable
49.73%	R	Reportable
58.66%	R	Reportable
53.45%	R	Reportable
58.28%	R	Reportable
85.90%	R	Reportable

21.48%	R	Reportable
28.52%	R	Reportable
78.76%	R	Reportable
89.87%	R	Reportable
91.34%	R	Reportable
86.73%	R	Reportable
77.95%	R	Reportable
75.31%	R	Reportable
84.05%	R	Reportable
63.42%	R	Reportable
39.87%	R	Reportable
64.24%	R	Reportable
43.42%	R	Reportable
70.09%	R	Reportable
48.44%	R	Reportable
75.82%	R	Reportable
55.74%	R	Reportable
66.96%	R	Reportable
44.99%	R	Reportable
76.25%	R	Reportable
67.07%	R	Reportable
55.38%	R	Reportable
54.80%	R	Reportable
64.88%	R	Reportable
86.77%	R	Reportable
52.67%	R	Reportable
65.59%	R	Reportable
95.12%	R	Reportable
84.83%	R	Reportable
33.33%	R	Reportable
56.17%	R	Reportable
39.68%	R	Reportable
65.50%	R	Reportable
77.83%	R	Reportable
39.00%	R	Reportable
80.50%	R	Reportable

45.50%	R	Reportable
69.50%	R	Reportable
77.69%	R	Reportable
73.43%	R	Reportable
53.63%	R	Reportable
40.73%	R	Reportable
19.54%	R	Reportable
20.25%	R	Reportable
NB	R	Required benefit not offered
NB	R	Required benefit not offered
85.12%	R	Reportable
74.77%	R	Reportable
NA	R	Denominator fewer than 30
72.04%	R	Reportable
89.60%	R	Reportable
94.34%	R	Reportable
89.52%	R	Reportable
61.60%	R	Reportable
86.11%	R	Reportable
84.10%	R	Reportable
91.49%	R	Reportable
90.70%	R	Reportable
86.55%	R	Reportable
96.43%	R	Reportable
87.61%	R	Reportable
91.94%	R	Reportable

91.51%	R	Reportable
34.20%	R	Reportable
61.20%	R	Reportable
62.86%	R	Reportable
58.62%	R	Reportable
52.68%	R	Reportable
40.69%	R	Reportable
54.80%	R	Reportable
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
92.22%	R	Reportable
68.00%	R	Reportable
89.08%	R	Reportable
1.78%	R	Reportable
1.33%	R	Reportable
3.33%	R	Reportable
10.89%	R	Reportable
82.67%	R	Reportable
1.77%	R	Reportable
0.22%	R	Reportable
1.10%	R	Reportable
3.31%	R	Reportable
6.84%	R	Reportable
15.23%	R	Reportable
71.52%	R	Reportable
76.50%	R	Reportable
62.70%	R	Reportable
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Audit Review Table

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None); Mea

The Auditor lock has been applied to this

Measure/Data Element	Report Measure	Benefit Offered	Rotated Measure
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	Y		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y		
BMI Percentile			
Counseling for Nutrition			
Counseling for Physical Activity			
Childhood Immunization Status (cis)	Y		
DTaP			
IPV			
MMR			
HiB			
Hepatitis B			
VZV			
Pneumococcal Conjugate			
Hepatitis A			
Rotavirus			
Influenza			
Combination #2			
Combination #3			
Combination #4			
Combination #5			
Combination #6			
Combination #7			
Combination #8			
Combination #9			
Combination #10			
Immunizations for Adolescents (ima)	Y		
Meningococcal			
Tdap/Td			
Combination #1			
Human Papillomavirus Vaccine for Female Adolescents (hpv)	Y		
Lead Screening in Children (lsc)	Y		
Breast Cancer Screening (bcs)	Y		
Cervical Cancer Screening (ccs)	Y		
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	Y		
Chlamydia Screening in Women (chl)	Y		
16-20 Years			
21-24 Years			
Total			
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y	
Appropriate Treatment for Children With URI (uri)	Y	Y	

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y		
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y	
Systemic Corticosteroid			
Bronchodilator			
Use of Appropriate Medications for People With Asthma (asm)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Medication Management for People With Asthma (mma)	Y	Y	
5-11 Years - Medication Compliance 50%			
5-11 Years - Medication Compliance 75%			
12-18 Years - Medication Compliance 50%			
12-18 Years - Medication Compliance 75%			
19-50 Years - Medication Compliance 50%			
19-50 Years - Medication Compliance 75%			
51-64 Years - Medication Compliance 50%			
51-64 Years - Medication Compliance 75%			
Total - Medication Compliance 50%			
Total - Medication Compliance 75%			
Asthma Medication Ratio (amr)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Effectiveness of Care: Cardiovascular			
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y		
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Controlling High Blood Pressure (cbp)	Y		N
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y	
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)	Y		
Hemoglobin A1c (HbA1c) Testing			
HbA1c Poor Control (>9.0%)			
HbA1c Control (<8.0%)			
HbA1c Control (<7.0%)			
Eye Exam (Retinal) Performed			
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Medical Attention for Nephropathy			

Blood Pressure Control (<140/80 mm Hg)			
Blood Pressure Control (<140/90 mm Hg)			
Effectiveness of Care: Musculoskeletal			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y	
Use of Imaging Studies for Low Back Pain (lbp)	Y		
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)	Y	Y	
Effective Acute Phase Treatment			
Effective Continuation Phase Treatment			
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y	
Initiation Phase			
Continuation and Maintenance (C&M) Phase			
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	N	
30-Day Follow-Up			
7-Day Follow-Up			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	Y	Y	
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	Y		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	Y		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	Y	Y	
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y	
ACE Inhibitors or ARBs			
Digoxin			
Diuretics			
Anticonvulsants			
Total			
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y		
20-44 Years			
45-64 Years			
65+ Years			
Total			
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y		
12-24 Months			
25 Months - 6 Years			
7-11 Years			

12-19 Years			
Annual Dental Visit (adv)	Y	N	
2-3 Years			
4-6 Years			
7-10 Years			
11-14 Years			
15-18 Years			
19-21 Years			
Total			
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	N	
Initiation of AOD Treatment: 13-17 Years			
Engagement of AOD Treatment: 13-17 Years			
Initiation of AOD Treatment: 18+ Years			
Engagement of AOD Treatment: 18+ Years			
Initiation of AOD Treatment: Total			
Engagement of AOD Treatment: Total			
Prenatal and Postpartum Care (ppc)	Y		N
Timeliness of Prenatal Care			
Postpartum Care			
Call Answer Timeliness (cat)	Y		
Utilization			
Frequency of Ongoing Prenatal Care (fpc)	Y		N
<21 Percent			
21-40 Percent			
41-60 Percent			
61-80 Percent			
81+ Percent			
Well-Child Visits in the First 15 Months of Life (w15)	Y		
0 Visits			
1 Visit			
2 Visits			
3 Visits			
4 Visits			
5 Visits			
6+ Visits			
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y		
Adolescent Well-Care Visits (awc)	Y		
Frequency of Selected Procedures (fsp)	Y		
Ambulatory Care: Total (amba)	Y		
Ambulatory Care: Dual Eligibles (ambb)	Y		
Ambulatory Care: Disabled (ambc)	Y		
Ambulatory Care: Other (ambd)	Y		
Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y		
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	Y		
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	Y		
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	Y		

Identification of Alcohol and Other Drug Services: Total (iada)	Y	N	
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	Y	N	
Identification of Alcohol and Other Drug Services: Disabled (iadc)	Y	N	
Identification of Alcohol and Other Drug Services: Other (iadd)	Y	N	
Mental Health Utilization: Total (mpta)	Y	N	
Mental Health Utilization: Dual Eligibles (mptb)	Y	N	
Mental Health Utilization: Disabled (mptc)	Y	N	
Mental Health Utilization: Other (mptd)	Y	N	
Antibiotic Utilization: Total (abxa)	Y	Y	
Antibiotic Utilization: Dual Eligibles (abxb)	Y	Y	
Antibiotic Utilization: Disabled (abxc)	Y	Y	
Antibiotic Utilization: Other (abxd)	Y	Y	
Relative Resource Use			
Relative Resource Use for People With Diabetes (rdi)	Y		
Relative Resource Use for People With Asthma (ras)	N	N	
Relative Resource Use for People With Cardiovascular Conditions (rca)	N		
Relative Resource Use for People With Hypertension (rhy)	Y		
Relative Resource Use for People With COPD (rco)	N		
Health Plan Descriptive Information			
Board Certification (bcr)	Y		
Total Membership (tlm)	Y		
Enrollment by Product Line: Total (enpa)	Y		
Enrollment by Product Line: Dual Eligibles (enpb)	Y		
Enrollment by Product Line: Disabled (enpc)	Y		
Enrollment by Product Line: Other (enpd)	Y		
Enrollment by State (ebs)	Y		
Race/Ethnicity Diversity of Membership (rdm)	Y		
Language Diversity of Membership (ldm)	Y		
Weeks of Pregnancy at Time of Enrollment (wop)	Y		N

asurement Year - 2013

submission.

Rate	Reportable	Comment
NA	R	Denominator fewer than 30
57.84%	R	Reportable
37.53%	R	Reportable
33.77%	R	Reportable
67.14%	R	Reportable
86.29%	R	Reportable
82.86%	R	Reportable
86.57%	R	Reportable
86.29%	R	Reportable
82.86%	R	Reportable
70.57%	R	Reportable
67.71%	R	Reportable
58.86%	R	Reportable
43.14%	R	Reportable
64.86%	R	Reportable
60.86%	R	Reportable
50.57%	R	Reportable
46.57%	R	Reportable
33.71%	R	Reportable
40.86%	R	Reportable
29.14%	R	Reportable
27.43%	R	Reportable
24.00%	R	Reportable
60.43%	R	Reportable
79.14%	R	Reportable
60.12%	R	Reportable
19.11%	R	Reportable
37.43%	R	Reportable
NA	R	Denominator fewer than 30
44.88%	R	Reportable
6.66%	R	Reportable
26.16%	R	Reportable
42.03%	R	Reportable
30.50%	R	Reportable
44.68%	R	Reportable
64.93%	R	Reportable

42.31%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
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NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
63.27%	R	Reportable
NA	R	Denominator fewer than 30
80.50%	R	Reportable
55.19%	R	Reportable
36.93%	R	Reportable
24.16%	R	Reportable
48.55%	R	Reportable
56.02%	R	Reportable
20.75%	R	Reportable
67.22%	R	Reportable

45.23%	R	Reportable
67.63%	R	Reportable
NA	R	Denominator fewer than 30
75.81%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NB	R	Required benefit not offered
NB	R	Required benefit not offered
84.31%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
87.53%	R	Reportable
90.98%	R	Reportable
91.30%	R	Reportable
88.72%	R	Reportable
93.03%	R	Reportable
81.54%	R	Reportable
NA	R	Denominator fewer than 30

NA	R	Denominator fewer than 30
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
91.59%	R	Reportable
66.81%	R	Reportable
91.85%	R	Reportable
5.31%	R	Reportable
3.10%	R	Reportable
4.42%	R	Reportable
11.73%	R	Reportable
75.44%	R	Reportable
4.07%	R	Reportable
2.03%	R	Reportable
2.71%	R	Reportable
7.46%	R	Reportable
12.88%	R	Reportable
21.69%	R	Reportable
49.15%	R	Reportable
57.40%	R	Reportable
41.94%	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable

	R	Required benefit not offered
	R	Required benefit not offered
	R	Required benefit not offered
	R	Required benefit not offered
	R	Required benefit not offered
	R	Required benefit not offered
	R	Required benefit not offered
	R	Required benefit not offered
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	NR	Measure Unselected
	NR	Measure Unselected
	R	Reportable
	NR	Measure Unselected
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable

Adult BMI Assessment (ABA)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative or hybrid)	A
Eligible population	0
Number of numerator events by administrative data in eligible population (before exclusions)	NR
Current year's administrative rate (before exclusions)	NR
Minimum required sample size (MRSS) or other sample size	NR
Oversampling rate	NR
Final sample size (FSS)	NR
Number of numerator events by administrative data in FSS	NR
Administrative rate on FSS	NR
Number of original sample records excluded because of valid data errors	NR
Number of administrative data records excluded	NR
Number of medical records excluded	NR
Number of employee/dependent medical records excluded	NR
Records added from the oversample list	NR
Denominator	NR
Numerator events by administrative data	0
Numerator events by medical records	NR
Reported rate	NA
Lower 95% confidence interval	NA
Upper 95% confidence interval	NA

Weight Assessment and Counseling for Nutrition and Physical Activity for Childre

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	BMI Percentile			Counseling for Nut	
	3-11 years	12-17 years	Total	3-11 years	12-17 years
Measurement year	2013			2013	
Data collection methodology (administrative or hybrid)	H			H	
Eligible population	4286	2178	6,464	4286	2178
Number of numerator events by administrative data in eligible population (before exclusions)	32	20	52	21	6
Current year's administrative rate (before exclusions)	0.75%	0.92%	0.80%	0.49%	0.28%
Minimum required sample size (MRSS) or other sample size	411			411	
Oversampling rate	0.1			0.1	
Final sample size	453			453	
Number of numerator events by administrative data in FSS	2	3	5	0	1
Administrative rate on FSS	0.44%	0.66%	1.10%	0.00%	0.22%
Number of original sample records excluded because of valid data errors	0			0	
Number of administrative data records excluded	0			0	
Number of medical records excluded	0			0	
Number of employee/dependent medical records excluded	0			0	
Records added from the oversample list	0			0	
Denominator	291	162	453	291	162
Numerator events by administrative data	2	3	5	0	1
Numerator events by medical records	168	89	257	123	46
Reported rate	58.42%	56.79%	57.84%	42.27%	29.01%
Lower 95% confidence interval	52.58%	48.85%	53.18%	36.42%	21.72%
Upper 95% confidence interval	64.25%	64.73%	62.49%	48.12%	36.31%

n/Adolescents (WCC)			
rition	Counseling for Physical Activity		
Total	3-11 years	12-17 years	Total
	2013		
	H		
6,464	4286	2178	6,464
27	1	1	2
0.42%	0.02%	0.05%	0.03%
	411		
	0.1		
	453		
1	0	0	0
0.22%	0.00%	0.00%	0.00%
	0		
	0		
	0		
	0		
	0		
453	291	162	453
1	0	0	0
169	88	65	153
37.53%	30.24%	40.12%	33.77%
32.96%	24.79%	32.27%	29.31%
42.10%	35.69%	47.98%	38.24%

Childhood Immunization Status (CIS)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	General Measure Data	DTaP	IPV	MMR	HiB
Measurement year	2013				
Data collection methodology (administrative or hybrid)	H				
Eligible population	351				
Number of numerator events by admin data in eligible population (before exclusions)		0	3	211	2
Current year's administrative rate (before exclusions)		0.00%	0.85%	60.11%	0.57%
Minimum required sample size (MRSS) or other sample Size	350				
Oversampling rate	0				
Final sample size	350				
Number of numerator events by admin data in FSS		113	151	266	164
Administrative rate on FSS		32.29%	43.14%	76.00%	46.86%
Number of original records excluded because of valid data errors	0				
Number of administrative data records excluded	0				
Number of medical data records excluded	0				
Number of employee/dependent medical records excluded	0				
Records added from the oversample list	0				
Denominator	350				
Numerator events by administrative data		113	151	266	164
Number of numerator events by medical records		122	151	24	139
Reported rate		67.14%	86.29%	82.86%	86.57%
Lower 95% confidence interval		62.08%	82.54%	78.77%	82.86%
Upper 95% confidence interval		72.21%	90.03%	86.95%	90.29%

Hepatitis B	VZV	Pneumo-coccal Conjugate	Hepatitis A	Rotavirus	Influenza	Combination 2	Combination 3
1	209	0	187	0	78	0	0
0.28%	59.54%	0.00%	53.28%	0.00%	22.22%	0.00%	0.00%
65	261	121	221	88	126	43	37
18.57%	74.57%	34.57%	63.14%	25.14%	36.00%	12.29%	10.57%
65	261	121	221	88	126	43	37
237	29	126	16	118	25	184	176
86.29%	82.86%	70.57%	67.71%	58.86%	43.14%	64.86%	60.86%
82.54%	78.77%	65.65%	62.67%	53.56%	37.81%	59.71%	55.60%
90.03%	86.95%	75.49%	72.76%	64.16%	48.47%	70.00%	66.11%

Combination 4	Combination 5	Combination 6	Combination 7	Combination 8	Combination 9	Combination 10
0	0	0	0	0	0	0
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
29	23	20	21	17	12	12
8.29%	6.57%	5.71%	6.00%	4.86%	3.43%	3.43%
29	23	20	21	17	12	12
148	140	98	122	85	84	72
50.57%	46.57%	33.71%	40.86%	29.14%	27.43%	24.00%
45.19%	41.20%	28.62%	35.56%	24.24%	22.61%	19.38%
55.95%	51.94%	38.81%	46.15%	34.05%	32.25%	28.62%

Immunizations for Adolescents (IMA)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	General Measure Data	Meningococcal	Tdap/Td	Combination 1
Measurement year	2013			
Data collection methodology (administrative or hybrid)	H			
Eligible population	326			
Number of numerator events by admin data in eligible population (before exclusions)		120	158	113
Current year's administrative rate (before exclusions)		36.81%	48.47%	34.66%
Minimum required sample size (MRSS) or other sample Size	326			
Oversampling rate	0			
Final sample size	326			
Number of numerator events by admin data in FSS		161	205	155
Administrative rate on FSS		49.39%	62.88%	47.55%
Number of original records excluded because of valid data errors	0			
Number of administrative data records excluded	0			
Number of medical data records excluded	0			
Number of employee/dependent medical records excluded	0			
Records added from the oversample list	0			
Denominator	326			
Numerator events by administrative data		161	205	155
Number of numerator events by medical records		36	53	41
Reported rate		60.43%	79.14%	60.12%
Lower 95% confidence interval		54.97%	74.58%	54.65%
Upper 95% confidence interval		65.89%	83.71%	65.59%

Human Papillomavirus Vaccine for Female Adolescents (HPV)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative or hybrid)	H
Eligible population	157
Number of numerator events by administrative data in eligible population (before exclusions)	3
Current year's administrative rate (before exclusions)	1.91%
Minimum required sample size (MRSS) or other sample size	157
Oversampling rate	0
Final sample size (FSS)	157
Number of numerator events by administrative data in FSS	17
Administrative rate on FSS	10.83%
Number of original sample records excluded because of valid data errors	0
Number of administrative data records excluded	0
Number of medical data records excluded	0
Number of employee/dependent medical records excluded	0
Records added from the oversample list	0
Denominator	157
Numerator events by administrative data	17
Numerator events by medical records	13
Reported rate	19.11%
Lower 95% confidence interval	12.64%
Upper 95% confidence interval	25.58%

Lead Screening in Children (LSC)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Lead Screening in Children	
Data Elements which do not apply to the selected data collection methodology will not appear	General Measure Data
Measurement year	2013
Data collection methodology (administrative or hybrid)	H
Eligible population	351
Number of numerator events by admin data in eligible population (before exclusions)	117
Current year's administrative rate (before exclusions)	33.33%
Minimum required sample size (MRSS) or other sample size	350
Oversampling rate	0
Final sample size (FSS)	350
Number of numerator events by administrative data in FSS	117
Administrative rate on FSS	33.43%
Number of original sample records excluded because of valid data errors	0
Number of administrative data records excluded	0
Number of medical data records excluded	0
Number of employee/dependent medical records excluded	0
Records added from the oversample list	0
Denominator	350
Numerator events by administrative data	117
Numerator events by medical records	14
Reported rate	37.43%
Lower 95% confidence interval	32.22%
Upper 95% confidence interval	42.64%

Breast Cancer Screening (BCS)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**General Measure Data**
Measurement year	2013
Data collection methodology (administrative)	A
Eligible population	0
Numerator events by administrative data	0
Reported rate	NA
Lower 95% confidence interval	NA
Upper 95% confidence interval	NA

Cervical Cancer Screening (CCS)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative or hybrid)	H
Eligible population	1089
Number of numerator events by administrative data in eligible population (before exclusions)	355
Current year's administrative rate (before exclusions)	32.60%
Minimum required sample size (MRSS) or other sample size	411
Oversampling rate	0.1
Final sample size (FSS)	453
Number of numerator events by administrative data in FSS	133
Administrative rate on FSS	29.36%
Number of original sample records excluded because of valid data errors	0
Number of administrative data records excluded	0
Number of medical data records excluded	23
Number of employee/dependent medical records excluded	0
Records added from the oversample list	0
Denominator	430
Numerator events by administrative data	133
Numerator events by medical records	60
Reported rate	44.88%
Lower 95% confidence interval	40.07%
Upper 95% confidence interval	49.70%

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative)	A
Eligible population	706
Number of optional exclusions	0
Numerator events by administrative data	47
Reported rate	6.66%
Lower 95% confidence interval	4.75%
Upper 95% confidence interval	8.57%

Chlamydia Screening in Women (CHL)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	General Measure Data	16-20 years	21-24 years	Total
Measurement year	2013			
Data collection methodology (administrative)	A			
Eligible population		367	138	505
Numerator events by administrative data		96	58	154
Reported rate		26.16%	42.03%	30.50%
Lower 95% confidence interval		21.53%	33.43%	26.38%
Upper 95% confidence interval		30.79%	50.63%	34.61%

Appropriate Testing for Children with Pharyngitis (CWP)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative)	A
Eligible population	864
Numerator events by administrative data	386
Reported rate	44.68%
Lower 95% confidence interval	41.30%
Upper 95% confidence interval	48.05%

Appropriate Treatment for Children With URI (URI)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative)	A
Eligible population	2190
Numerator events by administrative data	768
Reported rate	64.93%
Lower 95% confidence interval	62.91%
Upper 95% confidence interval	66.95%

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative)	A
Eligible population	52
Total numerator events by administrative data	30
Reported rate	42.31%
Lower 95% confidence interval	27.92%
Upper 95% confidence interval	56.70%

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative)	A
Eligible population	0
Numerator events by administrative data	0
Reported rate	NA
Lower 95% confidence interval	NA
Upper 95% confidence interval	NA

Pharmacotherapy Management of COPD Exacerbation (PCE)			
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)			
Pharmacotherapy Management of COPD Exacerbation			
Data Elements	Measure Data	Systemic corticosteroid	Bronchodilator
Measurement year	2013		
Data collection methodology (administrative)	A		
Eligible population	26		
Numerator events by administrative data		15	17
Reported rate		NA	NA
Lower 95% confidence interval		NA	NA
Upper 95% confidence interval		NA	NA

Use of Appropriate Medications for People With Asthma (ASM)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	General Measure Data	5-11 years	12-18 years	19-50 years	51-64 years
Measurement year	2013				
Data collection methodology (administrative)	A				
Eligible population		0	0	0	0
Number of required exclusions		0	0	0	0
Numerator events by administrative data		0	0	0	0
Reported rate		NA	NA	NA	NA
Lower 95% confidence interval		NA	NA	NA	NA
Upper 95% confidence interval		NA	NA	NA	NA

Total
0
0
0
NA
NA
NA

Medication Management for People With Asthma (MMA)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

		5-11 years		12-18 years	
Data Element	**General Measure Data**	**Medication Compliance 50%**	**Medication Compliance 75%**	**Medication Compliance 50%**	**Medication Compliance 75%**
Measurement year	2013				
Data collection methodology (administrative)	A				
Eligible population		0		0	
Number of required exclusions		0		0	
Numerator events by administrative data		0	0	0	0
Reported rate		NA	NA	NA	NA
Lower 95% confidence interval		NA	NA	NA	NA
Upper 95% confidence interval		NA	NA	NA	NA

19-50 years		51-64 years		Total	
Medication Compliance 50%	Medication Compliance 75%	Medication Compliance 50%	Medication Compliance 75%	Medication Compliance 50%	Medication Compliance 75%
0		0		0	
0		0		0	
0	0	0	0	0	0
NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA

Asthma Medication Ratio (AMR)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	Measure Data	5-11 years	12-18 years	19-50 years	51-64 years
Measurement year	2013				
Data collection methodology (administrative)	A				
Eligible population		0	0	0	0
Number of required exclusions		0	0	0	0
Numerator events by administrative data		0	0	0	0
Reported rate		NA	NA	NA	NA
Lower 95% confidence interval		NA	NA	NA	NA
Upper 95% confidence interval		NA	NA	NA	NA

Total
0
0
0
NA
NA
NA

Cholesterol Management for Patients With Cardiovascular Conditions (CMC)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	General Measure Data	LDL-C Screening	LDL-C level <100 mg/dL
Measurement year	2013		
Data collection methodology (administrative or hybrid)	A		
Eligible population	0		
Number of numerator events by administrative data in eligible population (before exclusions)		NR	NR
Current year's administrative rate (before exclusions)		NR	NR
Minimum required sample size (MRSS) or other sample size	NR		
Oversampling rate	NR		
Final sample size (FSS)	NR		
Number of numerator events by administrative data in FSS		NR	NR
Administrative rate on FSS		NR	NR
Number of original sample records excluded because of valid data errors	NR		
Number of employee/dependent medical records excluded	NR		
Records added from the oversample list	NR		
Denominator	NR		
Numerator events by administrative data		0	0
Numerator events by medical records		NR	NR
Reported rate		NA	NA
Lower 95% confidence interval		NA	NA
Upper 95% confidence interval		NA	NA

Controlling High Blood Pressure (CBP)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**General Measure Data**
Measurement year	2013
Data collection methodology (hybrid)	H
Eligible population	247
Number of numerator events by administrative data in eligible population (before exclusions)	0
Current year's administrative rate (before exclusions)	0.00%
Minimum required sample size (MRSS) or other sample size	230
Oversampling rate	0
Final sample size (FSS)	230
Number of numerator events by administrative data in FSS	0
Administrative rate on FSS	0.00%
Number of original sample records excluded because of valid data errors	1
Number of records excluded because of false positive diagnoses	1
Number of administrative data records excluded	3
Number of medical data records excluded	0
Number of employee/dependent medical records excluded	0
Records added from the oversample list	0
Denominator	226
Numerator events by administrative data	0
Numerator events by medical records	143
Reported rate	63.27%
Lower 95% confidence interval	56.77%
Upper 95% confidence interval	69.78%

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative)	A
Eligible population	2
Numerator events by administrative data	0
Reported rate	NA
Lower 95% confidence interval	NA
Upper 95% confidence interval	NA

Comprehensive Diabetes Care (CDC)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	HbA1c Testing	HbA1c Poor Control (>9.0%)	HbA1c Control (<8.0%)	HbA1c Control (<7.0%) for a Selected Population	Eye Exam
Measurement year	2013	2013	2013	2013	2013
Data collection methodology (administrative or hybrid)	H	H	H	H	H
Eligible population	244	244	244	188	244
Number of numerator events by administrative data in eligible population (before optional exclusions)	186	244	0	0	96
Current year's administrative rate (before optional exclusions)	76.23%	100.00%	0.00%	0.00%	39.34%
Minimum required sample size (MRSS) or other sample size	241	241	241	241	241
Oversampling rate	0	0	0	0	0
Final sample size (FSS)	241	241	241	241	241
Number of numerator events by administrative data in FSS	187	241	0	0	100
Administrative rate on FSS	77.59%	100.00%	0.00%	0.00%	41.49%
Number of original sample records excluded because of valid data errors	0	0	0	0	0
Number of optional administrative data records excluded	0	0	0	0	0
Number of optional medical data records excluded	0	0	0	0	0
Number of HbA1c <7 required medical records excluded				7	
Number of HbA1c <7 required administrative data records excluded				56	
Number of employee/dependent medical records excluded	0	0	0	0	0
Records added from the oversample list	0	0	0	0	0
Denominator	241	241	241	178	241
Numerator events by administrative data	187	99	0	0	100
Numerator events by medical records	7	34	89	43	17
Reported rate	80.50%	55.19%	36.93%	24.16%	48.55%
Lower 95% confidence interval	75.29%	48.70%	30.63%	17.59%	42.03%
Upper 95% confidence interval	85.71%	61.67%	43.23%	30.73%	55.07%

LDL-C Screening	LDL-C Level <100 mg/dL	Medical Attention for Nephropathy	Blood Pressure Controlled <140/80 mm Hg	Blood Pressure Controlled <140/90 mm Hg
2013	2013	2013	2013	2013
H	H	H	H	H
244	244	244	244	244
128	0	155	0	0
52.46%	0.00%	63.52%	0.00%	0.00%
241	241	241	241	241
0	0	0	0	0
241	241	241	241	241
130	0	157	0	0
53.94%	0.00%	65.15%	0.00%	0.00%
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
241	241	241	241	241
130	0	157	0	0
5	50	5	109	163
56.02%	20.75%	67.22%	45.23%	67.63%
49.54%	15.42%	61.09%	38.74%	61.52%
62.49%	26.07%	73.35%	51.72%	73.75%

Disease Modifying Anti-Rheumatic Drug therapy in Rheumatoid Arthritis (ART)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative)	A
Eligible population	13
Numerator events by administrative data	7
Reported rate	NA
Lower 95% confidence interval	NA
Upper 95% confidence interval	NA

Use of Imaging Studies for Low Back Pain (LBP)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative)	A
Eligible population	124
Numerator events by administrative data	30
Reported rate	75.81%
Lower 95% confidence Interval	67.87%
Upper 95% confidence Interval	83.75%

Antidepressant Medication Management (AMM)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	General Measure Data	Effective Acute Phase Treatment	Effective Continuation Phase Treatment
Measurement year	2013		
Data collection methodology (administrative)	A		
Eligible population	0		
Numerator events by administrative data		0	0
Reported rate		NA	NA
Lower 95% confidence interval		NA	NA
Upper 95% confidence interval		NA	NA

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	General Measure Data	Initiation Phase	Continuation and Maintenance Phase
Measurement year	2013		
Data collection methodology (administrative)	A		
Eligible population		0	0
Numerator events by administrative data		0	0
Reported rate		NA	NA
Lower 95% confidence interval		NA	NA
Upper 95% confidence interval		NA	NA

Follow-Up After Hospitalization for Mental Illness (FUH)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	General Measure Data	30-day follow-up	7-day follow-up
Measurement year	NB		
Data collection methodology (administrative)	NB		
Eligible population	NB		
Numerator events by administrative data		NB	NB
Reported rate		NB	NB
Lower 95% confidence interval		NB	NB
Upper 95% confidence interval		NB	NB

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative)	A
Eligible population	51
Number of required exclusions	19
Numerator events by administrative data	43
Reported rate	84.31%
Lower 95% confidence interval	73.35%
Upper 95% confidence interval	95.28%

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative)	A
Eligible population	8
Numerator events by administrative data	4
Reported rate	NA
Lower 95% confidence interval	NA
Upper 95% confidence interval	NA

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative)	A
Eligible population	0
Numerator events by administrative data	0
Reported rate	NA
Lower 95% confidence interval	NA
Upper 95% confidence interval	NA

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative)	A
Eligible population	3
Number of required exclusions	40
Numerator events by administrative data	1
Reported rate	NA
Lower 95% confidence interval	NA
Upper 95% confidence interval	NA

Annual Monitoring for Patients on Persistent Medications (MPM)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	General Measure Data	ACE Inhibitors or ARBs	Digoxin	Diuretics	Anti-convulsants
Measurement year	2013				
Data collection methodology (administrative)	A				
Eligible population		0	0	0	0
Numerator events by administrative data		0	0	0	0
Reported rate		NA	NA	NA	NA
Lower 95% confidence interval		NA	NA	NA	NA
Upper 95% confidence interval		NA	NA	NA	NA

Total
0
0
NA
NA
NA

Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)					
Data Element	**General Measure Data**	**20-44 years**	**45-64 years**	**65+ years**	**Total**
Measurement year	2013				
Data collection methodology (administrative)	A				
Eligible population		1163	532	69	1,764
Numerator events by administrative data		1018	484	63	1,565
Reported rate		87.53%	90.98%	91.30%	88.72%
Lower 95% confidence interval		85.59%	88.45%	83.93%	87.21%
Upper 95% confidence interval		89.47%	93.51%	98.68%	90.22%

Children and Adolescents' Access to Primary Care Practitioners (CAP)					
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)					
Data Element	**General Measure Data**	**12-24 months**	**25 months - 6 years**	**7-11 years**	**12-19 years**
Measurement year	2013				
Data collection methodology (administrative)	A				
Eligible population		732	3473	0	0
Numerator events by administrative data		681	2832	0	0
Reported rate		93.03%	81.54%	NA	NA
Lower 95% confidence interval		91.12%	80.24%	NA	NA
Upper 95% confidence interval		94.95%	82.85%	NA	NA

Annual Dental Visit (ADV)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	Measure Data	2-3 Years	4-6 Years	7-10 Years	11-14 Years
Measurement year	NB				
Data collection methodology (administrative)	NB				
Eligible population		NB	NB	NB	NB
Numerator events by administrative data		NB	NB	NB	NB
Reported rate		NB	NB	NB	NB
Lower 95% confidence interval		NB	NB	NB	NB
Upper 95% confidence interval		NB	NB	NB	NB

15-18 Years	**19-21 Years**	**Total**
NB	NB	NB
NB	NB	NB
NB	NB	NB
NB	NB	NB
NB	NB	NB

Initiation and Engagement of AOD Dependence Treatment (IET)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Elements	General Measure Data	13-17 years		18+ years	
		Initiation of AOD Treatment	Engagement of AOD Treatment	Initiation of AOD Treatment	Engagement of AOD Treatment
Measurement year	NB				
Data collection methodology (administrative)	NB				
Eligible population		NB		NB	
Numerator events by administrative data		NB	NB	NB	NB
Reported rate		NB	NB	NB	NB
Lower 95% confidence interval		NB	NB	NB	NB
Upper 95% confidence interval		NB	NB	NB	NB

Total	
Initiation of AOD Treatment	**Engagement of AOD Treatment**
NB	
NB	NB
NB	NB
NB	NB
NB	NB

Prenatal and Postpartum Care (PPC)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	Timeliness of Prenatal Care	Postpartum Care
Measurement year	2013	2013
Data collection methodology (administrative or hybrid)	H	H
Eligible population	895	895
Number of numerator events by administrative data in eligible population (before exclusions)	420	336
Current year's administrative rate (before exclusions)	46.93%	37.54%
Minimum required sample size (MRSS) or other sample size	411	411
Oversampling rate	0.1	0.1
Final sample size (FSS)	453	453
Number of numerator events by administrative data in FSS	235	179
Administrative rate on FSS	51.88%	39.51%
Number of original sample records excluded because of valid data errors	1	1
Number of employee/dependent medical records excluded	0	0
Records added from the oversample list	0	0
Denominator	452	452
Numerator events by administrative data	235	179
Numerator events by medical records	179	123
Reported rate	91.59%	66.81%
Lower 95% confidence interval	88.92%	62.36%
Upper 95% confidence interval	94.26%	71.27%

Call Answer Timeliness (CAT)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative)	A
Eligible population	9011
Numerator events by administrative data	8277
Reported rate	91.85%
Lower 95% confidence interval	91.28%
Upper 95% confidence interval	92.42%

Frequency of Ongoing Prenatal Care (FPC)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	General Measure Data	<21 Percent	21-40 Percent	41-60 Percent	61-80 Percent
Measurement year	2013				
Data collection methodology (administrative or hybrid)	H				
Eligible population	895				
Number of numerator events by administrative data in eligible population (before exclusions)		469	214	46	41
Current year's administrative rate (before exclusions)		52.40%	23.91%	5.14%	4.58%
Minimum required sample size (MRSS) or other sample size	411				
Oversampling rate	0.1				
Final sample size (FSS)	453				
Number of numerator events by administrative data in FSS		234	95	27	22
Administrative rate on FSS		51.66%	20.97%	5.96%	4.86%
Number of original sample records excluded because of valid data errors	1				
Number of employee/dependent medical records excluded	0				
Records added from the oversample list	0				
Denominator	452				
Numerator events by administrative data		24	13	5	11
Numerator events by medical records		0	1	15	42
Reported rate		5.31%	3.10%	4.42%	11.73%
Lower 95% confidence interval		3.13%	1.39%	2.42%	8.65%
Upper 95% confidence interval		7.49%	4.81%	6.43%	14.80%

81+ Percent
125
13.97%
75
16.56%
85
256
75.44%
71.36%
79.52%

Well-Child Visits in the First 15 Months of Life (W15)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	Measure Data	0 visits	1 visit	2 visits	3 visits
Measurement year	2013				
Data collection methodology (administrative or hybrid)	H				
Eligible population	295				
Number of numerator events by administrative data in eligible population (before exclusions)		15	14	17	40
Current year's administrative rate (before exclusions)		5.08%	4.75%	5.76%	13.56%
Minimum required sample size (MRSS) or other sample size	295				
Oversampling rate	0				
Final sample size (FSS)	295				
Number of numerator events by administrative data in FSS		15	14	17	40
Administrative rate on FSS		5.08%	4.75%	5.76%	13.56%
Number of original sample records excluded because of valid data errors	0				
Number of employee/dependent medical records excluded	0				
Records added from the oversample list	0				
Denominator	295				
Numerator events by administrative data		12	6	6	14
Numerator events by medical records		0	0	2	8
Reported rate		4.07%	2.03%	2.71%	7.46%
Lower 95% confidence interval		1.64%	0.25%	0.69%	4.29%
Upper 95% confidence interval		6.49%	3.81%	4.73%	10.63%

4 visits	**5 visits**	**6 or more visits**
61	114	34
20.68%	38.64%	11.53%
61	114	34
20.68%	38.64%	11.53%
24	40	34
14	24	111
12.88%	21.69%	49.15%
8.89%	16.82%	43.28%
16.87%	26.57%	55.03%

Adolescent Well-Care Visits (AWC)	
Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2013
Data collection methodology (administrative or hybrid)	H
Eligible population	3600
Number of numerator events by administrative data in eligible population (before exclusions)	1348
Current year's administrative rate (before exclusions)	37.44%
Minimum required sample size (MRSS) or other sample size	411
Oversampling rate	0.1
Final sample size (FSS)	453
Number of numerator events by administrative data in FSS	172
Administrative rate on FSS	37.97%
Number of original sample records excluded because of valid data errors	0
Number of employee/dependent medical records excluded	0
Records added from the oversample list	0
Denominator	453
Numerator events by administrative data	172
Numerator events by medical records	18
Reported rate	41.94%
Lower 95% confidence interval	37.29%
Upper 95% confidence interval	46.60%

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Data Element	Measure Data
Measurement year	2013
Data collection methodology (administrative or hybrid)	H
Eligible population	2899
Number of numerator events by administrative data in eligible population (before exclusions)	1452
Current year's administrative rate (before exclusions)	50.09%
Minimum required sample size (MRSS) or other sample size	411
Oversampling rate	0.1
Final sample size (FSS)	453
Number of numerator events by administrative data in FSS	233
Administrative rate on FSS	51.43%
Number of original sample records excluded because of valid data errors	0
Number of employee/dependent medical records excluded	0
Records added from the oversample list	0
Denominator	453
Numerator events by administrative data	233
Numerator events by medical records	27
Reported rate	57.40%
Lower 95% confidence interval	52.73%
Upper 95% confidence interval	62.06%

Frequency of Selected Procedures (FSP)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Male	Female	Total
0-9	67,958	65,172	133,130
10-19	42,744	41,630	84,374
15-44		46,500	
20-44	6,091	28,851	
30-64	7,036		
45-64	3,749	5,789	

Procedure	Age	Sex	Number of Procedures	Procedures / 1,000 Member Months
Bariatric weight loss surgery	0-19	Male	0	0.00
		Female	0	0.00
	20-44	Male	2	0.33
		Female	3	0.10
	45-64	Male	0	0.00
		Female	1	0.17
Tonsillectomy	0-9	Male & Female	128	0.96
	10-19		45	0.53
Hysterectomy, Abdominal	15-44	Female	7	0.15
	45-64		2	0.35
Hysterectomy, Vaginal	15-44	Female	14	0.30
	45-64		4	0.69
Cholecystectomy, Open	30-64	Male	1	0.14
	15-44	Female	2	0.04
	45-64		0	0.00
Cholecystectomy (laparoscopic)	30-64	Male	4	0.57
	15-44	Female	67	1.44
	45-64		6	1.04
Back Surgery	20-44	Male	2	0.33
		Female	17	0.59
	45-64	Male	3	0.80
		Female	7	1.21
Mastectomy	15-44	Female	0	0.00
	45-64		2	0.35
Lumpectomy	15-44	Female	4	0.09
	45-64		0	0.00

Ambulatory Care: Total (AMBA)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months
<1	14,360
1-9	118,770
10-19	84,374
20-44	34,942
45-64	9,538
65-74	580
75-84	292
85+	81
Unknown	0
Total	262,937

Age	Outpatient Visits		ED Visits	
	Visits	Visits/ 1,000 Member Months	Visits	Visits/ 1,000 Member Months
<1	10605	738.51	1109	77.23
1-9	33422	281.40	4020	33.85
10-19	19978	236.78	2453	29.07
20-44	15138	433.23	2870	82.14
45-64	7243	759.38	774	81.15
65-74	318	548.28	34	58.62
75-84	171	585.62	5	17.12
85+	32	395.06	2	24.69
Unknown	0		0	
Total	86,907	330.52	11,267	42.85

Ambulatory Care: Dual Eligibles (AMBB)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months
<1	0
1-9	0
10-19	0
20-44	0
45-64	0
65-74	0
75-84	0
85+	0
Unknown	0
Total	0

Age	Outpatient Visits		ED Visits	
	Visits	Visits/ 1,000 Member Months	Visits	Visits/ 1,000 Member Months
<1	0	NA	0	NA
1-9	0	NA	0	NA
10-19	0	NA	0	NA
20-44	0	NA	0	NA
45-64	0	NA	0	NA
65-74	0	NA	0	NA
75-84	0	NA	0	NA
85+	0	NA	0	NA
Unknown	0		0	
Total	0	NA	0	NA

Ambulatory Care: Disabled (AMBC)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months
<1	0
1-9	0
10-19	0
20-44	0
45-64	0
65-74	0
75-84	0
85+	0
Unknown	0
Total	0

Age	Outpatient Visits		ED Visits	
	Visits	Visits/ 1,000 Member Months	Visits	Visits/ 1,000 Member Months
<1	0	NA	0	NA
1-9	0	NA	0	NA
10-19	0	NA	0	NA
20-44	0	NA	0	NA
45-64	0	NA	0	NA
65-74	0	NA	0	NA
75-84	0	NA	0	NA
85+	0	NA	0	NA
Unknown	0		0	
Total	0	NA	0	NA

Ambulatory Care: Other (AMBD)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months
<1	14,360
1-9	118,770
10-19	84,374
20-44	34,942
45-64	9,538
65-74	580
75-84	292
85+	81
Unknown	0
Total	262,937

Age	Outpatient Visits		ED Visits	
	Visits	Visits/ 1,000 Member Months	Visits	Visits/ 1,000 Member Months
<1	10605	738.51	1109	77.23
1-9	33422	281.40	4020	33.85
10-19	19978	236.78	2453	29.07
20-44	15138	433.23	2870	82.14
45-64	7243	759.38	774	81.15
65-74	318	548.28	34	58.62
75-84	171	585.62	5	17.12
85+	32	395.06	2	24.69
Unknown	0		0	
Total	86,907	330.52	11,267	42.85

Inpatient Utilization--General Hospital/Acute Care: Total (IPUA)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months
<1	14,360
1-9	118,770
10-19	84,374
20-44	34,942
45-64	9,538
65-74	580
75-84	292
85+	81
Unknown	0
Total	262,937

Total Inpatient

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	83	5.78	390	27.16	4.70
1-9	173	1.46	717	6.04	4.14
10-19	268	3.18	828	9.81	3.09
20-44	1052	30.11	2635	75.41	2.50
45-64	277	29.04	1159	121.51	4.18
65-74	16	27.59	127	218.97	7.94
75-84	7	23.97	20	68.49	2.86
85+	1	12.35	15	185.19	15.00
Unknown	0		0		NA
Total	1,877	7.14	5,891	22.40	3.14

Medicine

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	69	4.81	242	16.85	3.51
1-9	135	1.14	422	3.55	3.13
10-19	77	0.91	306	3.63	3.97
20-44	116	3.32	320	9.16	2.76
45-64	186	19.50	637	66.79	3.42
65-74	13	22.41	77	132.76	5.92
75-84	7	23.97	20	68.49	2.86
85+	1	12.35	15	185.19	15.00
Unknown	0		0		NA
Total	604	2.30	2,039	7.75	3.38

Surgery

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	14	0.97	148	10.31	10.57
1-9	38	0.32	295	2.48	7.76
10-19	20	0.24	115	1.36	5.75
20-44	77	2.20	261	7.47	3.39
45-64	91	9.54	522	54.73	5.74
65-74	3	5.17	50	86.21	16.67

75-84	0	0.00	0	0.00	NA
85+	0	0.00	0	0.00	NA
Unknown	0		0		NA
Total	243	0.92	1,391	5.29	5.72
Maternity*					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	171	2.03	407	4.82	2.38
20-44	859	24.58	2054	58.78	2.39
45-64	0	0.00	0	0.00	NA
Unknown	0		0		NA
Total	1,030	7.99	2,461	19.10	2.39

***The maternity category is calculated using member months for members 10-64 years.**

Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (IPUB)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months
<1	0
1-9	0
10-19	0
20-44	0
45-64	0
65-74	0
75-84	0
85+	0
Unknown	0
Total	0

Total Inpatient

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	0	NA	0	NA	NA
1-9	0	NA	0	NA	NA
10-19	0	NA	0	NA	NA
20-44	0	NA	0	NA	NA
45-64	0	NA	0	NA	NA
65-74	0	NA	0	NA	NA
75-84	0	NA	0	NA	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	0	NA	0	NA	NA

Medicine

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	0	NA	0	NA	NA
1-9	0	NA	0	NA	NA
10-19	0	NA	0	NA	NA
20-44	0	NA	0	NA	NA
45-64	0	NA	0	NA	NA
65-74	0	NA	0	NA	NA
75-84	0	NA	0	NA	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	0	NA	0	NA	NA

Surgery

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	0	NA	0	NA	NA
1-9	0	NA	0	NA	NA
10-19	0	NA	0	NA	NA
20-44	0	NA	0	NA	NA
45-64	0	NA	0	NA	NA
65-74	0	NA	0	NA	NA

75-84	0	NA	0	NA	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	0	NA	0	NA	NA
Maternity*					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	0	NA	0	NA	NA
20-44	0	NA	0	NA	NA
45-64	0	NA	0	NA	NA
Unknown	0		0		NA
Total	0	NA	0	NA	NA
***The maternity category is calculated using member months for members 10-64 years.**					

Inpatient Utilization--General Hospital/Acute Care: Disabled (IPUC)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months
<1	0
1-9	0
10-19	0
20-44	0
45-64	0
65-74	0
75-84	0
85+	0
Unknown	0
Total	0

Total Inpatient

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	0	NA	0	NA	NA
1-9	0	NA	0	NA	NA
10-19	0	NA	0	NA	NA
20-44	0	NA	0	NA	NA
45-64	0	NA	0	NA	NA
65-74	0	NA	0	NA	NA
75-84	0	NA	0	NA	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	0	NA	0	NA	NA

Medicine

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	0	NA	0	NA	NA
1-9	0	NA	0	NA	NA
10-19	0	NA	0	NA	NA
20-44	0	NA	0	NA	NA
45-64	0	NA	0	NA	NA
65-74	0	NA	0	NA	NA
75-84	0	NA	0	NA	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	0	NA	0	NA	NA

Surgery

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	0	NA	0	NA	NA
1-9	0	NA	0	NA	NA
10-19	0	NA	0	NA	NA
20-44	0	NA	0	NA	NA
45-64	0	NA	0	NA	NA
65-74	0	NA	0	NA	NA

75-84	0	NA	0	NA	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	0	NA	0	NA	NA
Maternity*					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	0	NA	0	NA	NA
20-44	0	NA	0	NA	NA
45-64	0	NA	0	NA	NA
Unknown	0		0		NA
Total	0	NA	0	NA	NA
***The maternity category is calculated using member months for members 10-64 years.**					

Inpatient Utilization--General Hospital/Acute Care: Other (IPUD)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months
<1	14,360
1-9	118,770
10-19	84,374
20-44	34,942
45-64	9,538
65-74	580
75-84	292
85+	81
Unknown	0
Total	262,937

Total Inpatient

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	83	5.78	390	27.16	4.70
1-9	173	1.46	717	6.04	4.14
10-19	268	3.18	828	9.81	3.09
20-44	1052	30.11	2635	75.41	2.50
45-64	277	29.04	1159	121.51	4.18
65-74	16	27.59	127	218.97	7.94
75-84	7	23.97	20	68.49	2.86
85+	0	0.00	15	185.19	NA
Unknown	0		0		NA
Total	1,876	7.13	5,891	22.40	3.14

Medicine

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	69	4.81	242	16.85	3.51
1-9	135	1.14	422	3.55	3.13
10-19	77	0.91	306	3.63	3.97
20-44	116	3.32	320	9.16	2.76
45-64	186	19.50	637	66.79	3.42
65-74	13	22.41	77	132.76	5.92
75-84	7	23.97	20	68.49	2.86
85+	1	12.35	15	185.19	15.00
Unknown	0		0		NA
Total	604	2.30	2,039	7.75	3.38

Surgery

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	14	0.97	148	10.31	10.57
1-9	38	0.32	295	2.48	7.76
10-19	20	0.24	115	1.36	5.75
20-44	77	2.20	261	7.47	3.39
45-64	91	9.54	522	54.73	5.74
65-74	3	5.17	50	86.21	16.67

75-84	0	0.00	0	0.00	NA
85+	0	0.00	0	0.00	NA
Unknown	0		0		NA
Total	243	0.92	1,391	5.29	5.72
Maternity*					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	171	2.03	407	4.82	2.38
20-44	859	24.58	2054	58.78	2.39
45-64	0	0.00	0	0.00	NA
Unknown	0		0		NA
Total	1,030	7.99	2,461	19.10	2.39

***The maternity category is calculated using member months for members 10-64 years.**

Identification of Alcohol and Other Drug Services: Total (IADA)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months (Any)			Member Months (Inp	
	Male	Female	Total	Male	Female
0-12	NB	NB	NB	NB	NB
13-17	NB	NB	NB	NB	NB
18-24	NB	NB	NB	NB	NB
25-34	NB	NB	NB	NB	NB
35-64	NB	NB	NB	NB	NB
65+	NB	NB	NB	NB	NB
Unknown	NB	NB	NB	NB	NB
Total	NB	NB	NB	NB	NB

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
13-17	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
18-24	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
25-34	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
35-64	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
65+	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Unknown	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Total	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB

atient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB

NB	NB	NB	NB	NB	NB	NB

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB

Identification of Alcohol and Other Drug Services: Dual Eligibles (IADB)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months (Any)			Member Months (Inp	
	Male	Female	Total	Male	Female
0-12	NB	NB	NB	NB	NB
13-17	NB	NB	NB	NB	NB
18-24	NB	NB	NB	NB	NB
25-34	NB	NB	NB	NB	NB
35-64	NB	NB	NB	NB	NB
65+	NB	NB	NB	NB	NB
Unknown	NB	NB	NB	NB	NB
Total	NB	NB	NB	NB	NB

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
13-17	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
18-24	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
25-34	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
35-64	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
65+	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Unknown	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Total	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB

atient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB

Identification of Alcohol and Other Drug Services: Disabled (IADC)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months (Any)			Member Months (Inp	
	Male	Female	Total	Male	Female
0-12	NB	NB	NB	NB	NB
13-17	NB	NB	NB	NB	NB
18-24	NB	NB	NB	NB	NB
25-34	NB	NB	NB	NB	NB
35-64	NB	NB	NB	NB	NB
65+	NB	NB	NB	NB	NB
Unknown	NB	NB	NB	NB	NB
Total	NB	NB	NB	NB	NB

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
13-17	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
18-24	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
25-34	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
35-64	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
65+	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Unknown	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Total	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB

atient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB

Identification of Alcohol and Other Drug Services: Other (IADD)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months (Any)			Member Months (Inp	
	Male	Female	Total	Male	Female
0-12	NB	NB	NB	NB	NB
13-17	NB	NB	NB	NB	NB
18-24	NB	NB	NB	NB	NB
25-34	NB	NB	NB	NB	NB
35-64	NB	NB	NB	NB	NB
65+	NB	NB	NB	NB	NB
Unknown	NB	NB	NB	NB	NB
Total	NB	NB	NB	NB	NB

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
13-17	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
18-24	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
25-34	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
35-64	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
65+	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Unknown	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Total	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB

atient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
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NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB

Mental Health Utilization: Total (MPTA)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months (Any)			Member Months (Inp	
	Male	Female	Total	Male	Female
0-12	NB	NB	NB	NB	NB
13-17	NB	NB	NB	NB	NB
18-64	NB	NB	NB	NB	NB
65+	NB	NB	NB	NB	NB
Unknown	NB	NB	NB	NB	NB
Total	NB	NB	NB	NB	NB

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
13-17	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
18-64	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
65+	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Unknown	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Total	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB

atient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB

Mental Health Utilization: Dual Eligibles (MPTB)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months (Any)			Member Months (Inp	
	Male	Female	Total	Male	Female
0-12	NB	NB	NB	NB	NB
13-17	NB	NB	NB	NB	NB
18-64	NB	NB	NB	NB	NB
65+	NB	NB	NB	NB	NB
Unknown	NB	NB	NB	NB	NB
Total	NB	NB	NB	NB	NB

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
13-17	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
18-64	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
65+	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Unknown	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Total	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB

atient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB

Mental Health Utilization: Disabled (MPTC)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months (Any)			Member Months (Inp	
	Male	Female	Total	Male	Female
0-12	NB	NB	NB	NB	NB
13-17	NB	NB	NB	NB	NB
18-64	NB	NB	NB	NB	NB
65+	NB	NB	NB	NB	NB
Unknown	NB	NB	NB	NB	NB
Total	NB	NB	NB	NB	NB

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
13-17	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
18-64	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
65+	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Unknown	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Total	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB

atient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB

Mental Health Utilization: Other (MPTD)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months (Any)			Member Months (Inp	
	Male	Female	Total	Male	Female
0-12	NB	NB	NB	NB	NB
13-17	NB	NB	NB	NB	NB
18-64	NB	NB	NB	NB	NB
65+	NB	NB	NB	NB	NB
Unknown	NB	NB	NB	NB	NB
Total	NB	NB	NB	NB	NB

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
13-17	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
18-64	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
65+	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Unknown	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB
Total	M	NB	NB	NB	NB
	F	NB	NB	NB	NB
	Total	NB	NB	NB	NB

atient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB
NB	NB	NB	NB	NB	NB	NB

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB
NB	NB	NB	NB

Antibiotic Utilization: Total (ABXA)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Pharmacy Benefit Member Months			
Age	**Male**	**Female**	**Total**
0-9	67958	65172	133,130
10-17	38859	36608	75,467
18-34	7871	26869	34,740
35-49	3097	8976	12,073
50-64	2757	3817	6,574
65-74	177	403	580
75-84	106	186	292
85+	6	75	81
Unknown	0	0	0
Total	120,831	142,106	262,937

Antibiotic Utilization

Age	Sex	Total Antibiotic Scrips	Average Scrips PMPY for Antibiotics	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Antibiotic Scrip
0-9	**M**	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
10-17	**M**	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
18-34	**M**	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
35-49	**M**	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
50-64	**M**	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
65-74	**M**	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
75-84	**M**	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
85+	**M**	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
Unknown	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Total	**M**	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA

Antib

Age	Sex	Total Quinolone Scrips	Average Scrips PMPY for Quinolones	Total Cephalo-sporin 2nd-4th Generation Scrips	Average Scrips PMPY for Cephalo-sporins 2nd-4th Generation
0-9	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
10-17	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
18-34	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
35-49	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
50-64	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
65-74	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
75-84	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
85+	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
Unknown	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Total	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00

Age	Sex	Total Absorbable Sulfonamide Scrips	Average Scrips PMPY for Absorbable Sulfonamides	Total Amino-glycoside Scrips	Average Scrips PMPY for Amino-glycosides
0-9	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
10-17	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
18-34	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
35-49	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00

50-64	**M**	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
65-74	**M**	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
75-84	**M**	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
85+	**M**	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
Unknown	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Total	**M**	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00

Total Number of Scrips for Antibiotics of Concern	Average Scrips PMPY for Anitbiotics of Concern	Percentage of Antibiotics of Concern of all Antibiotic Scrips
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA

iotics of Concern Utilization

Total Azithromycin and Clarithro-mycin Scrips	Average Scrips PMPY for Azithromycins and Clarithro-mycins	Total Amoxicillin/ Clavulanate Scrips	Average Scrips PMPY for Amoxicillin/ Clavulanates	Total Ketolides Scrips	Average Scrips PMPY for Ketolides	Total Clindamycin Scrips	Average Scrips PMPY for Clindamycins
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00

All Other Antibiotics Utilization

Total 1st Generation Cephalo-sporin Scrips	Average Scrips PMPY for 1st Generation Cephalo-sporins	Total Lincosamide Scrips	Average Scrips PMPY for Lincosamides	Total Macrolides (not azith. or clarith.) Scrips	Average Scrips PMPY for Macrolides (not azith. or clarith.)	Total Penicillin Scrips	Average Scrips PMPY for Penicillins
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00

0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00

Total Misc. Antibiotics of Concern Scrips	Average Scrips PMPY for Misc. Antibiotics of Concern
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	NA
0	NA
0	NA
0	0.00
0	0.00
0	0.00

Total Tetracycline Scrips	Average Scrips PMPY for Tetracycline s	Total Misc. Antibiotic Scrips	Average Scrips PMPY for Misc. Antibiotics
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00

0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00

Antibiotic Utilization: Dual Eligibles (ABXB)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Member Months

Age	Member Months		
	Male	Female	Total
0-9	0	0	0
10-17	0	0	0
18-34	0	0	0
35-49	0	0	0
50-64	0	0	0
65-74	0	0	0
75-84	0	0	0
85+	0	0	0
Unknown	0	0	0
Total	0	0	0

Antibiotic Utilization

Age	Sex	Total Antibiotic Scrips	Average Scrips PMPY for Antibiotics	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Antibiotic Scrip
0-9	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
10-17	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
18-34	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
35-49	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
50-64	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
65-74	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
75-84	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
85+	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Unknown	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Total	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA

Antib

Age	Sex	Total Quinolone Scrips	Average Scrips PMPY for Quinolones	Total Cephalosporin 2nd-4th Generation Scrips	Average Scrips PMPY for Cephalosporins 2nd-4th Generation
0-9	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
10-17	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
18-34	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
35-49	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
50-64	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
65-74	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
75-84	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
85+	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Unknown	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Total	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA

Age	Sex	Total Absorbable Sulfonamide Scrips	Average Scrips PMPY for Absorbable Sulfonamides	Total Aminoglycoside Scrips	Average Scrips PMPY for Aminoglycosides
0-9	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
10-17	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
18-34	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
35-49	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA

50-64	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
65-74	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
75-84	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
85+	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Unknown	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Total	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA

Total Number of Scrips for Antibiotics of Concern	Average Scrips PMPY for Anitbiotics of Concern	Percentage of Antibiotics of Concern of all Antibiotic Scrips
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA

iotics of Concern Utilization

Total Azithromycin and Clarithromycin Scrips	Average Scrips PMPY for Azithromycins and Clarithromycins	Total Amoxicillin/ Clavulanate Scrips	Average Scrips PMPY for Amoxicillin/ Clavulanates	Total Ketolides Scrips	Average Scrips PMPY for Ketolides	Total Clindamycin Scrips	Average Scrips PMPY for Clindamycins
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA

All Other Antibiotics Utilization

Total 1st Generation Cephalosporin Scrips	Average Scrips PMPY for 1st Generation Cephalosporins	Total Lincosamide Scrips	Average Scrips PMPY for Lincosamides	Total Macrolides (not azith. or clarith.) Scrips	Average Scrips PMPY for Macrolides (not azith. or clarith.)	Total Penicillin Scrips	Average Scrips PMPY for Penicillins
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA

0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA

Total Misc. Antibiotics of Concern Scrips	Average Scrips PMPY for Misc. Antibiotics of Concern
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA

Total Tetracycline Scrips	Average Scrips PMPY for Tetracyclines	Total Misc. Antibiotic Scrips	Average Scrips PMPY for Misc. Antibiotics
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA

0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA

Antibiotic Utilization: Disabled (ABXC)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Member Months

Age	Member Months		
	Male	Female	Total
0-9	0	0	0
10-17	0	0	0
18-34	0	0	0
35-49	0	0	0
50-64	0	0	0
65-74	0	0	0
75-84	0	0	0
85+	0	0	0
Unknown	0	0	0
Total	0	0	0

Antibiotic Utilization

Age	Sex	Total Antibiotic Scrips	Average Scrips PMPY for Antibiotics	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Antibiotic Scrip
0-9	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
10-17	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
18-34	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
35-49	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
50-64	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
65-74	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
75-84	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
85+	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Unknown	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Total	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA

Antib

Age	Sex	Total Quinolone Scrips	Average Scrips PMPY for Quinolones	Total Cephalosporin 2nd-4th Generation Scrips	Average Scrips PMPY for Cephalosporins 2nd-4th Generation
0-9	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
10-17	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
18-34	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
35-49	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
50-64	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
65-74	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
75-84	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
85+	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Unknown	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Total	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA

Age	Sex	Total Absorbable Sulfonamide Scrips	Average Scrips PMPY for Absorbable Sulfonamides	Total Aminoglycoside Scrips	Average Scrips PMPY for Aminoglycosides
0-9	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
10-17	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
18-34	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
35-49	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA

50-64	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
65-74	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
75-84	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
85+	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Unknown	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Total	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA

Total Number of Scrips for Antibiotics of Concern	Average Scrips PMPY for Anitbiotics of Concern	Percentage of Antibiotics of Concern of all Antibiotic Scrips
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	NA	NA

iotics of Concern Utilization

Total Azithromycin and Clarithromycin Scrips	Average Scrips PMPY for Azithromycins and Clarithromycins	Total Amoxicillin/ Clavulanate Scrips	Average Scrips PMPY for Amoxicillin/ Clavulanates	Total Ketolides Scrips	Average Scrips PMPY for Ketolides	Total Clindamycin Scrips	Average Scrips PMPY for Clindamycins
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA

All Other Antibiotics Utilization

Total 1st Generation Cephalosporin Scrips	Average Scrips PMPY for 1st Generation Cephalosporins	Total Lincosamide Scrips	Average Scrips PMPY for Lincosamides	Total Macrolides (not azith. or clarith.) Scrips	Average Scrips PMPY for Macrolides (not azith. or clarith.)	Total Penicillin Scrips	Average Scrips PMPY for Penicillins
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA

0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA

Total Misc. Antibiotics of Concern Scrips	Average Scrips PMPY for Misc. Antibiotics of Concern
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA
0	NA

Total Tetracycline Scrips	Average Scrips PMPY for Tetracyclines	Total Misc. Antibiotic Scrips	Average Scrips PMPY for Misc. Antibiotics
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA

0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA

Antibiotic Utilization: Other (ABXD)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Member Months

Age	Member Months		
	Male	Female	Total
0-9	67958	65172	133,130
10-17	38859	36608	75,467
18-34	7871	26869	34,740
35-49	3097	8976	12,073
50-64	2757	3817	6,574
65-74	177	403	580
75-84	106	186	292
85+	6	75	81
Unknown	0	0	0
Total	120,831	142,106	262,937

Antibiotic Utilization

Age	Sex	Total Antibiotic Scrips	Average Scrips PMPY for Antibiotics	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Antibiotic Scrip
0-9	M	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
10-17	M	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
18-34	M	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
35-49	M	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
50-64	M	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
65-74	M	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
75-84	M	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
85+	M	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA
Unknown	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Total	M	0	0.00	0	NA
	F	0	0.00	0	NA
	Total	0	0.00	0	NA

Antib

Age	Sex	Total Quinolone Scrips	Average Scrips PMPY for Quinolones	Total Cephalosporin 2nd-4th Generation Scrips	Average Scrips PMPY for Cephalosporins 2nd-4th Generation
0-9	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
10-17	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
18-34	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
35-49	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
50-64	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
65-74	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
75-84	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
85+	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
Unknown	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Total	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00

Age	Sex	Total Absorbable Sulfonamide Scrips	Average Scrips PMPY for Absorbable Sulfonamides	Total Aminoglycoside Scrips	Average Scrips PMPY for Aminoglycosides
0-9	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
10-17	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
18-34	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
35-49	M	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00

50-64	**M**	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
65-74	**M**	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
75-84	**M**	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
85+	**M**	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00
Unknown	**M**	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Total	**M**	0	0.00	0	0.00
	F	0	0.00	0	0.00
	Total	0	0.00	0	0.00

Total Number of Scrips for Antibiotics of Concern	Average Scrips PMPY for Anitbiotics of Concern	Percentage of Antibiotics of Concern of all Antibiotic Scrips
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA
0	NA	NA
0	NA	NA
0	NA	NA
0	0.00	NA
0	0.00	NA
0	0.00	NA

iotics of Concern Utilization

Total Azithromycin and Clarithromycin Scrips	Average Scrips PMPY for Azithromycins and Clarithromycins	Total Amoxicillin/ Clavulanate Scrips	Average Scrips PMPY for Amoxicillin/ Clavulanates	Total Ketolides Scrips	Average Scrips PMPY for Ketolides	Total Clindamycin Scrips	Average Scrips PMPY for Clindamycins
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00

All Other Antibiotics Utilization

Total 1st Generation Cephalosporin Scrips	Average Scrips PMPY for 1st Generation Cephalosporins	Total Lincosamide Scrips	Average Scrips PMPY for Lincosamides	Total Macrolides (not azith. or clarith.) Scrips	Average Scrips PMPY for Macrolides (not azith. or clarith.)	Total Penicillin Scrips	Average Scrips PMPY for Penicillins
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00

0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00

Total Misc. Antibiotics of Concern Scrips	Average Scrips PMPY for Misc. Antibiotics of Concern
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	0.00
0	NA
0	NA
0	NA
0	0.00
0	0.00
0	0.00

Total Tetracycline Scrips	Average Scrips PMPY for Tetracycline s	Total Misc. Antibiotic Scrips	Average Scrips PMPY for Misc. Antibiotics
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00

0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	0.00	0	0.00
0	0.00	0	0.00
0	0.00	0	0.00

Board Certification (BCR)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Type of Physician	Number of Physicians in Each	Board Certification	
		Number	Percent
Family Medicine	37	23	62.16%
Internal Medicine	15	11	73.33%
OB/GYN physicians	15	0	0.00%
Pediatricians	21	20	95.24%
Geriatricians	0	0	NA
Other physician specialists	92	46	50.00%

Total Membership (TLM)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Product/Product Line	Total Number of Members*
HMO (Total)	21,295
Medicaid	21295
Commercial	0
Medicare (cost or risk)	0
Other	0
PPO (Total)	0
Medicaid	0
Commercial	0
Medicare (cost or risk)	0
Other	0
POS (Total)	0
Medicaid	0
Commercial	0
Medicare (cost or risk)	0
Other	0
FFS (Total)	0
Medicaid	0
Commercial	0
Medicare (cost or risk)	0
Other	0
Total	21,295

*** Total number of members in each category as of December 31 of the measurement year.**

Enrollment by Product Line: Total (ENPA)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Male Member Months	Female Member Months	Total Member Months
<1	7407	6953	14,360
1-4	28110	26757	54,867
5-9	32441	31462	63,903
10-14	26202	23981	50,183
15-17	12657	12627	25,284
18-19	3885	5022	8,907
0-19 Subtotal	110,702	106,802	217,504
0-19 Subtotal: %	91.62%	75.16%	82.72%
20-24	1379	8273	9,652
25-29	1425	7456	8,881
30-34	1182	6118	7,300
35-39	1188	4186	5,374
40-44	917	2818	3,735
20-44 Subtotal	6,091	28,851	34,942
20-44 Subtotal: %	5.04%	20.30%	13.29%
45-49	992	1972	2,964
50-54	1011	1457	2,468
55-59	1023	1315	2,338
60-64	723	1045	1,768
45-64 Subtotal	3,749	5,789	9,538
45-64 Subtotal: %	3.10%	4.07%	3.63%
65-69	78	175	253
70-74	99	228	327
75-79	76	114	190
80-84	30	72	102
85-89	3	28	31
>=90	3	47	50
>=65 Subtotal	289	664	953
>=65 Subtotal: %	0.24%	0.47%	0.36%
Age Unknown	0	0	0
Total	120,831	142,106	262,937

Enrollment by Product Line: Dual Eligibles (ENPB)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Male Member Months	Female Member Months	Total Member Months
<1	0	0	0
1-4	0	0	0
5-9	0	0	0
10-14	0	0	0
15-17	0	0	0
18-19	0	0	0
0-19 Subtotal	0	0	0
0-19 Subtotal: %	NA	NA	NA
20-24	0	0	0
25-29	0	0	0
30-34	0	0	0
35-39	0	0	0
40-44	0	0	0
20-44 Subtotal	0	0	0
20-44 Subtotal: %	NA	NA	NA
45-49	0	0	0
50-54	0	0	0
55-59	0	0	0
60-64	0	0	0
45-64 Subtotal	0	0	0
45-64 Subtotal: %	NA	NA	NA
65-69	0	0	0
70-74	0	0	0
75-79	0	0	0
80-84	0	0	0
85-89	0	0	0
>=90	0	0	0
>=65 Subtotal	0	0	0
>=65 Subtotal: %	NA	NA	NA
Age Unknown	0	0	0
Total	0	0	0

Enrollment by Product Line: Disabled (ENPC)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Male Member Months	Female Member Months	Total Member Months
<1	0	0	0
1-4	0	0	0
5-9	0	0	0
10-14	0	0	0
15-17	0	0	0
18-19	0	0	0
0-19 Subtotal	0	0	0
0-19 Subtotal: %	NA	NA	NA
20-24	0	0	0
25-29	0	0	0
30-34	0	0	0
35-39	0	0	0
40-44	0	0	0
20-44 Subtotal	0	0	0
20-44 Subtotal: %	NA	NA	NA
45-49	0	0	0
50-54	0	0	0
55-59	0	0	0
60-64	0	0	0
45-64 Subtotal	0	0	0
45-64 Subtotal: %	NA	NA	NA
65-69	0	0	0
70-74	0	0	0
75-79	0	0	0
80-84	0	0	0
85-89	0	0	0
>=90	0	0	0
>=65 Subtotal	0	0	0
>=65 Subtotal: %	NA	NA	NA
Age Unknown	0	0	0
Total	0	0	0

Enrollment by Product Line: Other (ENPD)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Age	Male Member Months	Female Member Months	Total Member Months
<1	7407	6953	14,360
1-4	28110	26757	54,867
5-9	32441	31462	63,903
10-14	26202	23981	50,183
15-17	12657	12627	25,284
18-19	3885	5022	8,907
0-19 Subtotal	110,702	106,802	217,504
0-19 Subtotal: %	91.62%	75.16%	82.72%
20-24	1379	8273	9,652
25-29	1425	7456	8,881
30-34	1182	6118	7,300
35-39	1188	4186	5,374
40-44	917	2818	3,735
20-44 Subtotal	6,091	28,851	34,942
20-44 Subtotal: %	5.04%	20.30%	13.29%
45-49	992	1972	2,964
50-54	1011	1457	2,468
55-59	1023	1315	2,338
60-64	723	1045	1,768
45-64 Subtotal	3,749	5,789	9,538
45-64 Subtotal: %	3.10%	4.07%	3.63%
65-69	78	175	253
70-74	99	228	327
75-79	76	114	190
80-84	30	72	102
85-89	3	28	31
>=90	3	47	50
>=65 Subtotal	289	664	953
>=65 Subtotal: %	0.24%	0.47%	0.36%
Age Unknown	0	0	0
Total	120,831	142,106	262,937

Enrollment by State (EBS)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

State	Number
Alabama	0
Alaska	0
Arizona	17
Arkansas	1
California	8
Colorado	33
Connecticut	0
Delaware	0
District of Columbia	0
Florida	5
Georgia	1
Hawaii	4
Idaho	0
Illinois	1
Indiana	0
Iowa	40
Kansas	25
Kentucky	0
Louisiana	2
Maine	3
Maryland	0
Massachusetts	0
Michigan	5
Minnesota	11
Mississippi	1
Missouri	11
Montana	0
Nebraska	21010
Nevada	5
New Hampshire	0
New Jersey	0
New Mexico	0
New York	0
North Carolina	0
North Dakota	0
Ohio	3
Oklahoma	4
Oregon	3
Pennsylvania	2
Rhode Island	0
South Carolina	4
South Dakota	36
Tennessee	1
Texas	33
Utah	3
Vermont	0
Virginia	0
Washington	11
West Virginia	2
Wisconsin	5
Wyoming	5
American Samoa	0

Federated States of Micronesia	0
Guam	0
Commonwealth of Northern Marianas	0
Puerto Rico	0
Virgin Islands	0
Other	0
TOTAL	21,295

Race/Ethnicity Diversity of Membership (RDM)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Race/Ethnicity Diversity of Membership	
Total Unduplicated Membership During the Measurement Year	32025

Percentage of Members for Whom the Organization has Race/Ethnicity Information by Data Co

Direct Data Collection Method			Indirect Data Collection Method		Unkn
Race	Direct Total	100.00%	Indirect Total*	0.0000	Total*
	Health Plan Direct*	0.0000			
	CMS/State Database*	1.0000			
	Other*	0.0000			
Ethnicity	Direct Total	100.00%	Indirect Total*	0.0000	Total*
	Health Plan Direct*	0.0000			
	CMS/State Database*	0.0000			
	Other*	1.0000			

*Enter percentage as a value between 0 and 1.

Race	Hispanic or Latino		Not Hispanic or Latino		Unknown
	Number	Percentage	Number	Percentage	Number
White	0	0.00%	18070	84.21%	0
Black or African American	0	0.00%	928	4.32%	0
American-Indian and Alaska Native	0	0.00%	2250	10.49%	0
Asian	0	0.00%	177	0.82%	0
Native Hawaiian and Other Pacific Islanders	0	0.00%	32	0.15%	0
Some Other Race	7914	100.00%	0	0.00%	473
Two or More Races	0	0.00%	0	0.00%	0
Unknown	0	0.00%	0	0.00%	2181
Declined	0	0.00%	0	0.00%	0
Total	7,914	100.00%	21,457	100.00%	2,654

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0.0000
0.0000

Ethnicity	Declined Ethnicity		Total	
Percentage	Number	Percentage	Number	Percentage
0.00%	0	NR	18,070	56.42%
0.00%	0	NR	928	2.90%
0.00%	0	NR	2,250	7.03%
0.00%	0	NR	177	0.55%
0.00%	0	NR	32	0.10%
17.82%	0	NR	8,387	26.19%
0.00%	0	NR	0	0.00%
82.18%	0	NR	2,181	6.81%
0.00%	0	NR	0	0.00%
100.00%	0	NR	32,025	100.00%

Language Diversity of Membership (LDM)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Percentage of Members With Known Language Value from Each Data Source

Category	Health Plan Direct	CMS/State Databases	Other Third-Party Source
Spoken Language Preferred for Health Care*	0.0000	0.9958	0.0042
Preferred Language for Written Materials*	0.0000	0.9958	0.0042
Other Language Needs*	0.0000	0.9958	0.0042

*Enter percentage as a value between 0 and 1.

Spoken Language Preferred for Health Care

	Number	Percentage
English	10898	34.03%
Non-English	1591	4.97%
Unknown	19536	61.00%
Declined	0	0.00%
Total*	32,025	100.00%

Language Preferred for Written Materials

	Number	Percentage
English	10898	34.03%
Non-English	1591	4.97%
Unknown	19536	61.00%
Declined	0	0.00%
Total*	32,025	100.00%

Other Language Needs

	Number	Percentage
English	0	0.00%
Non-English	0	0.00%
Unknown	32025	100.00%
Declined	0	0.00%
Total*	32,025	100.00%

*Should sum to 100%

Weeks of Pregnancy at Time of Enrollment (WOP)

Arbor Health Plan (Org ID: 19575, SubID: 11078, Medicaid, Spec Area: None, Spec Proj: None)

Measurement Year		
Measurement Year	2013	
Weeks of Pregnancy	**Number**	**Percentage**
< 0 weeks	78	6.96%
1-12 weeks	80	7.14%
13-27 weeks	572	51.03%
28 or more weeks	336	29.97%
Unknown	55	4.91%
Total	1,121	100.00%

Audit Review Table

Keystone First (Org ID: 328, SubID: 4275, Medicaid, Spec Area: None, Spec Proj: PA Medicaid); Me

The Auditor lock has been applied to this

Measure/Data Element	Report Measure	Benefit Offered	Rotated Measure
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	Y		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y		
BMI Percentile			
Counseling for Nutrition			
Counseling for Physical Activity			
Childhood Immunization Status (cis)	Y		
DTaP			
IPV			
MMR			
HiB			
Hepatitis B			
VZV			
Pneumococcal Conjugate			
Hepatitis A			
Rotavirus			
Influenza			
Combination #2			
Combination #3			
Combination #4			
Combination #5			
Combination #6			
Combination #7			
Combination #8			
Combination #9			
Combination #10			
Immunizations for Adolescents (ima)	Y		
Meningococcal			
Tdap/Td			
Combination #1			
Human Papillomavirus Vaccine for Female Adolescents (hpv)	Y		
Lead Screening in Children (lsc)	Y		
Breast Cancer Screening (bcs)	Y		
Cervical Cancer Screening (ccs)	Y		
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	Y		
Chlamydia Screening in Women (chl)	Y		
16-20 Years			
21-24 Years			
Total			
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y	
Appropriate Treatment for Children With URI (uri)	Y	Y	

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y		
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y	
Systemic Corticosteroid			
Bronchodilator			
Use of Appropriate Medications for People With Asthma (asm)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Medication Management for People With Asthma (mma)	Y	Y	
5-11 Years - Medication Compliance 50%			
5-11 Years - Medication Compliance 75%			
12-18 Years - Medication Compliance 50%			
12-18 Years - Medication Compliance 75%			
19-50 Years - Medication Compliance 50%			
19-50 Years - Medication Compliance 75%			
51-64 Years - Medication Compliance 50%			
51-64 Years - Medication Compliance 75%			
Total - Medication Compliance 50%			
Total - Medication Compliance 75%			
Asthma Medication Ratio (amr)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Effectiveness of Care: Cardiovascular			
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y		
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Controlling High Blood Pressure (cbp)	Y		N
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y	
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)	Y		
Hemoglobin A1c (HbA1c) Testing			
HbA1c Poor Control (>9.0%)			
HbA1c Control (<8.0%)			
HbA1c Control (<7.0%)			
Eye Exam (Retinal) Performed			
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Medical Attention for Nephropathy			

Blood Pressure Control (<140/80 mm Hg)			
Blood Pressure Control (<140/90 mm Hg)			
Effectiveness of Care: Musculoskeletal			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y	
Use of Imaging Studies for Low Back Pain (lbp)	Y		
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)	Y	Y	
Effective Acute Phase Treatment			
Effective Continuation Phase Treatment			
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y	
Initiation Phase			
Continuation and Maintenance (C&M) Phase			
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	N	
30-Day Follow-Up			
7-Day Follow-Up			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	Y	Y	
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	Y		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	Y		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	Y	Y	
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y	
ACE Inhibitors or ARBs			
Digoxin			
Diuretics			
Anticonvulsants			
Total			
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y		
20-44 Years			
45-64 Years			
65+ Years			
Total			
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y		
12-24 Months			
25 Months - 6 Years			
7-11 Years			

12-19 Years			
Annual Dental Visit (adv)	Y	Y	
2-3 Years			
4-6 Years			
7-10 Years			
11-14 Years			
15-18 Years			
19-21 Years			
Total			
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	N	
Initiation of AOD Treatment: 13-17 Years			
Engagement of AOD Treatment: 13-17 Years			
Initiation of AOD Treatment: 18+ Years			
Engagement of AOD Treatment: 18+ Years			
Initiation of AOD Treatment: Total			
Engagement of AOD Treatment: Total			
Prenatal and Postpartum Care (ppc)	Y		N
Timeliness of Prenatal Care			
Postpartum Care			
Call Answer Timeliness (cat)	Y		
Utilization			
Frequency of Ongoing Prenatal Care (fpc)	Y		N
<21 Percent			
21-40 Percent			
41-60 Percent			
61-80 Percent			
81+ Percent			
Well-Child Visits in the First 15 Months of Life (w15)	Y		
0 Visits			
1 Visit			
2 Visits			
3 Visits			
4 Visits			
5 Visits			
6+ Visits			
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y		
Adolescent Well-Care Visits (awc)	Y		
Frequency of Selected Procedures (fsp)	Y		
Ambulatory Care: Total (amba)	Y		
Ambulatory Care: Dual Eligibles (ambb)	Y		
Ambulatory Care: Disabled (ambc)	Y		
Ambulatory Care: Other (ambd)	Y		
Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y		
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	Y		
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	Y		
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	Y		

Identification of Alcohol and Other Drug Services: Total (iada)	Y	N	
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	Y	N	
Identification of Alcohol and Other Drug Services: Disabled (iadc)	Y	N	
Identification of Alcohol and Other Drug Services: Other (iadd)	Y	N	
Mental Health Utilization: Total (mpta)	Y	N	
Mental Health Utilization: Dual Eligibles (mptb)	Y	N	
Mental Health Utilization: Disabled (mptc)	Y	N	
Mental Health Utilization: Other (mptd)	Y	N	
Antibiotic Utilization: Total (abxa)	Y	Y	
Antibiotic Utilization: Dual Eligibles (abxb)	Y	Y	
Antibiotic Utilization: Disabled (abxc)	Y	Y	
Antibiotic Utilization: Other (abxd)	Y	Y	
Relative Resource Use			
Relative Resource Use for People With Diabetes (rdi)	Y		
Relative Resource Use for People With Asthma (ras)	Y	Y	
Relative Resource Use for People With Cardiovascular Conditions (rca)	Y		
Relative Resource Use for People With Hypertension (rhy)	Y		
Relative Resource Use for People With COPD (rco)	Y		
Health Plan Descriptive Information			
Board Certification (bcr)	Y		
Total Membership (tlm)	Y		
Enrollment by Product Line: Total (enpa)	Y		
Enrollment by Product Line: Dual Eligibles (enpb)	Y		
Enrollment by Product Line: Disabled (enpc)	Y		
Enrollment by Product Line: Other (enpd)	Y		
Enrollment by State (ebs)	Y		
Race/Ethnicity Diversity of Membership (rdm)	Y		
Language Diversity of Membership (ldm)	Y		
Weeks of Pregnancy at Time of Enrollment (wop)	Y		N

asurement Year - 2013

submission.

Rate	Reportable	Comment
78.44%	R	Reportable
69.78%	R	Reportable
69.56%	R	Reportable
63.56%	R	Reportable
84.99%	R	Reportable
95.58%	R	Reportable
93.82%	R	Reportable
96.91%	R	Reportable
94.92%	R	Reportable
93.60%	R	Reportable
84.11%	R	Reportable
86.98%	R	Reportable
75.72%	R	Reportable
67.33%	R	Reportable
81.90%	R	Reportable
78.81%	R	Reportable
75.50%	R	Reportable
66.89%	R	Reportable
59.60%	R	Reportable
64.24%	R	Reportable
57.17%	R	Reportable
51.43%	R	Reportable
49.45%	R	Reportable
88.50%	R	Reportable
91.15%	R	Reportable
86.73%	R	Reportable
24.28%	R	Reportable
74.61%	R	Reportable
66.19%	R	Reportable
70.95%	R	Reportable
1.84%	R	Reportable
61.08%	R	Reportable
66.32%	R	Reportable
63.27%	R	Reportable
64.60%	R	Reportable
89.20%	R	Reportable

27.03%	R	Reportable
25.82%	R	Reportable
78.30%	R	Reportable
91.39%	R	Reportable
92.60%	R	Reportable
89.35%	R	Reportable
78.97%	R	Reportable
75.66%	R	Reportable
86.91%	R	Reportable
55.43%	R	Reportable
32.32%	R	Reportable
57.10%	R	Reportable
35.50%	R	Reportable
62.57%	R	Reportable
42.73%	R	Reportable
78.89%	R	Reportable
59.68%	R	Reportable
59.29%	R	Reportable
37.59%	R	Reportable
71.26%	R	Reportable
65.91%	R	Reportable
50.34%	R	Reportable
52.51%	R	Reportable
63.12%	R	Reportable
79.20%	R	Reportable
43.14%	R	Reportable
60.44%	R	Reportable
94.74%	R	Reportable
82.51%	R	Reportable
36.72%	R	Reportable
55.17%	R	Reportable
39.23%	R	Reportable
51.67%	R	Reportable
79.81%	R	Reportable
37.68%	R	Reportable
80.92%	R	Reportable

40.22%	R	Reportable
66.93%	R	Reportable
73.94%	R	Reportable
78.53%	R	Reportable
54.75%	R	Reportable
41.25%	R	Reportable
15.68%	R	Reportable
14.58%	R	Reportable
NB	R	Required benefit not offered
NB	R	Required benefit not offered
67.12%	R	Reportable
67.04%	R	Reportable
74.49%	R	Reportable
75.35%	R	Reportable
83.18%	R	Reportable
88.64%	R	Reportable
82.01%	R	Reportable
57.38%	R	Reportable
79.75%	R	Reportable
82.38%	R	Reportable
91.03%	R	Reportable
88.17%	R	Reportable
85.57%	R	Reportable
97.35%	R	Reportable
88.67%	R	Reportable
92.29%	R	Reportable

90.60%	R	Reportable
53.30%	R	Reportable
73.25%	R	Reportable
70.50%	R	Reportable
64.51%	R	Reportable
54.52%	R	Reportable
41.26%	R	Reportable
62.73%	R	Reportable
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
84.00%	R	Reportable
58.67%	R	Reportable
90.18%	R	Reportable
5.11%	R	Reportable
5.56%	R	Reportable
10.44%	R	Reportable
15.78%	R	Reportable
63.11%	R	Reportable
0.23%	R	Reportable
1.13%	R	Reportable
2.26%	R	Reportable
4.52%	R	Reportable
7.47%	R	Reportable
16.29%	R	Reportable
68.10%	R	Reportable
80.80%	R	Reportable
62.42%	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable

	R	Required benefit not offered
	R	Required benefit not offered
	R	Required benefit not offered
	R	Required benefit not offered
	R	Required benefit not offered
	R	Required benefit not offered
	R	Required benefit not offered
	R	Required benefit not offered
	R	Reportable
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	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable

Audit Review Table

MDwise, Inc. (Org ID: 2101, SubID: 10884, Medicaid, Spec Area: None, Spec Proj: None); Measuremer

The Auditor lock has been applied to this s

Measure/Data Element	Report Measure	Benefit Offered	Rotated Measure
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	Y		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y		
BMI Percentile			
Counseling for Nutrition			
Counseling for Physical Activity			
Childhood Immunization Status (cis)	Y		
DTaP			
IPV			
MMR			
HiB			
Hepatitis B			
VZV			
Pneumococcal Conjugate			
Hepatitis A			
Rotavirus			
Influenza			
Combination #2			
Combination #3			
Combination #4			
Combination #5			
Combination #6			
Combination #7			
Combination #8			
Combination #9			
Combination #10			
Immunizations for Adolescents (ima)	Y		
Meningococcal			
Tdap/Td			
Combination #1			
Human Papillomavirus Vaccine for Female Adolescents (hpv)	Y		
Lead Screening in Children (lsc)	Y		
Breast Cancer Screening (bcs)	Y		
Cervical Cancer Screening (ccs)	Y		
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	Y		
Chlamydia Screening in Women (chl)	Y		
16-20 Years			
21-24 Years			
Total			
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y	
Appropriate Treatment for Children With URI (uri)	Y	Y	

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y		
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y	
Systemic Corticosteroid			
Bronchodilator			
Use of Appropriate Medications for People With Asthma (asm)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Medication Management for People With Asthma (mma)	Y	Y	
5-11 Years - Medication Compliance 50%			
5-11 Years - Medication Compliance 75%			
12-18 Years - Medication Compliance 50%			
12-18 Years - Medication Compliance 75%			
19-50 Years - Medication Compliance 50%			
19-50 Years - Medication Compliance 75%			
51-64 Years - Medication Compliance 50%			
51-64 Years - Medication Compliance 75%			
Total - Medication Compliance 50%			
Total - Medication Compliance 75%			
Asthma Medication Ratio (amr)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Effectiveness of Care: Cardiovascular			
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y		
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Controlling High Blood Pressure (cbp)	Y		Y
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y	
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)	Y		
Hemoglobin A1c (HbA1c) Testing			
HbA1c Poor Control (>9.0%)			
HbA1c Control (<8.0%)			
HbA1c Control (<7.0%)			
Eye Exam (Retinal) Performed			
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Medical Attention for Nephropathy			

Blood Pressure Control (<140/80 mm Hg)			
Blood Pressure Control (<140/90 mm Hg)			
Effectiveness of Care: Musculoskeletal			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y	
Use of Imaging Studies for Low Back Pain (lbp)	Y		
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)	Y	Y	
Effective Acute Phase Treatment			
Effective Continuation Phase Treatment			
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y	
Initiation Phase			
Continuation and Maintenance (C&M) Phase			
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	Y	
30-Day Follow-Up			
7-Day Follow-Up			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	Y	Y	
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	Y		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	Y		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	Y	Y	
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y	
ACE Inhibitors or ARBs			
Digoxin			
Diuretics			
Anticonvulsants			
Total			
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y		
20-44 Years			
45-64 Years			
65+ Years			
Total			
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y		
12-24 Months			
25 Months - 6 Years			
7-11 Years			

12-19 Years			
Annual Dental Visit (adv)	N	N	
2-3 Years			
4-6 Years			
7-10 Years			
11-14 Years			
15-18 Years			
19-21 Years			
Total			
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	Y	
Initiation of AOD Treatment: 13-17 Years			
Engagement of AOD Treatment: 13-17 Years			
Initiation of AOD Treatment: 18+ Years			
Engagement of AOD Treatment: 18+ Years			
Initiation of AOD Treatment: Total			
Engagement of AOD Treatment: Total			
Prenatal and Postpartum Care (ppc)	Y		N
Timeliness of Prenatal Care			
Postpartum Care			
Call Answer Timeliness (cat)	Y		
Utilization			
Frequency of Ongoing Prenatal Care (fpc)	Y		N
<21 Percent			
21-40 Percent			
41-60 Percent			
61-80 Percent			
81+ Percent			
Well-Child Visits in the First 15 Months of Life (w15)	Y		
0 Visits			
1 Visit			
2 Visits			
3 Visits			
4 Visits			
5 Visits			
6+ Visits			
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y		
Adolescent Well-Care Visits (awc)	Y		
Frequency of Selected Procedures (fsp)	Y		
Ambulatory Care: Total (amba)	Y		
Ambulatory Care: Dual Eligibles (ambb)	N		
Ambulatory Care: Disabled (ambc)	N		
Ambulatory Care: Other (ambd)	N		
Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y		
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	N		
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	N		
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	N		

Identification of Alcohol and Other Drug Services: Total (iada)	Y	Y	
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	N	N	
Identification of Alcohol and Other Drug Services: Disabled (iadc)	N	N	
Identification of Alcohol and Other Drug Services: Other (iadd)	N	N	
Mental Health Utilization: Total (mpta)	Y	Y	
Mental Health Utilization: Dual Eligibles (mptb)	N	N	
Mental Health Utilization: Disabled (mptc)	N	N	
Mental Health Utilization: Other (mptd)	N	N	
Antibiotic Utilization: Total (abxa)	Y	Y	
Antibiotic Utilization: Dual Eligibles (abxb)	N	N	
Antibiotic Utilization: Disabled (abxc)	N	N	
Antibiotic Utilization: Other (abxd)	N	N	
Relative Resource Use			
Relative Resource Use for People With Diabetes (rdi)	N		
Relative Resource Use for People With Asthma (ras)	N	N	
Relative Resource Use for People With Cardiovascular Conditions (rca)	N		
Relative Resource Use for People With Hypertension (rhy)	N		
Relative Resource Use for People With COPD (rco)	N		
Health Plan Descriptive Information			
Board Certification (bcr)	N		
Total Membership (tlm)	N		
Enrollment by Product Line: Total (enpa)	N		
Enrollment by Product Line: Dual Eligibles (enpb)	N		
Enrollment by Product Line: Disabled (enpc)	N		
Enrollment by Product Line: Other (enpd)	N		
Enrollment by State (ebs)	N		
Race/Ethnicity Diversity of Membership (rdm)	Y		
Language Diversity of Membership (ldm)	Y		
Weeks of Pregnancy at Time of Enrollment (wop)	Y		N

nt Year - 2013

ubmission.

Rate	Reportable	Comment
76.64%	R	Reportable
63.50%	R	Reportable
63.02%	R	Reportable
48.66%	R	Reportable
74.21%	R	Reportable
88.81%	R	Reportable
88.56%	R	Reportable
89.54%	R	Reportable
90.51%	R	Reportable
88.08%	R	Reportable
74.94%	R	Reportable
76.89%	R	Reportable
62.77%	R	Reportable
47.93%	R	Reportable
72.02%	R	Reportable
68.13%	R	Reportable
62.04%	R	Reportable
52.55%	R	Reportable
41.12%	R	Reportable
50.36%	R	Reportable
40.15%	R	Reportable
33.82%	R	Reportable
33.09%	R	Reportable
89.67%	R	Reportable
96.74%	R	Reportable
89.67%	R	Reportable
11.48%	R	Reportable
53.28%	R	Reportable
66.20%	R	Reportable
61.85%	R	Reportable
6.76%	R	Reportable
47.36%	R	Reportable
59.05%	R	Reportable
51.33%	R	Reportable
55.35%	R	Reportable
81.07%	R	Reportable

23.46%	R	Reportable
35.80%	R	Reportable
64.55%	R	Reportable
80.00%	R	Reportable
90.22%	R	Reportable
84.28%	R	Reportable
71.43%	R	Reportable
69.23%	R	Reportable
85.76%	R	Reportable
52.38%	R	Reportable
29.15%	R	Reportable
49.68%	R	Reportable
24.07%	R	Reportable
56.25%	R	Reportable
35.63%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
51.88%	R	Reportable
28.08%	R	Reportable
76.11%	R	Reportable
61.72%	R	Reportable
49.32%	R	Reportable
44.74%	R	Reportable
67.60%	R	Reportable
80.68%	R	Reportable
43.18%	R	Reportable
59.68%	R	Reportable
NA	R	Denominator fewer than 30
83.21%	R	Reportable
45.26%	R	Reportable
46.90%	R	Reportable
36.47%	R	Reportable
50.55%	R	Reportable
71.90%	R	Reportable
31.39%	R	Reportable
70.07%	R	Reportable

39.42%	R	Reportable
68.43%	R	Reportable
77.17%	R	Reportable
77.32%	R	Reportable
54.48%	R	Reportable
34.69%	R	Reportable
50.80%	R	Reportable
62.97%	R	Reportable
75.31%	R	Reportable
51.27%	R	Reportable
70.43%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
40.51%	R	Reportable
98.67%	R	Reportable
NA	R	Denominator fewer than 30
97.94%	R	Reportable
99.12%	R	Reportable
98.36%	R	Reportable
84.62%	R	Reportable
91.15%	R	Reportable
NA	R	Denominator fewer than 30
85.75%	R	Reportable
96.67%	R	Reportable
88.42%	R	Reportable
91.26%	R	Reportable

90.84%	R	Reportable
NR	NR	Measure Unselected
NR	NR	Measure Unselected
NR	NR	Measure Unselected
NR	NR	Measure Unselected
NR	NR	Measure Unselected
NR	NR	Measure Unselected
NR	NR	Measure Unselected
42.01%	R	Reportable
18.20%	R	Reportable
38.72%	R	Reportable
11.38%	R	Reportable
39.42%	R	Reportable
12.83%	R	Reportable
89.05%	R	Reportable
71.53%	R	Reportable
89.69%	R	Reportable
3.65%	R	Reportable
0.97%	R	Reportable
2.68%	R	Reportable
8.76%	R	Reportable
83.94%	R	Reportable
1.95%	R	Reportable
1.46%	R	Reportable
1.70%	R	Reportable
5.60%	R	Reportable
8.52%	R	Reportable
9.73%	R	Reportable
71.05%	R	Reportable
76.89%	R	Reportable
58.88%	R	Reportable
	R	Reportable
	R	Reportable
	NR	Measure Unselected
	NR	Measure Unselected
	NR	Measure Unselected
	R	Reportable
	NR	Measure Unselected
	NR	Measure Unselected
	NR	Measure Unselected

	R	Reportable
	NR	Measure Unselected
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	NR	Measure Unselected
	NR	Measure Unselected
	NR	Measure Unselected
	R	Reportable
	R	Reportable
	R	Reportable

Audit Review Table

Select Health of South Carolina, Inc. (Org ID: 832, SubID: 9480, Medicaid, Spec Area: None, Spec P

The Auditor lock has been applied to this

Measure/Data Element	Report Measure	Benefit Offered	Rotated Measure
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	Y		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y		
BMI Percentile			
Counseling for Nutrition			
Counseling for Physical Activity			
Childhood Immunization Status (cis)	Y		
DTaP			
IPV			
MMR			
HiB			
Hepatitis B			
VZV			
Pneumococcal Conjugate			
Hepatitis A			
Rotavirus			
Influenza			
Combination #2			
Combination #3			
Combination #4			
Combination #5			
Combination #6			
Combination #7			
Combination #8			
Combination #9			
Combination #10			
Immunizations for Adolescents (ima)	Y		
Meningococcal			
Tdap/Td			
Combination #1			
Human Papillomavirus Vaccine for Female Adolescents (hpv)	Y		
Lead Screening in Children (lsc)	Y		
Breast Cancer Screening (bcs)	Y		
Cervical Cancer Screening (ccs)	Y		
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	Y		
Chlamydia Screening in Women (chl)	Y		
16-20 Years			
21-24 Years			
Total			
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y	
Appropriate Treatment for Children With URI (uri)	Y	Y	

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y		
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y	
Systemic Corticosteroid			
Bronchodilator			
Use of Appropriate Medications for People With Asthma (asm)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Medication Management for People With Asthma (mma)	Y	Y	
5-11 Years - Medication Compliance 50%			
5-11 Years - Medication Compliance 75%			
12-18 Years - Medication Compliance 50%			
12-18 Years - Medication Compliance 75%			
19-50 Years - Medication Compliance 50%			
19-50 Years - Medication Compliance 75%			
51-64 Years - Medication Compliance 50%			
51-64 Years - Medication Compliance 75%			
Total - Medication Compliance 50%			
Total - Medication Compliance 75%			
Asthma Medication Ratio (amr)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Effectiveness of Care: Cardiovascular			
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y		
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Controlling High Blood Pressure (cbp)	Y		N
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y	
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)	Y		
Hemoglobin A1c (HbA1c) Testing			
HbA1c Poor Control (>9.0%)			
HbA1c Control (<8.0%)			
HbA1c Control (<7.0%)			
Eye Exam (Retinal) Performed			
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Medical Attention for Nephropathy			

Blood Pressure Control (<140/80 mm Hg)			
Blood Pressure Control (<140/90 mm Hg)			
Effectiveness of Care: Musculoskeletal			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y	
Use of Imaging Studies for Low Back Pain (lbp)	Y		
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)	Y	Y	
Effective Acute Phase Treatment			
Effective Continuation Phase Treatment			
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y	
Initiation Phase			
Continuation and Maintenance (C&M) Phase			
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	Y	
30-Day Follow-Up			
7-Day Follow-Up			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	Y	Y	
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	Y		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	Y		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	Y	Y	
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y	
ACE Inhibitors or ARBs			
Digoxin			
Diuretics			
Anticonvulsants			
Total			
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y		
20-44 Years			
45-64 Years			
65+ Years			
Total			
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y		
12-24 Months			
25 Months - 6 Years			
7-11 Years			

12-19 Years			
Annual Dental Visit (adv)	Y	N	
2-3 Years			
4-6 Years			
7-10 Years			
11-14 Years			
15-18 Years			
19-21 Years			
Total			
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	N	
Initiation of AOD Treatment: 13-17 Years			
Engagement of AOD Treatment: 13-17 Years			
Initiation of AOD Treatment: 18+ Years			
Engagement of AOD Treatment: 18+ Years			
Initiation of AOD Treatment: Total			
Engagement of AOD Treatment: Total			
Prenatal and Postpartum Care (ppc)	Y		N
Timeliness of Prenatal Care			
Postpartum Care			
Call Answer Timeliness (cat)	Y		
Utilization			
Frequency of Ongoing Prenatal Care (fpc)	Y		N
<21 Percent			
21-40 Percent			
41-60 Percent			
61-80 Percent			
81+ Percent			
Well-Child Visits in the First 15 Months of Life (w15)	Y		
0 Visits			
1 Visit			
2 Visits			
3 Visits			
4 Visits			
5 Visits			
6+ Visits			
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y		
Adolescent Well-Care Visits (awc)	Y		
Frequency of Selected Procedures (fsp)	Y		
Ambulatory Care: Total (amba)	Y		
Ambulatory Care: Dual Eligibles (ambb)	Y		
Ambulatory Care: Disabled (ambc)	Y		
Ambulatory Care: Other (ambd)	Y		
Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y		
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	Y		
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	Y		
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	Y		

Identification of Alcohol and Other Drug Services: Total (iada)	Y	N	
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	Y	N	
Identification of Alcohol and Other Drug Services: Disabled (iadc)	Y	N	
Identification of Alcohol and Other Drug Services: Other (iadd)	Y	N	
Mental Health Utilization: Total (mpta)	Y	Y	
Mental Health Utilization: Dual Eligibles (mptb)	Y	Y	
Mental Health Utilization: Disabled (mptc)	Y	Y	
Mental Health Utilization: Other (mptd)	Y	Y	
Antibiotic Utilization: Total (abxa)	Y	Y	
Antibiotic Utilization: Dual Eligibles (abxb)	Y	Y	
Antibiotic Utilization: Disabled (abxc)	Y	Y	
Antibiotic Utilization: Other (abxd)	Y	Y	
Relative Resource Use			
Relative Resource Use for People With Diabetes (rdi)	Y		
Relative Resource Use for People With Asthma (ras)	Y	Y	
Relative Resource Use for People With Cardiovascular Conditions (rca)	Y		
Relative Resource Use for People With Hypertension (rhy)	Y		
Relative Resource Use for People With COPD (rco)	Y		
Health Plan Descriptive Information			
Board Certification (bcr)	N		
Total Membership (tlm)	Y		
Enrollment by Product Line: Total (enpa)	Y		
Enrollment by Product Line: Dual Eligibles (enpb)	Y		
Enrollment by Product Line: Disabled (enpc)	Y		
Enrollment by Product Line: Other (enpd)	Y		
Enrollment by State (ebs)	Y		
Race/Ethnicity Diversity of Membership (rdm)	Y		
Language Diversity of Membership (ldm)	Y		
Weeks of Pregnancy at Time of Enrollment (wop)	Y		N

roj: None); Measurement Year - 2013

submission.

Rate	Reportable	Comment
65.84%	R	Reportable
25.06%	R	Reportable
39.90%	R	Reportable
34.06%	R	Reportable
81.75%	R	Reportable
89.29%	R	Reportable
91.00%	R	Reportable
87.83%	R	Reportable
83.21%	R	Reportable
92.94%	R	Reportable
82.48%	R	Reportable
84.67%	R	Reportable
68.61%	R	Reportable
42.09%	R	Reportable
74.45%	R	Reportable
70.56%	R	Reportable
64.72%	R	Reportable
55.72%	R	Reportable
34.55%	R	Reportable
51.09%	R	Reportable
33.33%	R	Reportable
27.25%	R	Reportable
26.28%	R	Reportable
62.04%	R	Reportable
68.13%	R	Reportable
60.83%	R	Reportable
13.18%	R	Reportable
61.31%	R	Reportable
63.81%	R	Reportable
65.31%	R	Reportable
6.15%	R	Reportable
51.72%	R	Reportable
62.12%	R	Reportable
54.48%	R	Reportable
73.87%	R	Reportable
79.72%	R	Reportable

18.39%	R	Reportable
32.16%	R	Reportable
57.14%	R	Reportable
81.51%	R	Reportable
93.98%	R	Reportable
89.53%	R	Reportable
76.70%	R	Reportable
63.44%	R	Reportable
90.53%	R	Reportable
59.25%	R	Reportable
32.91%	R	Reportable
52.81%	R	Reportable
26.47%	R	Reportable
54.04%	R	Reportable
35.74%	R	Reportable
74.58%	R	Reportable
57.63%	R	Reportable
56.81%	R	Reportable
31.06%	R	Reportable
79.45%	R	Reportable
67.58%	R	Reportable
55.26%	R	Reportable
44.09%	R	Reportable
72.67%	R	Reportable
80.54%	R	Reportable
31.39%	R	Reportable
42.05%	R	Reportable
79.66%	R	Reportable
82.85%	R	Reportable
56.39%	R	Reportable
35.77%	R	Reportable
25.79%	R	Reportable
50.73%	R	Reportable
70.62%	R	Reportable
27.74%	R	Reportable
79.56%	R	Reportable

27.55%	R	Reportable
46.17%	R	Reportable
68.67%	R	Reportable
74.77%	R	Reportable
45.65%	R	Reportable
30.53%	R	Reportable
41.59%	R	Reportable
54.39%	R	Reportable
66.32%	R	Reportable
46.23%	R	Reportable
84.21%	R	Reportable
73.45%	R	Reportable
NA	R	Denominator fewer than 30
73.15%	R	Reportable
89.89%	R	Reportable
93.02%	R	Reportable
89.20%	R	Reportable
66.47%	R	Reportable
87.57%	R	Reportable
86.25%	R	Reportable
91.05%	R	Reportable
NA	R	Denominator fewer than 30
87.70%	R	Reportable
98.65%	R	Reportable
91.23%	R	Reportable
92.96%	R	Reportable

91.24%	R	Reportable
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
91.04%	R	Reportable
74.63%	R	Reportable
82.31%	R	Reportable
7.82%	R	Reportable
3.35%	R	Reportable
6.47%	R	Reportable
14.93%	R	Reportable
67.44%	R	Reportable
0.00%	R	Reportable
2.26%	R	Reportable
1.26%	R	Reportable
4.77%	R	Reportable
9.55%	R	Reportable
18.34%	R	Reportable
63.82%	R	Reportable
64.05%	R	Reportable
48.66%	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable

	R	Required benefit not offered
	R	Required benefit not offered
	R	Required benefit not offered
	R	Required benefit not offered
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	NR	Measure Unselected
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable

MDwise HEDIS 2013 Admininstrative Rates - Delivery System Comparison

HEDIS Access and Effectiveness	Wishard	IU Meth	St V	St C	FSM	SH	MDHA	TH
Appropriate Medications for People w/ Asthma (ASM)								
ASM - age 5 to 11*	90.08	93.19	95.68	80.36	93.75	92.41	89.23	98.00
ASM - age 12 to 50*	89.10	84.64	92.04	75.56	86.67	81.71	81.49	86.07
ASM - Combined * (ages 5-50)	89.71	89.48	94.40	78.22	90.32	86.96	85.54	92.65
Medications Management for People w/ Asthma (MMA)								
MMA - age 5 to 11 - Medication Compliance 50%	41.87	50.43	63.64	56.35	39.08	66.67	60.52	72.79
MMA - age 12 to 18 - Medication Compliance 50%	37.93	44.93	59.68	58.43	55.22	67.35	58.83	70.00
MMA - age 19-50 - Medication Compliance 50%	63.64	54.29	50.00	63.44	33.33	35.29	60.66	63.16
MMA Total (ages 5-64) - Medication Compliance 50%	41.70	48.73	61.64	57.52	45.63	62.96	59.89	71.06
MMA - age 5 to 11 - Medication Compliance 75%	18.98	24.78	35.06	33.33	20.69	39.13	38.87	41.91
MMA - age 12 to 18 - Medication Compliance 75%	17.24	22.22	33.87	26.97	26.87	34.69	35.04	31.25
MMA - age 19-50 - Medication Compliance 75%	36.36	28.57	37.50	27.27	0.00	17.65	34.43	42.11
MMA Total (ages 5-64) - Medication Compliance 75%	19.25	24.11	34.91	30.53	22.50	34.81	37.13	38.30

Data Sources: All P4P measures except Postpartum from NIP; All other from Verisk Software

MDwise HEDIS 2013 Admininstrative Rates - Delivery System Comparison

Asthma Medication Ratio (AMR)								
AMR - ages 5-11	51.21	62.73	77.50	62.28	65.63	81.01	71.42	90.00
AMR - ages 12-18	41.97	59.09	82.09	56.90	71.95	66.67	67.06	72.73
AMR - ages 19-50	50.00	45.10	42.11	47.37	42.86	28.00	49.20	69.57
AMR - ages 51-64	50.00	0.00	0.00	0.00	0.00	0.00	42.86	0.00
AMR Total (ages 5-64)	48.14	60.09	76.02	59.27	67.57	67.70	67.71	81.99
Comprehensive Diabetes Care(CDC)								
CDC - HbA1c Testing Admin	68.18	82.86	81.13	66.67	74.42	71.67	73.98	85.71
CDC - LDL-C Screening Admin	44.62	52.10	50.79	52.14	58.54	50.88	58.45	64.10

Data Sources: All P4P measures except Postpartum from NIP; All other from Verisk Software

V.1. Program Integrity

V.1 Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Include other best practices, you have utilized in other contracts that could be utilized in this contract.

Overview

AmeriHealth Caritas Louisiana (ACLA) is committed to implementing and maintaining the highest standards of ethical conduct in its business and operational practices, and commits to complying with all applicable Federal and State requirements. Through AmeriHealth Caritas Family of Companies (ACFC), we have adopted a company-wide compliance program structured to encourage and elicit collaborative participation at all levels across the organization and to stimulate a culture of compliance. The compliance program fosters an environment which requires associates to comply with all relevant laws and regulations and appropriately report any concerns about business and operational practices.

In addition to focusing on compliance from employees, ACLA's comprehensive integrity program is designed to prevent, detect, and investigate fraud, waste, and abuse (FWA) by providers and members. The program is developed in accordance with 42 CFR 438.608, 42 CFR 438.610 and Section 15 of the RFP, and all relevant state and federal laws, regulations, policies, procedures and guidance (including CMS Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks).

Compliance Plan

Our compliance plan includes the following elements, which are described in detail in the following pages:

1. Written policies, procedures, and standards of conduct that articulate ACLA's commitment to comply with all applicable federal and state standards;
2. Effective lines of communication between the Program Integrity Officer and ACLA's employees, providers, and contractors, enforced through well publicized disciplinary guidelines;
3. Provisions for the confidential reporting of plan violations;
4. Fraud, waste, and abuse training for all employees within thirty (30) days of hire and annually thereafter;
5. Protections to ensure that no individual who reports program integrity related violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with ACLA;
6. Procedures for ongoing monitoring and auditing of ACLA's systems;
7. Provisions for internal monitoring and auditing of reported fraud, waste, and abuse; and
8. Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the contract.

Written Policies and Procedures

ACFC has written policies and procedures to ensure that all officers, directors, managers and associates know and understand what is required to ensure that we observe and maintain high standards of ethical conduct in its business and operational practices.

Our written policies provide detailed information to associates, contractors, and agents about:

- Its policies and procedures for detecting and preventing FWA;
- Its Employee Handbook, which contains specific discussions of the federal and state False Claims Acts;
- The right of associates to be protected as whistleblowers, and its policies and procedures for detecting and preventing fraud, waste and abuse; and
- Its guidelines regarding HIPAA compliance.

Additionally, FWA-related issues are part of our employee and provider training curriculum, with updated and continuing training as necessary. Our commitment to preventing, detecting, and ameliorating fraud, waste, and abuse is evident in our detailed library of policies and procedures. Central to these policies and procedures is the Code of Ethics and Conduct, which is revised annually and made available to all associates. The Code discusses the rights of associates to be protected as whistleblowers.

We recognize that we are responsible for reporting suspected fraud and abuse by providers to appropriate regulatory and law enforcement authorities, and to provide protections for those who suspect and report wrongdoing.

Enforcement of Standards and Disciplinary Guidelines

ACLA does not contract or have other relationships with any provider or other person restricted by federal or state agencies from providing and receiving reimbursement for Medicaid and Medicare services. Furthermore, ACLA will not employ individuals or contract with individuals who are debarred, suspended, or otherwise excluded from participating in procurement activities.

Well-publicized disciplinary procedures will apply to all associates. ACLA has communicated, and will continue to communicate to associates its zero tolerance of associates violating any law, including failing to report violations. Associates who violate the Code, including failing to report violations, will be subject to disciplinary action, up to and including termination of employment. The company may also have an obligation to contact the appropriate law enforcement authorities, since certain violations may be a violation of federal or state laws.

Employee, Provider, and Vendor Selection

ACLA routinely takes steps to assure compliance with 42 CFR 438.610 and other relevant state and federal laws, regulations, policies, procedures, and guidance. ACLA does not employ individuals or contract with individuals who are debarred, suspended or otherwise excluded from participating in procurement activities.

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

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

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

Website Search for Employees, Providers, and Vendors

ACFC conducts a search of the following websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered is reported to DHH within three (3) business days using the Provider Fraud Form on the Louisiana Medicaid website. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid member cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries.

ACLA searches the following websites:

- Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);
- Excluded Parties List Serve (EPLS) www.EPLS.gov;
- Louisiana Adverse Actions List Search (LAALS);
- System of Award Management (SAM); and
- National Practitioner Data Bank (NPDB).

Excluded/Sanctioned Provider Process

ACLA's contracts with providers require prompt notification to ACLA if the provider is debarred or suspended from participation in Medicaid/Medicare, the Children's Health

Insurance Program (CHIP), and/or any federal health care program. Such contracts also contain provisions that require prompt notification to ACLA of any felony convictions or other changes in status that materially affect the provider's ability to perform under the contract. Upon receipt of such notification, as appropriate, ACLA terminates its contractual relationship with the provider. Compliance is also assured through the credentialing and recredentialing process.

ACFC's Special Investigation Unit (SIU) has significantly enhanced the Excluded and Sanctioned Provider process across the enterprise. The SIU, in conjunction with the Credentialing team, has established a screening process reviewing all participating and non-participating providers. On a monthly basis, ACLA provides all provider files to two vendors that screen for all federal and state exclusions and sanctions. These vendors are:

- Optum - This vendor will screen and update ACLA for all Practitioners excluded and sanctioned; and
- ProviderTrust - This vendor will screen and update ACLA for all Facilities excluded and sanctioned.

All practitioners and facilities identified by these vendors are immediately configured within the ACFC adjudication platform to have their submitted claims denied. Additionally, all excluded practitioners and facilities that submitted claims that were denied are transferred to the SIU for investigation. ACFC will also monitor all communications from DHH and suspend payment to any provider that is on payment hold under the authority of DHH or its authorized agent(s).

Any new non-participating provider (practitioner or facility) submitting a claim goes through a validation process to ensure the provider is not on the excluded/sanctioned provider list. This is accomplished during the initial steps of claims adjudication, where claims processors access Optum and ProviderTrust validation portals to validate the provider. ACFC will also screen new participating and non-participating providers using the websites listed in the section above.

Confidential Reporting of Plan Violations

ACFC maintains a Compliance Hotline, a telephone line to be used solely for the purpose of receiving reports from employees, members, contractors, vendors, and others of suspected improper/illegal activities or misconduct on a confidential basis. While individuals are able to communicate anonymously, those who provide such reports are encouraged to leave their name so that follow-up is possible. If a caller does identify himself/herself, ACFC will make every effort to keep the caller's identity confidential.

ACFC also maintains a toll-free Fraud Hotline for internal and external use. The Fraud Hotline number is promoted to vendors, providers, and enrollees through newsletters, handbooks, websites, and contracts. The Fraud Hotline is intended to be dedicated to fraud tips, concentrating on enrollee and provider fraud; however, both hotlines may be used to report infractions of the Code of Ethics and Conduct or fraud and abuse concerns. This telephone number is widely advertised and communicated by the ACFC so that every ACFC employee,

provider, vendor, or enrollee of the public can easily identify who to contact with fraud-related concerns and inquiries.

In addition to the hotlines, ACFC has a "Fraud Investigation Tip Form" and a compliance intake form on our intranet that permits associates to submit concerns related to compliance, fraud, and abuse. The ACFC Program Integrity Officer will provide quarterly activity reports on the number of calls, Tip Form submissions, and the nature of reported fraud and abuse issues. For 2013, ACLA opened and reported 59 SIU cases, with 21 of these cases coming from ACLA's non-SIU associates via the fraud tip hotline or email.

Employee Protections

ACFC's Code of Ethics and Conduct includes specific discussion of the federal and state False Claims Acts, the rights of associates to be protected as whistleblowers, and ACFC's policies and procedures for detecting and preventing fraud, waste, and abuse. By offering certain whistleblower provisions and protections, the Federal False Claims Act and State Acts encourage individuals to report misconduct involving false claims to the government. The whistleblower provisions allow individuals with actual knowledge of allegedly false claims made to the government to file a lawsuit on behalf of the government and to share in any monies recovered. Whistleblowers that report false claims to the government or cooperate in investigations are also entitled to protection from retaliation.

Training and Education

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

Employees complete new hire training within 30 days of beginning date of employment in the following areas:

- Code of Ethics and Conduct;
- Privacy and Security - Health Insurance Portability and Accountability Act;
- Fraud, waste, and abuse;
- Procedures for timely consistent exchange of information and collaboration with DHH;
- Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and
- Provisions that comply with 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.

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

The training program also includes our SIU's mission and purpose; identification of suspicious fraud, waste and/or abuse scenarios; and the SIU referral process. The provisions of the Targeted FWA and other related training are provided by SIU upon request, or otherwise as necessary. Annually, as a condition of continued employment, every associate (including full-time, part-time, and temporary associates) undergoes training on the Code of Conduct. The Code of Conduct instructs associates to report suspected FWA to the SIU.

ACLA provides additional training to its employees via quarterly associate education sessions and quarterly compliance newsletters. Topics vary from compliance and ethics to fraud, waste, and abuse reporting to DHH contract requirements. For example, ACLA hosted representatives from the Department of Justice, Federal Bureau of Investigation, and DHH's Program Integrity Unit during 2014's Compliance & Ethics week. Each department presented valuable information on the importance of reporting suspected fraud, waste, and abuse via the established channels. The panel also discussed collaboration between the departments and ACLA's Program Integrity team. Educational sessions are mandatory for all associates.

In furtherance of ACLA's commitment to combat fraud, waste, and abuse, SIU staff members are provided training opportunities to enhance their skill set and knowledge base. Investigators attend in-person and online Education and Training provided through the National Health Care Anti-Fraud Association.

Fraud, Waste, and Abuse Program

Through ACFC, ACLA has established a comprehensive Fraud and Abuse Operations Program. The program includes:

- Implementation of ACLA's fraud, waste, and abuse prevention and reduction activities;
- Detection, investigation, and prevention of cases of suspected fraud, waste, and abuse; and
- Performance of anti-fraud activities by the designated SIU.

The scope of the SIU's activities encompasses all contracted/non-contracted providers and specifically includes the authority to investigate allegations of fraud, waste, and abuse involving ACLA's members or other persons, as well as allegations related to the business practices of ACLA's contractors and subcontractors.

Prevention of Fraud

Prevention of fraud, waste and abuse is managed through various methods, including clinical editing during claims processing and the use of prepayment correct coding edits. The prepayment correct coding edits lead to claims cost avoidance that supports the reduction of fraud, waste, and abuse. ACFC has comprehensive systems in place to conduct claims editing on professional and outpatient encounters. Applicable clinical edits are added on a regular basis to the claims processing system, based largely upon National Correct Coding Initiative (NCCI) and American Medical Association (AMA) standards. Inpatient claims are evaluated using a two-pass data mining screening in order to identify overpayments. In addition, predictive scoring models are used on all facility paid claims to select medical records for claims validation and potential overpayment recoveries.

The medical claim payment policies are based on guidelines from established industry sources such as the CMS, the AMA, state regulatory agencies, and medical specialty professional societies. In making claim payment determinations, the company also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual, and the National Uniform Billing Code (NUBC).

Proactive Detection of Fraud

The SIU is responsible for detecting fraud, waste, and abuse throughout our claims payment processes. All employees are responsible for identifying suspected fraud, waste, and abuse during the handling of transactions, and referring them to the SIU as part of their regular duties. The SIU establishes, distributes, enforces, and revises, as necessary, written policies and procedures to be used by the SIU staff to detect, investigate, and fully document allegations of fraud, waste, and abuse.

The SIU proactively identifies potential incidents of suspected fraud and abuse as part of its program for ongoing monitoring and auditing. The SIU has procedures in place designed to prevent and detect potential or suspected fraud and abuse in the administration and delivery of services for this contract. They include the following:

- Periodic evaluation of claims data to detect abnormalities in provider billing, prior-authorizations, and member utilization patterns;
- Post-processing review of claims to include participating and non-participating providers;
- Periodic sampling of bills/claims to determine propriety of payments;
- Requirement that providers and subcontractors agree to adhere to program standards regarding fraud, waste and abuse as a condition of contracting;
- Dissemination of information to members and providers concerning fraud, waste and abuse;
- Encourage reporting of potential FWA through the Provider and Member Handbooks and newsletters; and

- Prepayment medical record reviews accompanying claims for SIU identified providers.

The SIU efforts are supported by industry-leading anti-fraud technology. The SIU utilizes a lead detection and pattern analysis tool providing automated early-warning fraud and abuse detection and overpayment protection capabilities. Rules, algorithms, and pattern detection capabilities evaluate, identify, compare, and rank providers and members who score on one or more rules or algorithms generating qualified leads for investigation. A powerful case tracking system provides support for general coordination and management of resources. Ad hoc claims-query capability is another important proficiency within the scope of the SIU technological capacity. This is explained further below in the Payment Integrity Architecture section.

The SIU also accesses an internal data warehouse to identify patterns that may be indicative of fraud, waste, and abuse. The data warehouse includes all claims processed. Combined, these tools are used to identify potential fraud, waste, and abuse such as:

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

Through data analysis, providers are evaluated against their peers. Outlier identification is focused on high risk FWA areas, including certain physician specialists and ancillary services. SIU Investigators work closely with the Clinical Nurse Coders to determine if medical records will be reviewed. The SIU team gathers information related to the practice that is being reviewed to determine associated entities and corporate structure, which may impact the review.

The SIU may refer members to ACLA's Lock-In process when the results of a preliminary investigation reveal pharmacy and medical claims utilization patterns that appear to be abnormally high as defined by the Plan's criteria. Responsive decision making capacity exists in the clinical judgment of ACLA's Medical Director.

Payment Integrity Unit (PIU) Architecture

The PIU uses external vendors and subcontractors, as well as internal methods, to identify fraud, waste, and abuse. The diagram below illustrates the overall architecture that the PIU operates within for cost avoidance, retrospective recoveries, and the SIU.

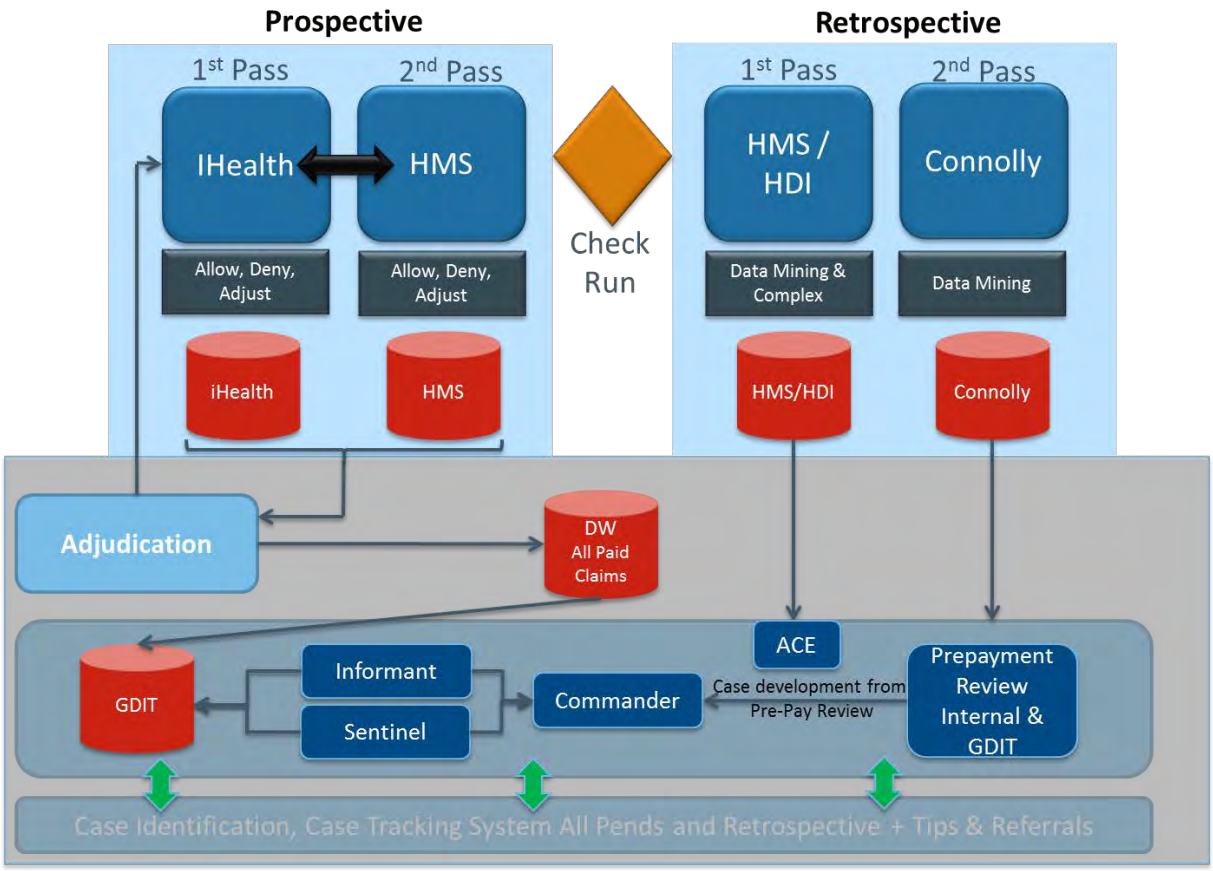


Exhibit V.1-1: Payment Integrity Unit

Prospective Cost Avoidance Operations

The Payment Integrity Group utilizes a first pass internal analysis (claims cost management) of claims pre-check run, and a two-pass prospective process utilizing external vendors in order to increase the accuracy of paying claims. The Medical Director as well as the Provider Network Management (PNM) reviews all clinical cost avoidance. The process steps include a high priority to ensure timely and accurate payments to providers:

- Internal staff develops queries that are executed prior to pre-check run to avoid claim payments;
- Incorrect Coordination of Benefits; and
- Inpatient Duplicates.

For 2013, this process ACLA avoided in excess of $0.1 million with the internal analysis, and for year to date July 2014, this internal process avoided $0.095 million.

iHealth Technologies

All outpatient, professional, and Durable Medical Equipment (DME) claims pass through iHealth Technologies (iHT) analytics engines post adjudicated, pre-check write on a daily basis. Claims are denied, reduced, or allowed to pay through this external vendor first-pass process.

In excess of $4.2 million in costs was avoided by ACLA in 2013 by utilizing iHT first pass clinical editing systems, and for July 2014 year to date in excess of $2.45 million in costs was avoided.

HMS

On a daily basis, all claims pass through HMS's prospective clinical editing systems after having run through iHT systems to further increase the accuracy of claims payment pre-check write. This process went live in the first quarter 2014, and as of July 2014, ACLA avoided $0.238 million in costs. Additionally, but not noted in the PIU architecture, HMS provides other carriers for third party liability files for cost avoidance due to other plan coverage.

Retrospective Data Mining and Recovery Operations

The Payment Integrity Group utilizes both internal and external sources to perform data mining for Fraud, Abuse and Waste. There are various distinct processes that are used for data mining and recovery operations. Internal Data Mining and Recovery (not depicted in PIU architecture) is performed by internal staff with queries that are focused on the following potential overcharges targeted for recovery:

- Outpatient charges during inpatient stay;
- Payment greater than billed charges;
- Duplicates; and
- Incorrect COB payment.

Internal data mining recoveries for 2013 totaled $0.048 million, and as of July 2014, $0.931 million was recovered.

HMS Data Mining and Coordination of Benefits Identification and Recovery

On a weekly basis, claims files, member eligibility files, provider files, and third party liability files are sent to HMS. HMS uses sophisticated analytics to identify potential overpayment of claims spanning professional, outpatient, facility, and DME. Formal processes have been developed internally which post overpayments into the PIU database. Overpayment request letters are sent to providers, with descriptions of the overpayments and providing them opportunities to dispute the findings. The majority of overpayment collections occur by offsetting future claims. This process was fully implemented in first quarter 2014. For 2013, third party liability recoveries were approximately $1.38 million. As of July 2014, over $0.775 million has been recovered from data mining and $0.779 million was recovered for third party liability.

Connolly Data Mining and Recovery

This vendor operates much in the same manner as HMS. Connolly reviews claims using additional sophisticated analytics and are referred to as our second pass vendor. For 2013,

Connolly recovered $0.05 million in claims overpayments. As of July 2014, ACLA recovered over $0.441 million.

HDI Complex Reviews and Recovery

A complex review, also known as a medical record review, is a new process that is being piloted across ACFC. This process utilizes predictive scoring models to identify claims that have a potential of being in error, and confirmation of overpayment occurs subsequent to clinical review of medical records. After identification, medical records are requested and reviewed for billing accuracy relative to medical record content. This is a new process and it is too early to report recoveries. The current review areas are focused on:

- Facility short stays.
- Pharmacy prescriptions.

Optum Credit Balance (not depicted in PIU architecture)

Optum has direct staff supporting facilities on site with the objective of reconciling credit balances. With this process Optum is able to identify overpayments and recovers on behalf of ACLA. This process will be implemented by year-end 2014.

Xerox Subrogation Services

ACLA provides claims files, provider files, member eligibility files and third party liability files on a monthly basis to Xerox. Xerox executes analytics focused on identifying motor vehicle accidents, product liability, premises liability and medical malpractice. For 2013, these services provided over $0.237 million in overpayment recoveries, and through July 2014, ACLA recovered over $0.544 million.

Internal PIU Collections

ACLA incorporates an internal team for overpayments from providers that cannot be recovered from future claims. This process starts with 61 day aging and continues up to 120 days.

GBCollects

For credit balances that exceed 120 days outstanding, the plans transfer recoveries to GBCollects for recoveries.

Special Investigation Unit (SIU) Operations

The SIU utilizes General Dynamics Information Technology (GDIT) STARSSolutions as part of an integrated solution for detection, investigation, and prevention of fraud, waste and abuse. These solutions as depicted in the architecture are defined below:

STARSInformant enables the SIU to perform ad hoc claims data exportation to fully support the investigative process.

STARSSentinel – This is an outsourced Fraud and Abuse lead generation solution. ACLA's claims are run through this analytics engine on a monthly basis. The output based upon statistics provides the SIU with suspicious providers and members for the current monthly cycle period, as well as congruently over time.

STARSCommander – This is the case management system used by the SIU. It enables the SIU management team to manage workload/caseload throughout the case lifecycle. Case reporting and status is monitored weekly and monthly with internal management and ACLA Director of Contract Compliance and Program Integrity Officer.

The workflow starts with all paid claims, and up to three years of historical claims being sent to GDIT, and managed within their data warehouse. The SIU analysts and investigators have the ability to perform ad hoc data mining on STARSInformant with internally developed queries to identify aberrant patterns, peer-to-peer comparisons, or research of Tips and Referrals. Independently, GDIT runs our claims data through STARSSentinel on a monthly basis. STARSSentinel provides the following information to the SIU:

- Peer-to-Peer Comparison;
- Predictive Scoring for Suspicious Providers;
- Scheme Outcome Scenarios;
- Billing Rule Violations; and
- Claims Submission Frequency Comparator.

All cases, through ad hoc data mining, Tips and Referrals, or STARSSentinel, are logged and tracked in STARSCommander from case initiation through referral and/or closure.

Samples of cases currently in the investigation stage in all lines of business are:

1. Internal Medicine providers/PCPs were referred by the plan with allegations of excess radiology and lab tests, as well as a high frequency of upcoding of Evaluation and Management (E&M). The initial probe review was completed and confirmed the allegation of excessive testing and upcoding; medical necessity. Review by the plan confirmed the findings and indicated possible quality of care issues due to the excessive testing. A referral was sent to the plan and the Medicaid Fraud Control Unit. Medical record review was expanded through a Statistically Valid Random Sample (SVRS) and additional records were requested from the provider. Records were received and reviewed by certified nurse coders. Providers were placed on a prepayment review in March 2014. The first claims to be reviewed were received in May 2014. Current Status: A provider preliminary extrapolated overpayment was identified in excess of $500k.
2. An OB/GYN provider was identified through SIU data mining as an outlier for the billing of 99215 E&M code. A SVRS sample was pulled off of the provider's 99215 claims and a request for records was sent to the provider; records were received. Clinical review of the records obtained confirmed the allegation of upcoding; the documentation did not support the billing of the 99215 services; 40 out of 41 claims were not supported by the documentation and no documentation was received for 1 out of 41 claims. A Referral was sent to the plan with recommendation of overpayment collection; the provider has previously been identified for upcoding in other MCOs. Current Status:

This case was referred to LADHH for their review, and recovery of $42k overpayment is in process.

3. A Pain Management provider was identified through SIU data mining as an outlier for billing excessive complex E&M codes, and excessive utilization of diagnostic and lab testing. The initial probe review was completed and confirmed the allegation. The case was expanded to include a SVRS. Records received and reviewed resulted in findings of 90%+ error rate. The case was referred to LADHH and reviewed with the plan. Current Status: Pursuit of an identified extrapolated overpayment in excess of $300k is in process.

AmeriHealth Caritas Louisiana – PIU/SIU Alignment

All prospective and retrospective clinical edits are reviewed and approved by ACLA, as well as overpayment recovery projects identified by the PIU, which are approved by ACLA prior to provider notification of the overpayment.

The SIU conducts audits/investigations in response to referrals that suggest that claims are being paid inappropriately. Referrals received from a variety of internal and external sources are important for monitoring and detecting potential FWA. Internal sources may include associates (including referrals made via the designated Fraud Tip e-mail box or the Internal Hotline) and routine reports. External sources may include complaints from members and/or providers, media reports, fraud alerts issued by other health insurance providers, and governmental and regulatory authorities.

Some examples of FWA that may be reported include:

- Billing for services not provided;
- Falsifying medical diagnoses or procedures to maximize payments;
- Misrepresentation of dates;
- Invalid descriptions of services or identities of subscribers/providers;
- Billing for a more costly service than the one that was provided, or billing for duplicate services;
- Accepting bribes for patient referrals;
- Billing for non-covered items or services (e.g., cosmetic surgery);
- Credit balances with failure to refund overpayment;
- Providing false membership information; and
- Prescription fraud.

All incoming referrals are recorded in the SIU case tracking tool. Coordination for fraud and abuse complaints received will be handled in accordance with all state requirements. This includes complaints about a member's eligibility, a member's utilization of benefits, and against a health care provider or contractor in the network. The SIU obtains necessary data for making a determination as to whether to investigate the case. The SIU notifies departments that are likely to be impacted by an investigation of the provider's or member's status, and of any special instructions relating to utilization by the provider or member.

Upon suspicion of FWA activity, the SIU management may request the Operations Service Director to suspend payment for all claims processed for the questionable provider and all claim payments for the provider being investigated will accordingly be suspended or withheld. Relevant departments, including but not necessarily limited to Operations, Provider Contracting, Medical Management and Finance, are notified of the suspension. The suspension is released upon completion of the investigation.

Across the organization, other departments support fraud and abuse prevention and detection through a system of controls, including the following:

- Upcoding, unbundling, and correct coding is identified through the claims system clinical editing;
- Approved guidelines to determine medical necessity and level of care are applied;
- Pre-authorization guidelines are applied to prevent abusive utilization patterns;
- Medical record and high dollar claims reviews;
- Management of excluded and sanctioned Providers;
- Credentialing and re-credentialing consistent with NCQA and/or URAC standards; and
- A system to prevent processing of fraudulent checks.

Action and Notification

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

The Program Integrity Officer will assure that all suspected fraud, waste, abuse, and neglect information is promptly reported to the Medicaid Fraud Control Unit (MFCU) and DHH within five business days of discovery. ACLA will also assure that DHH is notified within three business days of any actions taken against an employee, a provider, or contractor employee.

State Agency Reporting

ACFC and ACLA have established a cadence for monthly reporting including both payment integrity (cost avoidance and recoveries), and SIU provider case identification, planning and action plans. This organizational alignment provides transparency for all PIU and SIU activities and findings. In addition, the Program Integrity Officer ensures timely reporting and updates to the MFCU and DHH in accordance with the Medicaid HMO Contract and also brings forward investigation summaries to the Compliance Committee. From 2013 through June 2014, the Program Integrity Team reported 71 cases to DHH through statutory reporting. The Director of Compliance and Program Integrity Officer reviews and addresses requests for information about FWA, including, but not limited to losses, recoveries, and provider terminations. In

accordance with policy and procedure, prior to a FWA provider termination decision being made by ACLA, the Program Integrity Director and Compliance Officer may consult with multiple stakeholders including the plan's leadership, provider network management, operations, credential and risk management leaders to ensure that all affected systems are updated and peer review can take place if it is warranted. Legal Affairs may also weigh in with an opinion on how to communicate the termination action to the impacted provider and additionally address required notification to other stakeholders.

Reporting includes, but is not limited to:

1. Number of complaints of fraud, waste, abuse, neglect, and overpayments made to the MCO that warrant preliminary investigation;
2. Number of complaints reported to the Program Integrity Officer; and
3. For each complaint that warrants full investigation, ACLA provides DHH the following information:

- Provider Name and ID number;
- Source of complaint;
- Type of provider;
- Nature of complaint;
- Approximate range of dollars involved if applicable; and
- Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.

Explanation of Benefits for Service Verification

ACLA has a method to verify that services for which reimbursement was made were provided to members via service verification letters, or explanation of benefits (EOB) notices. Service verification letters are mailed monthly to members for whom claims are received within 45 days of payment. ACLA ensures that a minimum of 2% of all paid claims in a given month are represented in this sample. ACLA stratifies the paid claims sample to ensure all claim types are proportionally represented. To the extent that ACLA considers a subset of providers to warrant closer scrutiny, ACLA will focus on claims received from targeted provider specialties such as pain management, DME, and Home Health.

ACLA will track all service verification responses and related complaints received from members, as well as resultant interventions and actions, and report results to DHH on a monthly basis. In cases where survey results indicate that paid services may not have been received, the SIU shall forward all required information to DHH for review.

Rights of Review and Recovery

ACLA investigates all possible acts of provider fraud, waste, and abuse for all services under this contract, including those services that we subcontract to outside entities. We acknowledge that we have the exclusive right of review and recovery for 365 days from the original date of service of a claim to initiate a “complex” review of such claim to determine a potential overpayment and/or underpayment, by delivering notice to the provider in writing of initiation

of such a review. All of ACLA's complex reviews are complete within 120 days of the date of the notice to the provider unless authorized to extend by DHH. We will notify DHH, on at least a monthly basis, the results of reviews as well as instances of suspected fraud, collection status and/or audits.

ACLA has thirty calendar days from the date of notification of potential improper payment(s) to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department or its agent. We will neither correct the claims nor initiate an audit on the claims upon notification by DHH or its agent, unless directed to do so by the DHH.

In the event the provider does not refund overpayments identified by the Department or its agent to the State, or arrange for an acceptable payment plan with the State within thirty calendar days of notification to the provider of the overpayment, ACLA will initiate a payment withhold on the provider in the amount due to the DHH. ACLA will collect and refund the overpayment to DHH.

V.2. Program Integrity

V.2 Provide a description your Corporate Program Integrity Division including the Program Integrity Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart D in your response) involved in compliance along with staff levels of authority.

Overview

ACLA recognizes the importance of the Corporate Program Integrity Division and how essential it is to continually communicate across the highest levels of our corporate organization and assure direct access to executive staff to effectively govern the compliance program. The Corporate Program Integrity Officer reports directly to the Senior Vice President of Compliance and Risk Management, who reports to the Board of Directors. ACLA's local Director of Contract Compliance and Program Integrity Officer acts as Chair of the ACLA Program Integrity Committee, and reports directly to ACLA's Executive Director.

Corporate Program Integrity Department

The Corporate Program Integrity Department is structured to encourage and elicit collaborative participation at all levels of the AmeriHealth Caritas Family of Companies (ACFC). It serves to:

- Educate officers, managers and associates of ACFC concerning the legal risks of certain business practices;
- Encourage ACFC officers, managers, and associates to seek appropriate counsel regarding business practices and to conduct those activities within regulatory requirements and ethical standards;
- Ensure consistency with applicable compliance program guidelines established by the OIG and other regulatory agencies; and
- Support a corporate-wide focus and sharing of FWA trends to for detecting, investigating and mitigating fraud, waste and abuse throughout the organization's care management, and claims payment processes, as well as for the fraud and abuse compliance plan, employee training and monitoring.

Corporate Compliance Office

ACFC is committed to implementing and maintaining the highest standards of ethical conduct in its business and operational practices, and commits to complying with all applicable federal and state requirements. ACFC has adopted a company-wide compliance program structured to encourage and elicit collaborative participation at all levels across the organization and to stimulate a culture of compliance. The compliance program fosters an environment which requires associates to comply with all relevant laws and regulations and appropriately report any concerns about business and operational practices.

Key Personnel

- Senior Vice President of Compliance and Risk Management – The Senior Vice President of Compliance and Risk Management provides oversight of compliance, regulatory and risk management functions across the organization.
- Vice President of Corporate Compliance and Chief Privacy Officer – The Vice President of Corporate Compliance is responsible for directing and managing the Corporate Compliance and Privacy Offices. This position is also responsible for identifying and resolving corporate and regulatory compliance issues; establishing and implementing effective reporting, auditing and investigative processes; and developing and implementing compliance and privacy communications and training.
- Privacy and Compliance Manager – Assists with the implementation, maintenance and monitoring of the Corporate Privacy and Compliance programs.
- Compliance Manager – Supports the implementation and monitoring of the Corporate Compliance program and serves as a compliance consultant to all lines of business and departments.
- Vice President of Enterprise Risk Management - Helps management to more systematically and consistently identify and manage key risks. This position is also responsible for integrating Enterprise Risk Management with other critical processes, such as strategic planning, compliance, internal audit, Information Protection, BCP, market entry and new business activation.
- Regulatory Affairs Manager - Responsible for educating AmeriHealth Caritas about regulatory, program and contractual requirements affecting our business, they also standardize the collection and documentation of those requirements and align current state-based business practices.

Corporate Fraud, Waste, and Abuse Department

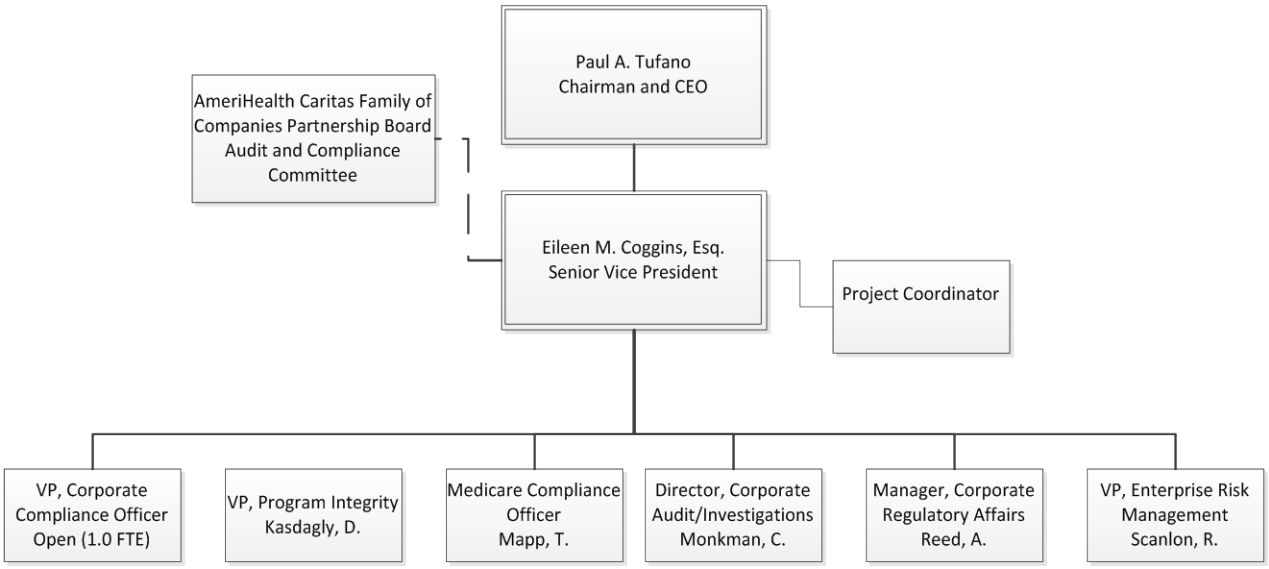
The Corporate Fraud, Waste and Abuse Department is responsible for the overarching objective to significantly offset the trend of overpayments resulting from fraudulent, abusive and/or wasteful billing practices in order to enable care for those of need, and is structured to ensure fraud, waste, and abuse alignment at the corporate level.

Key Personnel

- Vice President, Payment Integrity – Provides overall direction and coordination of resources for the department. This all-encompassing term identifies the singular goal of ensuring that Medicaid claims, payments and resources are used efficiently and responsibly for the benefit of members while supported by documentation and records which clinically justify provider determinations.
- Director, Fraud & Abuse Operations (Special Investigations Unit/S.I.U.) – Conduct objective, thorough, unbiased and timely investigations into allegations of fraud or abuse committed by members, providers or associates.

- Manager, SIU, Tips and Referral Validation & Data Mining – Provides input and case management support from receipt of referral through conclusion of review. Perform research and create reports to monitor progress of cases. Additionally, conducts proactive data mining to identify providers who are identified as outliers when compared to their peers. Identifies configuration and claims processing problems, errors or trends to discover suspected fraud, waste and abuse activities and provide recommendations for resolution.
- Clinical Operations – Provides clinical review and investigation analysis and reporting with specialized analytical skills and knowledge. Performs clinical review of medical records/other documentation to determine the accuracy and appropriateness of billings for provided services.
- Director, Client, and Vendor management – Provides leadership, oversight and direction for the payment integrity services provided by vendors that support the claims data analysis required by ongoing efforts to validate claims for cost avoidance and recover overpayments retrospectively.
- Director, Payment Integrity Operations – Leads the development of standard operating procedures, engineers and documents unit-strategies; trains associates accordingly.

Chart D



Local Program Integrity Office

The complexity of the challenges that Louisiana faces requires seasoned and mature associates to manage ACLA's compliance activities. ACLA has designated a local Program Integrity Officer and Program Integrity Committee that has the responsibility and authority for carrying out the provisions of the compliance program. ACLA's Program Integrity Department, under the leadership of the Program Integrity Officer, is located in Louisiana and is responsible for

overseeing local compliance activities to avoid and respond to fraud, waste and abuse (FWA). The Program Integrity Officer will be responsible for three areas. These areas are compliance, regulatory filings, and the Fraud and Abuse Unit.

Director of Contract Compliance and Program Integrity Officer

ACLA's Director of Contract Compliance and Program Integrity Officer provides strategic direction and leadership for compliance activities and management of state-contracted services. The Director of Contract Compliance and Program Integrity Officer will oversee monitoring and enforcement of the FWA Compliance Program to prevent and detect potential fraud, waste, and abuse activities pursuant to state and federal rules and regulations. This officer will also carry out the provisions of the compliance plan, including fraud, waste, and abuse policies and procedures, investigating unusual incidents and implementing any corrective action plans. The Program Integrity Officer acts as a liaison between the state, specifically DHH, and the plan.

The Director of Contract Compliance and the Program Integrity Officer report to the Executive Director, with a functional reporting relationship to the ACFC Chief Compliance and Privacy Officer. On behalf of ACLA, he or she will also assist the state and any federal agency charged with the duty of identifying, investigating or prosecuting suspected FWA by making required books and records available, permitting on-site reviews, and cooperating fully for required interviews, consultations and proceedings.

The Louisiana-based Director of Contract Compliance and the Program Integrity Officer is supported by the ACFC Payment Integrity Unit (PIU) and the Corporate Compliance Program, which are managed from our corporate offices in Philadelphia, PA.

Coordination with DHH

The Program Integrity Officer will serve as the primary point of contact for ACLA on issues related to Compliance and Fraud, Waste, and Abuse prevention. Additionally, the Program Integrity Officer, as well as the Corporate Vice President and PIU Director, will meet with DHH and MFCU quarterly, annually, and at DHH's request. We will ensure that DHH and MFCU are aware of suspected fraud within the required timelines and to discuss FWA issues. The Compliance Director and the PIU will work closely with the DHH, MFCU, State's Auditor's Office, Office of the Attorney General, General Accounting Office, Comptroller General, and/or any of the designees above, as often as necessary during the contract term, and for a period of six years after the contract ends.

Program Integrity Committee

ACLA's comprehensive Program Integrity Plan is monitored by the Program Integrity Committee. The Committee will receive reviews and findings from the Program Integrity Officer, make recommendations on the Annual Program Integrity Work Plan and provide guidance for all fraud, waste and abuse initiatives and activities. The Program Integrity Committee:

- Manages ACLA's fraud, waste and abuse policies and procedures, as well as the local Program Integrity program and work plan.
- Implements corrective action plans resulting from fraud, waste, and abuse incidents.
- Monitors ongoing analyses of business, industry, and legal risks and assures appropriate steps are undertaken to address these risks in a timely manner.
- Annually reviews procedures for the confidential and anonymous submission by associates of concerns regarding questionable or suspected fraud or misconduct.

ACLA's Program Integrity Committee meets bi-monthly. The Program Integrity Committee includes the following positions across ACLA:

- Director of Contract Compliance and Program Integrity Officer
- Director of Community Outreach
- Executive Director
- Director of Plan Operations and Administration
- Director of Provider Network Management
- Director of Community Outreach and Education
- Director of Fraud Operations and SIU
- ACLA Medical Director
- Vice President of Payment Integrity

ACLA's Program Integrity Committee serves to ensure plan integrity in reporting inappropriate conduct, fraudulent activities, and abusive patterns. The Program Integrity Committee creates accountability for distributing regulatory information. The ACLA Program Integrity Committee is comprised of ten voting members, including local directors and corporate compliance and fraud, waste, and abuse leadership.

Compliance & Regulatory Affairs Department

The ACLA Compliance & Regulatory Affairs Department is responsible for the development and implementation of the Program Integrity. This office, together with the Program Integrity Committee, is responsible for operating, monitoring, and evaluating the company's compliance program. The ACLA Compliance & Regulatory Affairs Department is comprised of the following staff:

- Regulatory Affairs Analyst – The Regulatory Affairs Analyst assists with carrying out the daily operations of this office, including coordination of DHH-required reporting. This position serves as a supplemental liaison between DHH and the plan.
- Contract Compliance Coordinator –The Contract Compliance Coordinator will serve as the primary point-of-contact for all contract compliance issues. These primary functions may include, but are not limited to, coordinating the tracking and submission of all contract deliverables; fielding and coordinating responses to DHH inquiries, coordinating the preparation and execution of contract requirements, and conducting random and periodic audits and ad hoc visits.

Fraud, Waste, and Abuse Investigators

FWA Investigators are responsible for detecting, investigating, and mitigating fraud, waste, and abuse throughout the organization's care management and claims payment processes, as well as for the fraud and abuse compliance plan, employee training and monitoring. The FWA Investigators will report to the Program Integrity Officer, but will functional reporting to the Director of SIU. Investigative efforts are supported by industry-leading anti-fraud technology. Investigators utilize lead detection and pattern analysis tools providing automated early-warning fraud and abuse detection and overpayment protection capabilities. Rules, algorithms, and pattern detection capabilities evaluate, identify, compare, and rank providers and members who score on one or more rules or algorithms generating qualified leads for investigation. A powerful case management tracking system provides support for general investigations coordination and management of resources. Ad hoc claims-query capability is another important proficiency within the scope of the investigators.

ACLA Program Integrity

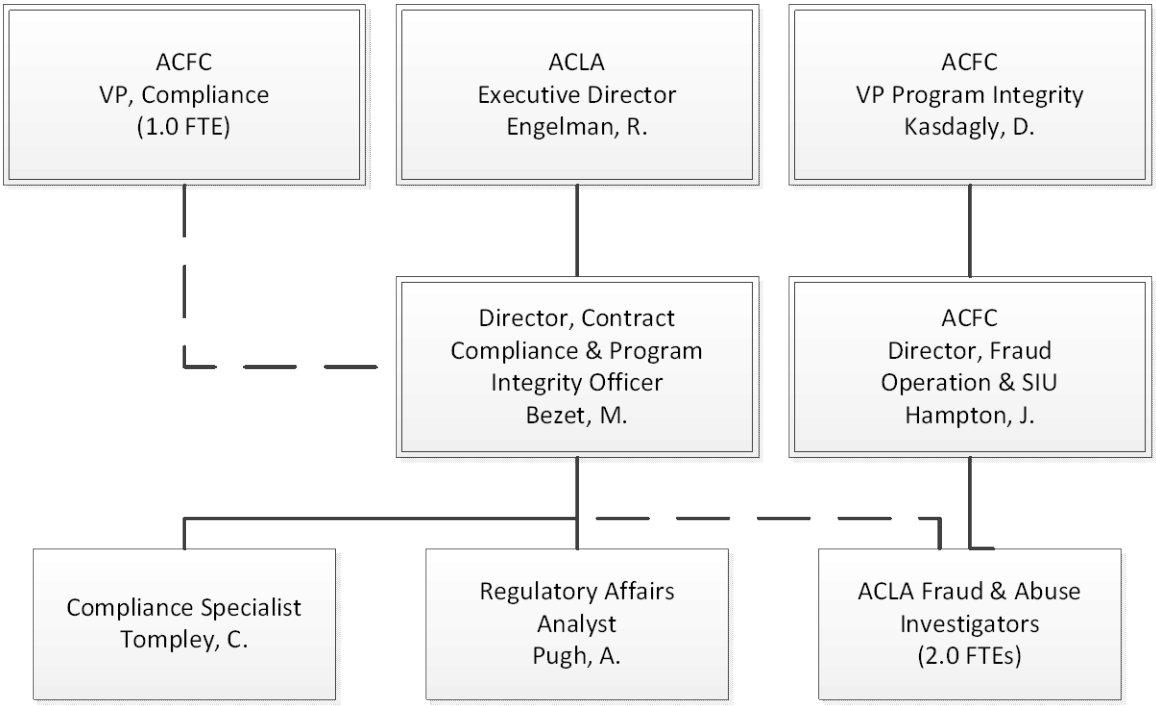


Exhibit V.2-1: Local Program Integrity Organizational Chart

W.1. Information Systems

W.1 Describe your approach for implementing a management information system in support of this RFP by identifying all information systems (those within and outside your span of control (for claims, clinical and accounting) through which service and utilization data for the La. Medicaid population is processed. Included a Louisiana Medicaid MCO-Program-specific work plan for system readiness and operations that captures:

- *All Key activities and timeframes,*
- *Projected resource requirements,*
- *Identify the number of dedicated or corporate full-time employees (FTEs) for implementing information systems in support of this contract, and*
- *Provide the work location of the FTE's before, during and after implementation.*

The work plan should cover activities from ramp up, implementation and ongoing operations.

Overview

AmeriHealth Caritas Louisiana (ACLA) implemented its current systems and subsystem during the initial Bayou Health contract term. This implementation was designed to be flexible and scalable to meet changing needs of DHH, and the Louisiana member and provider communities. Our current policies and procedures were developed and have been regularly updated to ensure effective integration of, collaboration between, and controls over, our management information system (MIS).

Our core claims, clinical care management, and accounting platforms do not require any major upgrades or modifications to meet the requirements outlined in the new RFP and Systems Companion Guide. Our comprehensive assessment identified only minor modifications are needed to fulfill the new expectations. Fully engaged resources across the Information Systems team have collaborated to identify these modifications and develop a work plan to address them during system readiness.

Key Components of ACLA's Implemented MIS

ACLA's information systems architecture is built to support our core business needs and health plan functions, including claims processing, clinical care management, and accounting/payment processing. Our core platforms are industry-leading, highly configurable applications that enable us to easily adjust to changes in contract requirements and leverage our experience in the state to provide the best care possible to the Bayou Health population.

The AmeriHealth Caritas Family of Companies (ACFC) maintains a robust suite of "best in class" enterprise applications for care management, healthcare benefits management, provider management and contact center domains. The assigned domain manager works with key ACLA stakeholders and the Enterprise Architecture Team to ensure the technology platforms address near term business operational needs, DHH requirements, and compliance changes as well as future strategic directions. All applications software and underlying infrastructure components are reviewed and maintained in accordance with vendor release schedules, transaction volumes

are reviewed to assess capacity needs, and hardware refresh needs are also considered. This is achieved through ongoing discussions with the ACLA, evaluation of vendor software releases, participation in vendor user groups, and performance monitoring and trend analyses.

Claims Administration MIS Components

TriZetto Facets®

ACLA 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 Bayou Health contract requirements.

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 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 easily available to Contact Center representatives as they help members and providers with eligibility and enrollment, appeals and grievances, and general inquiries.

iHealth Technologies (iHT) Analytics

ACLA utilizes *i*HT's solutions to enhance clinical and business rule editing for claims. *i*HT's system applies a comprehensive, customized library of clinical coding edits to professional and outpatient hospital claims to support accurate coding and payments. In addition to the company's generally accepted clinical edits, ACLA has built its own library of customized medical policies around Louisiana 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.

Johns Hopkins ACG® System

Member claim data is analyzed to determine concurrent and prospective risk levels using Johns Hopkins ACG® System. The ACG System defines a number of risk markers based on demographic, diagnosis, and/or medication data found in routinely available administrative data sources. The ACG System utilizes a linear regression approach, and leverages a nationally representative database provided by IMS Health. ACFC uses predictive risk scores normalized to ACLA's population to identify members most at risk for avoidable health care episodes. ACLA then reaches out to these members to review their assessments and establish or monitor their care plans.

Johns Hopkins recalibrates the ACG predictive models and reference data with each major software release, which occurs approximately every two years. The development data used for

the standard ACG predictive models is obtained from IMS Health. The current benchmark data is a subset of the Patient-Centric Database, which contains a national cross-section of managed care plans with a population of 3,523,473 Medicaid and commercially insured lives (less than 65 years old) as well as a population of 463,126 Medicare beneficiaries (65 years and older).

Support Tools for Claims Processing

- IBM InfoSphere DataStage® provides extract, transform, and load (ETL) functions to populate business intelligence data into our Oracle data warehouse from our information systems, including Facets®.
- HealthCare Management System, Inc. (HMS) systems apply a comprehensive, customized library of clinical coding edits to professional, outpatient, and facility claims to ensure that they are coded correctly and paid accurately. In addition to generally accepted clinical edits, ACLA has its own library of customized Medicaid-specific medical policies.

Clinical Care Management MIS Components

ZeOmega Jiva™

Jiva is ACLA's core clinical 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 feeds ACLA's case management, disease management, utilization management, and quality management strategies. Jiva's broad range of capabilities enables ACLA to provide quality health care to members while strengthening relationships with members and providers, optimizing operational efficiencies, and managing health care costs.

Jiva stores evidenced-based clinical pathways that enable ACLA care management and Rapid Response staff to help members through efficient and holistic management of their chronic conditions, pregnancy, and pediatric preventive care. The application also enables ACLA's care management staff to coordinate and collaborate with providers to improve health outcomes across shared populations, primarily through care gap alerts.

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 ACLA's 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 Continuity of Care (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.

TREO (now 3M) Services

TREO (3M) is a web-based suite of applications focused on analyzing information for quality improvement. Using sophisticated algorithms, chains of admission and readmission events are linked to identify opportunities for improvement of care and for use in pay-for-performance programs and other oversight and care management needs.

Support Tools for Clinical Care Management

- Our custom REL (race, ethnicity, language) 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 ACLA's 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 IDC-9/ICD-10 diagnosis codes.
- 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. ACLA loads monthly source files into the repository. Quality Spectrum is NCQA-certified for HEDIS reporting.
- 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.

Accounting MIS Components

As a core administration platform, Facets® stores benefits configurations and provider pricing schedules, and handles deductibles, copays, and coordination of benefits (COB) situations. Facets® generates checks for both individual providers and provider groups or independent practice associations (IPA) and delivers 1099 forms to these same entities.

Emdeon Business Services

ACLA contracts with Emdeon to process electronic fund transfers (EFT). 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.

ACLA promotes EFT services to our provider community through our regular provider communication channels, including links on the Provider Portal, provider newsletters, inserts into paper remittance advices, and IVR messaging.

Key MIS Support Systems and Technologies

SunGard EXP MACESS™

SunGard EXP MACESS™ is a state-of-the-art imaging-based operations management, workflow management, enterprise content management, and customer service solution that has been standardized specifically for managed health care organizations. ACFC and ACLA use EXP MACESS to help support plan operations and care management staff by automating various internal processes, especially managing the flow of data, documents, and business processes across corporate and regional functions and locations.

EXP MACESS indexes electronic images of documents in order to facilitate high-performance search functions across all records pertaining to members and providers. The system utilizes a 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.

Data Intake Solution

The Data Intake Solution extracts, transforms, and loads data from many internal and external sources including claims data from the Facets® claims processing system; care management data from the Jiva medical management information system; state data (member eligibility, third party liability, etc.); subcontractor claims and encounter data; pharmacy claims data; lab results; and diagnoses codes associated with member risk scores. Transaction control counts and reconciliations are performed to ensure the completeness and accuracy of the data loads into the data warehouse.

Oracle Data Warehouse

Information from the Data Intake Solution is housed in an Oracle 11g data warehouse. The data warehouse is a query-able relational database that includes membership data, provider network data, care management data (including health assessments, lab results, care gaps, care plans, disease management, and case management data), utilization data, authorizations, over/under-

utilization data, encounters and claims (e.g., medical, hospital, pharmacy, dental, vision, behavioral health, family planning), payments, appeals and grievances and outcomes data (e.g., HEDIS, maternity).

Call Center Support Tools

The Integrated Application Desktop (IAD) was developed in 2012 to allow customer-facing associates the ability to access several Enterprise data sources (like EXP MACESS, and Facets®) from one convenient desktop screen. All aspects of member and provider information are displayed for fast reference during calls with members and providers. The IAD product self-documents the contact with the member/provider and stores this information in EXP MACESS. This allows Member Services representatives to have a full view of the member's past experience speeds service for their current needs. Finally, the IAD application eliminated (via automation) more than 20 steps in the call documentation effort.

Business Intelligence, Reporting, and Analytics

We use several tools for business intelligence, reporting, and analytics.

- SAP Crystal Reports®, by Business Objects™, enables rapid development of flexible, versatile reports from the data warehouse, Facets®, and other sources. It is often used for reporting on claims, membership, provider, authorizations, and care management data.
- Statistical Analysis System (SAS) applications suite is an advanced analytics suite that includes data management and predictive analysis functions.
  - SAS Enterprise Guide is used for standard reporting.
  - SAS Office Analytics is used for on-demand, self-service reporting.
  - SAS Enterprise Miner is used for predictive modeling.
  - SAS Visual Analytics is used for data discovery, trending, and advanced visualizations.
- SQL Server Reporting Services (SSRS) is used to perform complex and customized reporting from information stored in Jiva, our clinical care management platform.

Service and Utilization Data Exchanges

Connecting to DHH and DHH Contractor Systems

During the initial Bayou Health contract term, ACLA worked closely with DHH, the Fiscal Intermediary, and the Enrollment Broker to configure information system infrastructure and data exchanges to achieve program requirements. ACLA currently exchanges inbound and outbound service and utilization data with DHH and its contractors through secure file transfer protocols (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, dental, and transportation.

Claims Clearinghouses

ACLA accepts claims through a number of clearinghouses, including Emdeon, Zirmed, NaviNet, and HDX clearinghouses. We primarily partner with Emdeon, which 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 ACLA.

Emdeon Provider WebConnect℠, ACLA's sponsored portal, 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 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 small practices with low claim volumes, including physical therapists, DME, and home health providers. Providers simply complete a self-service registration process and go through the initial set-up process. Online training is offered to assist with the initial set-up process and to address any product support inquiries.

2014 Bayou Health MIS Work Plan

ACLA has continually worked with DHH throughout the initial Bayou Health contract term to implement systems and ongoing operations, including system testing, regular data exchanges, and system changes and updates. As information and technology issues arose, we leveraged both local and enterprise resources, and collaborated with DHH, to resolve them as quickly as possible, while also paying attention to building sustainable solutions that would not create additional complications down the road.

Our cross-functional IS team has completed a comprehensive assessment of the new RFP and Systems Companion Guide, and confirmed that our existing core and auxiliary systems will continue to satisfy DHH's requirements with only minor modifications.

ACLA will collaborate with DHH to ensure all requirements are appropriately addressed in our implementation plan. All system changes will be implemented by ACLA and ACFC associates who have extensive experience managing the MIS. We are confident that the system changes will be operationalized during the readiness period, prior to the anticipated February 1, 2015 contract start date.

Key Implementation Activities and Timeframes

To implement and maintain our MIS, ACLA and ACFC adheres to an industry best-practice project lifecycle (PLC) to guide necessary systems updates and changes.

The process for system updates consists of four key implementation phases:

1. Initiation and Planning.
2. Design, Development, and Configuration.

3. Testing and Implementation.
4. Post-Production Stabilization.

Since program requirements involve only minor modifications (as outlined in W.2) to our existing capabilities, we will implement the system changes in a short timeline, with a high level of quality, in time for the contract start date. During each PLC phase, well-defined and standardized artifacts are produced, including business and functional requirements documents, design documents, and test plans and scripts.

The diagram below summarizes the timeline and activities associated with each implementation phase. ACLA will finalize the plan for system changes in collaboration with DHH and its agents upon award.

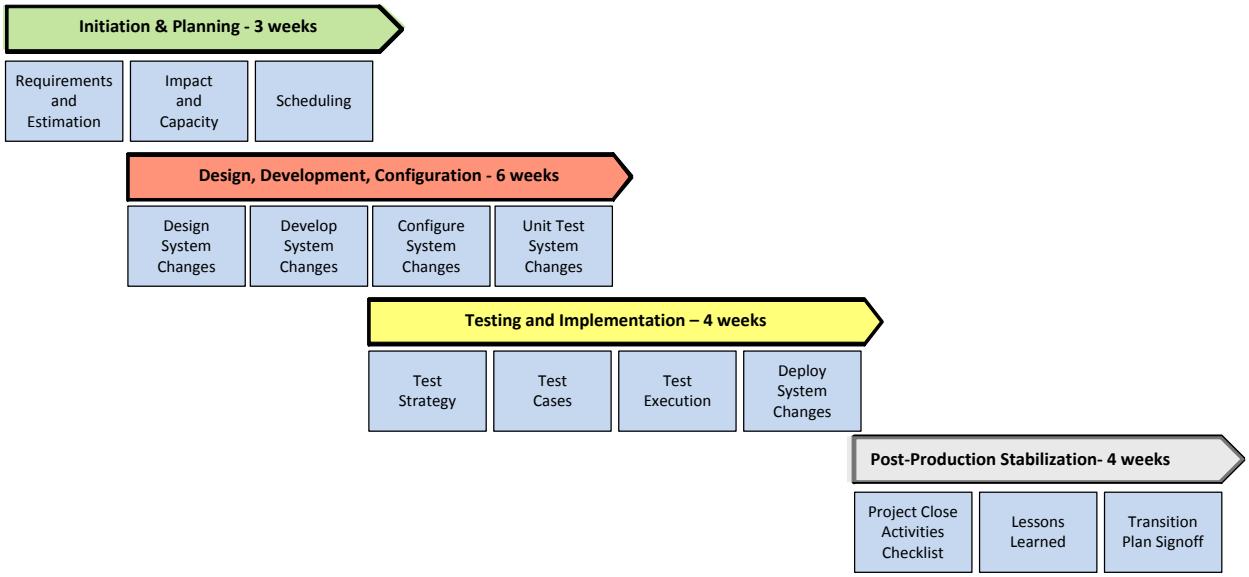


Exhibit W.1-1: High-Level Work Plan

Initiation & Planning Phase

In the Initiation and Planning Phase, the SDLC team ensures that requirements are well understood and estimated. The appropriate staff skill sets are identified and assigned based on staffing capacity. The system change is then scheduled for a future system change release. Business requirements that define what needs to be done are completed and provided to systems analysts, who create functional requirements that define how the business requirements will be accomplished. Through review of the RFP and accompanying documents, the initiation and planning phase is underway and estimated to be 40% complete.

Design, Development, & Configuration Phase

Systems analysts evaluate the business requirements and create functional requirements detailing how the business requirements will be satisfied. The requirements are delivered to developers, who modify the system to function according to the new design, unit test it, and prepare the system changes to be promoted to the quality assurance testing environment.

Testing & Implementation Phase

Testers receive the business and functional requirements at the same time as developers. While development is underway, testers develop the test strategy and test cases and have them approved by the business and analysts. This enables testing to begin the moment the system changes are promoted from development to the quality assurance environment. Testers then execute test cases to ensure that the system is functioning as requested and that there are no adverse effects from the system changes. User acceptance testing, which may involve DHH or one of its contracted entities, may also happen at this time as appropriate. When quality assurance testing and user acceptance testing are complete, the system change is approved to be deployed. A request for change is opened to the change advisory board and the system changes are promoted to production.

Post Production Stabilization Phase

In conjunction with the standard closure activities, ACFC ensures that the system is operational and that any risks/issues that may have been encountered are mitigated in a collaborative manner to facilitate the Transition Plan sign-off. System changes are monitored to ensure successful operation. For example, the date and time of the first production run of new or changed batch jobs are noted in the change ticket and monitored by production control operators.

Below are the tasks and resources required to accomplish the minor modifications outlined in W.2:

Task Name	Resource Names	Start	Finish
Bayou Health Re-Procurement System Changes		Tue 9/9/14	Mon 2/2/15
Initiation and Planning		Tue 9/9/14	Tue 10/28/14
Requirements		Tue 9/9/14	Mon 9/15/14
Checkpoint Full Disk Encryption (FDE)		Thu 9/11/14	Mon 9/15/14
Analyze full disk encryption requirements	Analyst		
Deliver FDE requirements document	Analyst		
Remittance Advice False Claim Warning		Tue 9/9/14	Thu 9/11/14
Analyze RA Warning requirements	Analyst		
Send wording to DHH for approval	Analyst		
Deliver RA Warning requirements document	Analyst		
Estimation		Tue 9/9/14	Tue 9/9/14
Estimate FDE effort	Developer		
Estimate RA Warning effort	Developer		
Impact and Capacity Assessment	Manager	Mon 10/27/14	Mon 10/27/14
Schedule FDE and RA Warning System Changes	Manager	Tue 10/28/14	Tue 10/28/14
Design, Development and Configuration		Tue 10/28/14	Tue 12/16/14

Task Name	Resource Names	Start	Finish
Design System Changes		Tue 10/28/14	Tue 11/4/14
FDE		Tue 10/28/14	Tue 11/4/14
Identify legacy desktops to be upgraded	Analyst		
Create SOW for Checkpoint FDE licenses	Analyst		
Deliver FDE functional requirements			
RA Warning		Tue 10/28/14	Thu 10/30/14
Create mockup of RA with warning	Analyst		
Deliver functional requirements to Emdeon Business Services	Analyst		
Develop System Changes		Tue 11/4/14	Tue 11/25/14
FDE		Tue 11/4/14	Tue 11/11/14
Create desktop package to deploy FDE	Developer		
RA Warning		Tue 11/4/14	Tue 11/25/14
Manage work of Emdeon Business Services	Developer		
Configure System Changes		Tue 11/25/14	Tue 12/2/14
FDE	Developer		
RA Warning	Developer		
Unit Test System Changes		Tue 12/2/14	Tue 12/9/14
FDE	Developer		
RA Warning	Developer		
Promote to Testing		Tue 12/9/14	Tue 12/16/14
FDE	Manager		
RA Warning	Manager		
Testing and Implementation		Tue 12/16/14	Mon 1/12/15
Test Strategy		Tue 12/16/14	Tue 12/23/14
FDE	Tester		
RA Warning	Tester		
Test Cases		Tue 12/23/14	Tue 12/30/14
FDE	Tester		
RA Warning	Tester		
Test Execution		Tue 12/30/14	Tue 1/6/15
FDE	Tester		

Task Name	Resource Names	Start	Finish
RA Warning	Tester		
Deploy System Changes		Mon 1/5/15	Mon 1/12/15
FDE	Manager		
RA Warning	Manager	Mon 1/5/15	Mon 1/12/15
Post-Production Stabilization		Mon 1/12/15	Mon 2/2/15
Project close activities	Manager	Mon 1/12/15	Mon 1/19/15
Lessons Learned	Manager	Tue 1/20/15	Mon 1/26/15
Transition plan signoff	Manager	Tue 1/27/15	Mon 2/2/15

Exhibit W.1-2: Key Work Plan Activities and Timeframes

Projected Resource Requirements

The estimated technical resource hours by role and location are displayed in the table below.

Role	#of Associates Dedicated to Implementation Efforts	Work Location of Associates (#/State)	Estimated Total Hours
Analyst	2	1/LA, 1/PA	168
Developer	2	2/PA	336
Manager	4	4/PA	296
Tester	3	2/PA, 1/LA	240

Exhibit W.1-3: Estimate of Resource Hours

Our core claims, clinical care management, and accounting platforms do not require any major upgrades or modifications to meet the requirements outlined in the new RFP and Systems Companion Guide. Our comprehensive assessment noted that only minor modifications are needed to fulfill the new expectations, and these will be operationalized during the readiness period, prior to the anticipated February 1, 2015 contract start date.

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W.2. Information Systems

W.2 Describe results of capability and capacity assessments performed of current systems to ensure they meet or exceed contract requirements.

Describe upgrades or enhancements to existing systems needed to meet or exceed contract requirements. Additionally, if no upgrades are anticipated for this project, describe what and when major system changes/enhancements were last made.

Overview

ACLA's MIS is supported by ACFC's Enterprise Information Solutions (IS) team, which has a long history of implementing and supporting the information and technology needs of Medicaid programs, including Bayou Health. 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 Bayou Health 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.
- Process – Consistent and repeatable methodologies and best practices for implementing and supporting state Medicaid programs.
- Technology – Industry-proven applications and infrastructure.

Ensuring Current Systems Meet or Exceed Requirements

ACFC's technology platform was designed to scale with the increased capacity needed to meet the increased membership volume in publicly funded health care accelerated by the Affordable Care Act, and to adapt to the new capabilities that the ruling mandated. In 2014 alone, ACFC's capacity has shouldered more than 500,000 new lives through affiliated managed care and third-party administration (TPA) contracts. Our system capabilities have easily accommodated the new mandates and new member types, including aged-blind-disabled (ABD) and managed long-term services and supports (MLTSS) populations, on the platform.

ACFC utilizes TriZetto's Facets® health care system as the foundation for healthcare benefits administration functions and supporting services. ACFC leverages partnerships with industry leaders such as Avaya, Cisco, EMC/VMware, Hewlett Packard (HP), Oracle and PeopleSoft. Our ability to leverage best-in-breed solutions positions ACFC to continue to assume sizable growth.

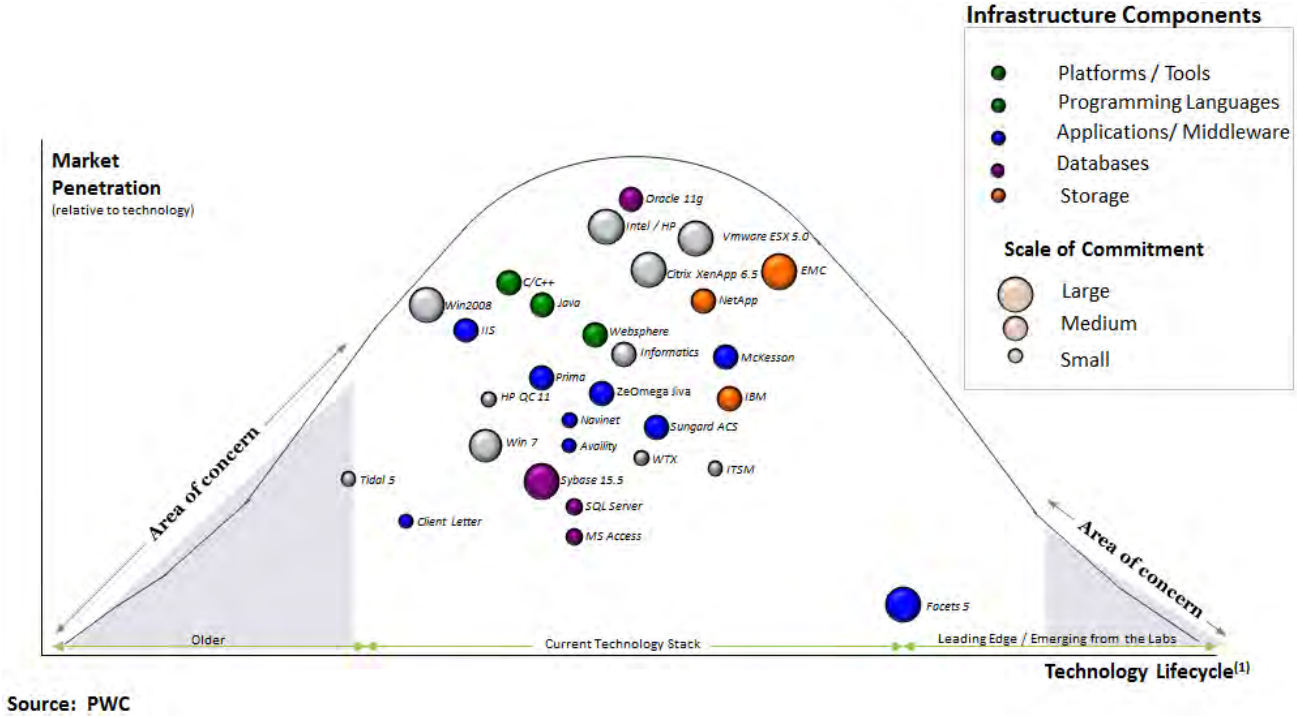
Facets® incorporates batch processing and load balancing models to readily resize and process expanded volumes of claims. This flexible approach to batch processing combined with our highly scalable VMware virtual server environment is the foundation for managing the scheduled claim processing growth for Louisiana.

ACFC continues to incorporate new technologies for our business-critical systems supporting Facets® and our data warehouse solutions. We also configure our systems to address capacity adjustments as needed.

ACFC uses a comprehensive approach to anticipate capacity based on the number of members we expect to serve. Collaborating with our health plans and business operations department, staff from our Application, Architecture, Infrastructure, and Data Center Operations teams use planning models to evaluate capacity across the IS spectrum, including network, storage, processors, voice communications, applications, and desktops. These teams continuously monitor system utilization to ensure our baselines and growth projections are within expected ranges. The team also plans and implements performance enhancements and ensures availability of our mission critical systems. Our redundant, scalable, and agile systems architecture allows us to expand capacity if volumes or performance exceed projected thresholds through increased enrollment or new opportunities.

Recent Upgrades or Enhancements to ACLA's Bayou Health MIS

ACFC's approach to system upgrades and technology adopted is to limit risk by avoiding technologies that are older and becoming outdated, as well as technologies that are just emerging and are therefore untested and potentially unstable. In 2013, Pricewaterhouse Coopers (PWC) assessed the currency of ACFC's technology platforms and concluded that we are in the excellent position of having a "current technology stack," as depicted in the diagram below:



Source: PWC

Exhibit W.2-1: Lifecycle of ACFC Technology Platforms

Since the inception of the Bayou Health program, ACFC has continued to upgrade its core platform technologies to enable new capabilities as well as maintain support levels and implement vendor patches. Facets® has been upgraded from version 4.61 to version 5.01 Release 13. Two of the major enhancements include improved auto-adjudication of coordination-of-benefits (COB) claims and support for MLTSS.

Our clinical care management platform, ZeOmega Jiva, has been updated with multiple service packs. These upgrades have concentrated mainly on efficiencies in the utilization management functions, creating improved workflows and ensuring that authorizations are complete and flow to Facets®, allowing claims that require authorization to auto-adjudicate. Other enhancements have addressed performance and enabled us to increase the Jiva user base.

In addition to core platform upgrades, ACLA has implemented enhancements to accommodate Bayou Health program changes, including, but not limited to,

- Carving in the pharmacy benefit.
- Changes to the ASC X12N 834 eligibility file.
- Enabling DHH to meet the improved data requirements of CMS through T-MSIS.
- Enhancing the information on ID cards.

Needed Upgrades or Enhancements

ACFC and ACLA thoroughly reviewed all of the requirements outlined in the Bayou Health MCO RFP, including, but not limited to a particular focus on Section 16, Systems and Technical Requirements, as well as the MCO Systems Companion Guide. We are confident that our current systems are configured and tailored to continue to meet the program's needs with the following minor modifications to accommodate new or changed program requirements.

16.1.5 Contractor must be capable of transmitting all non-proprietary data which is relevant for analytical purposes in XML format.

ACFC and ACLA do not currently transact with counterparties utilizing XML. We are capable, however, of transmitting all non-proprietary data that is relevant for analytical purposes in XML format. We have teams expert in extract, transform and load (ETL) processes and in developing transformations using our best-in-class product IBM Websphere Transformation Extender (WTX). After DHH indicates ACLA should begin sending non-proprietary data for analytical purposes to ULM, or any other contract support organization, we estimate that implementing the system changes would require approximately 12 weeks, which exceeds the 90-day requirement specified in Section 16.4.4.1 of the Bayou Health MCO RFP.

16.2.2 All HIPAA-conforming exchanges of data between DHH and MCO shall be subject to the highest level of compliance as measured using an industry-standard compliance checker.

ACLA uses an industry-standard, best-in-class transformation product called IBM Websphere Transformation Extender (WTX) for exchanging a wide variety of files and data, including HIPAA X12 electronic transactions. The WebSphere Transformation Extender Pack that

includes the HIPAA EDI Compliance Check application supports the data validation and compliance reporting for SNIP Types 1 through 7.

The rules for the higher levels of validation are user-configurable and will be adjusted to achieve the highest level of compliance based upon mutual agreement between trading partners (state, clearinghouse, vendor, and provider community). To establish a seamless process and ensure business continuity, ACLA will collaborate with all trading partners to establish a gradual approach that achieves the highest level of compliance. Our approach includes four major components: measure, assess impact, establish acceptable threshold, educate, and enforce compliance.

16.3.4 The MCO shall encourage all hospitals, physicians, and other providers in its network to adopt health information technology (HIT) and its meaningful use, with specific emphasis on connection to the Louisiana Health Information Exchange (LaHIE) and development of a secure, web-accessible health record for members, such as personal health record (PHR). The MCO shall participate in the planning and implementation of a single, all-payer PHR at such time that DHH requires.

ACLA does and will continue to encourage all hospitals, physicians, and other providers in our network to adopt health information technology (HIT) and achieve meaningful use. This includes encouraging connection to the Louisiana Health Information Exchange (LaHIE). Many of our existing providers are already participants in LaHIE. We pledge our support and business and technical leadership for the development of a secure, web-accessible health record for members in conjunction with DHH at such a time that DHH requires.

16.3.5 The MCO shall require all emergency departments (EDs) in its network to exchange admit discharge transfer (ADT) data with LaHIE's ED visit registry to aid in identification of and creation of policies around high utilizers, drug seeking behavior, and chronic disease management. The visit registry would consist of three basic attributes: 1) the ability to capture and match patients based on demographics information, 2) the ability to identify the facility at which care is being sought, and 3) at minimum, the chief complaint of the visit. These three pieces of information are commonly available through the HL7 ADT message standard and in use by most ED admission systems in use today across the country.

ACLA will amend existing contracts with providers to make exchange of admit discharge transfer (ADT) data with LaHIE's emergency department (ED) visit registry a condition of participation in ACLA's network. ACLA will work with DHH and our hospital providers to establish reasonable timeframes for their compliance.

With permission, ACLA also proposes to utilize ADT messages from LaHIE to trigger the return of a clinical summary to the ED that includes up-to-date information about the member's address, insurance, emergency contact, and PCP. Internally, ACLA will route ADT information to the appropriate care team using routing mechanisms to identify members with chronic conditions, pregnant members or members classified as super-utilizers.

16.3.6 The MCO shall require all network hospitals to comply with the data submission requirements of Louisiana Revised Statues Section 1300.111-114. Including, but not limited to, syndromic

surveillance data under the Sanitary Code of the State of Louisiana (LAC 51:II.105). MCOs shall encourage the use of LaHIE where direct connections to public health reporting information systems are not feasible or are cost prohibitive.

ACLA will amend existing contracts with hospitals to make compliance with the data submission requirements of Louisiana Revised Statues Section 1300.111-114, including, but not limited to, syndromic surveillance data under the Sanitary Code of the State of Louisiana (LAC 51:II.105), a condition of participation in ACLA's network. After contract award, ACLA will work with DHH and our hospitals to establish reasonable timeframes for their compliance.

16.3.11.2 Desktop Workstation Software: Have encryption protection enabled at the Operating System level.

All laptops, tablets, and desktops distributed for new deployments have CheckPoint hard drive full-disk encryption (FDE) active. Legacy desktops currently do not employ FDE. A capital project will be initiated to extend CheckPoint FDE to all workstations prior to the contract effective date.

17.4.3 In accordance with 42 CFR §455.18 and §455.19, the following statement shall be included on each remittance advice sent to providers: "I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."

ACLA will amend the paper image of the remittance advice to include a statement regarding payment and false claims indicating payments are from federal funds and that there are penalties for false statements. There is a limitation in the electronic version of the remittance advice (EDI 835 transaction) that precludes the inclusion of this type of statement. We will work with our vendor to ensure that the statement regarding payment and false claims is included on the paper image of the remittance advice as of the contract effective date.

Approach to System Changes

We are committed to maintaining a management information system that complies with DHH requirements, and are confident that our existing systems will meet or exceed contract requirements at the contract start date with the implementation of the minor modifications with the approaches outlined above. We have defined processes and teams responsible for implementing system changes, hardware changes, and provider networking changes. A preliminary work plan for the changes described above is included in Section W.1 of the response, and a detailed description of our change management process is described in Section W.4 of the response.

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AmeriHealth Caritas Louisiana

W.3. Information Systems

W.3 Describe how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. Your description should encompass information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major systems; and continuous testing of all applicable system functions.

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W.4. Information Systems

W.4 Provide a flow-chart (marked as Chart E) detailing your process for identifying, testing and implementing system changes, to include time frames associated with each step.

Overview

ACFC is committed to maintaining high-quality, stable information and technology systems that meet the needs of the state, its members, and Louisiana providers. Over time, those needs change, and ACFC implements system changes—from development 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.

Chart E-System Change Process Flow

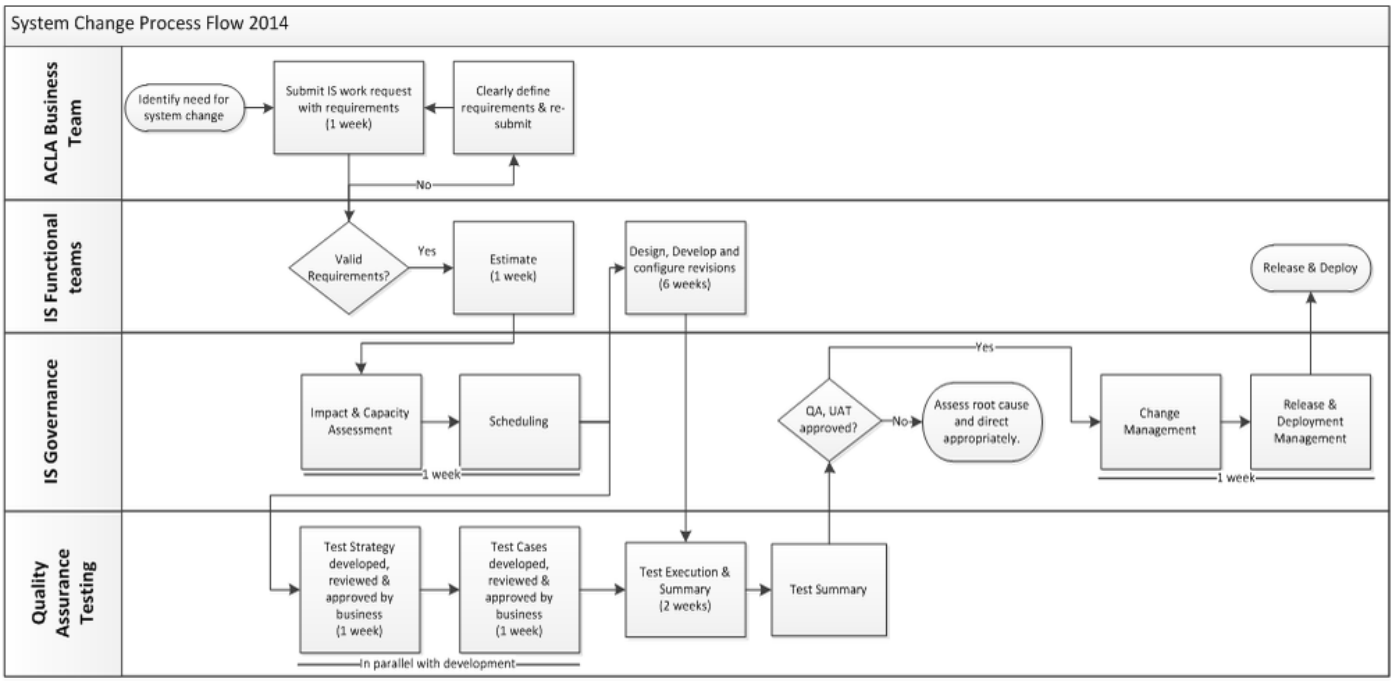

Chart E – Systems Change & QA Process Flow

System Change Management Process

ACFC's 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 contract requirements. In August 2013, the change management process was integrated into the FrontRange ITSM tool, providing a complete view of system changes from inception through implementation, as well as metrics. 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. The time frames associated with each step are identified in Chart E.

Identifying System Changes – ACLA Business Team

ACLA works closely with DHH and their respective vendors, attending DHH meetings where recommended system changes are identified and discussed. Upon receipt of requirements (e.g., revised System Companion Guides, file layouts), ACLA initiates the work intake process by completing an IS work request which identifies the requirements of the changes being requested.

Implementing System Changes – IS Functional Teams

The IS functional teams produce estimates which generate a Request for Change (RFC) within the Change, Release and Deployment process. IS functional teams use Project Lifecycle (PLC) best practices to design, develop, and configure system changes. Upon completion of unit testing, all system changes are migrated from the development environment to the Quality Assurance (QA) environment, entering the QA and Testing processes.

Implementing System Changes – IS Governance

The ACFC IS Release and Deployment Management team governs the process from intake through successful project close. The IS Governance team conducts an impact and capacity assessment before determining a high-level timeframe for delivering the requested change. The Impact Assessment is a structured process for considering the implications of a requested change on other business processes, either manual or automated.

IS governance reduces risk by controlling frequency of changes to the production environments, by bundling changes into related deployments and ensuring all required approvals and artifacts are in place.

Capacity Management and Scheduling

Capacity Management determines the availability of resources (human and infrastructure) to deliver the requested work coming into the IS department and schedules releases based on the availability of resources, through a defined governance process.

Change Management

Change Management minimizes business impact and risk from system changes in an efficient and effective manner. Adherence to these practices maintains SSAE 16 (formerly SAS 70) compliance as well as the proper balance between the need for change and the potential for detrimental impact to a business service.

All requested changes go through this industry-best practice enabling us to maintain a stable production environment as depicted below.

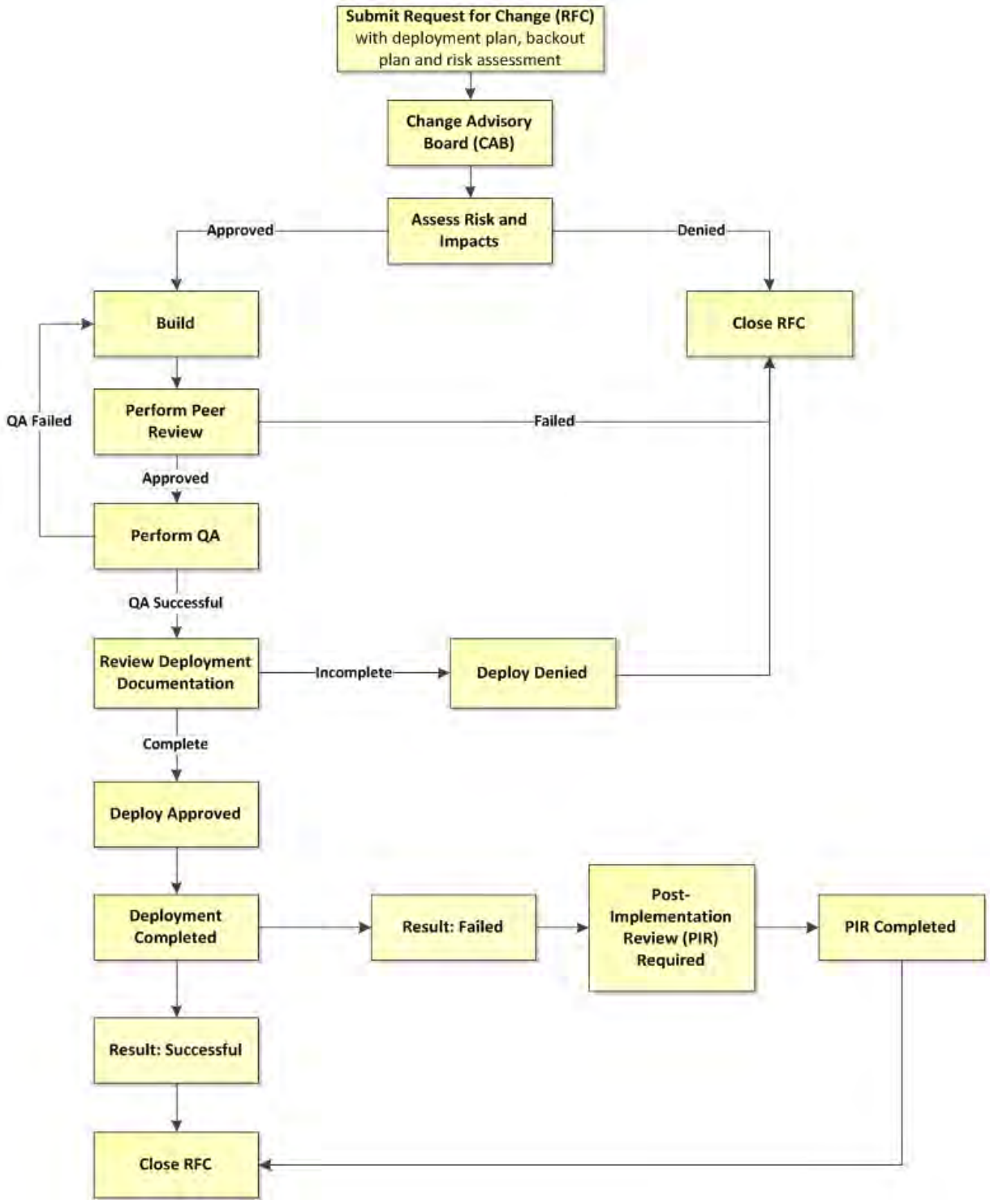

Exhibit W.4-1: Change Request and Management Process

Testing System Changes – Quality Assurance Center of Excellence

The IS Quality Assurance Center of Excellence (QACoE) provides "Best in Class" testing services in People, Process, and Technologies. The QACoE integrates enterprise testing tools and processes within our testing practices to ensure the quality and cost effectiveness of our systems. Through the consolidated QACoE model, project teams take advantage of the expertise, toolsets, and best practices developed by QACoE.

QACoE Associates (People)

Our QACoE staff have many years of testing experience in the Medicaid and Medicare industries. As a center of excellence, our staff is strongly encouraged to pursue industry certifications, such as ITIL Foundation certified, International Software Testing Qualifications Board (ISTQB), or Certified Software Quality Analyst (CSQA).

QACoE Testing Methodology (Process)

The QACoE testing methodology follows testing industry best practices providing consistent and standard testing approachs for all release processes. The QACoE uses metrics to measure our testing methodology, providing reports across test teams to improve visibility and transparency for project stakeholders. All software-testing processes follow a five-phased approach: Test Plan, Test Design, Test Construction, Test Execution, and Test Summary.

- The Test Planning phase aligns with the PLC Initiation and Planning phase. Our goals in this phase are to:
    - Identify project timelines.
    - Identify resources through capacity planning.
    - Review business requirements.
    - Provide high level testing effort and estimate.
- The Test Design phase aligns with the PLC's Planning and Design phase. Our goals in this phase are to:
    - Identify data needs.
    - Schedule environment.
    - Analyze functional and technical requirements.
    - Determine automation and performance testing needs.
    - Begin the process for configuring the testing tool.
    - Provide a refined testing effort and estimate.
    - Review and approve QACoE Test Strategy.
- The Test Construction phase aligns with the PLC's Design and Development phase. Our goals in this phase are to:
    - Prepare a comprehensive set of QA test cases.
    - Establish test coverage through traceability of requirements to test cases.
    - Automate identified test cases.
    - Continue to configure the testing tool.
    - Schedule triage meetings with project stakeholders.
    - Validate test environment readiness.

- The Test Execution phase aligns with the PLC's Development and Test phase. Our goals in this phase are to:
  - Execute smoke test.
  - Execute tests (types of testing identified within the test strategy).
  - Use testing tool for defect management.
  - Hold daily defect meetings.
  - Provide daily test report.
  - Capture test metrics.
  - Conduct User Acceptance Test (UAT) kickoff meeting.
- The Test Summary phase aligns with the PLC's Deployment and Stabilization phase. Our goals in this phase are to:
  - Conduct an internal review with development and QA team.
  - Submit an IT Closure/Test Summary Report to the project and business stakeholders.
  - Conduct a review with the business sponsors.
  - Provide inputs for lessons learned session.
  - Update regression test suite.

QACoE Tools (Technology)

The QACoE uses Hewlett Packard's (HP's) Enterprise Application Lifecycle Management (ALM) testing tool suite in support of our test methodology. The suite consists of Quality Center (Test Management), Quick Test Professional (QTP Automation), and Load Runner (Performance Testing).

Quality Center facilitates all testing activities including requirements management, traceability, test planning, test script storage, defect management, and reporting of testing metrics. Quality Center increases efficiency in our testing efforts by supporting geographically distributed testing teams to continue testing after business hours. QTP creates testing efficiencies by reducing manual time spent on regression testing and automating regression test cases, so users can execute them through the Quality Center tool.

Performance testing is considered when projects are introducing impacts that could affect the performance of processing system services, such as adjudicating claims. Load Runner allows QACoE to simulate concurrent users performing various business tasks to determine if the system experiences degradation in performance.

End-to-End Testing

End-to-end testing methodology integrates into the QACoE testing approach, confirming that the flow of business scenarios is performing as expected from start to finish. The purpose of carrying out end-to-end testing is to identify system dependencies and to ensure that the right information is passed between various system components. The end result provides validation that the revisions have not adversely impacted existing business processes.

ACFC's process for identifying, testing, and implementing system changes has enabled us to continue to meet Bayou Health requirements in a timely manner, utilizing information technology best practices to ensure system changes do not disrupt business services.

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W.5. Information Systems

W.5 Provide a flow-chart (marked as Chart F) detailing your process for receiving, processing and updating member enrollment, to include time frames associated with each step.

Overview

ACLA's enrollment process is built around nationally accepted HIPAA-compliant transactions, daily 834 transactions, monthly 834 files, and quarterly reconciliation files. All files are processed to add members, disenroll members, or update existing member eligibility data. Identified errors are corrected and reconciled with the Enrollment Broker's data, ensuring accurate data is stored in both systems.

We process eligibility transactions chronologically, ensuring the most current data is present in Facets®, our core claims administration platform. Upon completion of the eligibility file processing, ACLA automatically assigns primary care providers (PCP), and sends ID cards and new member welcome packets to members. ACLA accepts all members eligible to participate in the Bayou Health program, without discrimination.

Chart F-ACLA's Enrollment Process Flow

The flow chart on the following page details ACLA's process and timeframes for receiving, processing, and updating eligibility information.

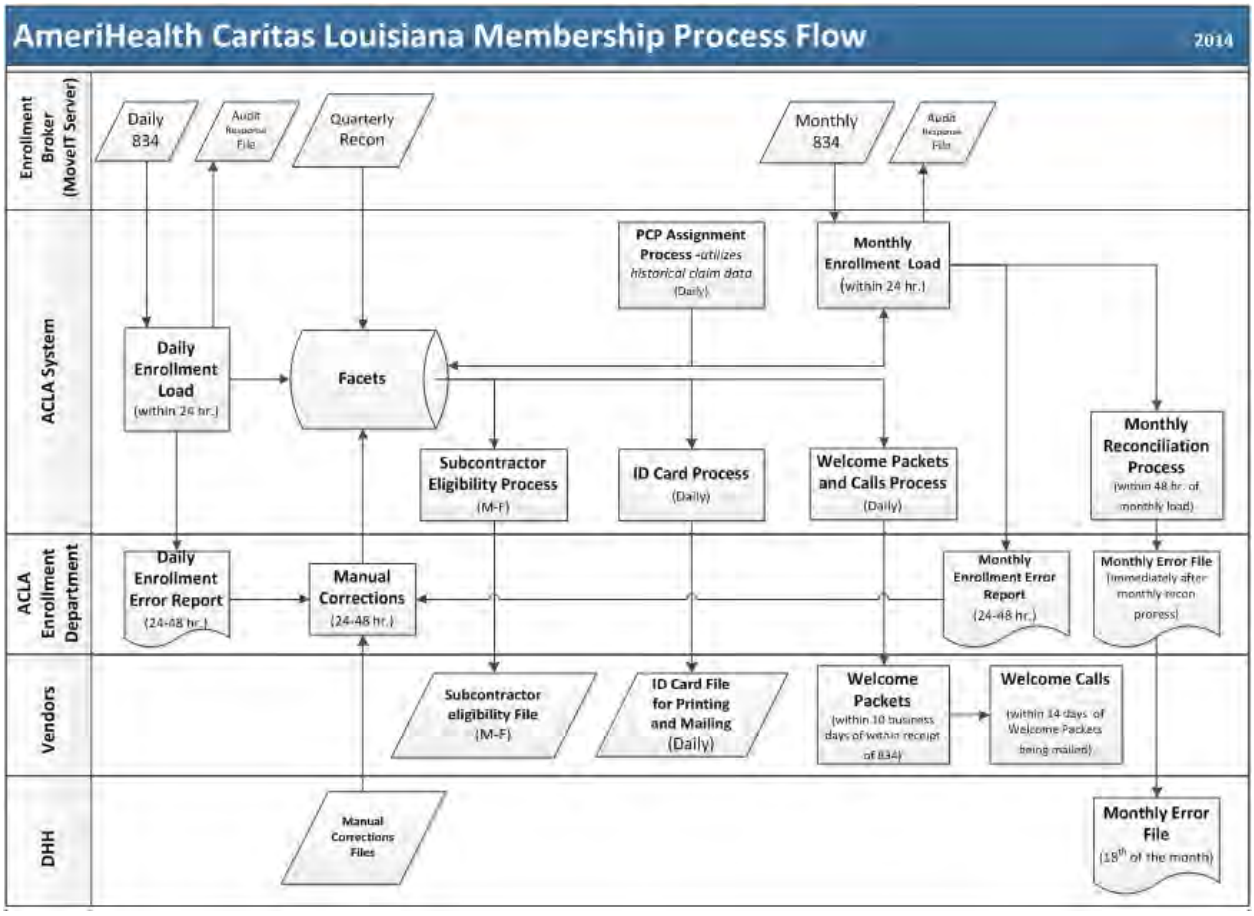

Chart F - AmeriHealth Caritas Louisiana Membership Process Flow

ACLA's Enrollment Process

ACLA collaborates with DHH and the Enrollment Broker, to exchange eligibility and enrollment data, conduct system and process testing, and achieve key milestones.

Daily ASC X12N 834 Enrollment Load (Inbound)

The daily membership file, in an ASC X12N 834 Benefit Enrollment and Maintenance transaction, is loaded into the Facets® system within 24 hours of receipt of the file. Facets® is the central repository for all member data. ACFC has written policies and procedures for receiving these updates, incorporating them into Facets®, and ensuring this information is available to our providers.

We compare eligibility transactions to our existing member records, update or add them as necessary, and create error reports. Designated employees in the Enrollment department review and reconcile the error reports.

DHH Manual Corrections Files

DHH delivers monthly manual corrections files and special corrections files to ACLA, including, but not limited to, Medicare dual-eligibles, retro date of death, terminations, plan identification, new enrollments, demographic updates, and retro newborns. Our Enrollment department works with DHH through weekly meetings to discuss various updates to the data ACLA receives in these files. The information provided contains the necessary elements for eligibility review and investigation, described below.

Identifying and Reconciling Discrepancies

The most common discrepancies are address changes, spelling errors, changes to third-party insurance coverage, or changes in telephone numbers. Eligibility data discrepancies are identified through a number of sources, including medical records, discharge planning, PCP notification, member communication, claims, and returned mail. ACLA's Member Services Representatives also identify discrepancies through routine member calls by asking members to verify their personal information as an extension of the privacy-protecting identification process.

All information collected is used to update the member's eligibility file. Our employees enter these updates into our Facets® system using Integrated Agent Desktop, a state of the art customer services desktop, or a custom-designed, front-end graphical user interface called Streamline.

ACLA works with members to ensure their demographic information is accurate. The demographic information we have in our systems is sent to members in writing at their request. Member Services representatives direct inquiries to the Enrollment department to resolve time-sensitive member questions about eligibility and enrollment, resulting in improved real-time issue resolution and increased member satisfaction.

PCP Selection and Auto-Assignment

The Enrollment Broker transmits member PCP choices in the Daily Membership Files. The New Member Welcome Packet and Welcome Call confirm the member's PCP selection. If no PCP is listed in the Daily Membership File, the member is asked to select one during the welcome call. If the member cannot be reached, or does not choose a PCP, ACFC auto-assigns a PCP using our DHH-approved PCP algorithm.

ID Cards, Welcome Calls, and New Member Welcome Packets

During eligibility file processing, a daily batch process identifies newly enrolled members and creates an ID card list, which is used to generate ID cards. ID cards and new member welcome packets are mailed to members, along with a letter that informs members about the ID cards they will receive from the state. ACLA's ID cards contain:

- Member's name, date of birth, plan, and Medicaid identification numbers.
- Member's PCP name and address (if selected during enrollment process).
- ACLA's name, logo, address, and toll-free numbers for our Member Services and Prior Authorization services.

- Instructions for how to respond to emergencies.
- Information on reporting Medicaid fraud.

ACLA's welcome packets also contain a New Member Assessment for members to complete. Members receive an incentive gift card if they complete and return the assessment.

The ACLA ID cards mail packet encourages members to call our toll-free Member Services telephone number to verify contact information, and get answers for any questions they may have about ACLA or the Bayou Health program.

New member welcome packets include instructions on how to use ID cards, how to contact ACLA to update contact information, and how to select a PCP if one is not printed on the card. All ACLA member materials include information on how to receive copies in Spanish and Vietnamese.

Weekly Communication with the State and Enrollment Broker

All data that does not match as expected—for example, if a reported eligibility end date is prior to the recorded eligibility begin date—is automatically categorized based on error numbers and provided to the Enrollment department in daily error reports. The Enrollment department researches these discrepancies and notifies the Enrollment Broker, typically within 48 hours but no later than 10 calendar days after receiving the daily enrollment file.

DHH's Medicaid Customer Service Unit is notified of any change in member status or demographics, such as address changes, death notifications, or Third Party Liability (TPL) changes within 48 hours, but no later than five business days, after identification. These changes are primarily identified by member calls to the Member Services team. If the change in status indicates ineligibility for the Bayou Health program—for example, if the member moved outside of Louisiana—an MCO Initiated Request for Disenrollment to the Enrollment Broker is submitted.

ACLA participates in the weekly DHH 834/820 teleconferences which enables all plans to discuss with DHH, the Enrollment Broker, and the Fiscal Intermediary (FI) all 834/820 items.

Monthly Enrollment Load and Reconciliation Process

ACFC reconciles the inbound monthly files, providing discrepancies to DHH by the 18th of each month. The discrepancies delivered to DHH include but are not limited to AC/TC inaccurate combinations, variances between the Enrollment Broker's daily and monthly 834s, and variances between DHH and Enrollment Broker data.

Monthly Eligibility File Process (Inbound)

Similar to the Daily Eligibility File, ACLA receives a Monthly Eligibility File from the Enrollment Broker that contains the most current record for each recipient who will become eligible within the current month. This file is a reconciliation of all of the daily files and any manual transaction files received from DHH for members effective during the current month. The Enrollment department also reviews this information to identify errors.

Monthly Eligibility File Reconciliation (Outbound)

Any data that does not match as expected—for example, if a member is in Facets® but not on the monthly file—is reported to the Enrollment department in monthly reconciliation error reports. The Enrollment department proactively reviews, researches, and reconciles these discrepancies within 48 hours. Any true discrepancies are provided to DHH via e-mail in the DHH preferred layout by the 18th of each month.

Quarterly Reconciliation (Inbound)

The Enrollment Broker sends ACLA Quarterly Reconciliation Files, which are full refreshes of ACLA membership. Processing of the daily 834 eligibility files is paused while the Quarterly Reconciliation File is processed to prevent data from being loaded out of order. Once the Quarterly Reconciliation file completes processing, the daily 834 files are loaded in the order received.

PCP Linkage Files

PCP Linkage File (Outbound)

ACLA produces a PCP Linkage Outbound File to DHH weekly, which is a full file representing all PCP-to-recipient linkages (current and historical) that are in Facets®. If errors are identified, designated employees in the Enrollment and the Provider Maintenance Departments remediated in Facets® for inclusion in the next week's submission.

PCP Linkage Error File (Inbound)

ACLA receives a PCP Linkage Error File from the FI containing the errors on the weekly submitted file. The PCP Error file is retrieved and provided to the Enrollment and Provider Maintenance Departments to research and remediate. Revisions are entered into Facets® for inclusion in the next week's submission. Since the implementation of this file requirement, ACLA has achieved 100% acceptance.

Subcontractor Files

Daily Eligibility File to Subcontractors (Outbound)

ACLA produces a Daily Subcontractor Eligibility Outbound File, which contains changes to member records since the last daily file. The subcontractor file is transmitted to the vendors via secure file transfer protocol (SFTP).

Monthly Eligibility File to Subcontractors (Outbound)

ACLA produces a Monthly Subcontractor Eligibility Outbound File, which contains all members effective for the upcoming month. Any subsequent changes to member records will be delivered in the daily files. The sub-contractor file is transmitted to the vendors via SFTP.

Acceptance of all Eligible Enrollees

ACLA enrolls any mandatory or voluntary Bayou Health member who self-selects the plan or is assigned to the plan, in the order they are received, without restriction and up to the maximum enrollment capacity limit specified in the contract. Our enrollment, re-enrollment, and disenrollment processes do not discriminate based on age, sex, ethnicity, language needs, health history, health status, need for health care services, or adverse change in health status.

W.6. Information Systems

W.6 Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates.

Overview

ACLA's parent, ACFC, has been heavily involved in health information exchange (HIE) initiatives in a number of states and actively supports network providers' use of Electronic Health Records (EHR). ACLA is currently contracted with over 95 percent of providers listed as participants or prospective participants in LaHIE. We look forward to working with DHH, the Louisiana Health Care Quality Forum (LHCQF), and Louisiana's providers to securely exchange information that will help coordinate care for Bayou Health members.

Throughout the initial Bayou Health contract term, ACLA's partnership with NaviNet enabled us to share member claim histories and clinical summaries with providers through the Provider Portal. NaviNet enables providers to access and download data from our core administration and clinical platforms. This information can then be uploaded into the provider's EHR system. The robust reporting tools in the Provider Portal enable providers to develop and customize reports that can be used to help them manage the health of their patient population.

Participation in Health Information Exchanges

ACLA recognizes that LaHIE will play a key role in real-time care coordination, health outcomes, and cost containment in Louisiana. Receiving real-time alerts about admissions, discharges and transfers will enhance ACLA's abilities to coordinate and manage member care, while providers will benefit from the increased access to member records such as recent claims summaries and medication lists.

Since ACLA contracts with more than 95 percent of the hospitals and affiliated clinics listed as LaHIE participants or prospective participants on the LHCQF website, we are well positioned to help providers adopt and leverage EHR. As connections continue to be built, ACLA is committed to supporting and participating in LaHIE as both a supplier and a consumer of member information.

Experience with HIEs

ACFC currently participates in health information exchanges in Pennsylvania, South Carolina, the District of Columbia, Nebraska, Indiana, Florida, Michigan, and Kentucky. ACFC has participated on numerous committees to address technical, operational, and security concerns, helping states design, implement, and fund their health insurance exchanges.

ACFC's Chief Medical Officer, Dr. Andrea Gelzer, is a member of the board of directors for the HealthShare Exchange of Southeastern Pennsylvania, Inc. (HSX), and the Medical Director of our South Carolina plan, Dr. Greg Barabell, is currently serving on the board of directors for SCHIEx. ACFC's eBusiness Solutions team is led by Joe Miller, FHIMSS. Mr. Miller is a

recognized national leader in HIE, has authored a book on EHR implementation, and is a frequent presenter at national conferences, government agencies, and other health information technology events.

Supporting HIE in the District of Columbia

One of ACFC's affiliates, AmeriHealth District of Columbia (AmeriHealth D.C.), is currently participating in the District of Columbia Health Information Exchange (DC HIE), as well as 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.

Providers in the District are encouraged to adopt and use health information technology to promote member care through the secure exchange of EHR. Any organization that participates in CRISP must sign a uniform data sharing agreement to enable sharing of member information between the parties. This collaboration between providers and payers—which is similar to the collaboration expected for LaHIE—creates opportunities to leverage EHR to address the needs of high-risk members and improve the quality of care.

Health information exchange in the District relies on several key functions offered through CRISP. This includes the Encounter Notification System and the Provider Query Portal.

Encounter Notification System

Since March 2014, AmeriHealth D.C. has been exchanging secure Health Level Seven (HL7) Admission, Discharge, and Transfer (ADT) messages with hospitals as part of CRISP's Encounter Notification System. These HL7 ADT messages primarily communicate a member's admission status or demographic information.

This exchange of information enables AmeriHealth D.C.'s care coordinators to know, in real time, when a member has presented in the emergency room, or if a member has been admitted, discharged, or transferred from or between inpatient facilities. After AmeriHealth D.C. receives notification of the event, a clinical summary for the member is pushed back to the hospital. AmeriHealth D.C. provides member information to the hospital, including up-to-date information about the member's address, insurance, emergency contact, and PCP. This information can be incorporated into the hospital's EHR system.

ACLA would like to utilize ADT messages from LaHIE to trigger the return of a clinical summary to the hospital that includes up-to-date information about the member's address, insurance, emergency contact, and PCP. While this functionality is not discussed in the Bayou Health MCO RFP, ACLA will work with LHCQF and network providers to explore this functionality.

CRISP's Provider Query Portal

As clinical information is created in and shared through CRISP, it is accessible at the point of care in real time to participating health care providers through the CRISP Portal. The portal allows providers to look up patient information securely through the Internet, including history

and physical information, medication information, lab results, radiology reports, discharge or transfer summaries, and operative notes.

Other Initiatives

In addition to the exchange of secure patient information through CRISP, AmeriHealth D.C. is working on a pilot program that will engage members through smartphone applications and text messaging. These technology tools will make accessing appropriate medical services easier while opening new channels for communication.

The exchange of information between providers and payers will also enable AmeriHealth D.C. to increase the meaningful use of patient data by providing additional details from EHR for use in care management and the development of tailored programs to address chronic conditions.

Infrastructure to Support Participation in LaHIE

ACFC has created a scalable and adaptable exchange infrastructure to support enterprise-wide integration with health information exchanges across the nation. ACFC adopted Mirth as the enterprise's HIE platform. The application is capable of exchanging messages in industry-standard ADT, Continuity of Care Document (CCD), and Consolidated Clinical Document Architecture (C-CDA) formats. Using Mirth, AmeriHealth D.C. connected to the CRISP exchange and began receiving messages in 60 days. ACFC anticipates that a similar time to market can be achieved with Louisiana's LaHIE.

One of the key functions available in Mirth is the ability to intelligently direct messages received through an exchange to the appropriate care team. For example, routing mechanisms are configured for members with chronic conditions, pregnant members, members classified as superutilizers, or members in the lock-in programs.

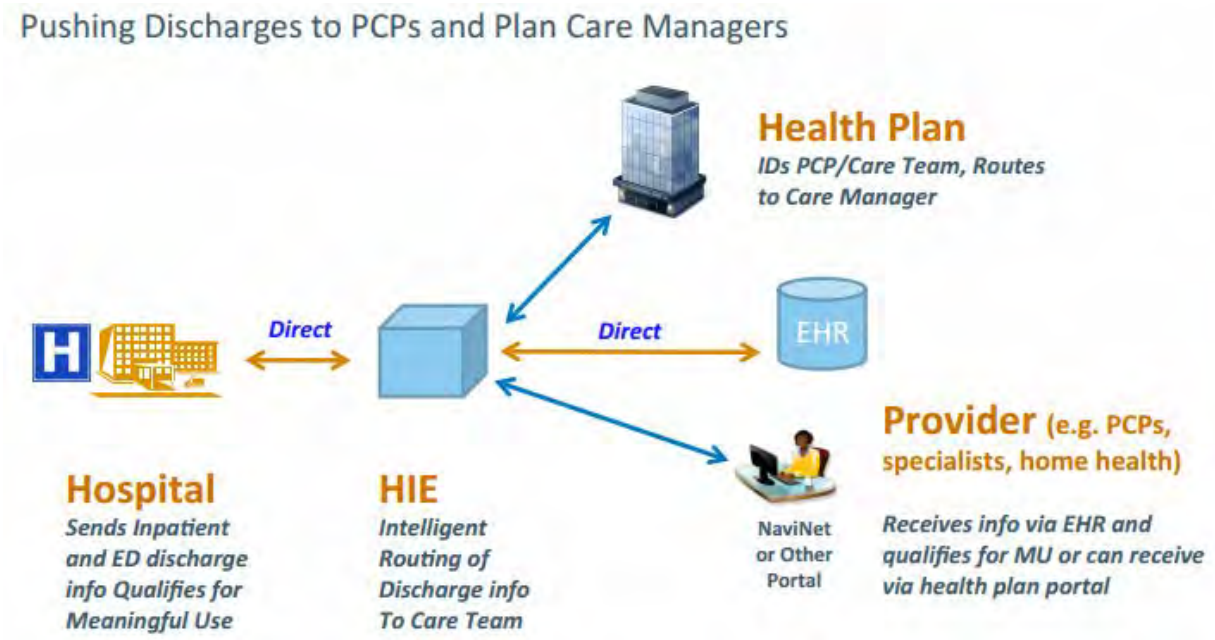

Exhibit W.6-1: Pushing Discharges to PCPs and Plan Care Managers

Currently, this "smart distribution" directs messages to the member's care team, enabling them to take immediate action to provide assistance or guidance to members. ACFC anticipates being able to distribute received messages to the member's primary care provider (PCP) in the future.

Access to Electronic Member Data through NaviNet

Participating in an HIE enables plans and providers to reduce medical errors and duplicated services, improve quality outcomes, and control costs. ACLA has provided electronic member clinical summaries and member claim histories through NaviNet's Provider Portal as a 'stepping stone' to achieve meaningful use throughout the original Bayou Health contract term.

The member clinical summaries provide information on prescriptions filled by the member, clinical conditions found in the member's claim data, recommended services, inpatient admissions, and emergency room admissions. This includes the care gaps identified by the care management software used by ACLA, ZeOmega Jiva.

Care gaps are clinically recommended services that would benefit a member (for example, preventive services, or chronic condition monitoring) based on the absence of claims for the service. This enables any appropriate participating provider to address these care needs during the member's next visit, reducing the need for members to access multiple points of care.

NaviNet is designed so providers can log in once to access all information for their patients that is stored in our core platforms. This can create a virtual bridge between provider systems.

NaviNet also grants providers secure, robust reporting capabilities using most of the member data available in ACFC's back-end systems, including data generated from other providers. Providers can build customized reports on key metrics, patient data, or outcomes related to pay-for-performance programs through filters and sorting. They can then print or download CCD or Excel CSV versions of the reports, which can be uploaded into their electronic health record systems.

CCD Information

ACFC's CCD payload includes a rich and timely set of clinical data on the member, including current dispensed medications; recent emergency room, inpatient, and ambulatory visits; diagnoses; and gaps in care for preventive health screenings and chronic disease management. A comprehensive set of data rules are in place to screen out prohibited data related to HIV, substance abuse, and mental health specific diagnoses, procedures, and medications.

Current and Future IT Federal Mandates

ACFC and ACLA have adapted to all of the recent federal mandates, from the adoption of the 5010 standard to remediating our systems to prepare for the ICD-10 transition. With our flexible systems and experienced staff, ACLA is well positioned to respond to future federal IT mandates. In addition to our investments in HIEs, ACFC is currently working on initiatives for Administrative Simplification and Transformed Medicaid Statistical Information System (T-MSIS).

Administrative Simplification

ACFC is working with business partners on the Administrative Simplification initiative. The Patient Protection and Affordable Care Act (PPACA) included a provision designed to decrease time spent on administrative tasks and increase the adoption and use of electronic transactions. ACFC has already adopted the functionalities specified in interim final rules issued by the U.S. Department of Health and Human Services for eligibility and claims status transactions as well as electronic fund transfers and electronic remittance advices.

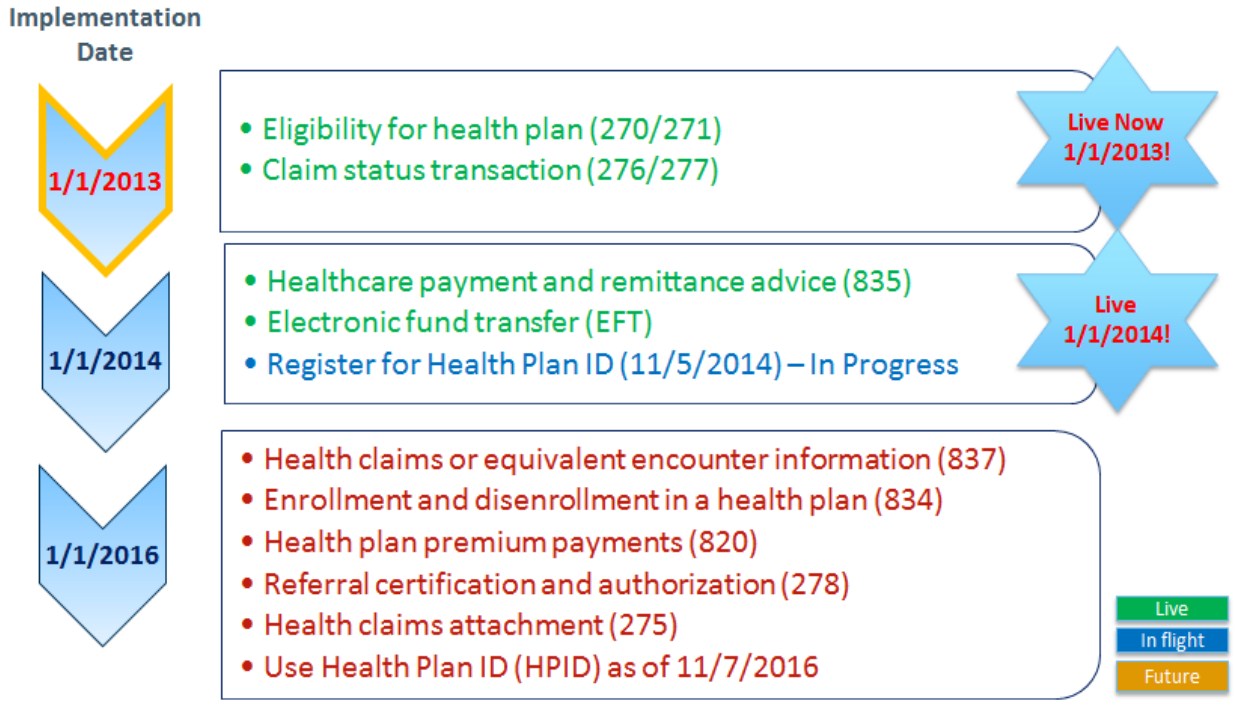

Exhibit W.6-2: ACFC's Administrative Simplification Activities

T-MSIS

ACLA has worked closely with DHH and its vendors to build and test T-MSIS revisions. Through the PPACA, CMS has required states to replace the existing member, provider, and plan databases with the Transformed Medicaid Statistical Information System.

The T-MSIS Louisiana Project affects core business functionality and systems within the organization, as well as many of our vendors, business partners, subcontractors, members, providers, and customers. T-MSIS activities include expanding the existing MSIS data extracts currently issued to CMS to comply with the new, federally mandated file layouts. The project leverages existing processes within the LMMIS system to provide a solution from Molina Healthcare.

ACLA has achieved compliance with all phases of design, development, and testing for the T-MSIS changes. This includes revisions to existing 837I, 837P, and National Council for Prescription Drug Programs (NCPDP) encounters files, as well as the creation of a new

Supplemental Provider Registry file. The 837I and 837P encounters test files have a 100 percent acceptance rate. NCPDP encounters file changes are in production, and currently have a 100 percent acceptance rate. The Supplemental Provider Registry File has a 100 percent acceptance rate as well.

ACFC and ACLA have demonstrated the ability to assist, guide, and support Louisiana's network providers' meaningful use of EHR during the initial contract term and plan to continue to expand the use of health information technology. Our focus on member needs and passion for innovation position ACLA to meet all current and future IT Federal mandates. ACFC and ACLA will continue to invest our time and talent to shape the direction and use of EHR to improve the health of its members.

W.7. Information Systems

W.7 Describe your plans to utilize ICD-10.

Overview

ACFC has been actively engaged in assessing the potential impacts to enterprise technology solutions from the ICD-10 transition. The first impact assessment was completed by a third-party in 2011, and additional assessments have been periodically completed in order to ensure a smooth transition. By the end of 2011, ACFC was using ICD-10 compliant versions of TriZetto Facets, the enterprise's health care benefits administration application, and ZeOmega Jiva, our medical/care management platform. Since then our ICD-10 efforts have focused on building system-wide compatibility and compliance, developing and completing end-to-end testing protocols, and providing guidance to staff and providers about the effects the ICD-10 transition will have on their daily practices.

With the extra year of preparatory time granted in the Protecting Access to Medicare Act of 2014, ACLA is working with ACFC resources to develop internal auditing processes, educate staff to better support provider network concerns, and expand end-to-end testing exercises to additional providers. ACLA hopes to work closely with Louisiana DHH to coordinate ACFC's Medicaid-specific General Equivalency Mappings (GEMS) with the State's preferred model and perform extensive end-to-end testing to ensure data is captured correctly and achieves financial and clinical neutrality.

ICD-10 Utilization

ACLA recognizes that implementing ICD-10 will significantly increase our ability to capture accurate health care data, measure health outcomes, and improve our care delivery and disease management programs. ACLA and ACFC have already begun reviewing and adapting our internal reports to the increased levels of specificity and detail afforded by ICD-10. We are also preparing to respond to the expectation of greater depth in reporting for federal, state, quality, and accreditation agencies. This improved reporting will lead to valuable insights that will help drive innovations in population health management. ACLA looks forward to working with DHH to leverage these insights to improve the health and lives of Louisiana members.

ICD-10 Implementation

While the ICD-10 implementation promises advances in care management, it also poses serious concerns for care continuity as many information systems used to support core operating functions need to be updated or replaced. Business continuity and revenue neutrality are also key concerns for providers, payers, and program management.

ACLA and its parent, ACFC, have been actively engaged in ICD-10 implementation activities since 2011 in order to best prepare the business and mitigate the potential effects of the conversion. These efforts have focused on building system-wide compatibility and compliance,

developing and completing end-to-end testing protocols, and providing guidance to staff and providers about the effects the ICD-10 transition will have on their daily practices.

We continue to align our implementation milestones with CMS's recommended timelines. ACLA and ACFC did not slow transition efforts after the April 2014 decision to extend the compliance date to October 1, 2015, and therefore anticipate achieving ICD-10 compliance well before the current mandated date. We have steadily continued to remediate our systems, while identifying opportunities afforded by the extra year to extend our testing and training activities.

Dedicated ICD-10 Implementation Team

ACLA is committed to ensuring we are ICD-10 compliant before the mandated date, and has had a dedicated project management team working on the ICD-10 transition since March 2011. In 2012, the team worked with each ACLA business area to assess the impacts that the transition to ICD-10 could have on the organization. This included assessing all clinical and claims applications, systems, and reports that include ICD-9 fields. Results from the assessment were captured in an implementation plan that includes a timeline to complete system design and development, internal and external testing, medical policy updates, communication initiatives, and training.

This dedicated implementation team ensures that appropriate governance and controls are applied consistently and throughout the organization. All decisions related to the ICD-10 transition are made by this team and in consideration of the system-wide impacts.

ICD-10 System Changes

Transitioning information systems to ICD-10 requires coordinated and comprehensive efforts that include provider contracting, care management, customer service, claims management, auditing, and compliance. The tools that support these functions, as well as those that assist in workflow and automation need to be updated to capture the higher levels of specificity capable in ICD-10. This includes significant changes to interfaces, alterations to reporting mechanisms, increased requirements for clinical documentation, training of clinical and non-clinical staff, and adjusted business rules.

To capture the scope of work necessary, ACLA and ACFC performed a complete analysis of applications and reports that currently use ICD-9 codes. Since completing the assessment, ACLA's largest and most impacted applications, TriZetto Facets and ZeOmega Jiva, have been upgraded to ICD-10 compatible versions, which can now load, store, and maintain ICD-10 diagnosis and procedure code sets, English language descriptions, and effective start/end dates. HLI's LEAP I-10 tool has been installed to provide terminology management, analytics, and reporting on the transition to ICD-10. Our new encounters system, EDM, will be implemented in the beginning of 2015. EDM is designed to natively process all ICD-9 and ICD-10 data that is loaded into the data warehouse from Facets. Remaining secondary applications are currently being remediated.

ACFC has also updated downstream systems, such as our data warehouse, and our database tables and file formats to accept ICD-10 codes. We have ensured that all necessary fields can handle the length of ICD-10 codes, and that logic is in place to manage reporting transitions for the one-to-many and the compound code sets. ACFC has also added ICD indicators in order to accommodate the data that will contain the indicators. They were implemented in Facets, Jiva, and all downstream systems as necessary.

Development of GEMs

CMS released general equivalence maps (GEMs) meant to serve as a general-purpose translation tool between ICD-9 and ICD-10 coded data. Over the past two years, ACFC has lightly customized the CMS GEMs in order to include additional ICD-9 codes that were not included in the CMS GEMs. These particularly relate to services used by the Medicaid population, as well as women's health and children's care services.

ACFC's customized GEMs are used to maintain consistent business logic through the entire transition period. ACFC has used them as a guide as we update our impacted information systems, including Facets and our data warehouse, ensuring consistency in the changes made. They will also be used, as needed, to translate between ICD-9 and ICD-10 for reporting, especially reports that track historical trends across the implementation date.

ACLA and ACFC are willing to coordinate our GEMs with any model required by the State of Louisiana. We have also coordinated with our partners and vendors to ensure that the same GEMs are being employed in order to avoid errors. ACFC's ICD-10 Implementation Team works with each vendor to assist them in adopting our GEMs.

Dual-Processing Approach to Natively Process Both Code Sets

ACLA and ACFC are implementing a dual-processing approach so that we can process both ICD-9 and ICD-10 through our core systems without the use of a crosswalk. Facets, and our other processing systems, will natively process incoming claims based upon date of service.

Beginning October 1, 2015, claims for dates of service 10/1/2015 and after will be natively adjudicated and processed against the ICD-10 code set based upon the custom GEMs created by ACFC. Claims for services rendered prior to 10/1/2015 will continue to use the existing ICD-9 code set natively. All outpatient and professional claims with dates of service on or after October 1, 2015 must contain ICD-10 diagnosis codes.

Ongoing and Future Implementation Activities

ACLA's medical policies are being updated to include the ICD-10 code set. These policy updates will be effective on October 1, 2015. ACLA and ACFC are also planning to complete thorough analysis and end-to-end testing and analysis to verify that the transition is complete. This includes assessing the financial and clinical neutrality and potential issues that may result in payment processing delays.

End-to-End Testing

The extended transition date allows ACLA and ACFC to broaden and lengthen testing scope so that we can extend testing activities to a wider array of scenarios in 2015. ACLA is preparing full end-to-end internal testing for all remediated systems, claims processing flows, and data warehouse processes. This is currently planned for the fourth quarter of 2014.

As part of the testing, ACLA and ACFC are developing an internal auditing process to assess the transition's impacts and assure systems compliance. If testing reveals that clinical neutrality is not found, ACLA and ACFC will identify the codes responsible for the imbalance and make appropriate corrections. We have completed our revenue neutrality analysis for ACLA, and the results came back within our targeted variance of +/- 2%.

Testing with Fiscal Intermediary

ACLA is currently preparing to test ICD-10 claims by submitting mocked ICD-10 encounters files to Molina in accordance with DHH's and Molina's timeframes, originally scheduled for July and August 2014. Following the deployment of ACLA's new encounters system, EDM, in early 2015, ACLA anticipates fully testing ICD-10 coded encounters no later than Q2 2015. Precise schedules for EDM deployment and testing are still being finalized.

All test files will be submitted to the MMIS test environment as specified in the testing instructions provided by DHH, with the goal of both code sets processing exactly the same. ACLA and ACFC will compare the adjudication results and resolve any discrepancies in how the ICD-9 and ICD-10 files were processed. ACLA will coordinate with Molina to verify and receive approval of the test results.

Testing with Providers

ACLA plans to begin testing with selected providers starting in October 2014 in order to verify full end-to-end ICD-10 claims processing. ACLA will select providers based on their claim volume, total claim amount, and breadth of claims type to ensure that the full scope of provider claims is tested in the system. Currently, ACLA anticipates partnering with at least two of Louisiana's major health systems to perform the testing. Through ACLA's affiliates, ACFC expects to test with approximately 30 providers nationwide. The Louisiana providers that are ultimately selected to participate will be required to submit ICD-10 test claims to our clearinghouse vendor, Emdeon, for inclusion in the testing process. ACLA is currently working with Emdeon to develop the test plan.

ACLA's Provider ICD-10 Resource Center

Communicating with the provider network is a key component of ACLA's planning and implementation efforts. Understanding how providers are preparing for ICD-10 and identifying potential risks prior to the implementation date will help mitigate and control the impacts of the transition across the provider network. ACLA communicates with providers about the ICD-10

transition through a variety of channels, including ACLA's website, our provider newsletters, Fax blasts, NaviNet Plan Central, "e-lerts", Messenger, and the Provider Resource Center.

Plan to Mitigate Risk for a Smooth ICD-10 Transition

To make your transition to ICD-10 smooth, consider following these steps:

- Establish a transition plan. Outline the steps your practice intends to follow to comply with ICD-10 requirements. Establish milestones to keep your practice on track. Share your transition plan with your electronic health record and practice management system vendors and billing services. Talk to them about how you can set up testing before the deadline.
- Communicate with your vendors regularly; encourage them to take action now to avoid reimbursement delays. Talk to your vendors about making sure your practice management systems will be able to handle ICD-10 transactions. Ask them about their schedule for training your practice's staff on the system changes. Make sure you and your vendors allow ample time for testing ICD-10 systems.
- Identify everywhere that your practice uses ICD-9. Any function where you currently use ICD-9 will be affected by the transition to ICD-10. By taking a look at where you use ICD-9, you will see where you need to be prepared to use ICD-10 codes.
- Plan for staff training. Decide who needs training, what type of training they need, and when they need it. Anyone who will test ICD-10 systems before the transition will need training in advance so they can perform meaningful testing. Others who use ICD codes can be trained six to nine months before the October 1, 2014 transition.
- Network with peers. Talking with your peers in other practices can help you to identify best practices and opportunities for sharing resources.
- Set up an emergency fund to cover potential cash-flow disruptions from claims processing. If you think you might have a serious disruption in getting claims processed after the transition, having a cash reserve on hand could be helpful.
- Process ICD-9 transactions before the deadline. Get claims with ICD-9 transactions processed before the deadline to avoid facing a major backlog after the October 1, 2014 ICD-10 transition.

Keep Up to Date on ICD-10

Visit the CMS ICD-10 website at **http://www.cms.gov/Medicare/Coding/ICD10/index.html**?redirect=/icd10 for the latest news and resources to help you prepare for the October 1, 2014 deadline.

Exhibit W.7-1: July 2013 Connections Newsletter

ACLA's ICD-10 Resource Center

ACLA's provider communications team regularly communicates updates on timelines and policies about the ICD-10 transition through the ACLA ICD-10 Resource Center. ACLA also maintains an online FAQ page that is regularly updated with the most up to date information about ACLA's implementation plans. Providers can ask about ACLA's ICD-10 implementation through the secure contact form available on the website; there is a dedicated option for "Provider – ICD 10 Questions" that will route the question directly to ACLA's ICD-10 Implementation Team.

Developing Organizational Readiness

The ICD-10 Implementation team has been tasked with ensuring that the organization is ready to meet the new demands of ICD-10. ACLA and ACFC have already begun training associates on ICD-10 requirements and our implementation plans to better support and communicate with our provider network and the State of Louisiana during and after the ICD-10 implementation.

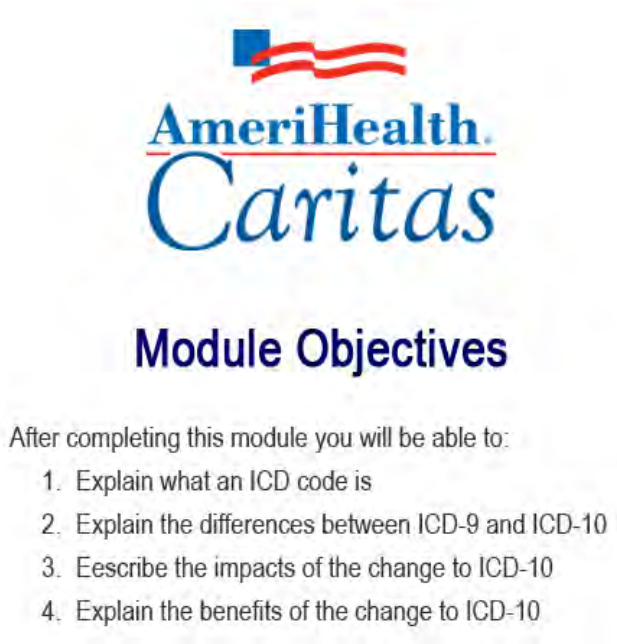

Exhibit W.7-2: AmeriHealth Caritas ICD-10 Transition Training Module

ICD-10 Awareness Training

ACFC's Learning and Organizational Development (L&OD) team facilitated several meetings with key enterprise leaders in early 2014. In these meetings, potential impacts to information and technology systems, as well as staff training and coding needs, were identified.

Using information gathered from enterprise leaders, the L&OD team developed an enterprise-wide communication plan to assist associates in understanding how the ICD-10 implementation will affect their daily activities. Internal communications are planned to be released throughout 2014 and 2015 to coincide with the implementation and testing timeframes.

Building ICD-10 Competency and Enterprise Knowledgebase

As the implementation date approaches, ACFC and ACLA plan to increase training provided to associates to ensure the knowledge is timed to best support the transition and ongoing ICD-10 coding needs. We are currently sourcing vendors to provide the needed training to ACFC and ACLA associates.

To address the need for updated and collaborative knowledge, an enterprise knowledgebase is being developed. ICD-10 updates, e-learning modules, coding guidelines, system testing timeframes, and other critical information will be accessible to all associates.

X.1. Claims Management

X.1 Describe system capabilities and limitations of all requirements stated in Section 17.8 Encounter Data, and identify areas where change would be necessary based on requirements stated in the Systems Companion Guide.

Identify any limitations or disparities to requirements stated in Section 17.2, 17.8, and 17.10.

Describe system capabilities and limitations of all requirements stated in Section 17.10 Pharmacy Claims Processing and the NCPDP Guide located in the Systems Companion Guide.

If you presently unable to meet a particular requirement contained in Section 17, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.

Overview

AmeriHealth Caritas Louisiana's (ACLA) encounters generation and data exchange solution consists of multiple applications that produce and submit files compliant with the 837 ANSI X12 provider-to-payer-to-payer coordination of benefits (COB) and National Council Prescription Drug Programs (NCPDP) formats. These are checked for HIPAA compliance and then submitted through a secure file transfer process (SFTP) in accordance with required timeframes and file size limits. Our existing solution already has been EDIFECS certified, allowing ACLA to exchange complete, timely, and accurate claims and encounter data with DHH's fiscal intermediary (FI) in accordance with HIPAA requirements from day one of the new contract term. Throughout 2014, ACLA has consistently trended an encounters acceptance rate above 97 percent.

Our encounter processing system stores data in the appropriate formats with the appropriate level of detail, enabling our Enterprise Encounters Team to provide encounter files that meet state and FI requirements. ACLA accepts responsibility for submitting complete, timely, and accurate encounter data for our plan and for our subcontractors. All claims data is stored for up to 10 years, either in live or archival systems, and encounter files are stored for seven years.

System Capabilities for Claims Processing

ACLA recognizes that submitting accurate encounters is important for conducting data and rate analysis, HEDIS evaluations, and meeting many other program requirements. Meeting encounter data accuracy, timeliness, and completeness goals is a critical step in helping DHH and its agents achieve program objectives. ACLA has consistently trended an encounters completion rate above the state's performance requirement of 95 percent for the most recent 12-month period, as documented by Myers & Stauffer in their independent analysis for Bayou Health.

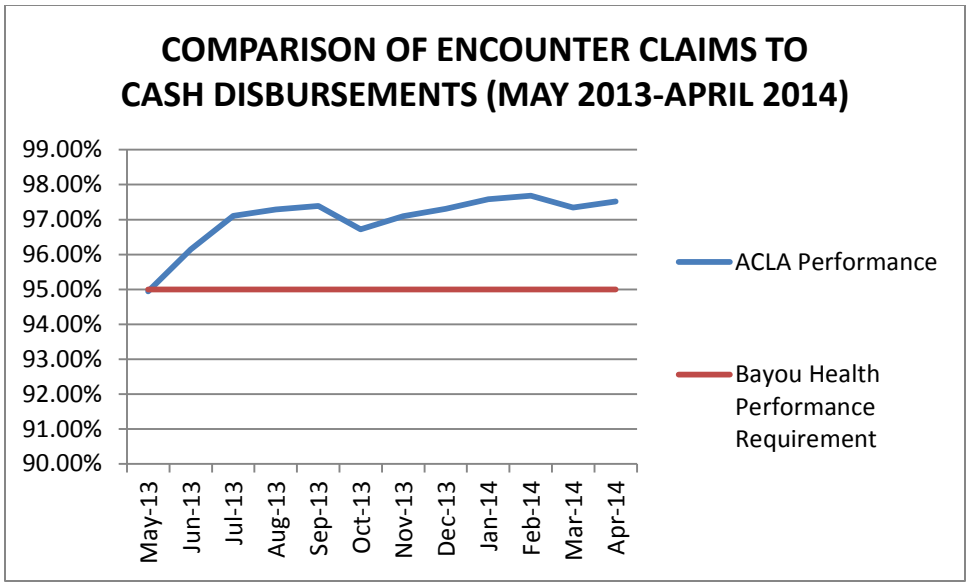

Exhibit X.1-1: Comparison of Encounter Claims to Cash Disbursements (5/2013 – 4/2014)

For the initial Bayou Health contract term, we developed an integrated technology solution to meet Louisiana-specific processes and procedures for Bayou Health's encounter requirements. These systems and processes continue to meet contract requirements, and ACLA is able to transmit encounter data to DHH's FI on day one of the contract start date without need for system changes.

Our encounter preparation and production process relies on our core claims administration platform, TriZetto Facets. 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 electronic 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 (COB) claims.

The following key functions are performed by Facets, directly supporting ACLA's ability to provide complete and accurate claims and encounters:

- Identifying the attending and billing provider of each service through unique identification numbers.
- Date-stamping the claim to identify the day ACLA receives the claim.
- Maintaining accurate and up-to-date claim history, including adjudication results, adjustments or appeals, and needed follow-up activities.
- Maintaining accurate and up-to-date payment activities, including dates and numbers for checks, electronic fund transfers (EFTs), or other forms of payment.
- Capturing all required data elements identified and specified in the Bayou Health MCO RFP, Systems Companion Guide, DHH provider billing manuals, and federal and/or DHH payment rules.

- Accepting all paper or electronic claims submitted in accordance with DHH requirements by providers caring for the Bayou Health population.
- Accepting electronic and paper adjustments and void transactions.
- Paying all claims, even those with a $0.00 balance.

We regularly update our claims 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.

Our integrated encounters solution produces and submits HIPAA 5010 ANSI X12 837 provider-to-payer-to-payer coordination of benefits (COB) transactions in professional, institutional, and National Council Prescription Drug Programs (NCPDP) formats. Files are transmitted via SFTP in accordance with the schedules documented in the RFP and Systems Companion Guide.

Supporting Information

As our core claims administration application, Facets stores member eligibility, Bayou Health benefit parameters, provider network status and pricing agreements, utilization and authorization requirements, and coordination of benefits information to support the completeness, timeliness, and accuracy of our claims processing.

- Enrollment files received by DHH's enrollment broker are loaded into Facets daily. Any 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 core 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.
- Coordination of benefits (COB) and third-party liability (TPL) information is stored in Facets, and is used to identify liable parties, determine order of benefits, and price the claims, to allow for appropriate processing of any applicable secondary payments.

Converting Paper Claims to Electronic Encounter Data

Paper claims are submitted by providers via US mail to the ACLA paper clearinghouse vendor for data entry. ACLA has a unique P.O. Box for providers to submit paper claims. Providers are required to submit paper claims in the appropriate format, including the National Provider Identifier (NPI) number (with the exception of atypical providers).

Our new paper clearinghouse vendor, effective January 1, 2015, incorporates a variety of industry standard auto-document classification and recognition technologies. Each image is

classified into a specific document type/category and then the images are batched together and routed for optical character recognition (OCR). Standard claims will be routed through multiple OCR engines for extraction of field information. Based on the image quality and zoning, OCR will extract the field values and assign a confidence level. A high confidence level indicates that the field value extracted is clean and can be routed directly to output.

Fields that have low confidence levels from OCR will be keyed through a data capture application. The data capture application utilizes snippets, which are portions of images that are zoned for a specific field. Snipping of images helps accelerate the keying process, when only a specific portion of an image that contains a field value is presented to the keyer. Snipping also has the advantage of hiding secured sections of the image from processers.

Claims Submission, Loading, and Adjudication through Facets

Once the claims have been received and are available in electronic form, they are loaded into the Facets system through a batch load process. The batch load process performs a series of edits to identify data entry errors and/or missing/incorrect information before claims are adjudicated.

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 can also send electronic remittance transactions to the trading partners in the HIPAA compliant 835 transaction set standard format.

Facets has robust capabilities, allowing it to leverage numerous edits and processing routines during the claim adjudications process based on the claim's data elements. These processes and edits allow Facets to take different actions based on member eligibility, Bayou Health benefit parameters, ACLA provider network status and pricing agreements, utilization and authorization requirements, and coordination of benefits information.

The edits below are used during the claims adjudication process and directly support ACLA's ability to provide complete, timely, and accurate claims and payments through the encounter submission process.

Membership and Care Management Edits

Eligibility – During claims adjudication, Facets' eligibility logic checks for valid eligibility and the benefits associated with the member.

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.

Provider and Pricing Edits

Provider/PCP/Network Determination – Facets determines whether the service provider on a claim is the member's PCP and whether the provider participates in ACLA's network.

Service Definition –Using the payment schedules for each executed provider contract, Facets identifies the service determination and service pricing.

Pricing – Facets uses all of the appropriate codes on the claim (procedure codes, revenue codes, CPT codes, ICD-9 codes, and place of service codes) to determine the appropriate reimbursement according to the provider agreement. Facets is already ready to process ICD-10 codes after the 10/1/15 ICD-10 implementation date.

Penalties – Facets can be configured to establish service penalties for application during claims processing. For example a penalty can be configured to apply when utilization management (UM) guidelines were not followed or an out-of-network provider was used without authorization. Penalties can be applied as a flat amount or a percentage; can be set to apply to the allowable or paid amount; and can include a maximum dollar limit.

Clinical Edits

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. We also utilize iHealth Technologies' (iHT's) and HealthCare Management System, Inc. (HMS) for enhanced clinical and business rule editing for claims. These systems apply a comprehensive, customized library of clinical coding edits to professional and outpatient hospital claims to ensure that they are coded correctly and paid accurately. In addition to generally accepted clinical edits, ACLA has a customized library of Louisiana Medicaid-specific medical policies.

Administrative Edits

Managed Care Edits – Edits are configured and applied based on ACLA's claims processing guidelines, benefit coverage and limits, and clinical authorization requirements. This includes edits for valid dates of service that coincide with membership eligibility span.

Duplicate Editing/Claims History Check – Facets performs a duplicate check for each claim line. Rules are used to define what constitutes a definite or possible duplicate claim. Numerous groups of claim parameters are configured and linked together and then run against the member's claim history to determine whether the current claim is a duplicate of a prior submission.

Service Rules – Service rules allow Facets to adjudicate payment based on multiple parameters. A Service Rule establishes the calculation method for the service, the claims processing edits to be applied, penalty types and amounts, and service tiers. For example, medical claims be priced based on reasonable and customary (R&C) rates, Fee Schedules, Per Diem/Per Case, DRG or percentage of charges. Facets has the flexibility to handle any pricing methodology.

TPL/Recovery Edits

Overrides – During claims processing, claims examiners are able to override co-pays and coinsurance on each line item. This becomes an issue when multiple tiers are accessed.

Coordination of Benefits (COB) – Facets is configured to meet the specific COB payment guidelines for the State.

Diagnostic Related Groups (DRG) Grouper

As DRG and APR-DRG pricing methods are currently used for affiliated plans supported by the AmeriHealth Caritas Family of Companies (ACFC), ACLA will be able to implement any changes made to Louisiana's payment rules for adjudicating hospital claims. The DRG Grouper Calculator determines the appropriate DRG based on the principal diagnosis code. The calculator considers the first diagnosis code entered into the calculator as the principal diagnosis and determines the major diagnostic codes.

System-Generated Provider Notifications

Remittance advices (RA) that list all claims paid, adjusted, or denied, are sent to providers twice weekly; the associated payment is the net of all debits and credits. The RAs include member' names and identification numbers; the dates of service; the total charges, plan payments, and member liabilities; reasons for the denials or adjustments; and any third-party liability information. ACLA contracts with Emdeon to distribute electronic and hardcopy RAs and payments, which are managed and monitored through production job alerts.

Claim status information is available to providers online, through an Interactive Voice Recognition (IVR) system, or by calling Member or Provider Services. ACLA partners with NaviNet for our Provider Portal, which allows providers to check the status of their claims, which are pulled directly from ACLA's back-end systems.

NaviNet | Plan Central | Office Central | NaviNet Central | Action Items | My Account | Help

Go To Admin Messages | Go To Action Items

AmeriHealth Caritas Louisiana | Claim Status Inquiry > Claim Search > Claim Status Details

AmeriHealth Caritas Louisiana

Claim Detail

Member Information

Member Name:	[illegible]	Date Of Birth:	[illegible]
Member ID:	[illegible]	Gender:	[illegible]

Provider Information

Servicing Provider ID:	[illegible]	Servicing Provider Name:	[illegible]

Claim Detail

Claim Number:	[illegible]		
Service Date Range:	[illegible]	Status Date:	07/30/2014
Total Amount Billed:	$68.00	Category Code:	F1
Total Amount Paid:	$35.08	Status Code:	107
Paid Date:	07/30/2014	Diagnosis Codes:	
Check Number:	[illegible]		
Medical Record Number:			

	Date From Charged Amt	Date To Paid Amt	Procedure Cd Allowed Amt	Modifiers Copay Amt	Units COB Amt	Claim Status Deductible Amt	Category Cd Withhold Amt	Revenue Cd Remark Cd	CAP DRG	NDC Cd Diag Cd	NDC Units POS	NDC UM DX Cd Pointers
1.	07/22/2014	07/22/2014	[illegible]	26	1	107	F1					
	$68.00	$35.08	$35.08	$.00	$.00	$.00	$.00	PXN		[illegible]	22	1

Claim Category	Claim Category Description
F1	Finalized/Payment - The claim/line has been paid.
Claim Status	**Claim Status Description**
107	Processed according to contract/plan provisions.
Remark Code	**Remark Code Description**
PXN	NETWORX STD FEE SCHEDULE

The Paid Date field represents the date the claim updated to Accounts Payable. Please allow 2 business days for check processing.

Exhibit X.1-2: Status of a Paid Claim Using NaviNet's Claim Detail Screen

Third Party Liability

ACFC's dedicated Recovery Department identifies and obtains third party payer information, including Medicare, commercial insurance, and/or accident-related coverage. The Recovery Department expertly administers the collection and adjudication of TPL information.

Once TPL data is loaded into Facets, it is available immediately to all system users; including, claim examiners, customer service representatives, provider service representatives, enrollment associates, medical management associates, and cost containment/TPL e-associates.

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 ACFC's and the alternate insurer(s)'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 Recovery

Department. The Recovery Department verifies TPL data from the carrier and updates the member's information in the system, and returns the claim to the Claim Examiner for coordination of benefits.

Additionally, ACFC's system supports processing of claim files received from the State, such as Medicare crossover claims. The system also supports the ability to pay cost-sharing requirements, such as copays and deductibles, when necessary. .

System Capabilities for Encounter Generation

Fully adjudicated claims, those that were paid or denied, are loaded and reconciled into the data warehouse twice weekly. The Enterprise Encounter team then builds ACLA's encounter files from the data warehouse. The diagram below outlines the process flow to submit, correct, and reconcile encounter data.

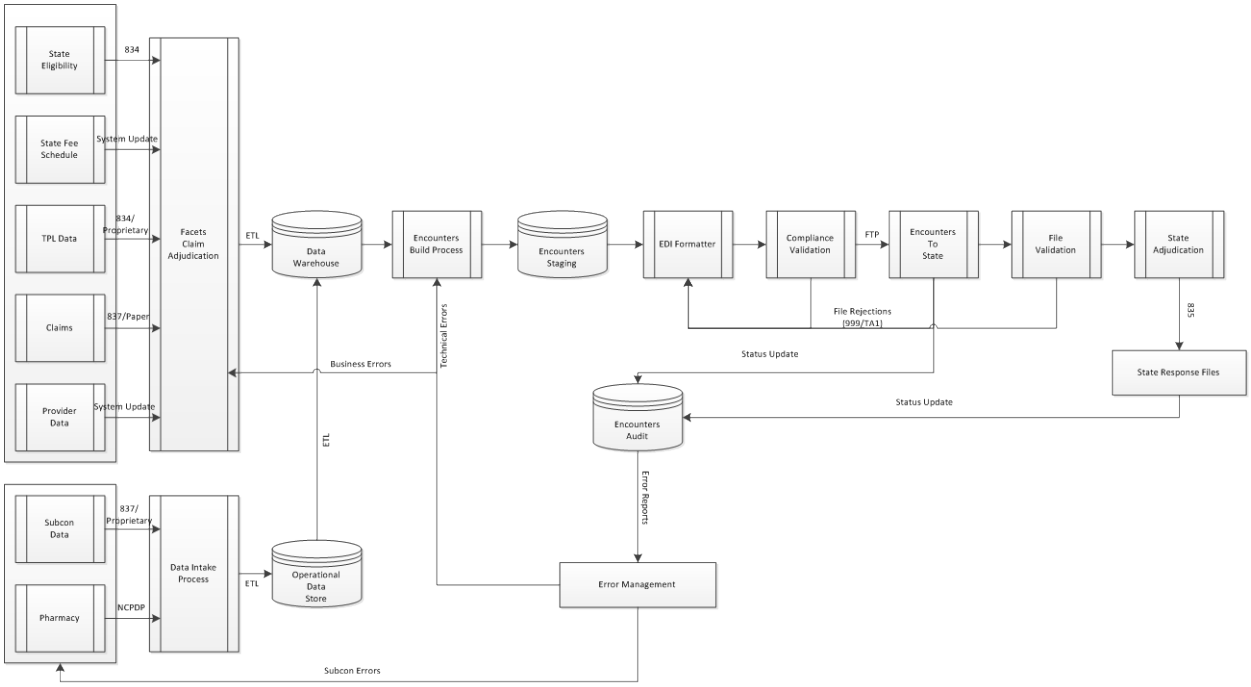

Exhibit X.1-3: Process Flow for ACLA Encounters

All claims data is stored for up to 10 years, either in live or archival systems. Encounter files are stored for seven years.

Enterprise Encounter Team

The Enterprise Encounters Team, illustrated in the organization chart below, is comprised of local, IS, and operations stakeholders. This team works to provide complete, timely, and accurate encounters submissions, as well as analysis and remediation of all rejected encounters. ACLA's Encounter Data Quality Coordinator based locally serves as a point of contact between the plan and DHH to identify, resolve, and monitor encounter data issues. Through this

coordination, the Encounter Data Quality Coordinator provides recommendations to improve the accuracy and timeliness of our encounter data processing and throughput. This role is currently filled by an ACLA Business Systems Analyst, located in Louisiana and is supported by the Regional Director of Data & Technical Services who has a long history of managing encounter submissions for our affiliates.

Preparing Compliant Encounters

All fully adjudicated claims, including those submitted on paper, are loaded into ACFC's data warehouse for encounter data submission. Encounter files are prepared in 837-I (Institutional) and 837-P (Professional) transaction formats, using the appropriate DME, PHY, REH, TRA, NAM, UB9, and HOM file extensions. Pharmacy encounters from our PBM (Pharmacy Benefit Manager) are prepared as HIPAA National Council for Prescription Drug Programs (NCPDP) transactions. These files include all paid, adjusted, denied, or voided claims, including those showing a zero-dollar amount.

All encounter files are checked for completeness and accuracy, which includes verifying claim counts as well as HIPAA compliance validation, to identify potential TA1 or 999 errors. Any encounter that results in an error is analyzed, and either resolved or removed for further investigation. The process is repeated until a compliant file is created.

New encounters with multiple claim lines are sent at the document level. When these claims are adjusted, adjustments are sent at the line level. New inpatient claims and subsequent adjustments are sent at the document level. Our encounter processing system is configured to accept transaction control numbers from the FI at both the document and line level.

Total financial charges are included at the header level, and line level charges are included for each procedure code for professional and outpatient encounters. We include interest at the header level. For inpatient services, we include all charges at the header level.

Third-Party Liability Data

Third-party liability (TPL) data is included in the 837 header and at the line level. The header information includes the following segments:

- Subscriber (SBR).
- Claim level adjustment amount (CAS).
- Member, other payer, and carrier information in the NM1 segments.
- City, state, and zip in the N3 and N4 segments.
- Claim/service adjudication date (DTP).

At the line level, we include TPL using service line adjudication information (SVD), claim level adjustment amounts (CAS), and claim/service adjudication dates (DTP).

Provider Taxonomy Data

Encounters include provider taxonomy in the 837 billing provider loop. For atypical providers, the Medical Assistance Identification Number (MAID) is included in the Billing Provider Secondary Identification (REF segment of Loop 2010BB). We also submit a separate supplemental provider registration file that includes provider taxonomy; this file is submitted to the FI every week.

Submitting Compliant Encounters

The ACLA encounters processing system is configured to limit the encounter claims to a maximum of 20,000 encounters per file, which complies with the encounter file restrictions outlined in the Bayou Health MCO RFP and the Systems Companion Guide. We submit complete encounter data weekly by the 25th calendar day of the month following the month in which the claims were processed. To ensure compliance, we have a weekly submission planning process to determine and document which volumes are to be submitted each week and on which allowed submission day.

ACLA encounters are submitted using the appropriate control numbers. Our Internal Control Number (ICN) complies with the specified format, including the four-digit prefix. Trading partner control information is sent in the Interchange Control Header (ISA), Functional Group Header (GS), Functional Group Trailer (GE), and Interchange Control Trailer (IEA) segments of the 837 files. For NCPDP, control information is sent as per standard D.0 formats and System Companion Guide instructions.

Approved 837 files are transmitted to the FI and posted to our encounter audit table and audit history table. To provide predictable and reliable processing, CISCO's Tidal Enterprise Scheduler is used to automate sending and receiving files between ACFC and the FI. The predetermined schedules alert the Enterprise Encounters Team if a file is not sent or received when expected, if any processing step fails, or if the file transfer is not successful. These alerts are monitored (24x7x365) so that immediate action can be taken to ensure contract requirements are met.

An attestation statement, signed by ACLA's Executive Director, is submitted to the FI on a weekly basis, attesting to the truthfulness, accuracy, and completeness of the submitted files listed on the statement.

File transfers—inbound and outbound—are securely conducted using dedicated point-to-point connectivity over SFTP. Each exchange is archived and logged, in case it is needed for future reference or processing, using a lock-step method.

Including Encounters for Subcontractor Data

Subcontractors submit paid claims data to ACLA on a monthly basis. ACLA checks the counts, content, and quality of the received data to verify that all required elements are included. These checks occur by processing the subcontractor's 837 encounter files through our HIPAA

compliance checking prior to submittal to the FI. All subcontractor encounters are submitted by ACLA, with ACLA's trading partner control numbers.

Providing Corrections for Repairable Encounter Errors

After receiving response files, the FI's dispositions (accepted, rejected, translation error, etc.) are reconciled to our encounter audit tables. Analysts on the Enterprise Encounter Team are responsible for reviewing each rejected encounter and coordinating its remediation within 30 days. This includes actively managing and tracking error resolution through completion. Analysts collaborate with internal departments and subcontractors to capture corrected information in our encounters processing system. Corrected encounters with repairable errors are included in the next encounters build processes and resubmitted to the FI.

Capabilities of PBM's Claims Processing System

ACLA has partnered with our affiliate, PerformRx, for pharmacy benefit management (PBM) services. PerformRx has provided comprehensive pharmacy services for Medicaid beneficiaries since 1999.

PerformRx can currently meet all requirements specified in Section 17.10 of the Bayou Health MCO RFP without requiring system changes or upgrades, and will continue accepting claims and submitting encounters for ACLA members.

As ACLA's PBM, PerformRx currently uses the Integrated Pharmacy Network System (IPNS®) claims engine to administer ACLA's pharmacy benefits. IPNS® currently supports more than 300,000 unique benefit programs for customers throughout the United States. The system also enables a high degree of flexibility is designing and implementing customized claim edits.

System Capabilities

PerformRx has been in a strategic partnership with Argus Health Systems to provide claims processing for our PBM services since 1999. IPNS® is an automated claims processing system that support the electronic submission of HIPAA-compliant NCPDP D.0 claims. The system maintains over 99.5% percent up-time/availability, ensuring that electronic claims are accepted and adjudicated in a timely fashion. Paper claims are loaded into the system retroactively. After adjudication, NCPDP batch files are transmitted to ACLA who submits them to the DHH/FI.

RxNova™ is the next generation of Integrated Pharmacy Network System (IPNS), with quicker turn-around times for any major benefit changes, as less hard coding is required. RxNova™ may be implemented in the future; ACLA and PerformRx will collaborate with DHH and the FI, in accordance with contract requirements, to develop implementation and testing plans.

National Drug Code File

PerformRx updates the drug file for both retail and specialty drugs as changes are available from third-party data sources; we update the file at least every seven days, and often daily.

We maintain a series of National Drug Code (NDC) databases that contain drug information from each nationally recognized third-party drug price source utilized by PerformRx:

- First Databank (FDB).
- Micromedex.
- MediSpan.

These files contain records for the drugs recognized by the NDC system. Both daily and weekly files include addition of new drugs, deletion of drugs no longer recognized by the NDC, and changes to existing drugs. PerformRx provides Drug Information Updates on new drugs to ACLA Leadership and Pharmacy Department staff on a monthly basis.

The 11-digit NDC—which indicates labeler, product, and package size—is listed on all pharmacy claims.

Historical Claims Retention

Pharmacy claims and encounter data submitted to ACLA by PerformRx will be maintained in accordance with specified retention periods; as mentioned above, ACLA claims data is stored for up to 10 years, and encounters data is stored for seven years.

PerformRx also maintains a historical claims archive for up to 10 years. Claims submitted or adjusted during the previous 90-day period remain in the production environment. Claims information is available for reporting at any time for a rolling 36 months.

Claim Submission and Processing

PerformRx integrates data and claims adjudication through the IPNS® claims engine. IPNS® processes point-of-sale (POS) claims, mail order claims, batch electronic claim files, paper claims, and pharmacy reimbursements. All POS claims are processed in real-time, while manual claims are loaded into IPNS® retroactively. Electronic claims can be batched into the system. POS claims are submitted using industry standard formats, including NCPDP Version D.0 format.

PerformRx encourages pharmacy providers to submit electronic POS claims. The IPNS® POS interface is responsive and easy to use, resulting in timely and accurate claims.

Supporting 340B Pharmacies and Drugs

PerformRx has successfully implemented and administered 340B programs with 340B pharmacies throughout the U.S. PerformRx will continue collaborating with ACLA to ensure customized parameters are established for the Bayou Health.

Using information provided by ACLA, PerformRx's claims processing system matches members, physicians, covered entities, and covered drugs based on specific 340B formulary inclusion/exclusion criteria. The adjudication system matches the appropriate data elements, such as the NCPDP field, and flags the prescription as 340B; and after the claim is adjudicated, the pharmacy receives the contracted 340B reimbursement.

Adjudicating Claims

PerformRx adjudicates all submitted pharmacy claims by applying a set of edits customized to Bayou Health and ACLA specifications. On average, 150 edits are performed on each submitted claim, which happens immediately if submitted at the POS. These edits include eligibility verification, drug coverage and formulary programs, benefit limitations and prior authorizations, prescriber eligibility verification, as well as prospective and concurrent drug utilization. The system also applies edits to detect duplicate claims, early refills, and dispensing limits. Retail and mail-order claims are adjudicated against the same edits. Services identified as "once-in-a-lifetime" are maintained permanently.

Coordination of Benefits

PerformRx has extensive coordination of benefits (COB) capabilities. PerformRx administers COB logic based on a combination of the submission of NCPDP COB segment and eligibility indicators. For each other payer included on the claim, the pharmacy submits information on whether the other payer paid all or a portion of the claim or whether the other payer denied the claim. The COB segment also includes the other payer coverage type (primary, secondary, tertiary, etc.), the ID of the other payer, and the date the other payer adjudicated the claim. PerformRx can review up to three additional payers per claim. The claim processing system is customized so COB respects Medicaid as the payer of last-resort.

Drug Utilization Review Program

Concurrent drug utilization edits are part of PerformRx's Drug Utilization Review (DUR) program, which plays a key role in preventing drug complications before the member receives the medication. DUR edits can include:

- Drug-Drug Interactions.
- Duplicate Drug Therapy.
- Too Early Refill or Over-Utilization.
- Drug to Allergy.
- Drug to Disease.

If the claim results in a "hard" error, it is denied; however, the system also allows for "soft" errors, which result in customized messages that offer information about the request. The logic that determines whether the claim is denied or accepted is developed based on common scenarios and potential severity levels.

For example, when a non-specialty pharmacy attempts to enter a claim for a specialty drug. An error message will appear stating "PA REQUIRED SPEC RX CALL 555-555-5555," encouraging the pharmacy to call PerformRx to request prior authorization.

On average, 60-80% of claims receive some form of DUR message at the point of sale. If more than one message is returned, they are displayed based on a hierarchy of importance, developed by PerformRx through collaboration with pharmacy providers, to better serve their

needs. Pharmacies submitting claims for ACLA members will receive POS messages customized for the Bayou Health program.

Claim Reversals

The pharmacy originally submitting the claim has the ability to electronically reverse or adjust a claim before it is paid. The pharmacy would correct the original claim (e.g., revising the quantity, prescriber information, days' supply) and resubmit the claim. When the claim is readjudicated, the original will be reversed and the new claim will be processed. This process supports submittal of complete and accurate pharmacy claims and encounters.

Payment

After the end of each financial cycle, PerformRx prepares a payment claims transmission record layout to report the payment status of pharmacy third-party claims, which is submitted to ACLA. All claims are finalized once a week, with pharmacies receiving payment no more than 14 days from claim submission.

Claim Adjustments

If a claim has already been adjudicated and paid, an adjustment may be made at the request of the pharmacy, health plan, PerformRx, or DHH. An adjustment transaction record is created to cancel the previous claim, its DUR history, and its cost-sharing consequence. Adjustments use separate fields to capture modified data, including fields that indicate the reason for the adjustment. PerformRx can perform both manual and batch adjustments.

The system provides batch processing for large-volume adjustment requests. Smaller volume adjustments can be performed online. The system will track to the same claim number throughout the process, whether it is paid, reversed, or denied. Corrected claims are included in the next available financial cycle to adjust and either credit or debit the original.

Once changes are reviewed, the claims will be finalized through a financial cycle and the required financial adjustments will be processed. The result of the net change to the claim is then credited or debited from the pharmacy originally processing the claim and/or reimbursed to the member. An out of cycle financial cycle is run to total impact at a member level. Recoupment requests or reimbursement checks are then mailed to the member.

Encounters Processing

PerformRx partners with ACLA to provide pharmacy encounters to DHH. Our encounter data comes from the claims information submitted in the HIPAA 5010 NCPDP D.0 transaction format. PerformRx's NCPDP batch encounter files are transmitted to ACLA, who then submits them to DHH via SFTP. PerformRx makes every effort to correct and resubmit any disputed pharmacy encounters no later than 60 days after notice from DHH. If a disputed encounter cannot be corrected for whatever reason, PerformRx returns a response file that explains why the claim could not be corrected and details our efforts to successfully resolve the issue.

Enhancements to be Implemented for the New Contract Term

Our assessments of the requirements in the Bayou Health MCO RFP and Systems Companion Guide have indicated that the systems that currently support ACLA's encounters generation do not have any limitations or deficiencies that would prevent ACLA from complying with the requirements stated in Sections 17.2 and 17.8 of the RFP.

Additionally, our PBM's claims processing system currently meets all requirements specified in Section 17.10 of the Bayou Health MCO RFP without requiring system changes or upgrades, and will continue to accept claims and submit encounters for ACLA members.

Claims Submitted Outside Timely Filing Window

The Facets system applies hierarchical edits to submitted claims to identify whether claims are received within timely filing guidelines. The system is currently configured to impose a 365-day timely filing requirement. Under the new rules, the hierarchical edit will be updated to ensure claims received outside of the 180-day timely filing guideline will be denied, with the exception of situations regarding coordination of services or subrogation, in which the provider is pursuing payment from a third party. We anticipate that the configuration change will be accomplished before the contract start date, using approximately 40 staff hours for design, implementation, and quality assurance testing.

Exchanging Prior Authorization Data

ACLA recognizes the importance of exchanging the prior authorization data described in Section 17.8.5 of the RFP to support DHH's efforts to support of care transitions and continuity of care. We made this implementation a priority, and began exchanging prior authorization data with DHH's FI in accordance with the timeframes requested by DHH. ACLA will continue to collaborate with DHH and the FI on this initiative, in addition to the ongoing exchange of data.

TriZetto Encounter Data Manager

While not necessitated by the current or new contract requirements, ACLA and ACFC have invested in TriZetto Encounter Data Manager (EDM) to increase and improve our encounters processing capabilities. Designed to integrate with ACLA's core claims and administration platform, EDM is a HIPAA-compliant application that supports accurate data submissions. The application automates the entire encounter process, from accessing source data, validating it for compliance with specified rules, and then generating the encounter files, allowing dedicated encounters staff to focus on functions that cannot be automated.

EDM maps across multiple data sources to support the creation of schedules. When a schedule runs, the application connects directly to the source systems to pull down the defined data elements. The download process includes a scrubbing feature that prevents claims that would fail the encounter process from inclusion in the file. The scrub process flags these claims errors, enabling associates to research and correct the data in the source system. The download process

generates files that will be reviewed prior to submission to the FI. Response files from the FI can be automatically retrieved and reconciled through the application as well.

EDM also provides robust encounter tracking and reporting tools. Outcomes tracking for batch loading and reconciliation, for example, can be analyzed to drive process improvements.

ACFC has begun deploying EDM across the enterprise. A roadmap is currently being developed to define the migration process for ACLA, which will include enterprise and local resources. Currently, we anticipate that EDM will be implemented and operationalized in Louisiana during the first half of 2015. We have already approached DHH and the FI about the possibility of testing ICD-10 encounters once this system is live.

X.2. Claims Management

X.2 Explain in detail your process for ensuring that all claims (paid, denied, adjustments and voids) are submitted to the Fiscal Intermediary timely and accurately.

Overview

ACLA's claims management strategy focuses on promoting efficiency and accuracy in processing by employing well-trained associates, a rigorous quality assurance process, and state-of-the-art technology. These people, processes, and technologies enable claim payments to be accurate and timely processed to ensure complete, timely, and accurate encounter submission to the FI.

TriZetto Facets® is the core claims administration platform that supports ACLA's claims processing functions. ACFC processes 26 million claims annually, over 88 percent of which are electronically submitted by providers. All non-electronic claims are scanned and adjudicated within the same timeframes and quality standards as those submitted electronically. To support complete, accurate, and timely claims submission, ACLA encourages providers to submit electronic claims, receive reimbursement through electronic fund transfer (EFT), as well as receive their remittance advices electronically.

End to End Claims Process

ACLA's claims processing is done through Facets, TriZetto's industry-leading health plan administration software. ACFC, the parent of ACLA, has used the application for more than 10 years to support the unique requirements for Medicaid plans in Pennsylvania, South Carolina, Louisiana, Florida, Michigan, New Jersey, Indiana, Nebraska, 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 electronic 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.

The claims/encounters processing, eligibility/enrollment tracking, member data management, provider data management, financial data, and third-party liability functions for ACLA are all supported through Facets. Facets has proven to be able to successfully meet the requirements outlined in the 2014 RFP and the Systems Companion Guide for the 2015-2018 contract term. ACLA will continue to collaborate with DHH to address any potential subsequent additional required changes.

Timely and accurate encounter submission is dependent on the ability to accurately process claims, and requires a robust system to ensure all claims are tracked and appropriately paid in accordance with RFP and Systems Companion Guide.

Claims Submission and Loading

Claims are only accepted in an approved format, whether submitted electronically, or on paper. Paper claims are batched and scanned into digital form using high-speed scanners immediately after they are received. Each image is classified into a specific document type/category and then the images are batched together and routed to the Optical Character Recognition (OCR). Numerous edits alert to any inconsistencies during entry, and predefined system warning messages facilitate increased accuracy and productivity. Both the claim image and the digitized data are stored. Once the claims have been received and are available in electronic form, they are loaded into the Facets system through a batch load process.

Facets' interface functionality makes information from the Facets databases easily available to ACLA's Provider Services and Provider Claim Services representatives, who respond to provider inquiries. Provider Claim Services representatives can also adjust claims, if warranted, for providers in real-time, while they are on the phone.

Providers can also easily check the status of their claims by querying through our Interactive Voice Recognition (IVR) system or accessing our NaviNet Provider Portal.

Claims Adjudication

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

Claims are processed in an automated fashion, with full support for highly productive electronic adjudication. ACLA has an industry-leading auto adjudication rate of 84.9% percent for 2014 YTD. These high rates have been achieved by utilizing standard provider agreements and pricing methodology. 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 can also send electronic remittance transactions to the trading partners in the HIPAA compliant 835 transaction set standard format.

Month	2012	2013	2014
January	–	84.4%	85.2%
February	82.2%	80.6%	84.2%
March	77.1%	84.6%	84.5%
April	83.2%	80.7%	85.4%
May	83.3%	85.0%	86.4%
June	78.6%	84.4%	83.0%
July	83.0%	83.5%	85.9%
August	81.0%	83.6%	–
September	79.2%	84.6%	–
October	80.7%	85.5%	–
November	80.8%	77.7%	–
December	82.7%	85.0%	–
Year to Date	**81.1%**	**83.3%**	**84.9%**

Exhibit X.2-1: ACLA's Auto-Adjudication Rate for 2012-2014

Auto-Adjudication

ACLA has achieved high accuracy levels and auto-adjudication rates through end-to-end integration of health plan data. During the various stages of the adjudication process, Facets interacts with member eligibility, product benefit parameters, provider pricing agreements, care management requirements and clinical editing information to provide accurate and highly automated adjudication of claim and/or encounter submissions.

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

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 through 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 their review.

Facets Claims Edits

Facets has robust capabilities, allowing it to leverage numerous edits and processing routines during the claim adjudications process based on the claim's data elements. As our core claims administration application, Facets stores member eligibility, Bayou Health benefit parameters, provider network status and pricing agreements, utilization and authorization requirements, COB and TPL information to support the completeness, timeliness, and accuracy of our claims processing. These processes and edits allow Facets to take different actions based on member eligibility, Bayou Health benefit parameters, ACLA provider network status and pricing agreements, utilization and authorization requirements, and coordination of benefits information.

The edits below are used during the claims adjudication process and directly support ACLA's ability to provide complete, timely, and accurate claims and payments.

- Eligibility
- Service Authorization Procedures
- Provider Network Determination.
- Service Definition.
- Pricing.
- Penalties.
- Clinical Edits
- Duplicate/Claims History Check.
- Service Rules.
- Co-pay and coinsurance overrides.
- Coordination of benefits.

Manual Claim Adjudication

We have developed detailed claims-processing procedures to guide claims examiners as they manually process claims. 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 prior to system auto-adjudication. The claim procedures outline the payment rules and detailed steps an examiner must follow to ensure accuracy of provider payments. These rules are developed by cross-functional representation from the Claims, Provider Network Management, Medical Management, Quality Auditing, and System Configuration departments. Our agile process allows for real-time updates to the processing rules.

Diagnostic Related Groups (DRG) Grouper

ACLA will be ready when changes are made to the state payment rules for adjudicating hospital claims, as we currently utilize DRG and APR-DRG pricing methods in the other health care markets we support. The DRG Grouper Calculator determines the appropriate DRG based on the principal diagnosis code. The calculator considers the first diagnosis code entered into the calculator as the principal diagnosis and determines the Major Diagnostic Codes (MDC).

Communicating Requirements to Providers

To encourage the submission of timely and accurate claims, ACLA disseminates 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, ACLA's Claims Filing Instructions, provider orientation and ongoing training, as well as "Connections", ACLA's provider newsletter. Copies of these materials are available through ACLA's 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.

Value codes must be input in sequential order.

- 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.

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.
- Behavioral health claims should submitted to Magellan Health Services.

Exhibit X.2-2: Addressing Claim Requirements through December 2013 Provider Newsletter

Through these materials, ACLA advises providers about the 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 ACLA's 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 • Prompt Pay Requirements • Third-Party Liability Instructions • Dispute Resolution (Complaints/Grievances, Appeals) • Fraud, Waste, Abuse Requirements • Electronic Claims Submission and Monitoring • Supplemental Claims Information for Covered Services • Common Reasons for Claim Rejections & Denials	• Claims Submission • Electronic Claims Submission (EDI) • Claim Mailing • Claim Filing Deadlines • Claim Form Field Requirements • Electronic Billing Inquiries • Supplemental Claims Information for Covered Services

Exhibit X.2-3: Topics Included in ACLA's Provider Handbook and Claims Filing Instructions

ACLA also has a full-time Provider Claims Educator who provides guidance about our claims submission requirements, coding updates, electronic claims transactions (EDI) and electronic fund transfer (EFT) capabilities, and available plan information to providers. This is done through routine site visits and Provider Workshops held by the Provider Claims Educator within provider communities for their convenience. The Provider Claims Educator also conducts Regional Provider Trainings across the state to target billing questions and issues. Changes and updates to claims and billing are included in our regular provider communications.

Ensuring Completeness of Claims Data

ACLA has defined processes to ensure that all claims submitted by providers are processed appropriately and that claim acknowledgements are returned to providers. ACLA accepts claims submitted via electronic data interface (EDI) methods or on a paper claim form, which is converted to electronic format for processing through Facets.

Provider Claims Reconciled Upon Receipt

Claims/encounters are submitted by providers via electronic data interface methods or on a paper claim form, which is converted to electronic format, through our designated clearinghouses. The clearinghouse edits specific claim data to set business rules and returns claims that do not meet editing rules back to the provider. Claims that meet editing rules are processed through Facets, which verifies the completeness and accuracy of provider numbers, member ID numbers, diagnosis codes, and procedure codes. Claim acknowledgements are returned to providers via the clearinghouse for EDI submitted claims. A control process ensures all claims received are acknowledged.

For our paper clearinghouse, providers submitting claims that have missing or invalid data, including but not limited to, NPI number, use of CMS 1500 (08/05), UB-92 formats and/or codes are rejected. A rejection letter is generated informing the provider of all the reasons for the rejection(s). The letter sent to the provider is accompanied by a copy of the claim form

submitted. A copy of both the rejection letter and claim are sent ACLA via a XML file, for storage in the SunGard EXP MACESS tool. EXP MACESS is an imaging-based operations management, workflow management, enterprise content management and customer service solution that has been standardized for managed healthcare organizations.

Once the claims have been received and are available in electronic form, they are loaded into the Facets system through a batch load process.

Reconciling Pended, Paid, or Denied Claims to Remittance Advices

The claims processing system sets the claim to a status of Pend, Deny, or ready for Payment. Pended claims are claims that require a manual review before adjudication can be finalized. Pended claims are routed to claims examiners via an automated workflow system. The workflow system tracks each pended claim until adjudication is finalized. 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 does not constitute a new claim for purposes of establishing the timeframe for timely filing. The remittance advice (RA) includes information on all claims paid, denied, and adjusted during the claim payment cycle. The associated payment to the provider is the net of all debits and credits.

Support for Electronic Data Interface

ACLA seeks to maximize claims submission via EDI, encouraging providers to utilize electronic claims submission, as well as electronic funds transfer (EFT) for payment, and adopt electronic remittance advice. Through June of 2014, ACLA's providers submitted, on average, more than 89 percent of their claims electronically. These electronic claims are submitted through secure, web-based portals, such as Emdeon's Provider WebConnect℠.

ACLA has partnered with Emdeon so that providers submitting claims for ACLA members can submit through Emdeon at no cost.

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

Once processed through the clearinghouse, electronic claims are then loaded into Facets, which verifies the completeness and accuracy of provider numbers, member ID numbers, diagnosis codes, and procedure codes.

ACLA works with Emdeon, Zirmed, NaviNet, and HDX clearinghouses to achieve this high level of provider participation. ACLA's primary clearinghouse is Emdeon, which has a large footprint in provider offices, and receives "pass-through" claims from virtually every other clearinghouse.

Optical Character Recognition of Paper Claims

ACLA's paper claims are converted into electronic data by a vendor, who scans received claims with OCR and performs a character repair function. Claims that do not pass OCR are keyed through a data capture application.

Supporting Timeliness of Claims Data

ACLA currently meets or exceeds each of the requirements as specified in the Electronic Claims Management Functionality and the Adherence to Key Claims Management Standards by administering claims through Facets. ACLA consistently exceeds the clean claim paid requirement for 15 business days and 30 calendar days.

Clean Claims Paid	Goal	2013				2014		
		Q1	Q2	Q3	Q4	Q1	Q2	Q2
15 Business Days	**90.0%**	98.75%	97.88%	99.29%	99.16%	99.90%	99.92%	99.88%
30 Calendar Days	**99.9%**	99.98%	99.99%	99.99%	99.99%	100.00%	100.00%	100.00%

Exhibit X.2-4: ACLA's Compliance with Requirements for Clean Claims Paid

Payment timeliness and accuracy is achieved by having; appropriate claims editing, accurate system configuration, claims payment testing strategy, claims processing rules and a quality auditing/monitoring program.

Claims Submitted Outside Timely Filing Window

The Facets system applies hierarchical edits to submitted claims to identify whether claims are received within timely filing guidelines. The system is currently is configured to impose a 365-day timely filing requirement. Under the new rules, the hierarchical edit will be updated to ensure claims received outside of the 180-day timely filing guideline will be denied, with the exception of situations regarding coordination of services or subrogation, in which the provider is pursuing payment from a third party. A remittance advice is sent to the provider clearly stating that the claim was denied due to untimely filing.

Claims Management Oversight

ACFC has well-established processes to monitor claim payment status and to ensure the timeliness of all claims paid. Timeliness of payment is achieved through the following processes and activities:

- **Auto-adjudication Rate** – in 2014, ACLA averaged an auto-adjudication rate of 84.9%, an increase from 81.1% in 2012.
- **Management Reporting** – ACFC has a suite of standard-operating reports produced and reviewed daily that show the age, pend status and claims-on hand. These reports are used to assign work to ensure payments meet all ACLA payment requirements.

- **Claims Docflow** – Claim examiners are assigned to specific claim queues within Facets on a daily basis. Examiners work the claims based on a first-in-first-out (FIFO) methodology.
- **Inventory Escalation Reporting** – Policies are in place that outline criteria when Supervisors are required to escalate to their managers when the days-on-hand and percentage of claims are in danger of missing time-to-pay requirements.
- **Payment Cycles** – ACLA performs two payment cycles processed each week to meet provider needs.

Reporting on Key Claims Management Standards

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

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

Workflow Region Status Queue Name	00 to 05		06 to 10		11 to 15		Totals
LOB 2100 FACETS	3550	91%	263	7%	83	2%	3896
New	3433	96%	142	4%	0	0%	3575
LOB 2100 ACA Pend - Medical	3033	97%	92	3%	0	0%	3125
LOB 2100 Invalid Provider	400	89%	50	11%	0	0%	450
Pended	117	36%	121	38%	83	26%	321
Catch-All	35	25%	58	41%	47	34%	140
LOB 2100 ACA COB Pend - Medical	3	33%	6	67%	0	0%	9
LOB 2100 Adjusted Claims - Hospital	1	25%	3	75%	0	0%	4
LOB 2100 Adjusted Claims - Medical	0	0%	5	100%	0	0%	5
LOB 2100 COB Hospital	1	50%	1	50%	0	0%	2
LOB 2100 COB Medical	0	0%	1	100%	0	0%	1
LOB 2100 Error Hospital	11	41%	6	22%	10	37%	27
LOB 2100 Error Medical	29	40%	24	33%	20	27%	73
LOB 2100 High Dollar Adjustment Hosp	2	50%	1	25%	1	25%	4

Exhibit X.2-5: Claims Inventory Report

Claims Tracking through Facets

The Facets system has comprehensive claims tracking capability that identifies the date of receipt of the claim and encounter information, real-time accurate history with appropriate dates of adjudication results, relevant pended claim or appeals information, and payment transaction data.

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

SunGard EXP MACESS – Document Management/Workflow Solutions

SunGard EXP MACESS (EXP) is an imaging-based operations management, workflow management, enterprise content management, and customer service solution that has been standardized for managed healthcare organizations. EXP helps track and manage the flow of data, documents, and business processes through our organization. EXP's tools for capturing, centralizing, and archiving data and documents help ensure that all of our operations are standardized and integrated. Reporting tools monitor workflow, helping managers identify bottlenecks and increase efficiency. Some of the documents we capture include:

- Incoming correspondence from members or providers
- Claims
- Prior Authorization records
- Letters of medical necessity (electronic and scanned images)
- Outgoing correspondence to a member or provider. (e.g., letters to request additional information, notice of Action, notice of appeal resolution.)

EXP's Doc Flow module enables records/documents to be processed into work queues for efficient work assignment and management. The Doc-Flow module of EXP enables queue-based work distribution. Time sensitive documents trigger alerts. Users can flag certain documents for dual review. Active X scripting enables integration of Doc Flow with other applications, such as Facets, Argus (used to administer pharmacy benefits), TopDown Client Letter, Jiva (our care management information system), and the Data Warehouse.

All claims that pend for additional review are also tracked in the EXP system. EXP tracks 100 percent of all pended claims and manages the flow of the claim through resolution. By using the Doc-Flow component of the system, pended claims are circulated in a queue-based workflow distribution, which ensure timely resolution of the claims per established metrics.

Key Provider-Facing Tool

NaviNet is designed so that providers log in once and have access to information from multiple payers. ACFC supports all standard transactions through NaviNet, including eligibility and benefits, claim status, and referrals submission. Provider manuals, forms, and other important administrative information providers need are also accessible through the portal.

ACFC also supports the secure and robust reporting capabilities in NaviNet, which pulls information from ACFC's back-end systems. The reporting tool allows providers to customize their reports by setting filters and sorting, which are then available in both print-ready and Excel or Continuity of Care (CCD) compatible formats.

Enforcing Accuracy of Claims Data

We use several strategies to ensure that the claims data submitted is accurate. This includes testing payment configurations, automated editing against a full-suite of clinical and administrative rules, maintaining up-to-date system rules and edits, and regularly monitoring quality through audit programs.

Claims Payment Testing Strategy

ACLA has a robust testing strategy to ensure the accuracy of claim payments. Payment configuration is tested when one of the following triggers occurs: initial set-up of providers in a new market, loading of a new provider agreement, introduction of a new payment methodology, identification in trends in claim payment errors, and fee-schedule updates.

Testing is performed by:

- Loading of "test" claims with specific test conditions to ensure that all claim types are captured, with the specific test conditions will match the adjudication logic.
- Adjudicating "test" claims in Facets utilizing the appropriate processing rules.
- Reviewing of test-adjudication output to validate and show that appropriate adjudication logic and claim edits were applied (i.e. claim paid, denied or pended appropriately with the correct reason code applied).
- Reviewing payments to ensure payment results are consistent with payments scheduled and outlined in the provider's contract.
- Running test-payment batch cycle to validate payments, which appear on the remittance advice appropriately and payment is going to the correct provider at the right location.

Claims Processing Rules

ACLA has developed standard claims-processing rules that are used during the adjudication process. The standard rules are tailored to meet the specific requirements of ACLA's provider agreements and any state-specific requirements. Claim examiners have access to the processing rules to aid them during the adjudication process through our Online Help software.

Processing rules are updated when new rules are identified and/or when the quality-auditing process has identified specific areas for enhancement.

Compliance with Industry Standards, State and Federal Requirements

Updated code files are obtained and loaded into the claim adjudication system quarterly or annually, as published. Claim payment policies are also updated regularly.

These updates are derived from standard industry sources, such as:

- The National Uniform Billing Code (NUBC).
- Health Care Common Procedure Coding System (HCPCS).
- Current Procedure Terminology (CPT).
- ICD-9 guidelines.
- CMS National Correct Coding Initiative (NCCI) manual.
- NCCI facility and professional procedure to procedure edits.
- CMS manuals.
- Outpatient Professional Payment System (OPPS) guidelines.
- Integrated Outpatient Code Editor (I/OCE) guidelines.
- Louisiana state regulatory guidelines.

Quality Monitoring

ACLA and ACFC use several approaches to ensure claims and encounters are accurate and timely. Our dedicated Quality Auditing Department is accountable for reviewing adjudicated claims for financial, procedural, and claim accuracy.

ACFC tracks encounter performance, as well as the performance of our subcontractors and providers. Our monitoring programs help us achieve compliance with DHH encounter data reporting requirements, and highlights when follow-up is required to resolve issues regarding encounter reporting by subcontractors or providers.

Reports are regularly generated through our monitoring and audit programs, and distributed to appropriate leadership and workgroups for review and any necessary remediation activities. We also perform a monthly internal credibility audit to validate the accuracy of auditing statistics.

Our self-service reporting application is available to operations management teams. Reports pulled from the application are based on real-time claims data.

Stratified Health Plan Audit Program

In compliance with RFP Section 17.7.1, a stratified health plan audit is completed on a monthly basis, which consists of a random sample, by payment strata, of at least 385 electronic and paper claims processed in the previous month. The strata is adjusted depending on claims volume and is then divided into three payment strata, with a fourth stratum used for adjusted claims, and a fifth stratum for zero paid claims. Payment stratum parameters are based off of the previous year's historical data.

The Stratified Plan Audit produces the claims payment accuracy percentage for ACLA's entire population of electronic and paper claims that were processed upon initial submission.

Claims pulled for stratified audits consist of manually adjudicated and system adjudicated claims, as well as those handled by HP Quick Test Pro, a claims testing tool we use to process

routine claims that fall outside of our auto-adjudication process. The quality scores achieved for each plan serve as the official score. The scores include financial, procedural and payment accuracy percentages.

In addition, other recurring or targeted audits are performed on a pre- or post-disbursement basis. For example, the high dollar pre-disbursement audit is a reoccurring audit, which consists of a review of all claims with billed charges equal or greater than $100,000.

Monthly Encounter Status Reports

Monthly status reports are pulled from the encounter audit table to validate the integrity of the encounter data and overall system. Analysts monitor the rejections on each error file received and use cumulative encounter error reports to identify trends.

Performance Audits

We also perform regular audits on the claims processed by certain associates or teams. This includes our new hires, our Cost Containment team, and our Claim Reconciliation Recovery Unit (CRRU).

For each new hire, daily audits are performed on a random sample of 5 to 30 percent of the claims they processed each day for the five weeks of training. Quality Auditors are available to review errors with new associates two to three times per week, and with the Trainer/Supervisor at least once per week.

Intervention for Accuracy

Quality scores are shared with the management team on a daily and monthly basis. If error trends are identified, targeted training modules are developed. Depending on the nature of the errors, the entire claim staff may be required to attend the training. If the errors are isolated, the examiners who committed the errors will be required to attend the training.

Provider reported payment errors are handled by a specially trained unit within the claims department (Research and Analysis team). The Research and Analysis team will work with the provider to determine the root causes of the payment errors, such as system set-up or provider billing error. Once the root cause is determined, the appropriate remediation action is implemented such as: provide education, system enhancements or claim examiner training.

Payment errors resulting from incorrect system configuration or provider set-up will trigger the development of a system change request/work request. Change requests are reviewed by the functional business owners and sent to the Configuration team to be updated. Once updated, standard testing processes will occur to ensure the accuracy of the change.

Preparing and Submitting Encounter Data

Fully adjudicated claims, those that were paid or denied, are loaded and reconciled into the data warehouse twice weekly. The Enterprise Encounter team then builds ACLA's encounter files from the data warehouse.

Claims System Interface for Encounter Submission

All claims adjudicated, as well as adjustments and voids, are extracted though the automated encounter application, which generates encounter files in HIPAA-required formats.

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 "dropped" to a report to be reviewed and worked by the Enterprise Encounters Team. These dropped 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 Encounters Team has 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 cause 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.

Correcting Repairable Errors Identified by FI

When 999 and 835 response files are received from the FI, analysts on the Enterprise Encounter Team are responsible for reviewing each rejected encounter and coordinating its remediation within 30 days. The team actively manages and tracks error resolution through completion. Corrected encounters with repairable errors are included in the next encounters build processes and resubmitted to the FI.

Controls to Ensure Timely Encounter Submissions

Our automated encounter application also processes response files received from the FI. The FI's dispositions are loaded into an audit table in our data warehouse, and our automated encounter application categorizes encounters as accepted and rejected encounters. Rejected encounters are reviewed and analyzed for correction and resubmission to the FI.

All 999 and 835 response files received from the FI are reconciled to the encounter audit table and audit history table, and the FI's dispositions (accepted, rejected, translation error, etc.) are used to update the status of the encounters in the tables. Analysts on the Enterprise Encounter Team are responsible for reviewing each rejected encounter and coordinating its remediation within 30 days. The team actively manages and tracks error resolution through completion. Corrected encounters with repairable errors are included in the next encounters build processes and resubmitted to the FI.

The Enterprise Encounters Team tracks all encounter submissions through file tracking and acknowledgement response files from the FI. Analysts address identified issues by correcting and resubmitting files that were not successfully transmitted. This may be accomplished internally or through collaboration with the FI and/or DHH, as necessary.

Controls to Ensure Complete Encounter Submissions

At specific milestones during the reconciliation period, plan and subcontractor encounter status data is reconciled to the cash disbursement journal (CDJ) to ensure that all claims processed during the period have been submitted to the FI and recorded as cash. ACLA reconciles encounters data and provider payments to 97% or greater completeness. This also enables the Enterprise Encounter Team to identify repairable gaps in either encounter or cash reporting. At the close of the period, a final data capture and report are generated for use in the review and validation of the published draft and final audit findings.

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X.3. Claims Management

X.3 Describe your ability to provide and store encounter data in accordance with the requirements of the RFP and the Louisiana Medicaid specific requirements described in the Systems Companion Guide.

Overview

The ACLA encounters processing system is ready to successfully submit encounters that are complete, timely, and accurate at the contract start date. Our assessment of the requirements in the Bayou Health MCO RFP and the Systems Companion Guide indicates that our existing encounters generation and data exchange solution will continue to fully support exchanging claims and encounter data with DHH and the contracted FI in accordance with DHH's requirements. Our system is capable of submitting prior authorization data per DHH requirements, and as of July 2014, ACLA has completed successful submissions.

Our encounters system is comprised of people, process, and technology ensuring accurate, complete and timely encounter processing that is consistent with RFP and Companion Guide requirements. In addition to our information systems, we have a cross-functional Enterprise Encounter Team dedicated to managing the entirety of ACLA's encounters process. This process 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 ACLA's encounter data. Data submissions are transmitted securely in accordance to required timeframes and file limitations.

Providing Encounter Data

ACLA recognizes that providing contract-compliant encounters is critical for meeting program requirements. Our encounter files are built with settled claims, adjustments, denials, and voids, and submitted in the standard HIPAA 5010 transaction formats on a scheduled basis to comply with DHH and FI timing and file size requirements. This includes the ANSI X12N 837 provider-to-payer-to-payer Coordination of Benefits (COB) Transaction formats.

Encounter and claims system components are regularly updated with new state and federal requirements, as well as updated editions of CPT, HCPCS, ICD-9, ICD-10, HCPCS Level II, and Category II CPT codes. DHH provider billing manuals and DHH-approved payment rules are used to prepare ACLA's encounter files.

The Enterprise Encounters Team is responsible for preparing ACLA's encounter files, as well as analyzing and remediating all rejected encounters. This team uses formalized policies and desk procedures to build and exchange encounter data.

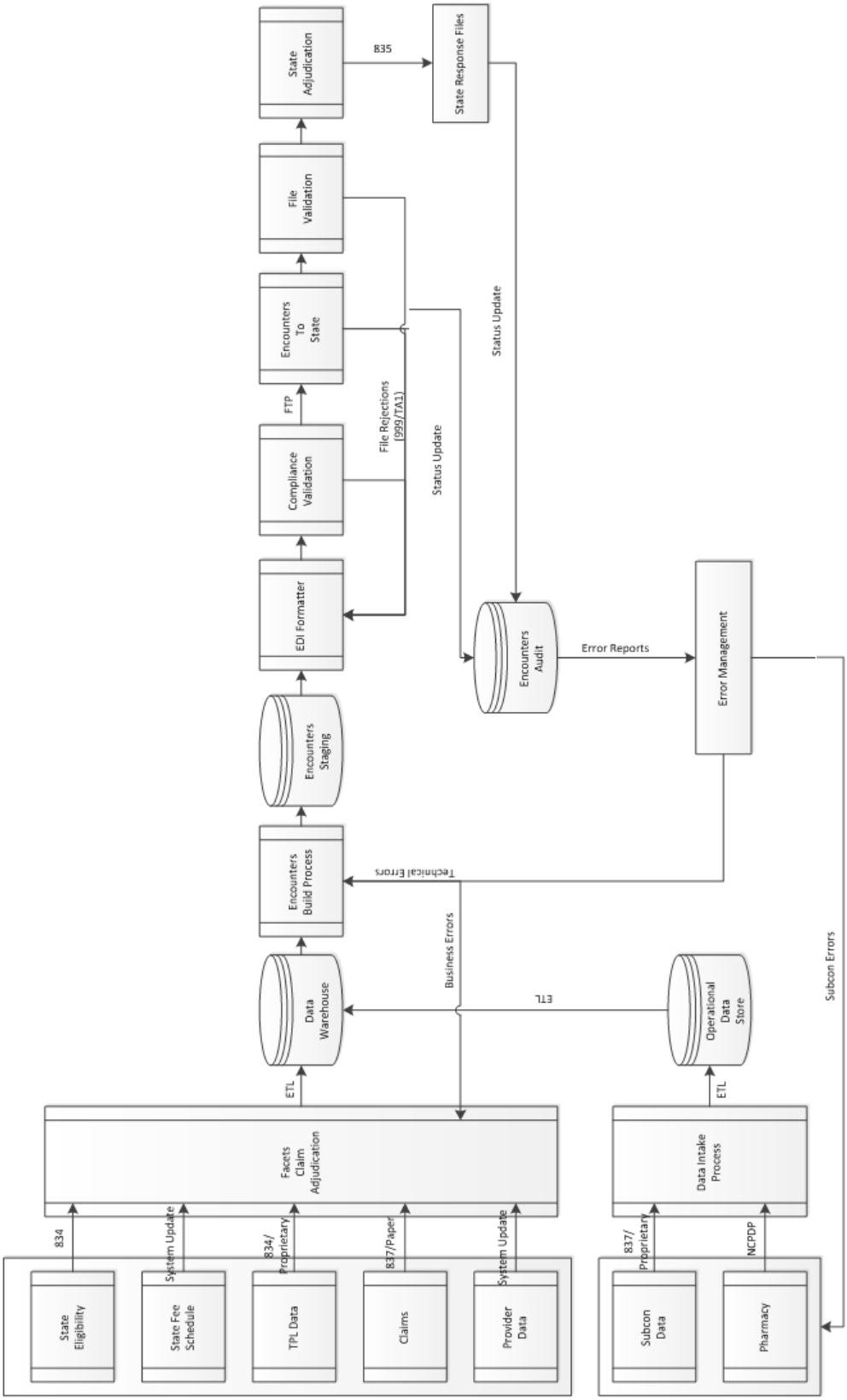

Exhibit X.3-1: Process Flow for ACLA Encounters

People: Dedicated Enterprise Encounter Team

The Enterprise Encounters Team, illustrated in the organization chart below, is comprised of local, IS, and operations stakeholders. This team works to provide complete, timely, and accurate encounters submissions, as well as analysis and remediation of all rejected encounters. ACFC has formalized policies and desk procedures for building and exchanging encounter data, ensuring thorough and consistent understanding across the dedicated encounters team.

Daily meetings are held to review acceptance rates, inventory management, and error resolution. The Enterprise Encounters Team participates in the weekly DHH Encounters meeting 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.

ACLA's Encounter Data Quality Coordinator based locally serves as a point of contact between the plan and DHH to identify, resolve, and monitor encounter data issues. Through this coordination, the Encounter Data Quality Coordinator provides recommendations to improve the accuracy and timeliness of our encounter data processing and throughput. This role is currently filled by an ACLA Business Systems Analyst, located in Louisiana and is supported by the Regional Director of Data & Technical Services who has a long history of managing encounter submissions for our affiliate plans.

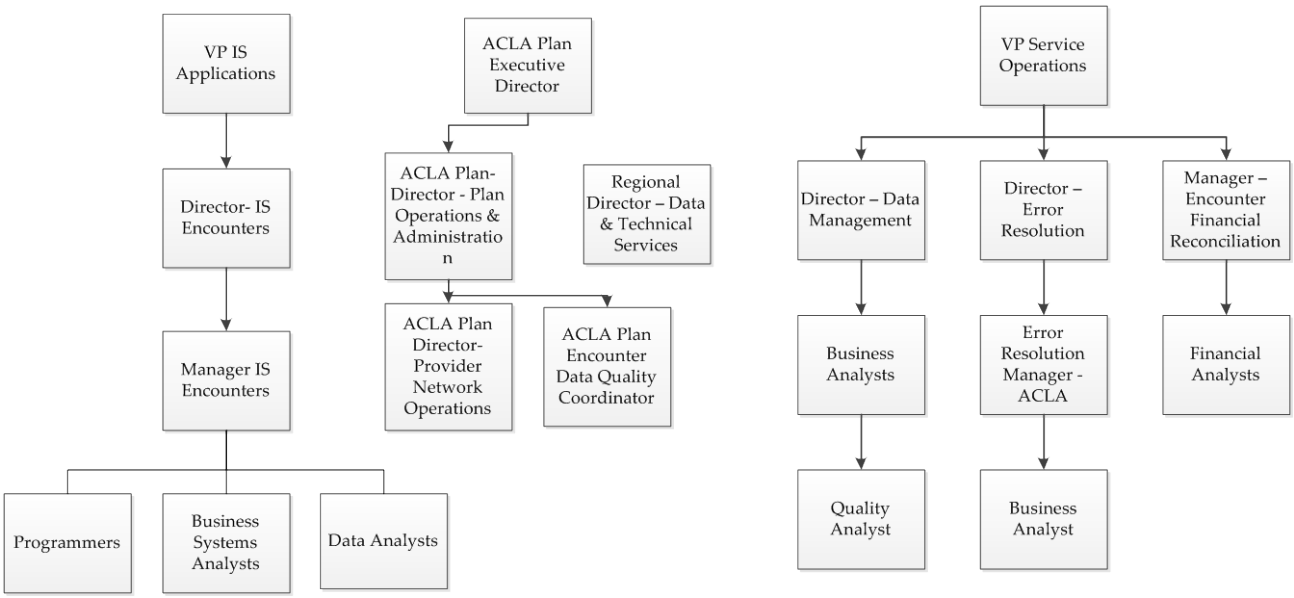

Exhibit X.1-2: Enterprise Encounters Team

Processing Claims through TriZetto Facets

Electronic and digitized paper claims are checked for compliance and completeness before being batch loaded into Facets for adjudication. All claims receive a Facets-generated unique claim number and are date stamped. Warning/Error edits are applied pre-payment and trigger an alert so an adjudicator can initiate any system edits needed to resolve the warning or error message.

Claims loaded into Facets undergo preprocessing edits verifying the completeness and accuracy of provider numbers, member ID numbers, diagnosis codes, and procedure codes. Any claims with missing or incorrect information are rejected and returned to providers with remittance advices that clearly identify the error and what is needed to correct the claim. ACLA processes claims on a daily basis.

ACFC employs a high degree of electronic adjudication through Facets, which stores ACLA's member eligibility, Bayou Health benefit parameters, provider pricing agreements, utilization and authorization requirements, and clinical editing rules. Electronic adjudication processing is fast and accurate, enabling claims processors to focus on the pended claims that require expert review. Pended claims are disbursed to different work queues to be manually reviewed and adjudicated.

Fully adjudicated claims, those that were paid or denied, are loaded and reconciled into the data warehouse twice weekly. As a part of the load process, the data is reconciled between Facets and the data warehouse.

Process: Encounters Preparation and Submission to FI

Fully adjudicated ACLA and subcontractor claims are loaded into ACFC's data warehouse. All relevant information—including member eligibility files and provider taxonomy—is also stored in the data warehouse. The IS Encounter team builds 837 encounter files from the data warehouse on a daily basis to comply with DHH's timeframes and the FI's encounter file limitations. These files include all paid, adjusted, and denied claims, including those showing a zero-dollar amount, and are formatted as 837 professional and institutional files, as appropriate.

The 837s are checked for completeness and accuracy, which includes verifying claim counts as well as HIPAA compliance validation, to identify any TA1 or 999 errors. Any encounter that results in an error is analyzed, and either resolved or removed for further investigation. The compliance process is repeated until a compliant file is created. Trading partner control information is sent in the Interchange Control Header (ISA), Functional Group Header (GS), Functional Group Trailer (GE), and Interchange Control Trailer (IEA) segments of the 837 files.

Claim issues may be identified throughout the encounter build process. Claims and encounters staff collaborate with internal resources to research and resolve the issues, and then ensure the corrected information is appropriately captured in our claims system and data warehouse so it can be included in the next encounter submission.

Approved 837 files are transmitted to the FI and posted to our encounter audit table and audit history table. To provide predictable and reliable processing, CISCO's Tidal Enterprise Scheduler is used to automate sending and receiving files between ACFC and the FI. The predetermined schedules alert the Enterprise Encounters Team if a file is not sent or received when expected, if any processing step fails, or if the file transfer is not successful. These alerts are monitored (24x7x365) so that immediate action can be taken to ensure contract requirements are met.

An attestation statement, signed by ACLA's Executive Director, is submitted to the FI on a weekly basis, attesting to the truthfulness, accuracy, and completeness of the submitted files listed on the attestation.

File transfers—inbound and outbound—are securely conducted using dedicated point-to-point connectivity over SFTP. Each exchange is archived and logged, in case it is needed for future reference or processing, using a lock-step method.

If a fully adjudicated claim is adjusted after its encounter data has been submitted to the FI, the Enterprise Encounter Team submits adjustments or voids for the encounter claim.

Inclusion of Subcontractor Encounter Data

Subcontractors submit post-adjudicated, paid claims data to ACLA on monthly basis, in accordance with the completeness, timeliness, and accuracy expectations established in their contracts. ACLA checks the counts, content, and quality of the received claims to ensure they contain all required elements, including member identification, service provider identification, and dates of service. Any claims that fail preprocessing are returned to the vendor, requiring claim errors to be resolved and claims resubmitted within 7 days.

Post-adjudicated subcontractor claims are loaded to the data warehouse and 837 files are generated. All 837 files, including those that contain subcontractor data, are HIPAA-compliance checked before they are submitted to the FI with ACLA's submitter identification number.

The subcontractor claims in the data warehouse are used alongside ACLA claims and other data sources to develop and report on quality and performance measures, including HEDIS reporting, so all services provided by or through the plan are appropriately captured and reflected.

To support accurate subcontractor encounter data reporting, Delegation Oversight meets with the subcontractors monthly to identify, discuss, and resolve claims or encounters issues resulting from FI response files. Performance is regularly monitored against documented and agreed upon standards.

ACLA 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.

ACLA delegates the performance of some health plan functions to subcontractors, but remains fully accountable for the performance of those functions. ACLA's Quality of Service Committee is responsible for reviewing, approving, and monitoring subcontractor activities associated with service standards, access, and availability.

Technology: Planning, Scheduling, and Automating Encounter Submission

The ACLA encounters processing system is configured to limit the encounter claims to a maximum of 20,000 encounters per file, which complies with the encounter file restrictions outlined in the Bayou Health MCO RFP and the Systems Companion Guide. We submit complete encounter data weekly by the 25th calendar day of the month following the month in which the claims were processed. To ensure compliance, we have a weekly submission planning process to determine and document which volumes are to be submitted each week and on which allowed submission day. Submissions are kept under the claim and encounter limits, and we coordinate with the FI prior to submitting high volumes of encounters to ensure smooth processing.

CISCO's Tidal Enterprise Scheduler is used to manage and automate encounter file exchanges with the FI, including 837, NCPDP, TA1, 999, and 835 files, in accordance with weekly 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.

All file transfers are conducted via a secure inbound and outbound movement of data using dedicated point-to-point connectivity over SFTP. Using a lock-step method for each data movement ensures all received and outbound exchanges are archived and logged for any future reference or processing needs.

Correcting Errors in Encounter Data and Reconciling Responses from FI

All 999 and 835 response files received from the FI are reconciled to the encounter audit table and audit history table, and the FI's dispositions (accepted, rejected, translation error, etc.) are used to update the status of the encounters in the tables. Analysts on the Enterprise Encounter Team are responsible for reviewing each rejected encounter and coordinating its remediation within 30 days. The team actively manages and tracks error resolution through completion. Corrected encounters with repairable errors are included in the next encounters build processes and resubmitted to the FI.

Historical claims data older than 36 months is archived for up to 10 years, and all 837, NCPDP, and 835 files are archived through the encounter processing system and stored for seven years.

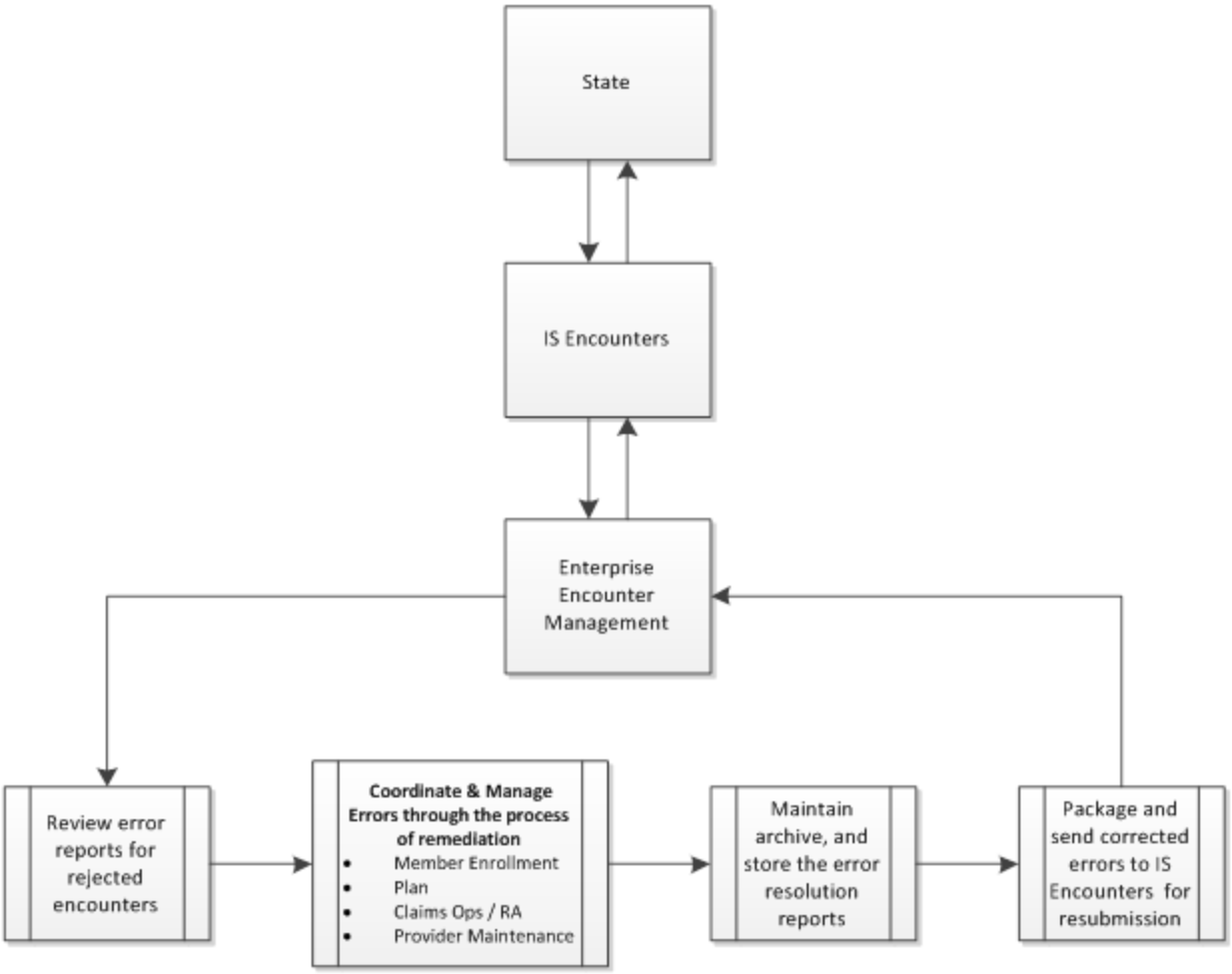

Exhibit X.1-3: Process Flow for Encounter Error Reconciliation

Reconciling to Cash Disbursement Journal

We reconcile encounters data to provider payments to 97% or greater completeness. We use a standard methodology to reconcile medical and subcontractor claims, encounters, and cash. Upon receipt of the Draft Encounter Report reconciliation is finalized.

At specific milestones during the reconciliation period, plan and subcontractor encounter status data is reconciled to claims and payments data in the cash disbursement journal (CDJ) to ensure that all claims processed during the period have been submitted to the FI and recorded as cash. This also enables the Enterprise Encounter Team to identify repairable gaps in either encounter or cash reporting. At the close of the period, a final data capture and report are generated for use in the review and validation of the published draft and final audit findings.

Upon publication, the Enterprise Encounters Team reviews the accuracy and completeness of the Draft Reconciliation Report. The team also conducts a review of suspected duplicate and/or calculated void records. Using data supplied by the audit firm, ACLA has developed a standard, documented process that compares the draft's results to the final internal report at

both the summary and individual encounter level. System logic has been specifically developed to process the suspected duplicate/calculated void records and determine the appropriate response; the system also provides the encounter details that support the designation.

Storing Encounter Data

All fully adjudicated claims and subcontractor data are loaded and stored in the data warehouse. The data warehouse also stores member demographic data, member eligibility, provider taxonomy, and provider demographic information. The encounters processing system uses the data in this repository to build the encounter files. Encounter data is loaded and stored in encounter audit tables and audit history tables in the data warehouse as well, to facilitate file, claim, and financial reconciliations.

In accordance with DHH's requirements, ACLA's historic claims data are maintained for 36 months in our production environment, and are accessible in real-time through Facets. Claim data older than 36 months is archived, but can be restored as needed into Facets, either individually or in batch. Our data warehouse stores all historical claims for up to 10 years. All 837, NCPDP, and 835 files are archived through the encounter processing system and stored for seven years.

X.4. Claims Management

X.4 Describe your methodology for ensuring that claims payment accuracy standards will be achieved. At a minimum address the following in your response:

- *The process for auditing a sample of claims as described in Section 17.5. Sampling of Paid Claims;*
- *Documentation of the results of these audits; and*
- *The processes for implementing any necessary corrective actions resulting from the audit.*

Overview

ACLA utilizes multiple methods to ensure payment accuracy and promote efficiency by using state-of-the-art technology, well-trained employees, and a rigorous quality assurance process. Our claims management system is able to be configured to automate nearly all payment scenarios and requirements, including DHH-specific requirements, such as state fee schedules, DRG methodologies, and EPSDT claims, among others. It has been customized to support the unique requirements of the Bayou Health program.

Our flexible claims system enables us to ensure accuracy through:

- Delivering provider table driven edits of claims ICD-9/10; CPT4; category of service; provider type; 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;
- Tracking timeliness of claim payments;
- Tracking claims pended for additional information or review; and
- Providing detailed reporting for current inventory, aging inventory, and pended claims.

Auditing Programs and Sampling Methodologies

ACLA has a number of programs in place that allow the Quality Auditing department to perform reviews of adjudicated claims for procedural, financial, and claim accuracy, as outlined in Section 17.5 of the RFP and through corporate policy.

Stratified Health Plan Audit Program

We perform a stratified health plan audit on a monthly basis, which consists of a random sample, by payment strata, of at least 385 electronic and paper claims processed in the previous month. The strata is adjusted depending on claims volume and is then divided into three payment strata, with a fourth stratum used for adjusted claims, and a fifth stratum for zero paid claims. Payment stratum parameters for ACLA are based off of the previous year's historical data.

Claims pulled for stratified audits consist of manually adjudicated, system adjudicated, and Rational Robot tested claims. Rational Robot is a claims testing tool that we utilize to process routine claims that fall outside of the system's auto adjudication process. The quality scores achieved serve as the official score. The scores include financial, procedural and claim accuracy percentages.

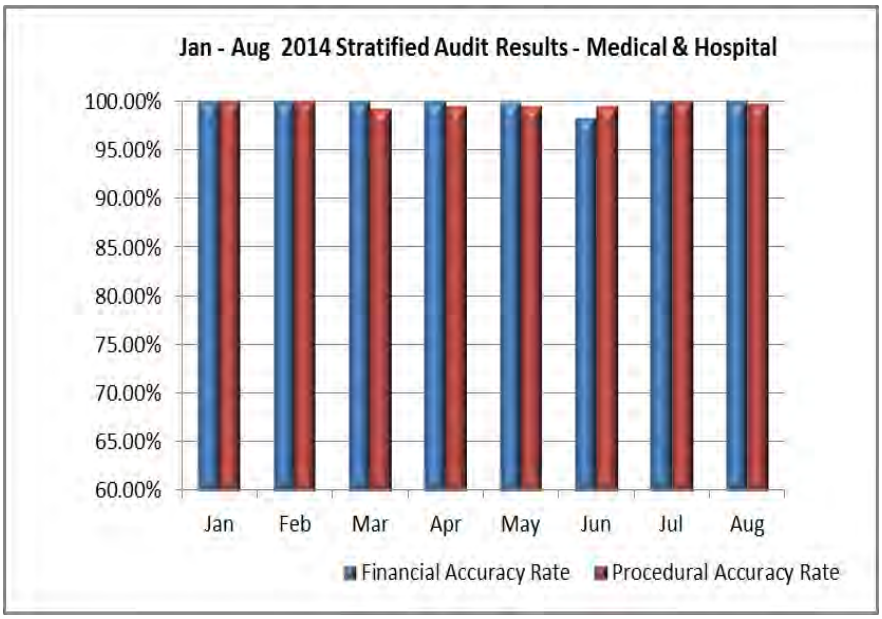

Exhibit X.4-1: Stratified Audit Results

Manually Adjudicated Audit Program

On a daily basis, the selection for this audit consists of a random sample of at least three percent of each claim examiner's processed work. Audits are performed on a pre or post-disbursement basis. The quality scores achieved for each claim examiner serve as a performance management tool for the Claims Operations management team. If it is determined that a claims 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 of time.

Rational Robot Audit Program

On a daily basis, the selection for this audit consists of a random sample of at least one percent of Rational Robot claims. The Rational Robot team processes both production jobs (original claims) and claims from projects (adjusted claims.) Claims selected from projects are audited against the project documentation and the plan's processing rules. The quality results are utilized by the Rational Robot team to identify process improvement opportunities. The Rational Robot team is responsible for the remediation of identified errors.

Cost Containment/Claim Reconciliation Recovery Unit (CRRU) Audit Program

For this daily audit, we choose a random sample of at least 10 percent of monthly claims adjusted by the Claim Reconciliation Recovery Unit (CRRU) and at least three percent of monthly claims adjusted by the Cost Containment team. Audits are performed on a pre- or post-disbursement basis. The quality scores achieved for each examiner serve as a performance management tool for the Cost Containment and CRRU management teams. Upon request from the CRRU/Cost Containment management teams, a higher percentage of an individual's processed claims can be pulled and audited for an agreed upon period of time.

System Adjudicated Target Audit Program

The sample criteria for this audit are based on claims management team requests, which may include previously identified quality auditing errors, recent configuration changes to the claim system (Facets), etc. The sample is focused on high-risk auto adjudicated claims and calculated to meet a minimum of a 95 percent confidence level and +/- five percent precision level. Target audits are performed on a pre- or post-disbursement basis as requested by the claims management team. Errors assessed during the target audit are sent by the Quality Audit (QA) department to the Configuration and Claims Operations management teams for review.

High Dollar Pre-Disbursement Audit Program

The criteria for this audit are all claims with total billed charges equal to or greater than $100,000. These claims are reviewed by the QA team to audit for procedural, financial, and payment accuracy. Any identified discrepancies are resolved prior to claim adjudication/payment.

New Hire Quality On-Boarding Audit Program

The selection for this audit consists of a random sample between five and 30 percent of the daily number of claims processed for each new employee to allow for early identification of performance gaps. The training program is broken into three modules to allow new employees to learn to process one type of claim and gain experience in that claim type, before moving on to another type of claim. Modules exist for: medical, hospital, and Coordination of Benefits claims. As each module of the training program concludes, the employee begins processing that claim type in the production environment and the auditing periods begin. The audit period following medical claim processing training, the first module, is three weeks, with a two-week period following the hospital and COB modules. The Quality Auditors may review any errors with an employee up to two to three times per week and with the trainer/supervisor at least once per week.

The quality scores achieved for each employee serve as a performance management tool for the trainer and the claims management team. Upon completion of the "new hire" claims training and audit period, the employee is monitored through the Manually Adjudicated Audit Program.

Explanation of Benefits (EOB)

On a monthly basis, ACLA mails service verification letters or explanation of benefits (EOB) notices to a group of members for whom claims are received. Using state-approved sampling methodology, ACLA generates notices which include a description of the service provided, the provider of described service, the date on which the service occurred, as well as the amount of payment made. ACLA ensures that a minimum of 2% of all paid claims in a given month are represented in this sample. ACLA tracks all complaints received by the member services department, as well as any actions taken as a result of an inquiry. ACLA will report the results to DHH on a quarterly basis and utilize the results to target high-risk provider types and/ or services. In cases where survey results indicate that paid services may not have been received, ACLA shall forward all required information to the Special Investigation Unit (SIU) and DHH for review.

Claims Payment Subcontractor Audit

The plan collects accuracy percentage from the monthly delegation performance report submission required of all delegates. Additionally, we ensure the delegate has approved procedures which include a process for reviewing claims for accuracy and acceptability. These policies are reviewed by the plan during the annual delegation audit.

Local ACLA Review Audit Processes

In order to address errors in a timely manner, ACLA utilizes a local Quality Auditor. This auditor is responsible for the review of the lifecycle of all claims, contracting, configuration updates, fee schedule updates, provider maintenance, member reassignments, and monitoring of statutory reports/performances metrics from the Network Operations Department. Audited information is tracked and any discrepancies or identified claims issues are reported at the weekly meetings between PNO and the Claims Unit team. If updates or corrections are identified, the appropriate steps are taken to address the issues as soon as possible. Additional staff within the PNO department also audits 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 resides in a dedicated database. The audit results for the monthly Stratified Plan Audit are distributed to the Claims Operations management team monthly. The audit results for the Manually Adjudicated Claim Audit are available to the Claims Operations management team in real-time, as the management team has administrative access to pull quality audit results either by individual examiner or by department at any time. For both audits, the QA department issues a Claim Summary report with the financial, procedural, and claim accuracy scores for the month, and a Claim Detail report to support claim errors identified in the audit.

Claim Detail Report for LOB 2100

Record Number	Claim Number	Paid Date	Payment Time	Paid Incorrect	Date Reviewed	Comments
		7/9/2014	Over Payment	$478.95	8/5/2014 6:34:18 AM	

Error Description	Error Comments	Error Type	Dispute Status	Dispute Level	Dispute Decision	Decision Comments
CLAIM INAPPROPRIATELY PAID - OTHER	Claim paid incorrectly, frequency code 8 submitted on claim. Per the Adjusted Claims Hospital rules, Void/Cancel of Prior Claim (this bill type is used for retractions), Deny all frequency 8 claims - X53, even if an EOB is attached to the claim.	Financial				

Figure X.4-2: Stratified Plan Audit Report

Audit points for stratified and manually adjudicated claims are based on coordination of benefits, clinical editing, configuration, duplicates, input, timely filing, authorization/referral and processing rules and procedures. Audit points for Rational Robot, Cost Containment and CRRU claims are based on the process rules for the specific project. Audit points for auto adjudicated claims are based on the claim specific criteria. For example, if an EOB from another carrier is submitted with the claim, the auditor will check to see if the benefits were coordinated appropriately and in accordance with COB guidelines in effect at the time the claim was processed.

Once the results are compiled, the Claims Operations teams access the results through a self-service reporting application. Reports are available on a real-time basis and include the following:

- Claim detail report by individual
- Health Plan summary report
- Supervisor summary report

Audit results are 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 includes, but is not limited to individual coaching, targeted training (e.g. authorization, COB training), progressive performance management, etc. Results and any associated action plans are reported to the plan's Quality of Service Committee and to the executive management team responsible for the plan.

Necessary Corrective Action Processes

Claim Operations Managers/Supervisors are responsible for reviewing the manually adjudicated (performance management) audit reports and determining if the errors are charged appropriately. If there is a discrepancy, the supervisor/team leader follows a formal appeal process to have the audit result reviewed. In addition, an internal credibility audit is 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 develops an action plan, which includes 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, are reviewed monthly and remain active until identified errors are resolved. Any claim payment error identified is immediately corrected and reprocessed for appropriate payment.

Team Leads/Supervisors also work with individuals with poor audit scores through coaching and retraining. Employees with repeated poor audit performance are placed on a formal Performance Improvement Program. In addition, audit results are also used as part of the development plan process for individual employees. Continued poor performance could result in termination of employment.

AmeriHealth Caritas Louisiana

Y.1. Value Added to Members

Y.1 Provide a listing, description and conditions under which you will offer value added benefits as described in the RFP Section 6.1.3.

The proposed monetary value of these benefits will be considered a binding contract deliverable. If for some reason, including but not limited to lack of member participation, the aggregated annual per member per month PMPM proposed is not expended the department reserves the right to require the MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.

For each value-added benefit proposed:

- *Define and describe the expanded benefit;*
- *Identify the category or group of Members eligible to receive the expanded service if it is a type of service that is not appropriate for all Members;*
- *Note any limitations or restrictions that apply to the expanded benefit*
- *Identify the types of providers responsible for providing the expanded benefit, including any limitations on Provider capacity if applicable.*
- *Propose how and when Providers and Members will be notified about the availability of such expanded benefits; and*
- *Describe how a Member may obtain or access the Value-added Service;*

- *Describe how, you will identify the expanded benefit in administrative data or encounter data.*

  Indicate the PMPM actuarial value of expanded benefits assuming enrollment of 200,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information.

  The department will work with its contract actuary to independently review any statements of actuarial value.
- *Include a statement of commitment to provide the expanded benefits for the entire thirty six (36) month term of the initial contract.*

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AmeriHealth Caritas Louisiana

Z.1. Value Added to Providers

Z.1 Provide a listing, description and conditions under which you will offer value added incentives or enhanced payments to providers in accordance with Section 9.8 of the RFP.

The proposed monetary value of these incentives and/or enhanced payments will be considered a binding contract deliverable. If for some reason, including but not limited to lack of provider participation or performance, the aggregated annual per member per month PMPM proposed is not expended the department reserves the right to require the MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.

For each value-added incentive proposed:

- *Define and describe the provider incentives or expanded payments and associated measures of performance;*
- *If not applicable to all providers; identify the category or group of providers eligible to participated in the incentive or receive enhanced payments;*
- *Note any limitations or restrictions that apply to the incentives or enhanced payments;*
- *Describe how and when Providers and Members will be notified about the availability of such expanded benefits; and*
- *Describe how provider input and feedback will be used to realign incentives as appropriate.*

- *Describe how you will identify the associated payments in administrative data or encounter data.*
- *Indicate the PMPM actuarial value of the proposed provider incentives based on an enrollment of 250,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information. The department will work with its contract actuary to independently verify any statements of actuarial value.*
- *Include a statement of commitment to provide the expanded benefits for the entire thirty six (36) month term of the initial contract.*

Appendix PP must be submitted as part of the proposal.

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AmeriHealth Caritas Louisiana

AA.1. Value Added to Louisiana Employees

AA.1 Describe the workplace wellness program and employee incentives you will have in place for your Louisiana-based employees within 3 months from the effective date of the contract. Include incentives for participation. Program components, and expected results.

The proposed annual monetary expenditure for this program and will be considered a binding contract deliverable. If for some reason, including but not limited to lack of employee participation, the proposed annual expenditure is not expended the department reserves the right to require the MCO to provide an alternate employee wellness benefit of equal value and/or may conduct reconciliation for the amount unexpended.

For each value-added incentive proposed:

- *Define and describe the wellness program/employee incentives and associated measures of performance;*
- *If not applicable to all employees; identify the category or group of employees eligible*

(continued on the next page)

  to participate in the incentive or receive enhanced payments;
- *Note any limitations or restrictions that apply to the wellness benefits/incentives;*
- *Describe how and when employees will be notified about the availability of such programs/incentives; and*
- *Describe how employee input and feedback will be used to realign incentives as appropriate.*

- *Describe how you will identify the associated payments in administrative data,*
- *Indicate the total annual expenditures proposed for each of the three (3) contract years.*

Include a statement of commitment to provide these expenditures for this purpose for the entire thirty six (36) month term of the initial contract.

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AmeriHealth Caritas Louisiana

BB.1. Veteran Initiative and Hudson Initiative

BB.1 If applicable, provide documentation that the proposer (including parent organization, affiliates, and subsidiaries) and/or its subcontractor has been certified by the Louisiana Department of Economic Development as a:

- *Veteran-Owned,*
- *Service- Connected Disabled Veteran-Owned small entrepreneurship (LaVet), or*
- *Louisiana Initiative for Small Entrepreneurships (Hudson Initiative).*

If a proposer is not a certified small entrepreneurship as described herein, but plans to use certified small entrepreneurship(s), proposer shall include in their proposal the names of their certified Veteran Initiative or Hudson Initiative small entrepreneurship subcontractor(s), a description of the work each will perform, and the dollar value of each subcontract.

Overview

ACLA, as well as its parent and affiliates, have an exceptional supplier diversity program, which we continue to grow. In 2011, ACFC was trending from $10 to $12 million annually in corporate spending through the diversity program. The company's former president set a goal of tripling its diversity spending by 2015. The company is now trending at more than $30 million annually in diversity corporate spending.

ACLA Veteran Initiative and Hudson Initiative Subcontractors

Having a strong supplier diversity program in place enables us to meet the needs of our business effectively while also supporting our community. Our culture is one of openness, integrity, and respect where we value the contributions of our talented people and support their varied backgrounds and viewpoints.

ACLA Hudson / Veteran Vendors							
Vendor Name	Certification	Experience/ Qualifications	Commercial Business	CONFIDENTIAL [redacted]	[redacted]	[redacted]	[redacted]
All Phase Construction (DARMCO, LLC)	SEHUD	Licensed Commercial contractor, 25 years' experience	Construction	CONFID	[redacted]	[redacted]	[redacted]
American Business Systems, Inc. Moran sub-contractor	SEHUD	Printing & Fulfillment company with 5 plus years' experience	Printing Fulfillment	CONFI	[redacted]	[redacted]	[redacted]
Corporate Business Supplies	SEHUD/ MBE	Commercial office supply and furniture company with 18 years'' experience	Office Furniture	CONFID	[redacted]	[redacted]	[redacted]

Landscape 180	SEHUD	Landscape, build and maintain HomeAdvisor screened contractor with combined experience of 15 years in the landscape industry	Office Plants	CONF	[redacted]	[redacted]	[redacted]
Lemonade Creative Marketing	SEHUD/ MWBE	Marketing and promotional company with 4 years' experience, Awarded 2013 - Top 10 "Fast Growing Affiliate Company" for IPromoteU (Out of 600 companies).	Promotional Items	CONF	[redacted]	[redacted]	[redacted]
Teal Paper Products	SEHUD	Commercial office supply company with 28 years' experience providing office products to State and local agencies	Office Expense/ Paper Products	CONF	[redacted]	[redacted]	[redacted]
Dempsey Business Systems of LA	SECDVET/MBE	Louisiana Technology company with 32 years' experience	IT Equipment/ Services	CONF	[redacted]	[redacted]	[redacted]
Vivid Ink	SEHUD/SEVET	Large format digital print company with 15 years of industry experience	Promotional Items/Printing	CONF	[redacted]	[redacted]	[redacted]
Corporate Mechanical Contractors	SEHUD	Maintenance solutions company with 32 years' experience	Equipment Maintenance	CONFI	[redacted]	[redacted]	[redacted]
Verity	SEHUD	Fiscal intermediary for Baton Rouge General	Fiscal intermediary	CONFID	[redacted]	[redacted]	[redacted]
TBD	SEHUD/ SEVET	Advertising	Advertising/ Media Buy	C	[redacted]	[redacted]	[redacted]

To Do List Errand Services LLC (LogistiCare sub contractor)	SEHUD	Licensed Non emergency transportation company with 5 years experience	Member Transportation	CONFI	[redacted]	[redacted]	[redacted]
Noel Medical Transportation (LogistiCare sub contractor)	SEHUD	Licensed Non emergency transportation company	Member Transportation	C	[redacted]	[redacted]	[redacted]
One Bunch Hook Up (LogistiCare sub contractor)	SEHUD	Licensed Non emergency transportation company with 15 years' experience	Member Transportation	CONFID	[redacted]	[redacted]	[redacted]
Punctual Transportation LLC (LogistiCare sub contractor)	SEHUD	Licensed Non emergency transportation company with 5 years' experience	Member Transportation	CONFI	[redacted]	[redacted]	[redacted]
Covington Transportation Services (LogistiCare sub contractor)	SEHUD	Licensed Non emergency transportation company with 2 years' experience	Member Transportation	CONFI	[redacted]	[redacted]	[redacted]
Julia's Care Transportation (LogistiCare sub contractor)	SEHUD	Non-emergency transportation, 1 year of experience	Member Transportation	CONFI	[redacted]	[redacted]	[redacted]
Quality Transportation Services (LogistiCare sub contractor)	SEHUD	Non-emergency transportation, 18 years' experience	Member Transportation	CONFI	[redacted]	[redacted]	[redacted]
ABMN Inc. (LogistiCare sub contractor)	SEHUD	Non-emergency transportation, 2 years' experience	Member Transportation	CONFI	[redacted]	[redacted]	[redacted]
M & M Taxi (LogistiCare sub contractor)	SEHUD	Non-emergency transportation, 15 years' experience	Member Transportation	CONFID	[redacted]	[redacted]	[redacted]
Dana's Medical (LogistiCare sub contractor)	SEHUD	Licensed non-emergency transportation, 2 years' experience	Member Transportation	CONFI	[redacted]	[redacted]	[redacted]
Meditrans Inc. (LogistiCare sub contractor)	SEHUD	Licensed non-emergency transportation, 6 years' experience	Member Transportation	CONFI	[redacted]	[redacted]	[redacted]

Preventive Measures Programs, Inc. (LogistiCare sub contractor)	SEHUD	Licensed non-emergency transportation, 4 years' experience	Member Transportation	CONFI	[redacted]	[redacted]	[redacted]
J&D Transit (LogistiCare sub contractor)	SEHUD	Licensed non-emergency transportation, 1 year of experience	Member Transportation	CONFI	[redacted]	[redacted]	[redacted]
Andrea's Medical Transportation (LogistiCare sub contractor)	SEHUD	Licensed non-emergency transportation	Member Transportation	CONFI	[redacted]	[redacted]	[redacted]
Greenlight Transportation (LogistiCare sub contractor)	SEHUD	Licensed non-emergency transportation, 12 years' experience	Member Transportation	CONFI	[redacted]	[redacted]	[redacted]
AA Academy Transportation (LogistiCare sub contractor)	SEHUD	Licensed non-emergency transportation, 11 years' experience	Member Transportation	CONFI	[redacted]	[redacted]	[redacted]
Len Transportation	SEHUD	Licensed non-emergency transportation, 1+ year of experience	Member Transportation	CONFID	[redacted]	[redacted]	[redacted]
			Total Spend	CONFIDE	[redacted]	[redacted]	[redacted]

ACLA Commitment to Supplier Diversity

We actively cultivate and value our relationships with minority-owned and women-owned businesses. We respect the diversity of our customers and believe that we can serve them most effectively by embracing diversity and inclusion within our company.

ACLA Minority Diverse Vendors							
Vendor Name	Certification	Experience / Qualifications	Commercial Business	CONFID ENTIAL [redacted]	[redacted]	[redacted]	[redacted] e
Alpha Office Supplies Incorporated	MBE	Provide office furniture, flooring, and supplies, 35 years' experience	Office Supplies	CONFI	[redacted]	[redacted]	[redacted]
A1 Imaging	MBE		Office Supplies (Ink)	C ;ON	[redacted]	[redacted]	[redacted]

Frazee, Inc.	MWBE	Professional staffing solutions, 31 years' experience	Temporary Staffing	CONFID	[redacted]	[redacted]	[redacted]
Grand Ideas	MWBE	Promotional and marketing firm, 11 years' experience	Promotional Items	CONFID	[redacted]	[redacted]	[redacted]
Language Services Associates, Inc.	MBE	Full range of language translation services, 23 years' experience	Language Translation	CONF	[redacted]	[redacted]	[redacted]
Mendoza Group Incorporated	MBE	Full service Hispanic advertising agency, 19 years' experience	Language Translation	CONFI	[redacted]	[redacted]	[redacted]
Mid Atlantic Color Graphics	MBE	Printing and document management services, 29 years' experience	Member Card Printing	CONFID	[redacted]	[redacted]	[redacted]
Zolan Tech Resources (RightSourcing sub contractor)	MBE	Information Technology staffing services to government clients, 6 years' experience	Temporary Staffing	CONF	[redacted]	[redacted]	[redacted]
SHI International Corp.	MWBE	Corporate reseller of software, hardware and related services, 3 years' experience	IT Equipment	CONFID	[redacted]	[redacted]	[redacted]
Sourcium Group, Inc.	MWBE	Sourcing and procurement of IT equipment and software, 12 years' experience	IT Software	CONFI	[redacted]	[redacted]	[redacted]
Touch of Class Promotions	MWBE	Promotional product distributor	Promotional Items	CONF	[redacted]	[redacted]	[redacted]

Universal Printing Company	MWBE	Commercial printing and fulfillment services, 75 years' experience	Printing	CONF	[redacted]	[redacted]	[redacted]
LEGEND **MWBE:** Minority Women Owned Business **MBE:** Minority Business Enterprise **SEHUD:** Small Entrepreneurship Hudson Initiative **SEVET:** Small Entrepreneurship Veteran Owned **SECDVET:** Small Entrepreneurship Service Disabled Veteran Owned			**Total Spend**	CONFIDE	[redacted]	[redacted]	[redacted]
			Grand Total Spend	CONFIDE	[redacted]	[redacted]	[redacted]

Southern Regional Minority Diversity Council (SRMDC)

AmeriHealth Caritas of Louisiana (ACLA) is a member of the Southern Regional Minority Diversity Council (SRMDC). ACLA has been an active participant in the SRMDC's Gateway Business Connections program; and ACLA will continue to utilize the SRMDC's MBE matchmaking sessions to identify qualified diversity suppliers to provide goods and services to ACLA and our affiliated corporate entities.

Parent and Affiliate Commitment to Supplier Diversity

We are committed to attracting and sustaining a talented workforce that reflects the diversity of the community where we live and work.

Vendor name	Certification	Experience/ Qualifications	Commercial Business	CONFIDENTIAL [redacted]	[redacted]	[redacted]	[redacted]
Millennium 3 Management, Inc.	MBE	Advertising firm with over 20 years' experience	Advertising	CONFID	[redacted]	[redacted]	[redacted]
Agio Brand Solutions, LLC	LGBT	Promotional supplier with 7 years' experience	Promotional Material	CONFI	[redacted]	[redacted]	[redacted]
Zolon Tech Solutions, Inc.	MBE	IT strategic services company with over 8 years' experience	Consultant	CONFID	[redacted]	[redacted]	[redacted]

Zones, Inc.	MBE	IT solutions and services company with over 25 years' experience	IT Solutions	CONFID	[redacted]	[redacted]	[redacted]
503 Corporation	MBE	Janitorial product supplier with 20 years' experience	Janitorial Supplies	CONFID	[redacted]	[redacted]	[redacted]
A Pomerantz And Company	MBE	Office supply and furniture supplier with over 15 years' experience	Office Supplies	CONFID	[redacted]	[redacted]	[redacted]
A+ Imaging Systems Inc.	MBE	Office supply and IT equipment supplier with over 15 years' experience	Office Supplies	CONFID	[redacted]	[redacted]	[redacted]
Agile1 Workforce Solutions	MBE	Staffing and consultant company with over 20 years' experience	Staffing	CONF	[redacted]	[redacted]	[redacted]
Alpha Office Supplies	MBE	Commercial office supply and furniture company with over 20 years' experience	Office Supplies	CONFID	[redacted]	[redacted]	[redacted]
Alpha Omega Investigations	MBE	Investigation company with over 19 years' experience	Investigator	CONFI	[redacted]	[redacted]	[redacted]
Amoore Health Systems	MBE	Executive Education and Coaching firm with over 18 years' experience	Consultant	CONFI	[redacted]	[redacted]	[redacted]
AppleOne Employment Services	MBE	Search firm with over 25 years' experience	Staffing	CONFI	[redacted]	[redacted]	[redacted]
Aquent LLC	MBE	Staffing and consultant company with over 25 years' experience	Staffing	CONFID	[redacted]	[redacted]	[redacted]
ASI System Integration, Inc.	MBE	IT service company with over 25 years' experience	Consultant	CONFI	[redacted]	[redacted]	[redacted]
AV International, Inc.	MBE	Employee benefits consulting company with over 30 years' experience	Audio/Video	CONFID	[redacted]	[redacted]	[redacted]

Battles Transportation Inc.	MBE	Transportation company with over 37 years' experience	Member Transportation	CONFID	[redacted]	[redacted]	[redacted]
Blue Chip, LLC	MBE	Promotional supplier with over 8 years' experience	Promotional Material	CONFID	[redacted]	[redacted]	[redacted]
Bodacious Promotions Inc.	MBE	Promotional supplier with over 12 years' experience	Promotional Material	CONF	[redacted]	[redacted]	[redacted]
Brenneman Printing Inc.	MBE	Communications and marketing services company with over 45 years' experience	Printing	CONFI	[redacted]	[redacted]	[redacted]
Burks Companies	MBE	Facilities management company with over 20 years' experience	Facilities	CONFIDE	[redacted]	[redacted]	[redacted]
CI Solutions	MBE	Furniture supplier with over 7 years' experience	Furniture	CONFIDE	[redacted]	[redacted]	[redacted]
Clark Resources, Inc.	MBE	Call center and customer support company with over 15 years' experience	Consultant	CONFID	[redacted]	[redacted]	[redacted]
Connexus Technology, LLC	MBE	Health data management company with over 12 years' experience	IT Consulting	CONFI	[redacted]	[redacted]	[redacted]
Deluxe Delivery System, Inc.	MBE	Logistics, distribution and supply chain management company with over 22 years' experience	Delivery, Logistics, & Management	CONFI	[redacted]	[redacted]	[redacted]
DISYS, LLC	MBE	Global staffing firm with over 20 years' experience	Staffing	CONFI	[redacted]	[redacted]	[redacted]
Diversant LLC	MBE	IT staffing and diversity products	Staffing	CONFI	[redacted]	[redacted]	[redacted]
Endeavor Investigation	MBE	Investigative services company with over 10 years' experience	Private Investigation Services	CONFI	[redacted]	[redacted]	[redacted]

ESG Technical Services LLC	MBE	Real estate management company with over 10 years' experience	Real Estate	CONFID	[redacted]	[redacted]	[redacted]
Government Systems Technologies Inc.	MBE	IT infastructure company with over 13 years' experience	Information Technology Services	CONFI	[redacted]	[redacted]	[redacted]
Impact Dimensions	MBE	Corporate gift and advertising specialty company with over 15 years experience	Promotional Material	CONFI	[redacted]	[redacted]	[redacted]
J2 Solutions	MBE	IT project and program management company with over 12 years experience	Consultant	CONFID	[redacted]	[redacted]	[redacted]
JB Medical Supply Co. Inc.	MBE	Medical supply company with over 20 years experience	DME	CONFIDE	[redacted]	[redacted]	[redacted]
JI Consulting Group, LLC	MBE	Promotional material consultant with over 4 years' experience	Consultant	CONFI	[redacted]	[redacted]	[redacted]
Keystone Computer Associates, Inc.	MBE	Information technology and life sciences staffing company with over 49 years' experience	IT Staffing	CONFI	[redacted]	[redacted]	[redacted]
La Fortaleza	MBE	Health and wellness company with over 20 years' experience	Rehabilitation	CONFID	[redacted]	[redacted]	[redacted]
Language Service Associates	MBE	Full language service company with over 20 years' experience	Translation/Interpreting	CONFID	[redacted]	[redacted]	[redacted]
Lehigh Print and Data	MBE	Print and fulfillment supplier with over 10 years' experience	Printing	CONFID	[redacted]	[redacted]	[redacted]
LNC Communications	MBE	Wireless Internet service provider with over 13 years' experience	Telecom	CONFID	[redacted]	[redacted]	[redacted]
Logos Medical Supply	MBE	Medical supply company with over 10 years' experience	Medical Supplies	CONFID	[redacted]	[redacted]	[redacted]

Mendoza Group	MBE	Advertising firm with over 15 years' experience	Advertising	CONFID	[redacted]	[redacted]	[redacted]
Metasense, Inc.	MBE	Full IT firm with over 15 years' experience	Web design	CONFID	[redacted]	[redacted]	[redacted]
Midlantic Color Graphics	MBE	Print and fulfillment supplier with over 14 years' experience	Printing	CONFIDE	[redacted]	[redacted]	[redacted]
Miller's of Columbia, Inc.	MBE	Office furniture dealer with over 45 years' experience	Furniture	CONF	[redacted]	[redacted]	[redacted]
MJK Electric	MBE	Fire alarm and emergency lighting systems company with 19 years' experience	Fire Alarm and Lighting	CONFI	[redacted]	[redacted]	[redacted]
Parmetech	MBE	Managed print services company with over 13 years' experience	Managed print services	CO IN	[redacted]	[redacted]	[redacted]
Perryman Building and Construction	MBE	Construction company with over 14 years' experience	Construction	C :ONF	[redacted]	[redacted]	[redacted]
Pest Free Maintenance	MBE	Full service pest control company with over 7 years' experience	Exterminator	CONFI	[redacted]	[redacted]	[redacted]
Philadelphia Tribune	MBE	Newspaper with over 50 years' experience	Newspaper	CONFID	[redacted]	[redacted]	[redacted]
Populus Group	MBE	IT consulting firm with over 10 years' experience	Consultant	CONFID	[redacted]	[redacted]	[redacted]
Pozent Corporation	MBE	Technology consulting service company with over 7 years' experience	Consulting	CONFID	[redacted]	[redacted]	[redacted]
Premier Comp Solutions	MBE	Cost containment solutions company with over 11 years' experience	Cost Containment	CONFID	[redacted]	[redacted]	[redacted]

PRWT Services	MBE	Customer service, fulfillment, payment processing, or Program management services company with 14 years' experience	Consultant	CONFIDE	[redacted]	[redacted]	[redacted]
Robinson Group Consulting, Inc.	MBE	Information Technology (IT), finance, and transformation management company with over 8 years' experience	Consultant	CONFIDE	[redacted]	[redacted]	[redacted]
RW Sorrell Enterprises LLC	MBE	Supplier diversity consultant with over 20 years' experience	Consultant	CONFI	[redacted]	[redacted]	[redacted]
Software House International	MBE	IT software supplier with over 15 years' experience	IT Software	CONFID	[redacted]	[redacted]	[redacted]
Team Clean	MBE	Janitorial service supplier with 15 years' experience	Janitorial Services	CONFID	[redacted]	[redacted]	[redacted]
TechLink Systems, Inc.	MBE	Full service staffing company with over 15 years' experience	Staffing	CONFID	[redacted]	[redacted]	[redacted]
Telrose Corp	MBE	Office supplier and copier supplier with over 14 years' experience	Office Supplies	C :ON	[redacted]	[redacted]	[redacted]
The Swarthmore Group, Inc.	MBE	Investment firm with over 23 years' experience	Investment Company	CONFID	[redacted]	[redacted]	[redacted]
The Washington Informer	MBE	African American newspaper with over 49 years' experience	News Paper	CONFI	[redacted]	[redacted]	[redacted]
Mitchell & Titus, LLP	MEB	Accounting firm with over 13 years' experience	Accounting/Audit	CONF	[redacted]	[redacted]	[redacted]
Opera Solutions, LLC	MEB	Data science company with over 9 years' experience	Data Analytics	CONFI	[redacted]	[redacted]	[redacted]

Imprints Unlimited	MVE	Print and Fulfillment supplier with over 17 years' experience	Printing	CONFI	[redacted]	[redacted]	[redacted]
IntePros Consulting	SDVOSB	Full service staffing firm with over 17 years' experience	Consultant	CONFID	[redacted]	[redacted]	[redacted]
NumericLink LLC	SDVOSB	Consulting services and project management support company with over 7 years' experience	IT Services	CONFI	[redacted]	[redacted]	[redacted]
Penn Graphics Associates	SDVOSB	Print, fulfillment and promotional company with over 10 years' experience	Print Management	CONFI	[redacted]	[redacted]	[redacted]
ACS Claim Service, Inc.	WBE	ACS Claim Service, Inc. is certified as a Women Business Enterprise (WBE) in Pennsylania. Providing medical claims services.	Consultant	CONFID	[redacted]	[redacted]	[redacted]
AREUFIT Health Services Inc	WBE	Health promotion and wellness company with over 20 years' experience	Health and Wellenss	CONFID	[redacted]	[redacted]	[redacted]
Atrium Staffing	WBE	Staffing firm with over 18 years' experience	Staffing	CONF	[redacted]	[redacted]	[redacted]
Becker Technical Staffing, Inc.	WBE	Staffing company with over 45 years' experience	Staffing	CONFID	[redacted]	[redacted]	[redacted]
Career Concepts, Inc.	WBE	Full service staffing company with over 25 years' experience	Staffing	CONFI	[redacted]	[redacted]	[redacted]
Careers USA	WBE	National staffing firm with over 32 years' experience	Staffing	CONFID	[redacted]	[redacted]	[redacted]

Changing Spaces	WBE	Office furniture company with over 17 years' experience	Office Furniture	CO [redacted]	[redacted]	[redacted]	[redacted]
Continental Resources Inc.	WBE	IT products and solutions company with over 50 years' experience	IT Products and Solutions Firm	CONFIDE [redacted]	[redacted]	[redacted]	[redacted]
Corporate Facilities of New Jersey	WBE	Furniture supplier with over 15 years' experience	Furniture	CONFID [redacted]	[redacted]	[redacted]	[redacted]
Diversified Search, Inc.	WBE	Executive search firm with over 13 years' experience	Executive Search	CONFID [redacted]	[redacted]	[redacted]	[redacted]
Fineline Printing	WBE	Print and Fulfillment supplier with over 12 years' experience	Printing	CONFI [redacted]	[redacted]	[redacted]	[redacted]
Frazee Recruiting Consultants	WBE	Professional staffing and executive search firm with over 20 years' experience	Staffing	CONFI [redacted]	[redacted]	[redacted]	[redacted]
Genesio Company	WBE	HVAC company with over 35 years' experience	HVAC	CONFID [redacted]	[redacted]	[redacted]	[redacted]
Grand Ideas, Inc.	WBE	Full service promotional company with over 10 years' experience	Promotional Material	CONFID [redacted]	[redacted]	[redacted]	[redacted]
IMEDICS	WBE	Innovative medical solutions company with over 10 years' experience	Medical Software	CONF [redacted]	[redacted]	[redacted]	[redacted]
IMS Technology Services, Inc.	WBE	Audiovisual integration company with over 19 years' experience	Audio/Video	CONFID [redacted]	[redacted]	[redacted]	[redacted]
Key Leadership Initiatives	WBE	Executive coaching firm with over 20 years' experience	Executive Coaching	CONFI [redacted]	[redacted]	[redacted]	[redacted]

Language Services Consultants Inc.	WBE	Translation, interpreting and proofreading/editing services company with over 22 years' experience	Translation/Interpreting	CONFID	[redacted]	[redacted]	[redacted]
Law Office of Stacie Merkin	WBE	Worker's compensation; civil litigation firm with over 15 years' experience	Law	CONFID	[redacted]	[redacted]	[redacted]
Light Touch Interior Landscaping, Inc.	WBE	Full service landscaping company with over 44 years' experience	landscaping	CO	[redacted]	[redacted]	[redacted]
Medisys, Inc.	WBE	HEDIS® data collection, medical record review, and project management company with over 23 years' experience	Data Management	CONFID	[redacted]	[redacted]	[redacted]
Monarch Staffing	WBE	Staffing company with over 14 years' experience	Staffing	CONFI	[redacted]	[redacted]	[redacted]
MTM Linguasoft	WBE	Full service translations company with over 12 years' experience	Translation/Interpreting	CONFI	[redacted]	[redacted]	[redacted]
Naples Law LLP	WBE	Litigation and transaction law firm with over 13 years' experience	Law Firm	CONFID	[redacted]	[redacted]	[redacted]
Occupational Resource Specialists, Inc	WBE	Medical Case Management, managed care and vocational Rehabilitation company with over 20 years' experience	Medical Case Management/ Managed Care/Vocational Rehabilitation	C			
OLSA Resources Inc.	WBE	Full service staffing company with over 18 years experience	Staffing	CONFID	[redacted]	[redacted]	[redacted]
Overture Premiums and Promotions	WBE	Premium and promotional company with 13 years' experience	Promotional Material	CONF	[redacted]	[redacted]	[redacted]

Partners Consulting, Inc.	WBE	Staffing company with 6 years' experience	Staffing	CONFIDE	[redacted]	[redacted]	[redacted]
Plantscape Inc	WBE	Indoor landscaping company with 40 years' experience	landscaping	CO	[redacted]	[redacted]	[redacted]
PPT Consulting	WBE	IT and management consulting firm with over 11 years' experience	Consulting	CONFID	[redacted]	[redacted]	[redacted]
Prest & Associates	WBE	Medical review specialists with 10 years' experience	Medical Review Specialists	CONFID	[redacted]	[redacted]	[redacted]
ProForma Albrecht & Company	WBE	Promotional products and printing company with over 12 years' experience	Promotional Material	CONF	[redacted]	[redacted]	[redacted]
Progeny Health, Inc.	WBE	Care management firm with over 10 years' experience	Care Management Solutions	CONFID	[redacted]	[redacted]	[redacted]
Protocall, Inc.	WBE	Recruitment and staffing firm with over 45 years' experience	Staffing	CONFID	[redacted]	[redacted]	[redacted]
Quad656	WBE	Recruitment and staffing firm with over 13 years' experience	Staffing	CONFI	[redacted]	[redacted]	[redacted]
Rising Star	WBE	Print, fulfillment and promotional supplier with over 18 years' experience	Print/Promotional	CONFID	[redacted]	[redacted]	[redacted]
SoNoted, LLC	WBE	Technology consulting service company with over 12 years' experience	Consultant	CO	[redacted]	[redacted]	[redacted]
Sourcium Group, Inc.	WBE	IT products company with over 12 years' experience	IT Hardware	CONFIDE	[redacted]	[redacted]	[redacted]

Systems Staffing Group, Inc.	WBE	Clinical and scientific professionals, financial services and government staffing firm with over 45 years' experience	Staffing	CONFID	[redacted]	[redacted]	[redacted]
The Boss Group	WBE	Staffing firm with over 25 years' experience	Staffing	CONFID	[redacted]	[redacted]	[redacted]
The Kingstree Group	WBE	Communications coaching company with over 10 years' experience	Consultant	CONFI	[redacted]	[redacted]	[redacted]
The Riff Group	WBE	Furniture installer with over 14 years' experience	Furniture Installers	CONFIDE	[redacted]	[redacted]	[redacted]
The Smyler Firm	WBE	Corporate law firm with over 12 years' experience	Law Firm	CONFI	[redacted]	[redacted]	[redacted]
The Training Associates	WBE	Learning and development company with over 18 years' experience	Learning and Development	CONFI	[redacted]	[redacted]	[redacted]
Touch of Class Promotions	WBE	Promotional company with over 6 years' experience	Promotional Material	CONFI	[redacted]	[redacted]	[redacted]
Universal Printing Co	WBE	Print and fulfillment supplier with over 14 years' experience	Printing	CONFIDE	[redacted]	[redacted]	[redacted]
Validity LLC	WBE	Business consulting and payroll services company with over 10 years' experience	Consulting	CONFID	[redacted]	[redacted]	[redacted]
LEGEND **AA:** African American **MBE:** Minority Business Enterprise **LGBTBE:** Lesbian Gay Bisexual Transgender Business Enterprise **WBE:** Women Business Enterprise **SDVOSB:** Service Disabled Veteran Owned Small Business (not LA accredited			**Total**	[redacted]	[redacted]	[redacted]	[redacted]

Independence Blue Cross, LLC. Supplier Diversity Program

Additionally, through Independence Blue Cross, LLC's Supplier Diversity Program, we provide opportunities to businesses that are at least 51 percent owned by a minority group member or a woman. By cultivating these relationships, we can foster the growth of these businesses while promoting the long-term growth of Independence Blue Cross, LLC. It is our goal to continue these partnerships and ensure an equal opportunity for all companies who want to do business with us.

ACFC Protégé Program

ACFC leaders also donate time to counsel numerous small businesses. This professional support helps small "protégé" companies develop the management expertise they need to grow, which, in turn, produces new jobs and other economic benefits for the communities they serve.

ACFC 2013 Regional Corporation of the Year Award

ACFC was recently awarded the 2013 Regional Corporation of the Year Award from the Pennsylvania-New Jersey-Delaware Minority Supplier Development Council (MSDC) for its commitment to growing and improving the individual communities it serves, including its financial and professional support of local and disadvantaged businesses.

The Corporation of the Year award recognizes a company's exemplary achievements in the area of minority supplier development. This award is regarded as the most significant honor to a major corporation for the utilization of Asian, Black, Hispanic and Native American suppliers. In winning the award, a company demonstrates exceptional strength in areas critical to maintaining a solid minority supplier development process.

Companies were nominated for the award by MSDC-member suppliers. ACFC was chosen from among four finalists, judged by a nomination panel on four criteria: policies, procurement, minority business development, and leadership.

ACFC leaders also donate time to counsel numerous small businesses. This professional support helps small "protégé" companies to develop the management expertise they need to grow, which, in turn, produces new jobs and other economic benefits for the communities they serve.

ACFC 2013 H.I.R.E Award

ACFC was presented with a 2013 H.I.R.E Award at the Close It Summit in Washington, DC. Sponsored by Innovate and Educate, a leader in research-based strategies to address the national skills gap, the H.I.R.E award recognizes employers who use creative methods to discover talent, promote diversity, develop a work-ready talent pipeline, and bridge the opportunity divide. ACFC earned the award for its workforce hiring and development strategy, which strengthens the company by finding quality talent from often overlooked channels and

helps fulfill its mission to build strong, healthy communities by improving educational opportunities. ACFC has implemented the following initiatives, among others:

Partnering with Philadelphia Works and Pennsylvania CareerLink to find, recruit, train, and hire 104 unemployed or underemployed workers since February 2012 for claims examiner, customer service representative and provider claims representative positions, generating more than $1.7 million of increased economic activity in the Philadelphia area;

Through a partnership with the Philadelphia Youth Network, hiring 55 at-risk Philadelphia high school students since 2007 for an internship program that provides participants with valuable workforce skills;

We have awarded nearly 900 scholarships worth almost $2 million since 1988 to Pennsylvania members through the Keystone First and AmeriHealth Caritas Pennsylvania's Member Scholarship programs, helping those members pursue trade certifications or college degrees. We also participate in job fairs like the one at the 2013 National Urban League.

ACFC Eastern Minority Supplier Development Council's (EMSDC)

The ACFC diversity program was recently featured at the Eastern Minority Supplier Development Council's (EMSDC) 2014 general meeting held in Wilmington, Delaware. The EMSDC is a nonprofit organization that focuses on developing business opportunities for minority-owned enterprises by certifying and linking them to corporation and public agencies. ACFC participated in the EMSDC's "Demystifying Success" discussion panel, where MBE suppliers were provided strategies and feedback on how to successfully engage with procurement professionals.