COORDINATION OF CARE

CONTENTS

QUESTION 1

Describe the procedures and processes you have in place for coordination of care to ensure a smooth transition for MA consumers who transfer between delivery systems during the initial enrollment and auto assignment period, as well as throughout the ongoing program. (This includes the current ACCESS Plus Program)

(Limit to two pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy has established policies and procedures to ensure a smooth transition for MA consumers who transfer between delivery systems during the initial enrollment and auto assignment period, and on ongoing basis.

Coordination during the Initial Enrollment and Auto Assignment Period

AmeriHealth Mercy's approach to coordinating seamless transitions for members during the initial enrollment and auto-assignment period is informed by our experience during the initial implementation of the HealthChoices Program in the Lehigh/Capital Zone, and the experience of our southeast Pennsylvania affiliate during the HealthChoices Southeast implementation. From this experience, we understand that seamless transitions can be achieved through the following key steps:

- Developing a comprehensive provider network to minimize the need for newly enrolled members to change providers.
- Providing timely, accurate updates to our provider network to facilitate plan selection and PCP assignments.
- Educating members and providers about the continuity of care provisions afforded to transitioning members that allow members to continue an ongoing course of treatment with a non-participating provider.
- Completing new member welcome calls to ensure that new members received a welcome packet and their identification card with their PCP assignment.
- Completing a Health Risk Assessment on new members to identify those with continuing or unmet needs and connecting them to our Rapid Response Team for immediate intervention, and/or to our Care Management Program.
- Engaging in extensive education and outreach in the community, with appropriate DPW approvals, to help members and community partners understand our plan and provide information on who to call for assistance.
- Working closely with Children and Youth agencies to education their staff about our provider network and facilitate the selection of participating PCPs and specialists.

Ongoing Coordination of Care

To facilitate seamless care transitions on an ongoing basis, we rely on the same key steps taken during the initial selection and auto-assignment process, and supplement those with our proven systems and processes to support data sharing and information exchange.

Our Member Clinical Summary (MCS) helps to ease transitions by capturing a claim-based medical history including pharmacy and medical management data sets, and any Care Gaps. The MCS is accessible through our secure Provider and Member Web Portals for print or download into an electronic medical record. Available to Members, PCPs, specialists and emergency room providers, the MCS provides key information for a physician who is seeing a member for the first time, and thereby reduces gaps in care, and duplication of services and prescriptions.

Our Rapid Response team is always available to facilitate immediate interventions to achieve seamless transitions, from assisting members in getting prescription drug orders and medical records transferred to new pharmacies or providers, to quickly meeting any needs for equipment and supplies that could otherwise be interrupted while transitioning between systems.

In addition, we routinely use the DPW Member Transfer Coordination of Care Form (Interplan Transfer Form) to provide the receiving delivery system with a snapshot of the transferring member's care coordination needs.

Looking Ahead

As part of our continual effort to improve our information sharing capabilities with providers, AmeriHealth Mercy actively participates in Pennsylvania's Health Information Exchange (HIE) projects at a statewide and local levels participating with the state PAeHC's development of their strategic plan for HIE through active involvement on the Business Operations and Finance committees, and the Southeast PA Health Information Organization, a collaborative effort with the Delaware Valley Healthcare Council. We also bring HIE experience working with other states, namely the Kentucky HIE, where we are delivering a Continuity of Care Document of health plan information (medications, admissions, office visits, etc.) to providers through the exchange.

During 2012, our ongoing efforts to improve integration between our Integrated Care Management platform and our Member and Provider Web portals will allow sharing of assessments and care plans through our secure portal sites.

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QUESTION 2

Describe the procedures and processes you have in place to ensure continuity of care whenever a MA consumer transitions between and among delivery systems. (This includes the current ACCESS Plus Program)

(Limit to two pages)

RESPONSE TO QUESTION 2

AmeriHealth Mercy has several processes and procedures to ensure continuity of care for transitioning members. Working with both the member and our health plan counterparts, we share health information relevant to the member's current plan of care, preventing any gaps in ongoing treatment that could otherwise result in negative and costly health outcomes.

Previously Approved Services

We encourage newly enrolled members to complete a Health Risk Assessment (HRA) through our new member welcome packet, and through our telephonic outreach. The data collected includes information on the member's current providers and services the member is receiving. We use this information to proactively identify the need for continued treatment from a non-participating provider and continued authorization of covered services. Our Utilization Management team coordinates entry of information on previously approved services into our claim system, and coordinates with out-of-network providers to ensure continuity of care, as appropriate. As needed, our network management team will intervene to negotiate a one-time payment rate for care that is being continued with a non-participating provider.

Continuity of Care

AmeriHealth Mercy takes necessary steps to ensure continuity of care for all newly enrolled members in an ongoing course of treatment with a non-participating provider, and for members in an ongoing course of treatment with a provider who has been terminated from AmeriHealth-Mercy's network for reasons that are not "for cause." Newly enrolled members who are pregnant on the effective date of enrollment with AmeriHealth Mercy may continue to receive ongoing treatment from a non-participating Obstetrician (OB) or Midwife through delivery and the completion of post-partum care related to the delivery.

Requests for continued treatment from a non-participating provider can be submitted by the member, the new PCP or the non-participating provider. Our Utilization Management team works with the provider, the member, and our Network Management team to enter information on the ongoing care and payment arrangements into our authorization system to enable the provider's claims to pay smoothly.

Transitioning to a Participating Provider

We assign all members receiving care from a non-participating provider to a Care Manager. The Care Manager works with the member and the non-participating provider to identify an appropriate point to move the member's care to an AmeriHealth Mercy participating provider. We will continue to approve ongoing care from the non-participating provider for an extended period of time if there is not sufficient expertise within the network to assume the member's care, or if transitioning to a participating provider would cause undue hardship for the member. In those situations, we will document the approved services and payment in writing, so the provider is clear on what services will be covered.

Collaboration with Other Delivery Systems

AmeriHealth Mercy routinely makes contact with other delivery systems in our market to facilitate collaboration for members who move from one system to another. As requested, we complete the Member Transfer Coordination of Care, also known as the Interplan Transfer Form, to provide the new delivery system with information on the member's care plan and utilization

history. We also have a detailed Member Clinical Summary, discussed below, that can be shared with the new delivery system and/or any new physicians seeing the member.

Our Special Needs Coordinator proactively reaches out to the member's prior Medical Assistance Delivery System for information on members with special care needs and obtains a copy of the prepared transfer summary.

Member Clinical Summary

Members who are transitioning from AmeriHealth Mercy can access and print a Member Clinical Summary (MCS) from the Member Web Portal prior to their termination date. The MCS is a claim-based medical history compiled from information in our claim and medical management data sets. In addition to PCP and demographic information, the MCS lists the member's chronic conditions, medications, recent inpatient, emergency room and physician visits and current care gaps. Care gaps are services that are recommended according to nationally-accepted clinical guidelines for which there is no record of the member having the service. A copy of our Member Clinical Summary is included as Attachment 1.

The Medication history on the MCS identifies the medication name, dose, date filled, number of days supply, prescribing physician and name of the pharmacy for medications filled in the last six months. The inpatient and emergency room section identifies the facility, the primary diagnosis and the dates of service. The physician visit section includes the name of the physician, the diagnosis, the date and the physician's specialty. With the member's permission, we will send a copy of the MCS to a new physician or Medical Assistance delivery system if the member transfers from AmeriHealth Mercy.

Looking Ahead

As part of our continual effort to improve our information sharing capabilities with providers, AmeriHealth Mercy has an active role in Pennsylvania's Health Information Exchange (HIE) projects at a state and local levels. AmeriHealth Mercy participated with the Pennsylvania e-Health Collaboratives (PAeHCs) development of their strategic plan for HIE through active involvement on the Business Operations and Finance committees. We are also involved at the local level in supporting the Southeast PA Health Information Organization (HIO), a collaborative effort with the Delaware Valley Healthcare Council which represents the major hospitals in the area and the Health Care Improvement Foundation. We also bring HIE experience working with other states, namely the KYHIE, where we are delivering a Continuity of Care Document of health plan information (medications, admissions, office visits, etc.) to providers through the exchange.

QUESTION 3

Describe the procedures and processes you will have in place for coordination of care with all current Pennsylvania waiver services and programs (listed and described in Appendix A, "Draft HealthChoices Agreement," Exhibit O, "Description of Facilities and Related Services," and Exhibit P, "Out-of-Plan Services."

(Limit to two pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy has nearly 30 years of experience, including 14 years in the HealthChoices program, working with Medical Assistance populations and coordinating care with Pennsylvania agencies and programs, such as the HIV/AIDS Waiver Program, the HIV/AIDS Targeted Case Management Program, the Healthy Beginnings Plus Program, and the Pennsylvania Department of Aging Waivers. We also provide continuous coordination of care for members receiving out-of-plan benefits and non-Medical Assistance covered services provided by other community programs and residential facilities, including Nursing facilities; Intermediate Care facilities; residential treatment facilities; acute, extended and/or extended-acute psychiatric facilities; Juvenile Detention Centers; and Early Intervention Services. We coordinate care and facilitate access to health care services for members in substitute care settings, including adoption assistance programs, foster care programs and transitional care homes, as well as for members who are part of any of Pennsylvania's Home and Community Based Waiver Programs.

We identify members involved in the above programs through flags on their eligibility record and our new member assessment process. Our Care Managers, being familiar with the member's health status and needs, review the services provided by the waiver or other programs and determine if the member has any treatment gaps or duplications in services. A comprehensive, coordinated care plan is developed in collaboration with the member's PCP, member/family or member representative, Waiver Case Manager (when applicable) and other service or support providers/representatives. See Attachment 2 for a narrative description of how AmeriHealth Mercy coordinates with waiver services programs.

Building on the foundation of our existing community partnerships with the programs and agencies serving the Pennsylvania Medicaid population, AmeriHealth Mercy has begun to create new relationships with the staff and agencies associated with the New West and New East Zones. As appropriate, we will provide program and agency representatives with access to the member's Member Clinical Summary (MCS) and care plan. These tools allow the agency/program representative to view information on the member's medications, chronic conditions, care gaps, inpatient admissions, emergency room visits and office visits. The MCS is an excellent source of information for a new substitute care/medical foster care caregiver. An EPSDT version of the MCS, containing information on immunization history and EPSDT screening services, is also available for children under age 21.

Ongoing Input

In addition, AmeriHealth Mercy will invite key members from the above program/agency community to participate in our Health Education Advisory Committee (HEAC). The HEAC serves as a mechanism for stakeholders to have a voice in our programs and policies. The HEAC is chaired by our Manager of Community Outreach and meets every other month. The HEAC provides valuable input on health education programs, specifically as they relate to public health priorities and the goal of empowering members to take responsibility for their health. AmeriHealth Mercy recognizes the importance of collaborating with the waiver programs and out-of-plan agencies to effectively serve this population and is committed to working closely with representatives in coordinating and communicating about the members we all serve.

Looking Ahead

As defined, waivers allow the states to cover home and community-based services for specific populations to avoid institutionalization. Waivers may increase optional and additional Medicaid

services, such as, respite care, environmental modifications and family training. As such, it is AmeriHealth Mercy's experience that tremendous overlap exists within the scope of services provided by each of the engaged delivery systems. The result is fragmentation, and diminished efficiencies, reducing members' ability to control their own care and presenting an unneeded burden on state and county budgets.

Through our work with HealthChoices members who are also receiving services through a waiver program, we have seen numerous instances of duplication of services and resources, causing frustration for the member, and unnecessary strain on the state's Medicaid delivery system. In most cases, these members are served by two, sometimes three care managers – one from the HealthChoices plan, one from the waiver program and possibly one from the Behavioral Health MCO. In addition, each program has a separate oversight team – whether through the Office of Medical Assistance Programs (OMAP), the Office of Developmental Programs (ODP) or the Office of Mental Health and Substance Abuse Services (OMSAS).

We would welcome the opportunity to partner with the DPW to pilot a system of care approach to the delivery of public welfare services to these vulnerable populations. Our success using this model to deliver behavioral health and developmental services in New Jersey has shown value through decreased medical and administrative costs and the improvement in care delivery that comes with coordinated, un-fragmented care. This type of coordination is a hallmark of a successful Medicaid program, allowing members to make educated decisions about their care, allowing the health plan to monitor and control cost and quality, and allowing the state to provide an efficient and streamlined system of care to its residents.

JP is an 18 year-old male with Cerebral Palsy, mental retardation, blindness, seizure disorder, who is non-verbal, non-ambulatory, incontinent of bowel and bladder, dependent for all activities of daily living (ADLs) and fed through a tube into his stomach. He lives at home with family and receives skilled nursing and home health aide services through his HealthChoices benefit plan, as well as additional home health aide services through the Office of Mental Retardation. Multiple entities control a portion of his care, including two Pennsylvania agencies, physical and behavioral health managed care organizations, a waiver coordinator and home health providers who are billing separate payors, depending on which benefit is covering the service. JP's care would benefit from a system of care approach with one entity coordinating all of his care and services.

QUESTION 4

What are your processes for transitioning and coordinating care for membership 21 years and under as they age into adult categories of assistance that may provide less service coverage? Describe your strategy moving forward to improve coordination of care.

(Limit to two pages)

Response to Question 4

AmeriHealth Mercy has extensive experience transitioning and coordinating care for members who age into adult categories of assistance that provide less service coverage. Our process focuses on early and clear communication to set expectations and active coordination to identify and pursue other options for services for these members whose benefit package changes when they become 21 years old. These pediatric members, who are medically fragile, are often receiving persistent in-home services due to chronic health care needs. These services, also called "shift care services," consist of hourly in-home skilled nursing, medical day care, and/or home health aide services, provided by an external nursing agency.

Clear Communication

We begin the communication process well in advance of the 21st birthday to allow the member and family adequate time to prepare for the transition and to provide the lead time necessary to navigate the waiver application process for members with complex service needs. The member's pediatric care manager sends a letter to the member/member's caregiver three months before member's 18th birthday to explain the transition that will occur when the child turns 21 and outline the process. The letter explains the difference in services available through the HealthChoices program and the Office of Long Term Living (OLTL) waiver. The letter is followed by a call from the care manager within three weeks to answer any questions and explain the process.

Active Coordination

Our care managers take a hands-on role to ensure that the member is connected to appropriate community and waiver services well in advance of the 21st birthday. The care managers complete the Resource Facilitation Team (RFT) forms and forward them to the Bureau of Managed Care Operations (BMCO) Human Service Program Specialist, currently Eric Ulsh. The care managers actively monitor the case to ensure that the Independent Enrollment Broker (IEB) interview occurs at least six months before the child's 21st birthday. Our care managers stay in close communication with BMCO staff to identify and address any barriers that arise during the process.

Three months before the 21st birthday, the care managers obtain and forward an updated Letter of Medical Necessity from the treating physician, along with a current service plan and care notes from the agencies providing the member's care. The care managers remain in close contact with the parent/caregiver and help clarify any questions about the new service plan. Once the waiver services are in place, the care managers follow up with the member/caregiver to determine whether the services are being delivered to the member/caregiver's satisfaction.

Transition to an Adult PCP

We also take an active role in the transition from a pediatric PCP to an adult PCP for children receiving shift care services and for other children who have special needs that do not require in-home services. We know from our extensive experience working with this population that many parents/caregivers have a strong relationship with their pediatric practitioner and are reluctant to transfer to a physician who does not know their child's history and care needs. Additionally, it can be difficult to identify adult practitioners who are able to meet the needs of young adults with special needs.

To ease this process, we survey our network to identify adult practitioners who are comfortable treating medically fragile young adults. Our care managers use the survey results to assist the members/caregivers to identify a suitable adult practitioner. We also established a special payment code that allows the adult practitioner to evaluate the member while the member was still assigned to the pediatric PCP. This system allows the member/caregiver and adult PCP to meet and discuss the member's care needs, making both parties more comfortable with the transition.

"N", a child in need of 24-hour a day personal care, was living in a pediatric long term care facility due to her chronic health care needs, including Mental Retardation (MR), Cerebral Palsy, Blindness, Microcephaly, and Dwarfism.

The AmeriHealth Mercy care management team contacted the member's case worker at the facility, and ascertained quickly that he was unaware that the member's coverage would change when she turned 21. The member's guardian was the county MH/MR agency, who also had not yet started working on funding for the member's ongoing care needs after she turned 21. "N" had no available family.

AmeriHealth Mercy's care manager stayed in close contact with the MH/MR social worker over the next year prompting her to submit the required paperwork necessary for services after "N" turned 21. After numerous meetings between the facility, the MH/MR social worker, and our care manager, it was determined that the best option for "N" was funding that would allow her to remain in a 24/7 skilled facility as opposed to a home-based waiver program.

AmeriHealth Mercy's care manager contacted the Association for Retarded Citizens (ARC) in "N's" county and worked to get the member an advocate through their program. She connected the ARC advocate with the MH/MR social worker and Human Services Program Specialist from the Division of Quality and Special Needs Coordination at DPW to coordinate efforts for this member. Our care management team continued to follow this case closely and was able to help find the member a place in an adult long term care MR facility.

Through this follow-up, the care manager became aware that the MH/MR social worker had not submitted the admission application to the MR facility. Our care manager contacted the Disability Rights Network to obtain a legal advocate for the member. Only with the continued coordination and follow up by our care managers were these wheels kept in motion for this member. With so many agencies involved, this member was poised to "slip through the cracks" as she had no family advocate and everyone had adopted an "it's not my problem" approach to finding her appropriate placement. Because of AmeriHealth Mercy's efforts, the member was placed in the facility, at age 21, and will remain there. Our role as an advocate for this profoundly retarded child with no voice of her own, ensured that she was appropriately and safely placed where all her needs will be met for the rest of her life.

QUESTION 5

Describe your plan to create, maintain, and continuously improve collaboration with HealthChoices Behavioral Health Managed Care Organizations (BH-MCO). Include a description of methods you will use to exchange information relevant to ensuring care coordination using behavioral health utilization data provided by the Department.

(Limit to two pages)

RESPONSE TO QUESTION 5

AmeriHealth Mercy has worked closely with Behavioral Health Managed Care Organizations (BH-MCOs) since the beginning of the HealthChoices Program to ensure coordination of care for our members with co-morbid behavioral health and physical health diagnoses.

Our Care Managers use an evidenced-based tool to screen members during initial assessment for multiple behavioral health conditions, including depression, anxiety, trauma exposure, suicide risk, substance abuse and autism (for children). We create referral pathways for members to connect them with clinical and behavioral health resources for further assessment and intervention. This screening process also includes pregnant members and is repeated during the new mother's postpartum period to identify new at-risk members and gauge improvement in previously identified participants.

We encourage members with co-morbid behavioral health issues to be part of our Chronic Care Program. Our Care Managers (registered nurses and social workers) sit at the center of the team and coordinate the participation of our Medical Director, pharmacists, and practicing physicians with expertise in the disease state to develop and monitor care plans. Advocacy groups, waiver providers, school district staff, behavioral health providers, and government agencies (for example, the Office of Children, Youth and Families, the Juvenile Probation Office, and the Guardian ad Litem/Child Advocacy) also participate on the care team as needed. The team collaboratively creates a plan of care to address the needs of participating members.

Behavioral health providers collaborate with AmeriHealth Mercy as a result of the Coordination Agreements. We currently have existing Coordination Agreements with the BH-MCOs serving the majority of the counties in the New West and New East Zones, and we are actively pursuing a coordination agreement with remainder. In addition to the coordination agreement required by the DPW HealthChoices contract, we also work jointly with the BH-MCOs to create cost-sharing agreements so that appropriate services are delivered without dispute over whether the service is purely "medical" or "behavioral."

Our efforts to coordinate care with the BH-MCOs in the New West and New East Zones will be tailored from our success in other zones. We will begin by building collaborative relationships between our employees and the administrators of residential treatment facilities. We will also develop Regional Behavioral Health Workgroups to collaborate with the BH-MCOs on various care coordination and data sharing initiatives. Collaborations in our current HealthChoices zones include programs on medication use (e.g. Selective Serotonin Reuptake Inhibitors – SSRIs) and adolescent suicide risk communication to practitioners; communication to PCPs on the identification of autism; development of an autism brochure for families, a joint Physical Health-Behavioral Health (PH-BH) medication formulary document; and a joint PH-BH medication prior authorization form.

For example, we worked with the Capital Area Behavioral Health Collaborative to develop practice guidelines for the appropriate use of Suboxone or Subutex in the treatment of opiate dependence. These efforts led to an initiative to use behavioral health MCO reinvestment dollars for the Recovery, Advocacy, Service, and Empowerment (RASE) Project to improve access to counseling services for patients with opiate dependence. We also worked with Magellan Behavioral Health in Bucks, Montgomery, and Delaware Counties to implement the Serious Mental Illness Innovation Project.

Information Exchange

AmeriHealth Mercy complies with all of the current requirements to exchange information with BH-MCO's, and would welcome the opportunity to have further discussions regarding ways to improve outstanding issues regarding information exchange between PH-MCOs and BH-MCOs. AmeriHealth Mercy currently shares pharmacy data with our behavioral health counterparts via electronic file exchange. AmeriHealth Mercy transmits a pharmacy paid claims file to the Department at least twice monthly in accordance with a predetermined schedule. Upon receipt of the files, DPW posts the data to a private website corresponding to the appropriate BH-MCO for each County.

In 2007-2008, AmeriHealth Mercy participated with DPW in efforts to find solutions for the sharing of BH utilization data with the physical health MCOs. Unfortunately, legal concerns governing confidentiality of information prohibited the sharing of most information. However, we are prepared to quickly integrate such data if it is provided by DPW in the future. We would use this data to support care plans, predictive modeling, programs for members with developmental disabilities and neurological conditions, and improved gaps-in-care analysis. Many programs already operating in conjunction with BH-MCOs will also benefit from this data, especially in terms of enhanced outcomes measurement.

Looking Ahead

AmeriHealth Mercy looks forward to collaborating with its behavioral health counterparts in the New West and New East Zones as we do today in the other HealthChoices zones. Ideally, we wish to extend the lessons learned from the other zones and continue the programs with our county partners in the new zones, improving our techniques and processes for information sharing and joint care management for members with behavioral health co-morbidities. Additionally, we will support and work with the Pennsylvania Psychiatric Society's Outreach Consultation Project, Psychiatrists on Call, which organizes volunteer psychiatrists to offer informal phone consultation for PCPs who need advice or guidance about a patient.

A hospital case manager contacted AmeriHealth Mercy on behalf of Mary, a member with multiple chronic health conditions, including asthma, emphysema, seizure disorder, migraines, and osteoporosis, who repeatedly overused the ER. Our Special Needs Unit contacted Mary and helped her coordinate neurology and orthopedic appointments and even accompanied her to an appointment. Our care manager identified that Mary was a victim of domestic violence and referred her to appropriate resources. Mary is now receiving regular outpatient behavioral health services, is engaged in our Care Management Program, and has had no recent ER visits.

QUESTION 6

Describe the process you will use to coordinate with County Offices of Children, Youth, and Families to ensure that Children in Substitute Care receive necessary services.

(Limit to two pages)

RESPONSE TO QUESTION 6

Children in Substitute Care

AmeriHealth Mercy has a strong track record of meeting the challenge of connecting children in substitute care with timely and appropriate care. In our two existing Pennsylvania HealthChoices plans, we work closely with the staff from the county Offices of Children, Youth and Families to ensure seamless care coordination for children in foster care, including children placed in medical foster care. We make a special effort to ensure that children in substitute care have a consistent Medical Home and plan of care. If awarded a contract to serve the New West and New East Zones, we will replicate the successful procedures we use today in the new zones.

AmeriHealth Mercy has identified a staff liaison within each of the PA Offices of Children, Youth and Families (OCYF) in our current service areas to facilitate care coordination. We also assign an AmeriHealth Mercy care manager as the single point of contact in our organization for OCYF office to facilitate communication. The designated AmeriHealth Mercy Care Manager maintains regular contact with the OCYF liaison, helping to navigate all AmeriHealth Mercy policies and procedures, and the physical health delivery system in general. The AmeriHealth Mercy care manager provides education and training for OCYF offices upon request, and works with OCYF as needed to address member-specific needs. Our efforts to coordinate care commonly focus on:

- Coordinating abuse screenings within mandated timeframes
- Managing adherence to EPSDT guidelines through the coordination of preventive services
- Educating OCYF staff and foster parents about covered benefits and how to use available health benefits
- Arranging dental and other specialty care services
- Coordinating behavioral health services, including home-based wrap-around services
- Coordinating shift nursing services
- Arranging for blood lead screenings
- Coordinating maternity care and infant wellness
- Helping OCYF staff and foster parents coordinate benefits with primary insurers

We are already initiating outreach to identify liaisons in the OCYF offices in the New West and New East counties to begin the process of developing relationships.

Drawing from our experience managing the implementation of the HealthChoices Lehigh/Capital and Southeast Zones, we will work very closely with the OCYF offices in the new zones to facilitate the selection of participating PCPs for members in substitute care, especially during the initial implementation phase. In addition, we will work together to share information about participating specialists and ancillary providers, and develop continuity of care plans for children in substitute care who select AmeriHealth Mercy, but are engaged in an ongoing course of treatment with a non-participating provider. We will comply with all DPW contract requirements related to continuity of care for members engaged in an ongoing course of treatment with a non-participating provider.

Another important area of care coordination for children in substitute care is working to ensure they receive all EPSDT screening services. AmeriHealth Mercy provides the OCYF Offices in our current service area with a monthly report identifying all children in substitute care who are

missing or overdue for an EPSDT screening. We will produce this same report for all OYCF Offices in the New West and New East Zones.

A final important area of focus in developing our relationship with OCYF Offices will be finding solutions to ensure that our written member materials get to the individuals caring for our members in substitute care. Again, based on our experience in our existing service area, we learned that OYCF staff members incur difficulties in delivering much of the written communication we sent to our members. Material that is critical to accessing care - Member ID Cards, for example - were mailed to the central OYCF address provided on the DPW enrollment file. Because of high case loads and over-worked staff, it is almost impossible for OCYF staff to ensure that health plan mailings are distributed in a timely manner to the member's placement agency and then on to the member's foster family. We want to work with OYCF to determine how we find solutions to this important problem.

Our southeast Pennsylvania affiliate, Keystone Mercy, has established procedures with interested OCYF offices to mail supplies of written materials directly to OCYF contracted placement agencies. The agencies provide the information directly to the foster families. Keystone Mercy supplies the agencies with New Member Welcome Kits (comprised of the Member Handbook, Notice of Privacy Practices, a co-pay schedule, a quick-reference benefits grid and information on what to do in an emergency) and Member Newsletters. Because these materials are not addressed to any specific member, this process is compliant with privacy rules. We will encourage the OCYF Offices in the New West and New East Zones to adopt similar processes with us.

Through the processes and procedures described above, and our ongoing communication and relationship building, AmeriHealth Mercy will form the strong connections necessary to ensure the seamless coordination of care for children in substitute care in the New West and New East Zones.

The relationship between Keystone Mercy [AmeriHealth Mercy's affiliated plan in Southeast Pennsylvania] and Delaware County has been, and continues to be, a great collaboration. Delaware County Children and Youth has been fortunate enough to have developed an ongoing relationship that has allowed us to trouble shoot on problems that arise regarding the children that we serve. Keystone Mercy continues to inform us of new programs that could benefit the children in our area. In the past we have brought to Keystone's attention that the bulk mailing was overwhelming and most likely would not reach the clients. In an effort to problem solve this, Keystone Mercy and Children and Youth Services came together and prioritized which information our foster parents are to receive and the best way to disseminate this information to the clients.

*- **Denise Stone**, MSW, Supervisor, HealthChoices/Education, Delaware County, Children and Youth Services*

QUESTION 7

Describe your process for care coordination to ensure that members receive adequate in-home services to divert them from entering long term care facilities.

(Limit to two pages)

RESPONSE TO QUESTION 7

AmeriHealth Mercy has a strong track record of supporting members with complex needs in the home setting. We are currently coordinating care for close to 1,000 HealthChoices enrollees who receive ongoing in-home services, ranging from caregiver support to nursing and ventilator care. Our approach includes aggressive planning, creative service delivery and ongoing monitoring and care management to minimize delays in service that often lead to poor health and costly hospital admissions.

Coordinating Service Planning and Delivery

Our planning process begins with a review of the member's health information. We identify all prior health care issues and past services, including services rendered immediately prior to any hospital admission.

Information gathered from the member Care Coordination Survey included in our New Member Welcome Packet and completed during new member welcome outreach calls (see Clinical Performance Measures Attachment 10), and other care management tools, provides a template of the member's needs and available supports, while data gathered from the member's treating physician, hospital social worker, and other involved healthcare professionals, provide a blueprint of care needs.

For high-volume hospitals, Transition Managers are placed onsite to help assess discharge needs and assists with arranging post-discharge care and physician appointments for those members needing long term in-home care. After a discharge date has been established, we facilitate communication of the member's clinical condition and plan of care to the identified home health, durable medical equipment and specialty home care providers. For members who need services not covered through the HealthChoices program, such as home modifications, we actively assist the member and caregiver to obtain the needed services through community agencies or additional programs.

Meeting Complex Home Health Needs

AmeriHealth Mercy Care Managers assemble each member's personal support network, encompassing the services needed for the member to remain in the comfort of their own homes regardless of complex needs. Skilled nursing facilities, home health agencies, DME suppliers, and other healthcare providers each fill a crucial role. As with the other HealthChoices zones we serve, we are committed to maintaining a robust network of home service providers. We are already contracted with Bayada, the largest home health provider in the state.

We are prepared to collect and report staffing and missed home health shifts in the mandatory DPW Monthly Missed Shift Report that we use today in our current HealthChoices zones.

Ongoing Monitoring and Care Management

AmeriHealth Mercy conducts follow-up phone calls to those members receiving in-home services. Following a hospital discharge, our Care Managers contact members who are currently in a care management program, while our Rapid Response team contacts all other members. Staffed by care managers and non-clinical Care Connectors, our Rapid Response team is a specialized unit dedicated to assisting members to identify and overcome healthcare barriers through facilitation and empowerment.

These follow-up calls focus on medication reconciliation, checking the status of ordered home services, confirming physician appointments and determining how well the member and caregivers understand physician instructions. Through this outreach, we work to make sure the member has the tools they need to progress in the recovery phase of their care and are prepared and able to use them.

All members receiving ongoing in-home care are enrolled in our Complex Care Management program. These members receive comprehensive and condition-specific assessments and reassessments, along with the development of short-term and long-term goals and an individual plan of care, created with input from the member, caregiver, physician, home service provider, and, when applicable, waiver program care manager.

Looking Ahead

The barriers associated with home health care are unique and need to be addressed creatively. Our analysis of the New West and New East Zones reveals that transportation for in-home caregivers is likely to be an issue, especially in remote areas such as Bradford and Tioga Counties. Our plan is to work with agencies when needed to provide additional reimbursement to cover travel costs for members who need care in remote areas, just as we do within our existing HealthChoices zones.

We will extend our Shift Care & Skilled Nursing Performance Incentive Program, specifically developed for the purpose of providing monetary incentives to improve the staffing of home-based shift care and skilled nursing services, to the New West and New East Zones. This DPW funded program allows us to distribute funds through action grants. Home Care Agencies submit proposals outlining programs to improve quality of care and/or reduce the incidence of missed home nursing shifts. Hiring bonuses, on-call nurses, and specialized education curriculums are examples of such proposals.

Avoiding Nursing Home Placement

"J." is a 44-year-old male who became eligible for Medicaid following a massive stroke. He had no prior medical coverage and had a feeding tube, tracheostomy, and multiple medications at the time of discharge. The AmeriHealth Mercy care manager assisted his family in coordinating skilled nursing and home health aide visits so he could return home, arranged for ambulance transportation to physician appointments after discharge, and worked closely with his provider prior to discharge to discuss his ongoing needs.

After speaking with our care manager, his provider agreed to complete a home visit to follow up, evaluate and coordinate his care. Our care manager also referred J. to a community agency to evaluate his needs and determine what type of services would be beneficial. As a result of this referral, his sisters have been designated as his primary caregivers and are being paid by the community agency to provide personal care services. Also with this referral, an application for his enrollment in the Independence Waiver (Pennsylvania) was completed and approved. With these supports, J. has successfully been cared for in his home since discharge.

QUESTION 8

Describe the procedures and processes you will have in place to comply with Department requirements related to the Enhanced Medical Home (EMH) model (as described in Appendix A, "Draft HealthChoices Agreement," Exhibit M(1), "QM/UM Program," under Standard V, Letter F).

(Limit to two pages)

RESPONSE TO QUESTION 8

AmeriHealth Mercy is a national Medical Home Pioneer and was founded on the principles of the Medical Home Model. In 1983, the staff of our founding plan, Mercy Health System, noticed that many of its Medicaid patients were using the emergency room for their primary care. They worked with DPW, and in response to this very expensive and inefficient delivery model, we created what became known as a Patient-Centered Medical Home (PCMH).

True to our roots, AmeriHealth Mercy has remained in the forefront as this concept evolved into the more intensive Enhanced Medical Home (EMH). As defined, this model of care places the primary care practitioner (PCP) at the center of our members' care, working with us to provide and coordinate a centralized spectrum of services to include acute, chronic, specialized treatment. In many cases, behavioral, nutritional, and dental services may be available and Electronic Medical Records are utilized.

AmeriHealth Mercy is already participating in each of the four pillars of the EMH model as described in Exhibit M(1) of the Draft Heath Choices Agreement and is prepared to expand our best practices into the New West and New East Zones.

Pillar 1: Embedded Care Managers in High Volume Practices (HVP)

Our southeastern Pennsylvania affiliate, Keystone Mercy, began using embedded care managers in Pennsylvania in 2009 with a care manager embedded in a clinical practice. In 2010, Health Affairs chose the program for presentation to the Centers for Medicare and Medicaid Services during November's Health Innovations Conference. The pilot, which was also selected by the Medicaid Health Plans of America (MPHA) for its 2011 Innovation Award, significantly reduced inpatient admissions and readmissions. See Attachment 3 for MHPA and Health Affairs articles for additional information on this award-winning program.

Pillar 2: Working With HVP(s) to Achieve Medical Home Quality

Our vast experience in the Medical Home realm is easily passed on to providers seeking NCQA Medical Home accreditation. Thoroughly trained Provider Network Representatives are a knowledgeable resource to practices working toward compliance, and access to NCQA certification standards is available through the provider portion of our website. Attachment 4 provides specific details of our efforts to facilitate NCQA accreditation in the following areas:

- Access and Communication
- Patient Tracking and Registry Functions
- Care Management
- Performance Reporting and Improvement

Pillar 3: Transition of Care (TOC) Nurses to Work with High Volume Health Systems

Our Transition Managers work collaboratively with the emergency room and hospital staff to assess members for discharge needs, assist with arrangements, and arrange post-discharge physician appointments. The Transition Managers explore the events leading up to unplanned hospital care and work with the member and AmeriHealth Mercy resources to address issues.

This function is particularly relevant in the New West and New East Zones, where rural localities make accessing care more difficult.

Pillar 4: Participation with Regional Learning Network Collaboratives

As part of the first phase of Pennsylvania's Chronic Care Initiative, AmeriHealth Mercy participated in Learning Collaboratives held between practices, the Department of Health (DOH), and commercial and Medicaid payers on a quarterly basis between 2008 and 2011. The purpose was to share best practices and challenges to implementation, execution and reporting requirements. During Phase II of this initiative, we will participate in learning collaboratives with a multitude of medical practices including 26 located in the Northeast region.

Looking Ahead

As we expand our service area to the New West and New East Zones, we are prepared to execute a comprehensive strategy consistent with our contractual obligations to the four pillars of the EMH model.

Working with DPW, it is our intention to begin identifying high volume practices in the each zone to identify the best locations for embedded care managers. We are prepared to begin the selection and implementation process upon our receiving an award in this procurement.

For those practices seeking NCQA Medical Home recognition we are prepared to assist with Baseline Assessments and calculations. Our affiliates are developing Medical Home reimbursement strategies to provide a financial incentive for practices to achieve NCQA Medical Home certification. This reimbursement strategy pilot program combines traditional fee-for-service, with a per member per month (PMPM) management fee, and has a discrete fee schedule to cover services not typically on a state Medicaid fee schedule. These services, like telephonic and online consultations and team conferences are consistent with Medical Home practices.

We are seeking facility partners to engage an initiative that will place Transition of Care Managers at high-volume hospitals in the New West and New East Zones to help coordinate care for members who are in the emergency room or on an inpatient unit.

We will continue to participate in Pennsylvania's Chronic Care Initiative for the second three year phase. As one of the participating health plans, we will attend the Learning Collaborative meetings and complete any requested Inter-Session assignments. We look forward to participating in the DOH-identified workgroups to address quality improvement opportunities in the state. We will also assist the participating practices through data sharing, system resources and practice education, as appropriate.

QUESTION 9

What methods do you use to ensure the quality of care delivered by out-of-network providers? Describe any potential barriers and the resolution process.

(Limit to two pages)

RESPONSE TO QUESTION 9

AmeriHealth Mercy's philosophy is to develop and maintain an extensive provider network to support easy access to high-quality providers for our members, while at the same time promoting high quality and cost-effective services through our network management, care management, and quality improvement activities. Even so, at times we find it necessary to authorize and coordinate out-of-network care, particularly for certain specialty/subspecialty care that is in short supply or does not exist in the region. We also coordinate care through non-participating providers to ensure continuity of care for newly enrolled members who are in an ongoing course of treatment with a non-participating provider. Though out-of-network providers are used infrequently, we have internal controls to ensure that we use only appropriately licensed, Medicaid-approved providers, and that all quality of care issues that may be identified retrospectively are handled in accordance with the same policies and procedures that we use to investigate and resolve quality of care concerns related to participating providers.

Procedures to Ensure Use of Licensed Out-of-Network Providers in Good Standing

When a member requires medically necessary care from a provider who is not represented in our network, the AmeriHealth Mercy Care Management staff work collaboratively with the member's referring physician and with the member to identify the right non-participating provider to serve the member. With limited exceptions, such as emergency services, we require prior approval of services obtained through out-of-network providers. The prior-approval process enables us to obtain necessary information to facilitate information sharing and care coordination with the member's PCP.

AmeriHealth Mercy uses only licensed providers when approving out-of-network services. Providers must submit their medical license number before services can be authorized. Transplant facilities must be licensed and Medicare certified. In addition, prior to authorizing care, we determine whether the provider has a Pennsylvania Medical Assistance (PROMISe) provider number, verify that the provider is not on the Medicheck list, and query our own quality of care database to verify that we have no record of past quality of care incidents related to the provider.

Monitoring the Quality of Out-of-Network Care

AmeriHealth Mercy's Prior Authorization Unit coordinates out-of-network care. All quality-of-care concerns that may occur after authorization are handled exactly as if the provider were in our network, with the concern forwarded to our Quality Management Department for investigation through a peer review process. Potential quality of care issues are reviewed by the physician-members of our Quality Assessment and Performance Improvement (QAPI) committee, which is comprised of several physicians from a variety of specialty backgrounds. The QAPI committee reviews each referral to determine whether the provider used acceptable standards of care in treating the member. The QAPI committee advises AmeriHealth Mercy's Medical Director of its findings, and appropriate follow-up action is taken in accordance with our policies and procedures for quality of care issues. Follow-up actions may include provider education or reporting to quality databanks.

Since requests for non-emergent out-of-network services require authorization, each request is entered into our Utilization Management information system. This allows us to track the use of

out-of-network providers at the member-level, as well as report and analyze data on an aggregate basis to identify and investigate trends.

Addressing Potential Barriers to Coordinating Out-of-Network Care

The most common challenge we face in coordinating out-of-network care is negotiating a mutually acceptable rate for the services to be provided. We attempt to address this issue by entering into participating provider contracts with out of area specialists that are not available in the service area, and with nearby children's hospitals located outside of the service area. For example, AmeriHealth Mercy currently contracts with the Children's Hospital of Philadelphia and with Nemours Medical Center in Delaware to facilitate access to specialty care that is not available in the Lehigh/Capital Zone. Furthermore, while it is not always feasible to enter into participating provider agreements with out of network providers, we are often able to negotiate a non-participating provider agreement with providers who are unwilling to open their practice fully to the Medicaid population, but are willing to accept special cases.

AmeriHealth Mercy reviews the frequency with which members are using non-participating providers on a quarterly basis and attempts to contract with those most frequently utilized.

Our robust contracting efforts, coupled with our tested quality monitoring and investigation processes allows our members to receive the same high level of quality from out-of-network provides as from our contracted providers.

CLINICAL PERFORMANCE MEASURES

CONTENTS

QUESTIONS 1-14

Questions 1-14 (answers to be provided using Appendix K (1), K (2), or K (3)

Provide HEDIS® rates for the following 14 measures:

1. *Controlling High Blood Pressure*
2. *Comprehensive Diabetes Care: HbA1c Poorly Controlled*
3. *Comprehensive Diabetes Care: LDL Control <100*
4. *Prenatal Care in the First Trimester*
5. *Frequency of Ongoing Prenatal Care:>81 Percent of the Expected Number of Prenatal Care Visits*
6. *Breast Cancer Screening (Ages 42-69)*
7. *Cervical Cancer Screening (Ages 24 to 64 years)*
8. *Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Controlled<100*
9. *Annual Dental Visits (Ages 2-21 years)*
10. *Well-Child Visits in the First 15 Months of Life*
11. *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
12. *Adolescent Well-Care Visits*
13. *Lead Screening in Children*
14. *Emergency Department Utilization*

RESPONSE TO QUESTION 1-14

HEDIS® REPORTING FORM

This Appendix is to be used by Offerors currently participating in the HealthChoices Program who have been participating in the HealthChoices Program since prior to April 1, 2010. Offerors must provide 2009 and 2010 HealthChoices HEDIS® rates for the HEDIS® performance measures displayed in this Appendix.

	HEDIS® PERFORMANCE MEASURE	2009 HealthChoices HEDIS® Rate	2010 HealthChoices HEDIS® Rate
1	Controlling High Blood Pressure	64.84	66.58
2	Comprehensive Diabetes Care: HbA1c Poorly Controlled	35.40	33.03
3	Comprehensive Diabetes Care: LDL Control <100	40.15	42.15
4	Prenatal Care in the First Trimester	89.89	90.28
5	Frequency of Ongoing Prenatal Care: >81 Percent of the Expected Number of Prenatal Care Visits	78.96	83.06
6	Breast Cancer Screening (Ages 42-69 years)	61.49	61.39
7	Cervical Cancer Screening (Ages 24 to 64 years)	70.43	71.84
8	Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Controlled <100	53.35	52.00
9	Annual Dental Visits (Ages 2-21 years)	44.96	50.27
10	Well-Child Visits in the First 15 Months of Life	70.73	72.70
11	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	78.05	74.65
12	Adolescent Well-Care Visits	57.78	56.08
13	Lead Screening in Children	72.02	73.72
14	Emergency Department Utilization	86.68	80.85

QUESTION 15

Describe your proposed strategy for controlling high blood pressure in members who reside in a rural service delivery area who are ages 18 to 85 years old and have been diagnosed with hypertension.

(Limit to two pages)

RESPONSE TO QUESTION 15

Cardiovascular disease (including Hypertension) is the leading cause of mortality in Pennsylvania, accounting for 33% of all deaths in the Commonwealth in 2007. AmeriHealth Mercy's approach to improving blood pressure control has demonstrated success in our two Pennsylvania plans. Both plans exceed the state Medical Assistance average, with AmeriHealth Mercy ranking in the 75th national Medicaid percentile. The following section outlines our strategies for controlling high blood pressure in a rural population. Our strategies can be grouped into the following categories and are reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information. We expect that using technology to remotely support our members with high blood pressure will improve member adherence to care plans, resulting in improved blood pressure control.

Telehealth

AmeriHealth Mercy will offer a Telehealth program for rural members with high blood pressure. Members with high blood pressure will receive a wireless digital blood pressure monitor for home use. The monitor automatically stores and sends the member's health information to designated medical professionals (e.g. their PCP) and to the AmeriHealth Mercy Care Manager. This process alerts the PCP and the AmeriHealth Mercy care management team to fluctuations in the member's blood pressure, allowing for timely intervention that may prevent an ER visit or hospital admission.

24/7 Nurse Line

Our 24/7 Nurse Line provides members with access to symptom counseling and healthcare guidance by a registered nurse. This is particularly helpful for a rural population, as clinical counseling is made available at all times to any member with access to a telephone. A summary of the member's interaction with the 24/7 Nurse Line is faxed to the PCP and to AmeriHealth Mercy's Rapid Response team. Our Rapid Response Care Connectors subsequently contact the member to assess any additional needs and to help reconnect the member with the PCP, if appropriate.

Member and Provider Portal

Currently, members and providers have access to our secure Web Portals which contain detailed information on care gaps and medication history. Care Gaps are recommended services supported by evidence-based clinical practice guidelines (such as LDL-C and blood pressure testing) for which there is no claim evidence that the member received the service. Providers receive an alert identifying patient-specific Care Gaps when the member's ID is entered in the portal.

In addition to providing care gap prompts, our Web Portals provide accurate, up-to-the-minute information on medications the member has received. The medication information provided through the portal allows the provider to see whether the member has filled the prescribed

medications and alerts the provider to medications the member is taking that were prescribed by a different provider.

This information is crucial in the management of hypertension. In some cases, members report that they are taking the prescribed dose of medication because they want to appear compliant, while the medication history indicates otherwise. This information can make the difference between prescribing unnecessary higher doses or additional medications and performing additional assessment and counseling related to the drivers of the member's medication non-adherence.

Both the provider and the member can view the member's care gaps and medication history through the Member Clinical Summary section of the respective Web Portals.

Community Outreach

Our extensive experience with the Medicaid population in rural markets demonstrates to us the importance of engaging members where they reside, and in a manner that fosters respect and trust. To that end, we sponsor and participate in over 1,000 local health-related events annually to bring health care directly to the communities we serve.

To support blood pressure management, these events offer blood pressure testing, nutrition counseling, medication adherence counseling, as well as a connection to our Integrated Care Management team, should a member need greater support in closing their care gaps and following their care plan.

To improve the rate of blood pressure control in the rural areas of the New West and New East HealthChoices Zones, we will use our Health Navigator infrastructure to deliver educational programs focusing on healthy heart habits and blood pressure control using our Heart Health and "Know your Numbers" outreach programs. To support our rural counties, Health Navigators, a type of Community Health Worker (CHW), will be stationed in each of the New West and New East counties. Through their familiarity with the county's population and local gathering spots, the Health Navigators will identify appropriate venues for delivery of these programs.

Member Education

We have found that for members to feel empowered to make behavioral changes, they first must be educated on the appropriate manner to make those changes. To that end, we utilize CHWs to provide culturally appropriate health education and information; empower people to obtain the care that they need; provide informal counseling and guidance on health-related behaviors; and advocate for individuals and community health care needs.

Provider Engagement

The relationship between the provider and the member is one of the strongest tools we possess for changing member behavior. In rural areas with low PCP density, we will expand access to care by contracting with pharmacies to provide counseling services for members with high blood pressure that fall within the pharmacists' scope of practice, but go beyond traditional medication counseling. We will also ensure that all providers have accurate and up-to-date data on member medications and offer Pay-for-Performance incentives for achievement of HEDIS completion rates.

QUESTION 16

Describe your proposed approach to achieve appropriate HbA1c control and cholesterol management for members with diabetes who reside in a rural service delivery area.

(Limit to two pages)

RESPONSE TO QUESTION 16

People with diagnosed diabetes have medical expenditures that are, on average, approximately 2.3 times higher than those without diabetes. AmeriHealth Mercy exceeds the state Medical Assistance average for HbA1c and cholesterol screening, as well as HbA1c poor control and cholesterol management (LDL <100 mg/dl). We anticipate achieving the same results in the rural counties belonging to the New West and New East Zones. The following section outlines our strategies for controlling blood glucose and cholesterol levels in a rural population. Our strategy can be grouped into the following categories and is reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information. We expect that using technology to support our members with diabetes will improve adherence to care plans, resulting in improved HbA1c control and cholesterol management.

Telehealth

To support rural members with diabetes, we will offer a Telehealth program. This program will provide cell-phone connected glucometers to high-risk diabetic members for daily uploading of blood glucose levels. This process alerts the PCP and AmeriHealth Mercy care management team to fluctuations in the member's blood sugar, allowing for timely intervention that may prevent an ER visit or hospital admission. Our affiliate, Keystone Mercy Health Plan, piloted this program in an underserved area of Philadelphia, and saw a decrease of 8.6 percent in HbA1c and a 13.5% decrease in emergency room visits among participants.

Home Test Kits

AmeriHealth Mercy recently entered into an agreement to provide home HbA1c and LDL test kits. The kits contain easy-to-use instructions and materials for collection of a finger-stick blood sample that is mailed to a certified laboratory for processing, saving the member from a separate trip to a laboratory site. The data collected from these at-home test kits are shared with the member's PCP and the AmeriHealth Mercy Care Manager.

24/7 Nurse Line

Our toll-free 24/7 Nurse Line provides members with access to symptom counseling and healthcare guidance by a registered nurse. This is particularly helpful for a rural population, as clinical counseling is made available at all times to any member with access to a telephone. A summary of the member's interaction with the 24/7 Nurse Line is faxed to the PCP and to AmeriHealth Mercy's Rapid Response team. Our Rapid Response Care Connectors subsequently contact the member to assess additional needs and reconnect the member with the PCP, if appropriate.

Member and Provider Portals and Dissemination of Care Gaps

Currently, members and providers have access to our secure Web Portals which contain detailed information on care gaps and medication history. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as HbA1c testing and control and LDL-C testing and control for diabetes) for which there is no claim evidence that the member received

the service. Providers receive an alert identifying patient-specific care gaps when the member's ID is entered in the portal. Both the provider and the member can view the member's care gaps and medication history through the Member Clinical Summary section of the respective Web Portals.

This information can be particularly helpful for rural members by ensuring that all required preventive care is completed during provider interactions. Members can use the information in the portal to track completion of recommended services. In addition to receiving alerts for members who need recommended services, providers gain insight into the member's behavior. For example, a member whose information in the Web Portal indicates an HbA1c result greater than eight percent, missing refills for diabetic testing supplies and has no refills for their oral hypoglycemic medication needs a different approach than a member who has an elevated HbA1c result and is compliant with blood glucose testing and medications.

Community Outreach

Our experience with the Medicaid population in rural markets demonstrates to us the importance of engaging members where they reside. To that end, we sponsor and participate in more than 1,000 local health-related events annually to bring health care directly to the communities we serve. To specifically support HbA1c and cholesterol control, these events offer blood draws, nutrition counseling, medication adherence counseling, as well as a connection to our Integrated Care Management team, should a member need greater support.

To improve HbA1c and cholesterol management in the rural areas of the New West and New East HealthChoices Zones, we will use our Health Navigator infrastructure to identify appropriate venues in the community and deliver educational programs focusing on healthy habits, medication adherence, and PCP communication. Health Navigators, a type of Community Health Worker (CHW), will be stationed in each of the New West and New East counties.

Member Education

We use CHWs to provide culturally appropriate health education, counseling, and guidance on health behaviors, as well as advocate for health care needs. Our successful Promotora program in the Lehigh/Capital Zone uses specially trained CHWs to provide educational sessions on healthy living with diabetes to Spanish-speaking members with diabetes and their families. The sessions, which are delivered in Spanish, address a wide range of topics including healthy eating and recipes. Participants receive the Platillos Latinos !Sabrosos y Saludables! (Delicious Heart Healthy Latino Recipes) cookbook. The program culminates with a "graduation" celebration. Please see Attachment 1 for an example of written material used to educate members about warning signs of diabetes, risk factors, and the availability of our Diabetes Program.

Provider Engagement

The relationship between the provider and the member is one of the strongest tools we possess for changing member behavior. In rural areas with low PCP density, we will expand access to care by contracting with pharmacies to provide counseling services for members with diabetes that fall within the pharmacists' scope of practice, but go beyond traditional medication counseling. We will also ensure that our providers have accurate and up-to-date data on member care gaps and prescription history. We currently include HbA1c and LDL-C measures in our Pay-for-Performance programs and will extend that program into the New West and New East Zones. See Attachment 2 for more information on our provider incentives.

QUESTION 17

Describe the proposed approach you will use to care manage pregnant women in rural service delivery areas to ensure they receive prenatal care in the first trimester and to ensure they receive "81% or greater" of the expected number of prenatal care visits.

(Limit to two pages)

RESPONSE TO QUESTION 17

We know that a preterm infant costs 10 times more than a healthy one.[1] AmeriHealth Mercy exceeds the state Medical Assistance average for Prenatal Care in the First Trimester and Frequency of Prenatal Care (>81% of expected visits), achieving the 75th and 90th national Medicaid percentiles, respectively. The following section outlines our strategies for ensuring pregnant women receive prenatal care in the first trimester and that they receive "81% or greater" of the expected number of prenatal care visits in a rural market. Our strategy can be grouped into the following categories and is reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information. We have seen improvements in prenatal care in the first trimester and prenatal care completion rates by remotely supporting members and their adherence to care plans.

We expect that using technology to remotely support our pregnant members will improve member adherence to care plans, resulting in improved prenatal and postpartum outcomes.

Early Pregnancy Identification

Adequate prenatal care starts with early identification of pregnant members. We accomplish this by analyzing claims and utilization data seeking pregnancy identifiers, including Logical Observation Identifiers Names and Codes (LOINC). LOINC are a data set of universal identifiers for laboratory and other clinical observations that facilitate communication of clinical results, including pregnancy. We ask members about their pregnancy status as part of the new member assessment and we encourage providers to alert us to new pregnancies and reimburse them for completing pregnancy risk assessment forms.

24/7 Nurse Line

Our toll-free 24/7 Nurse Line provides members with access to symptom counseling and healthcare guidance by a registered nurse. This is particularly helpful for a rural population, as clinical counseling is made available at all times to any member with access to a telephone. A summary of the member's interaction with the 24/7 Nurse Line is faxed to the PCP and to AmeriHealth Mercy's Rapid Response team. This allows us to follow-up with members who report symptoms related to a new pregnancy to ensure that they are connected to prenatal care and enrolled in our WeeCare (maternity management) program.

Text-4-Baby

We promote and encourage our members to participate in the nationally-recognized Text-4-Baby program, a no-cost text message education service. Launched by the National Healthy Mothers and the Healthy Babies Coalition, Text-4-Baby is a public health campaign which promotes good health for expectant mothers and babies. Members who sign up receive weekly text messages with prenatal care reminders.

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1 About Prematurity. March of Dimes. As viewed on the world wide web at http://www.marchofdimes.com/prematurity/21198_10734.asp on 12/9/2011.

Community Outreach and Member Education

To support our prenatal care goals, our Community Health Workers (CHWs) educate our members on the need for, and importance of, early and ongoing prenatal care, risk factors for premature birth, and more. To encourage early identification of pregnancies, we distribute pregnancy test kits at community events containing the toll-free phone number for our WeeCare department. Members who test positive and contact our WeeCare department are assisted in making a prenatal care appointment and coordinating needed transportation, and are enrolled in our WeeCare maternity program.

Our WeeCare program provides educational information to pregnant members and reminders about upcoming prenatal appointments. All members receive education on healthy pregnancy habits, smoking and alcohol cessation, choosing a pediatrician and the importance of immunizations and infant medical care during the first two years of life. Please see Attachment 3 for examples of written educational materials related to pregnancy.

All pregnant members are educated about the importance of dental care during pregnancy to reduce the risk of pre-term labor. We work with our OB/GYN providers to raise awareness of, and adherence to, dental care during pregnancy through our Smiling Stork program. We provide pregnant members who are in their first or second trimester with educational mailers and follow-up reminder calls to schedule dental appointments (see Attachment 3). In the first year of our Smiling Stork Program, we doubled the number of women who received dental care during pregnancy.

Members identified as high-risk receive individual care management through a team of WeeCare Care Managers (registered nurses experienced in maternity) and Care Connectors (non-clinical staff). Care Managers coordinate care and address various issues throughout the member's pregnancy and post-partum period. We screen all pregnant members for depression and coordinate behavioral health services as needed.

Dental Care during Pregnancy

Member Incentive Programs

AmeriHealth Mercy offers two member incentives to increase adherence to prenatal care. Our Community Baby Showers are held in local community venues. Women receive "shower gifts" in the form of baby supplies for attending prenatal care education sessions. Additionally, through our WeeCare Incentive Program members who complete their recommended prenatal care and post-partum care visits receive a gift card.

Provider Engagement

The relationship between the provider and the member is one of the strongest tools that we possess for changing member behavior. To that end, in rural areas with low PCP density, we contract with nurse midwives to increase access. Recently, our partner in the New East Zone, Blue Cross and Blue Shield of Northeastern Pennsylvania, funded a project with Maternal & Family Health Services' Nurse Family Partnership Program, supporting 200 new families throughout the region. Additionally, we recognize that in many rural areas, Family Practitioners perform deliveries. We will contract for those services accordingly.

QUESTION 18

Describe the approach you will use in a rural service delivery area to ensure access to mammograms to screen for breast cancer for women ages 42-69 years old.

(Limit to two pages)

RESPONSE TO QUESTION 18

The following section outlines our strategies for ensuring member access to mammograms in a rural population. AmeriHealth Mercy exceeds the state Medical Assistance average for breast cancer screening and is ranked in the 75th national Medicaid percentile. Our strategy can be grouped into the following categories and is reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information. We expect that using technology to remotely support our members will increase mammography screenings for women ages 42-69 years old.

Member and Provider Portals and Dissemination of Care Gaps

Currently, members and providers have access to our secure Web Portals which contain detailed information on care gaps and medication history. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as mammography for breast cancer screening) for which there are no claim evidence that the member received the service. Providers receive an alert identifying the care gap when the member's ID is entered in the portal. Both the provider and the member can view the member's care gaps through the Member Clinical Summary section of the respective Web Portals.

This information is particularly helpful for rural providers by serving as a point-of-care reminder to address the need for a mammogram with the member during the encounter. Members use the information in the portal to track completion of recommended services.

Customer Service Support

Care Gaps are integrated with all of our internal information systems, providing a pop-up alert to any AmeriHealth Mercy staff person that enters the member's ID number into our Member Service or Care Management systems. Care Management and/or Member Service staff members talking with the member address the care gap, following a role-specific protocol to connect the member to the recommended care. For instance, a Member Service Representative who receives an alert for a woman who is overdue for a mammogram will initiate a scripted exchange with the member designed to allow the representative to move the call to a Care Connector who will assist the member in making an appointment and coordinating transportation as needed.

Community Outreach

We sponsor and participate in over 1,000 local health-related events annually to bring health care directly to the communities we serve. These events offer education on women's health issues including the importance of mammograms, Pap tests, nutrition counseling, medication adherence counseling, and provide a connection to our Care Management team, should a member need greater support in connecting with a provider.

Gift for Life

AmeriHealth Mercy will implement the Gift for Life program, established by our Keystone Mercy affiliate, which engages, educates and empowers members who have not had a mammogram in the past two years. During the member outreach, members are encouraged to dedicate time to themselves and to give their families the "gift" of their own life through

preventive care screenings. To support their completion of the mammogram, we will provide transportation and arrange for screenings in the neighborhoods where our members live, shop, or seek medical care, leveraging Mobile Mammograms and Provider block schedules (discussed below). These strategies are particularly valuable in the rural market. Prior to the event, outreach team members will make reminder calls to maximize participation, and following the mammogram, members will receive a gift card incentive for their participation.

Mobile Mammography

To facilitate access in rural areas, we bring a mobile mammography unit to neighborhood locations, reaching out in advance to members to schedule mammograms. We work with the Lackawanna Mobile Diagnostic Services in the HealthChoices Lehigh/Capital Zone, and have started discussions with them to reserve dates for the New West and New East Zones, should we be awarded a contract.

Member Education

We use Community Health Workers (CHWs) to provide culturally appropriate health education and to educate members as to why they need mammograms. To support our rural counties, Health Navigators, a type of CHW, will be stationed in each of the New West and New East counties. Through their familiarity with the county's population and local gathering spots, the Health Navigators will identify appropriate venues for delivery of these programs. Please see Attachment 4 for an example of written material used to educate members and encourage them to get a mammogram.

Member Incentive Programs

AmeriHealth Mercy has often found that successful behavior change comes from combining actionable information with incentives. To that end, AmeriHealth Mercy offers a Gift Card incentive to members who participate in the Gift for Life program and complete their mammogram screening.

Provider Engagement

As discussed above, providers have access to our secure Provider Portal, which provides alerts and reports on members who have not had recommended screening mammograms. The closure of mammography care gaps is further supported our provider Pay-for-Performance program that rewards providers for their performance related to the HEDIS breast cancer screening (mammography) measure. See Attachment 2 for more information on our provider incentive.

Our partner in the New East Zone, Blue Cross and Blue Shield of Northeastern Pennsylvania, recently funded a project to provide digital mammography and diagnostic ultrasound screenings for 85 underserved individuals served through the Blue Mountain Health System.

Dedicated Schedule Blocks

As access can be an issue in rural settings, we partner with local providers to reserve blocks of time for our members to receive breast cancer screenings, and we work with our members to ensure that they keep their appointments. We help our members schedule the appointments and coordinate transportation if needed, and we follow up to remind them of upcoming appointments. We have started discussions with providers about scheduling mammography screening blocks in the New West and New East Zones should we be awarded a contract.

QUESTION 19

Describe the approach you will use in a rural service delivery area to ensure access to Pap tests to screen for cervical cancer for women ages 24-64 years old.

(Limit to two pages)

RESPONSE TO QUESTION 19

The following section outlines our strategies for ensuring member access to Pap tests in a rural population. AmeriHealth Mercy exceeds the state Medical Assistance average for Cervical Cancer Screening (Pap tests). Our strategy can be grouped into the following categories and are reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information. We expect that using technology to remotely support our members will increase our cervical cancer screening rate for women ages 24-64 years old.

Member Portal and Submission of Care Gaps

Currently, members and providers have access to our secure Web Portals which contain detailed information on care gaps and medication history. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as Pap testing for cervical cancer screening) for which there is no claim evidence that the member received the service. Providers receive an alert identifying the care gap when the member's ID is entered in the portal. Both the provider and the member can view the member's care gaps through the Member Clinical Summary section of the respective Web Portals.

This information is particularly helpful for rural providers by serving as a point-of-care reminder to address the need for a Pap test with the member during the encounter. Members use the information in the portal to track completion of recommended services.

Customer Service Support

Care Gaps are integrated with all of our internal information systems. This integration provides an alert to an AmeriHealth Mercy staff person that enters the member's ID number into our Member Service or Care Management systems. Care Management and/or Member Service staff members talking with the member address the care gap, following a role-specific protocol to connect the member to the recommended care. For instance, a Member Service Representative who receives an alert for a woman who is overdue for a Pap test will initiate a scripted exchange with the member designed to allow the representative to move the call to a Care Connector who will assist the member to make an appointment for the test. The Care Connector will assist the member with transportation arrangements, as necessary. The protocols contain decision and escalation points, providing staff with the ability to transfer the call directly to a clinical Care Manager if the member has questions of a clinical nature.

Community Outreach

We sponsor and participate in over 1,000 local health-related events annually to bring health care directly to the communities we serve. These events offer education on women's health issues including the importance of Pap tests, mammograms, nutrition counseling, medication adherence counseling, and provide a connection to our Care Management team, should a member need greater support in connecting with a provider.

Member Education

We have found that, for members to feel empowered to make behavioral changes, they first must be educated on the appropriate manner to make those changes. To that end, we utilize Community Health Workers (CHWs) to provide culturally appropriate health education and to educate members as to why the need Pap tests. To support our rural counties, Health Navigators, a type of CHW, will be stationed in each of the New West and New East counties. Through their familiarity with the county's population and local gathering spots, the Health Navigators will identify appropriate venues for delivery of these programs. Please see Attachment 4 for an example of written material used to educate members and encourage them to get a Pap test.

Member Incentive Programs

AmeriHealth Mercy has often found that successful behavior change comes from combining actionable information with incentives. To that end, AmeriHealth Mercy will offer a DPW-approved Gift Card incentive to members who complete a Pap test. To support their completion of the Pap test, we provide transportation and screenings in the neighborhoods where our members live, shop, or seek medical care leveraging Provider block scheduling (discussed below). These strategies are particularly valuable in the rural market. Prior to the event, outreach team members make reminder calls to maximize participation, and following the Pap test, members will receive the gift card incentive for their participation.

Provider Engagement

The relationship between the provider and the member is one of the strongest tools that we possess for changing member behavior. To that end, in rural areas with low PCP density, we contract with Nurse Practitioners to provide support for women's health needs as well as preventive care contracts with Planned Parenthood Facilities. We will also ensure that all providers have accurate and up-to-date data on member care gaps and include Pap test performance in our Pay-for-Performance provider incentive program. As discussed above, providers have access to our secure Provider Portal, which provides alerts and reports on members who have not had recommended screening Pap tests. The closure of the Pap test care gaps is further supported by our provider Pay-for-Performance program that rewards providers for their performance related to the HEDIS cervical cancer screening (Pap test) measure. The care gap information, coupled with the provider Pay-for-Performance incentive (See Attachment 2), is particularly helpful for rural providers who wish to ensure that all required preventive care is completed during member interactions.

Dedicated schedule blocks

As access can be an issue in rural settings, we partner with local providers to reserve blocks of time for our members to receive Pap tests, and we work with our members to ensure that they keep their appointments. We help our members schedule the appointments and coordinate transportation if needed, and we follow up to remind them of upcoming appointments.

We have started discussions with providers about scheduling blocks in the New West and New East Zones, should we be awarded a contract.

QUESTION 20

Describe the plan you propose to use in a rural service delivery area to provide disease management services for members with cardiovascular disease; including but not limited to cholesterol management.

(Limit to two pages)

RESPONSE TO QUESTION 20

The following section outlines our strategies to provide disease management services for members with cardiovascular disease in a rural population. AmeriHealth Mercy exceeds the state Medical Assistance average for cholesterol (LDL-C) screening and management. Our strategy can be grouped into the following categories and is reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information. We expect that using technology to remotely support our members with cardiovascular disease will improve member adherence to care plans, resulting in improved cholesterol management.

Home Test Kits

Convenient access to laboratory facilities is one barrier that can impede adequate cholesterol management. To address this issue, we provide members with cardiovascular disease with home LDL test kits. The kits contain easy-to-use instructions and materials for collection of a finger-stick blood sample that is mailed to a certified laboratory for processing. Collection of the blood sample involves the same type of finger-stick that individuals with diabetes use for home glucose monitoring. All collected data from the at-home test kits are shared with the member's PCP and AmeriHealth Mercy Care Management, should additional follow-up be needed.

24/7 Nurse Line

Our toll-free 24/7 Nurse Line provides members with access to symptom counseling and healthcare guidance by a registered nurse. This is particularly helpful for a rural population, as clinical counseling is made available at all times to any member with access to a telephone. A summary of the member's interaction with the 24/7 Nurse Line is faxed to the PCP and to AmeriHealth Mercy's Rapid Response team. Our Rapid Response Care Connectors subsequently contact the member to assess any additional needs and to help reconnect the member with the PCP, if appropriate.

Member and Provider Portals and Dissemination of Care Gaps

Currently, members and providers have access to our secure Web Portals which contain detailed information on care gaps and medication history. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as LDL-C testing and control for cardiovascular disease) for which there is no claim evidence that the member received the service. Providers receive an alert identifying the care gap when the member's ID is entered in the portal. Both the provider and the member can view the member's care gaps and medication history through the Member Clinical Summary section of the respective Web Portals.

Members use the information in the portal to track completion of recommended services. In addition to receiving an alert for members who need recommended services, providers gain insight into the member's behavior. For example, a member whose information in the Web Portal indicates care gap alerts for a LDL-C result greater than 100 mg/dl and no refills for their antilipidemic medication in the last two months needs a different approach than a member who has an elevated LDL-C result and is compliant with prescribed medications.

Community Outreach

We sponsor and participate in over 1,000 local health-related events annually to bring health care directly to communities. To specifically support cardiovascular disease management, these events offer blood pressure testing, blood draws, nutrition counseling, medication adherence counseling, as well as a connection to our Care Management team, should a member need greater support in closing their Care Gaps and adhere to their medications.

Member Education

We have found that education empowers members to make appropriate changes. To that end, we utilize Community Health Workers (CHWs) to provide culturally appropriate health education, counseling, and guidance on health behaviors, as well as advocate for health care needs.

To improve cardiovascular disease management in the rural areas of the New West and New East HealthChoices Zones, we will use our Health Navigator infrastructure to deliver educational programs focusing on healthy habits, medication adherence, and PCP communication. Health Navigators, a type of CHW, will be stationed in the New West and New East counties. Through their familiarity with the county's population and local gathering spots, the Health Navigators will identify appropriate venues for delivery of these programs. Please see Attachment 5 for an example of written material used to educate members about ways to maintain a healthy heart.

Integrated Care Management

Our Integrated Care Management (ICM) program, discussed in greater detail in the Coordination of Care section, provides a member with a single point-of-contact for all of their healthcare needs. Members are selected for ICM through our own data stratification process or though provider or member referral. Within our ICM program we provide intensive focus on complex members who have comorbidities with their cardiovascular disease. Depression screening and smoking cessation counseling are standard pillars of our comprehensive ICM program.

Provider Engagement

The relationship between the provider and the member is one of the strongest tools we possess to change member behavior. In rural areas with low PCP density, we will expand access to care by contracting with pharmacies to provide counseling services for members with cardiovascular disease that fall within the pharmacists' scope of practice, but go beyond traditional medication counseling. We will also ensure that providers have accurate and up-to-date data on member care gaps and prescription history. We currently include LDL-C performance measures in our provider Pay-for-Performance program (see Attachment 2), and will extend that program into the New West and New East Zones.

QUESTION 21

Describe your proposed strategy to ensure access to a dentist for an annual dental visit for 2 to 21 year olds who reside in a rural service delivery area.

(Limit to two pages)

RESPONSE TO QUESTION 21

Our strategies for ensuring access to an annual dental visit for 2 to 21 year olds, who reside in rural areas of the New West and New East Zones, focus on promoting the adoption of healthy behavior and increasing access to dental services. We use a combination of technology-driven and high-touch processes to connect members to dental care and services.

Our programs and approaches have successfully raised dental rates in our rural Lehigh/Capital HealthChoices population over the last three years. Since March of 2009 when we implemented a new dental fee schedule, we aggressively expanded our dental specialist network and improved access rates by double digits.

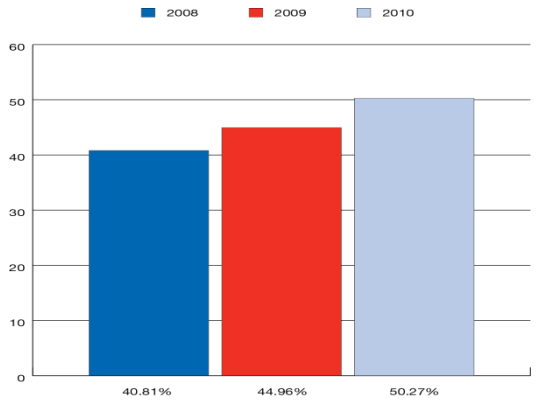

Figure 1: Dental Care Improvements Lehigh/Capital Zone

We know from conversations with multiple stakeholders in the New West and New East Zones, including Ron Errett, President and CEO of the Community Action Partnership in Mercer County, that access to dental care in those counties is a serious issue, more so than in the existing HealthChoices zones. Mr. Errett cited the high rate of missed appointments by Medicaid consumers and one reason why the few dentists in the New West and New East are reluctant to participate in HealthChoices.

We will leverage several intersecting strategies to improve dental access in the New West and New East Zones, including mobile dental vans, scheduling assistance, PCP engagement, care gap dissemination and educational outreach.

Expanding Access

We have identified and will coordinate with dental vans that service the New West and New East Zones to provide services for our members. Our Health Navigators, health plan outreach staff located in each of the counties, will identify locations within the communities to host the van. We use the mobile dental van strategy successfully today in the Lehigh/Capital Zone.

Our partners in the New East portion of this proposal, Blue Cross and Blue Shield of Northeastern Pennsylvania, recently funded the expansion of Tioga Dental Services' pediatric preventive dental program to reach an additional 370 children in the region.

Scheduling Assistance

For members who need help with scheduling dental visits, our nurses, Care Connectors and Member Services Representatives assist members in making an appointment with a dental provider. Our employed dental hygienist assists members with special needs who require special services, including anesthesia, as part of their dental care.

PCP Engagement

AmeriHealth Mercy encourages PCPs to screen patients for dental needs, and we pay PCPs to apply fluoride varnishes in the physician practice. Additionally, we will facilitate collaboration between dentists and PCPs to develop professional relationships that will support the referral of patients in need of dental and physical health care.

Care Gap Dissemination

Care gaps are recommended services supported by evidence-based clinical practice guidelines for which there is no claim evidence that the member received the service. We evaluate claim data at least monthly for all members. Care gap algorithms exist for a full range of preventive services and chronic disease states, including annual dental care. In the event there is no claim for a dental examination in the last 12 months, the system automatically generates a care gap.

Care gap data are loaded into our internal information systems and appear as an alert when a member ID number or name is entered. Care Management and/or Member Service staff members talking with the member are alerted to the need for a dental examination and offer to assist the member in making an appointment. Protocols in our system trigger a follow-up call to remind the member of the appointment and assess for transportation needs.

Care gaps are also used to conduct outreach campaigns. Members who are missing or overdue for recommended dental examinations are contacted, educated on the recommendation, and assisted with obtaining appointments for care. We segment our outreach to coordinate with planned visits of the dental van, contacting members who live in the area but have not had their annual examination.

Educational Outreach

Our approach to member outreach focuses on the three “E”s: Engagement, Education, and Empowerment. The primary goal of this strategy is to provide members with the educational programs and resources necessary to encourage self-management of care to the degree that each individual member is capable. Continuously available self-management resources, such as the 24/7 Nurse Line and Rapid Response call center assist members on a more individualized basis. Please see Attachment 6 for an example of written material used to educate members about important dental care issues for infants and young children.

Looking Ahead

We know from our experience in the Lehigh/Capital and Southeast Zones that access to dental care is a challenging issue in Pennsylvania. In addition to the proven strategies described above, we will implement a dental measure in our pay-for-performance program, similar to the one we are implementing in the Lehigh/Capital Zone this month.

QUESTION 22

Describe how you will ensure access to well-child visits in the first 15 months of life for those who reside in a rural service delivery area.

(Limit to two pages)

RESPONSE TO QUESTION 22

Our Pediatric Preventive Health Care program is designed to improve the health of members from birth to age 21 by increasing adherence to EPSDT and well-child visit guidelines. We have successfully improved well-child visit rates in the first 15 months of life. AmeriHealth Mercy's rates for this HEDIS measure are in the 90th national Medicaid percentile.

The following section outlines our strategies for ensuring that well-child visits occur in the first 15 months of life in a rural market. Our strategy can be grouped into the following categories and are reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information.

Member and Provider Portals

Members currently have access to our secure Member Portal, providing members a tool to help them understand and follow their care plan. This information can be particularly helpful for parents keeping track of all EPSDT requirements, including well child visits. Parents can view and print an EPSDT Clinical Summary listing the well child visits and other EPSDT services the child has received and the recommended frequency, assisting them to take responsibility for their child's care. Providers can view this same summary for any pediatric member they are treating.

Automated Outreach

Children need several well child visits and screenings during the first 15 months of life. To assist parents in making appointments, we program our automated phone outreach system to call the parent one month prior to the next needed visit. Calls are made at different times of the day and different days of the week. Parents receiving the call have the option to acknowledge the message or to be transferred to one of our Care Connectors for assistance scheduling an appointment.

To augment our reminder outreach, we mine claim data to identify children ages 6 months to one year who do not have any claims for well child care. Our Rapid Response team contacts the parent/guardian of these children to educate them on the need for well child care and help them to make an appointment. The appointment date is entered into our medical management system where it creates a reminder task for the Rapid Response team to contact the parent prior to the appointment to assess for any barriers and confirm transportation arrangements. We maintain contact with these parents/guardians to ensure that future appointments are made in accordance with the Periodicity schedule.

Making Every Contact Count through Family Link

Our care management and customer service systems also allow our staff to quickly access care gaps for other family members in one click by accessing the Family Link functions in our system. This allows a Care Connector or Member Service Representative to assist the parent/guardian to address the well-child care needs of all of the children during one call.

Community Outreach

We sponsor and participate in over 1,000 local health-related events annually to bring health care directly to communities. Events like the Poison Prevention and Health Me, Healthy You programs support parents and offer education on required child wellness care, nutrition counseling, general advice on child rearing and a connection to our Care Management team, should a member need additional support in completing a child's EPSDT services.

Emily Daly, Community Resources Coordinator for Pocono Services for Families and Children, a Head Start agency, has stated "AmeriHealth Mercy and its employees improve the health and lives of the children and families Monroe County Head Start serves. The Poison Prevention and Health Me, Healthy You programs visit our preschool classrooms and talk with the children about the dangers of poisonous substances and the importance of exercise and healthy eating habits. These programs have proven to be invaluable to our Head Start program."

Transportation

Our Rapid Response team assists parents with coordinating transportation as needed to complete appropriate well-child visits.

Member Education

For members to feel empowered to make behavioral changes, they first must be educated on the appropriate manner in which to make those changes. To that end, we utilize Community Health Workers (CHWs) to provide culturally appropriate health education and information; empower people to obtain their needed care; provide informal counseling and guidance on health-related behaviors; and advocate for individuals and community health care needs. Please see Attachment 7 for an example of written material used to educate members about the importance of EPSDT services and well-child visits.

WeeCare (Maternity Management)

To get parents started on the right foot, we begin our education on the importance and schedule for well child visits during the last trimester of pregnancy. Pregnant mothers are assisted with selecting a PCP for the baby, and given information on EPSDT services and screenings, including well-child check-ups. As part of the post-partum follow-up, our WeeCare staff contact the member to schedule a post-partum visit and to make sure that the infant has started receiving the required well-child visit.

Provider Engagement

The relationship between the provider and the member is one of the strongest tools we possess for changing member behavior. To that end, in rural areas with low PCP density, we partner with local schools, Head Start and Healthy Beginnings programs to increase access. We will also ensure that all providers have accurate and up-to-date data on member EPSDT requirements and include well-child visits in our Pay-for-Performance provider incentive program.

As discussed above, providers have access to our secure Provider Portal, which provides alerts and reports on members who have not had recommended EPSDT screens, including well-child visits. The EPSDT screening information, coupled with the provider Pay-for-Performance incentive, is particularly helpful for rural providers who wish to ensure that all required preventive care is completed during member interactions.

QUESTION 23

Describe how you will ensure access to well-child visits in the third, fourth, fifth, sixth years of live for those who reside in a rural service delivery area.

(Limit to two pages)

RESPONSE TO QUESTION 23

Our Pediatric Preventive Health Care program improves the health of members from birth to age 21 by increasing adherence to EPSDT and well-child visit guidelines, including well-child visits in the third, fourth, fifth, sixth years of life. In the Lehigh/Capital Zone, AmeriHealth Mercy's rates for well child care are higher than the state Medical Assistance average and in the 75th percentile nationally.

The following section outlines our strategies for ensuring that well-child visits occur in the third, fourth, fifth, sixth years of life in a rural market. Our strategy can be grouped into the following categories and are reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information.

Member and Provider Portals and Dissemination of Care Gaps

Currently, members and providers have access to our secure Web Portals, which contain detailed information on care gaps. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as well child visits) for which there is no claim evidence that the member received the service. Providers receive an alert identifying the care gap when the member's ID is entered in the portal. Both the provider and the member can view the member's care gaps through the Member Clinical Summary section of the respective Web Portals.

This information can be particularly helpful for rural members by ensuring that all required preventive care is completed during provider interactions. Parents can use the information in the portal to track completion of preventive care. Parents and providers can also view and print an EPSDT clinical summary, which lists the well child visits, screenings and immunizations the child received.

Care gaps are integrated with all of our internal information systems, providing a pop-up alert to any AmeriHealth Mercy staff person that enters the member's ID number into our Member Service or Care Management systems. Care Management and/or Member Service staff members talking with the member address the care gap, following a role-specific protocol to connect the member to the recommended care. For instance, a Member Service Representative who receives an alert for a child who has not had a well-child visit will initiate a scripted exchange with the member designed to allow the representative to move the call to a Care Connector who will assist the member to make an appointment and coordinate transportation for the visit.

Making Every Contact Count through Family Link

Our Care Management and Customer Service systems also allow our staff to quickly access care gaps for other family members in one click by accessing the Family Link functions in our system. This allows a Care Connector or Member Service Representative to assist the parent/guardian to address the well-child care needs of all of the children during one call.

Community Outreach

We partner with many organizations and agencies to help in our efforts to increase well-child visits, such as local Head Start offices, schools, the Healthy Beginnings program, YMCAs, homeless shelters, and faith-based organizations. We also sponsor and participate in over 1,000 local health-related events annually to bring health care directly to the communities we serve. Events that support parents offer education on required child wellness care, nutrition counseling, general advice on child rearing and a connection to our Care Management team, should a member need additional support in completing a child's EPSDT services.

Transportation

In coordination with our Rapid Response team, we also ensure that parents have access to whatever transportation they need to complete appropriate well-child visits.

Member Education

We have found that, for members to feel empowered to make behavioral changes, they first must be educated on the appropriate manner to make those changes. To that end, we utilize Community Health Workers (CHWs) to provide culturally appropriate health education and information; empower people to obtain needed care; provide informal counseling and guidance on health-related behaviors; and advocate for individuals and community health care needs.

To encourage member completion of EPSDT screenings, we mail birthday cards to members under 21 years of age that remind members of the importance of screenings and well visits. These cards also provide the phone number for our EPSDT unit. Please see Attachment 8 for a sample birthday card. Please also see Attachment 7 for an example of written material used to educate members about the importance of EPSDT services and well-child visits.

QUESTION 24

Describe how you will ensure access to primary care practitioners for well-care for 12-19 year old who reside in a rural service delivery area.

(Limit to two pages)

RESPONSE TO QUESTION 24

Our Pediatric Preventive Health Care program improves the health of members from birth to age 21 by increasing adherence to EPSDT and well-care visit guidelines. The following section outlines our strategies for ensuring that well-care occurs for 12-19 year olds in a rural market. Our strategy can be grouped into the following categories and are reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information.

Member and Provider Portals and Dissemination of Care Gaps

Currently, members and providers have access to our secure Web Portals which contain detailed information on Care gaps. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as adolescent well child visits) for which there is no claim evidence that the member received the service. Providers receive an alert identifying the care gap when the member's ID is entered in the portal. Both the provider and the member can view the member's care gaps through the Member Clinical Summary section of the respective Web Portals.

This information can be particularly helpful for rural members by ensuring that all required preventive care is completed during provider interactions. Parents can use the information in the portal to track completion of preventive care. Parents and providers can also view and print an EPSDT clinical summary, which lists the well care visits, screenings and immunizations the teenager received.

Care gaps are integrated with all of our internal information systems, providing a pop-up alert to any AmeriHealth Mercy staff person that enters the member's ID number into our Member Service or Care Management systems. Care Management and/or Member Service staff members talking with the member address the care gap, following a role-specific protocol to connect the member to the recommended care. For instance, a Member Service Representative who receives an alert for a teenager who has not had a well-care visit will initiate a scripted exchange with the member designed to allow the representative to move the call to a Care Connector who will assist the member to make an appointment and coordinate transportation for the visit.

Making Every Contact Count through Family Link

Our care management and customer service systems also allow our staff to quickly access care gaps for other family members in one click by accessing the Family Link functions in our system. This allows a Care Connector or Member Service Representative to assist the parent/guardian to address the well-care needs of all of the children during one call.

Community Outreach

We partner with many organizations and agencies to help in our efforts to increase well-child visits, such as schools, YMCAs, homeless shelters, and faith-based organizations. We also sponsor and participate in over 1,000 local health-related events annually to bring health care directly to the communities we serve. Events that support parents offer education on required

child wellness care, nutrition counseling, general advice on child rearing and a connection to our Care Management team, should a member need additional support in completing a child's EPSDT services.

Transportation

In coordination with our Rapid Response team, we also ensure that parents have access to whatever transportation they need to complete appropriate well-care.

Member Education

We have found that for members to feel empowered to make behavioral changes, they first must be educated on the appropriate manner to make those changes. To that end, we utilize Community Health Workers (CHWs) to provide culturally appropriate health education and information; empower people to obtain needed care; provide informal counseling and guidance on health-related behaviors; and advocate for individuals and community health care needs.

To encourage member completion of EPSDT screenings, we mail birthday cards to members under 21 years of age that remind members of the importance of screenings and well visits. These cards also provide the phone number for our EPSDT unit. Please see Attachment 8 for a sample birthday card. Please also see Attachment 7 for an example of written material used to educate members about the importance of EPSDT services and well-child visits.

Member Incentive Programs

AmeriHealth Mercy has often found that successful behavior change comes from combining actionable information with incentives. To that end, AmeriHealth Mercy provides network providers with movie tickets to give to adolescent members for completing EPSDT requirements. As this serves as an incentive for both the child and the parent, this is a step in educating children in managing their own healthcare.

QUESTION 25

Describe how you will ensure that children who reside in a rural service delivery area receive one or more capillary or venous lead blood tests for lead poisoning by their 2nd birthday.

(Limit to two pages)

RESPONSE TO QUESTION 25

The following section outlines our strategies to ensure that children who reside in a rural service delivery areas receive one or more capillary or venous lead blood tests for lead poisoning by their 2nd birthday. We have demonstrated consistent improvement in the lead screening rate in the Lehigh/Capital Zone since 2007, moving from a rate of 66% to 73%. Our strategy can be grouped into the following categories and is reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information.

Finger Stick Lead Tests

Convenient access to laboratory facilities and the difficulty performing a venipuncture on a small child are two barriers that can impede adequate lead testing. To address these issues, we have contracted with Medtox, a laboratory that provides finger stick lead screening kits to provider offices. The kits allow providers, including Federally Qualified Health Centers and Rural Health Centers, to collect the lead screen blood sample in the office, avoiding the need for the parent to make a separate laboratory appointment and sparing the child a venipuncture.

Member and Provider Portals and Dissemination of Care Gaps

Members and providers have access to our secure Web Portals, which contain detailed information on Care gaps. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as blood lead screening) for which there is no claim evidence that the member received the service. Both the provider and the member can view the care gaps through the Member Clinical Summary section of the respective Web Portals.

This information can be particularly helpful for rural members by ensuring that all required preventive care is completed during provider interactions. Parents and providers can also view and print an EPSDT clinical summary, which lists the child's blood lead screening, as well as any well child care, screenings and immunizations the child received.

Care gaps are integrated with all internal information systems, providing a pop-up alert to any AmeriHealth Mercy staff person that enters the member's ID number into our Member Service or Care Management systems. Care Management and/or Member Service staff members talking with the member address the care gap, following a role-specific protocol to connect the member to the recommended care. For instance, a Member Service Representative who receives an alert for a child who has not had a blood lead screen will initiate a scripted exchange with the member designed to allow the representative to move the call to a Care Connector who will assist the member to make an appointment with the PCP and coordinate transportation for the visit.

Making Every Contact Count through Family Link

Our care management and customer service systems also allow our staff to quickly access care gaps for other family members in one click by accessing the Family Link functions in our system. This allows a Care Connector or Member Service Representative to assist the parent/guardian to address the well-child care needs of all of the children during one call.

Community Outreach

We sponsor and participate in over 1,000 local health-related events annually to bring health care directly to the communities we serve. Where possible, we sponsor finger stick lead screening at the event.

Transportation

In coordination with our Rapid Response team, we also ensure that parents have access to whatever transportation they need to complete blood lead screening.

Member Education

We have found that for members to feel empowered to make behavioral changes, they first must be educated on the appropriate manner to make those changes. To that end, we utilize Community Health Workers (CHWs) to provide culturally appropriate health education and information; empower people to obtain needed care; provide informal counseling and guidance on health-related behaviors; and advocate for individuals and community health care needs. Please see Attachment 9 for an example of written material used to educate members about lead poisoning, risk factors, prevention, and the importance of testing for blood lead levels.

WeeCare (Maternity Management)

To get parents started on the right foot, we begin our education on the importance of EPSDT screenings, including blood lead levels, during the last trimester of pregnancy. Pregnant mothers are assisted with selecting a PCP for the baby, and given information on EPSDT services and screenings, including blood lead testing. As part of the post-partum follow-up, our WeeCare staff contact the member to schedule a post-partum visit and to make sure that the infant has started receiving the required well-child care and screenings.

Provider Engagement

Another key to success in getting children under age two screened for blood lead levels is ensuring providers will actively instruct parents/guardians to get the test. The current Pennsylvania Medical Assistance recommendation for screening every child under age two is more stringent than the American Academy of Pediatrics (AAP) guideline to screen only if certain risk factors are present. We know from numerous conversations with pediatricians and PCPs in Pennsylvania that many physicians do not see the need to screen all children, and instead follow the AAP guidelines. We provide ongoing education to providers on the Medical Assistance lead testing requirements in provider newsletters, quarterly information packets delivered to the provider's office and the Provider Web Portal.

As discussed above, providers have access to our secure Provider Portal, which provides alerts and reports on members who have not had recommended EPSDT services, including lead testing. The care gap information, coupled with the provider Pay-for-Performance incentive and convenience of the Medtox finger stick kits, is particularly helpful for rural providers who wish to ensure that all required preventive care is completed during member interactions.

QUESTION 26

Describe the initiatives you will implement in a rural service delivery area to educate members and providers about the appropriate use of hospital emergency departments.

(Limit to two pages)

RESPONSE TO QUESTION 26

Receiving non-urgent care in the Emergency Room (ER) setting lends itself to fragmented care, lack of continuity of medical history, duplicate testing, and inadequate post-ER follow up. Over the last two years, our successful approach resulted in a 6% decrease in the Emergency Room utilization rate in the Lehigh/Capital Zone.

The following section outlines the initiatives we will implement in the rural service delivery areas of the New West and New East Zones to educate members and providers about the appropriate use of hospital emergency departments. Our strategy can be grouped into the following categories and is reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members and providers in rural areas by increasing the flow of information.

Targeted Member Outreach

We analyze claim data to identify frequent ER users. Identified members are contacted by our care management team to offer education and assistance on using the correct care setting, including urgent care centers (UCCs). We also ask members during the new member assessment if "anyone in the household has been to the ER 4 times or more in the last 6 months?" Members who respond "yes" are flagged in the system and contacted by our Rapid Response team to connect them to a more appropriate level of care. We also encourage providers to alert us to members they know to be inappropriate high users of the ER.

24/7 Nurse Line

Our toll-free 24/7 Nurse Line provides members with access to symptom counseling and healthcare guidance by a registered nurse. This is particularly helpful for a rural population, as clinical counseling is made available at all times to any member with access to a telephone. A summary of the member's interaction with the 24/7 Nurse Line is faxed to the PCP and to AmeriHealth Mercy's Rapid Response team. Our Rapid Response Care Connectors subsequently contact the member to assess any additional needs and to help reconnect the member with the PCP, if appropriate. The 24/7 Nurse Line is an especially important tool for reducing unnecessary ER use, as it provides a resource for members needing guidance in how to manage an urgent health need when their PCP office is closed.

Automated Emergency Room Outreach Surveys and Discharge Outreach Surveys

Part of encouraging appropriate use of the ER in the future is to connect a member to appropriate follow-up care post discharge from the ER. The automated outreach and discharge surveys administered by AmeriHealth Mercy remind members about scheduling follow-up appointments with their PCP. If a member needs any additional support in connecting to care, they are connected to a Rapid Response Care Connector, who will address any identified barriers to care.

Community Outreach

We sponsor and participate in over 1,000 local health-related events annually to bring health care directly to the communities we serve. To specifically support appropriate ER utilization, these events offer education on when and where to get care. For example, our '4 Your Kids Care"

education program provides hands-on education for parents on how to care for sick children, effective home treatments, and when to seek medical or emergency care. Each participant is given a linguistically appropriate reference book that describes symptoms and recommended care for common childhood illnesses, and a thermometer. The Rapid Response Team follows-up with a telephone call to address identified health care barriers.

Member Education

We have found that education empowers members to make appropriate changes. For example, our new member Welcome Packets, available in English and Spanish (see Attachment 10), include an easy-to-read flow chart to educate members on the appropriate use of the ER. Additionally, our Rapid Response and Outreach Team contacts members who have recently been to the ER to reconnect them with their PCP for follow up appointments. Please see Attachment 11 for examples of written material used to educate members about how and where to get care for urgent medical needs.

Our chronically ill members are engaged in our Integrated Care Management (ICM) program, discussed in greater detail in the Coordination of Care section. The ICM program provides members with a single point-of-contact for all of their healthcare needs. Members are selected for ICM through our data stratification process or though provider or member referral. Our ICM program provides intensive focus on complex members, working to strengthen the member's self-management skills and decrease the incidence of avoidable episodes of care and exacerbations which could lead to an ER visit.

Provider Engagement

The relationship between the provider and the member is one of the strongest tools we possess to change member behavior. In rural areas with low PCP density, we will encourage providers through Pay-for-Performance incentives to be available for evening and Saturday hours. Additionally, we send information on UCC locations to members in the surrounding areas.

We also evaluate the PCP offices to determine compliance with access and availability standards. If we find a provider to be out of compliance, we will educate the PCP on our availability requirements and assist the PCP to develop a workable solution for the office.

Transition Managers

We also place care management resources in the Emergency Rooms of our high-volume facilities. Through personal contact with ER users during the ER event, we eliminate problems relating to inaccurate contact information and are able to assess in person any barriers and drivers that led the individual to the ER. We also use this opportunity to strengthen the Care Management relationship with the member, make an appointment with their PCP, and forward the ER discharge summary to the PCP office.

EMERGENCY PREPAREDNESS

CONTENTS

EMERGENCY PREPAREDNESS

Throughout our experience in operating Medicaid managed care plans in Pennsylvania and other states, we have responded to hurricanes, fires, floods, snow storms and technology failures. Our practical experience through lessons learned, combined with our use of industry best practices, makes AmeriHealth Mercy uniquely equipped to respond quickly and efficiently to any emergency. AmeriHealth Mercy's comprehensive Enterprise Business Continuity and Disaster Recovery plan serves as the foundation for the New West and New East plan.

AmeriHealth Mercy's Business Recovery Management Team

AmeriHealth Mercy has a Business Continuity Program Management Office (BCPMO). The full focus of the BCPMO is not only to quickly respond to any types of crises that need to be managed, but also to plan for such events and to coordinate the response. The team works closely with all functional areas across the company to facilitate the development and testing of preparedness plans.

The Business Recovery Management Team is responsible for making all critical decisions and directing the recovery process for all AmeriHealth Mercy affiliates and offices. The management team members will include the New West and New East Executive Director, as well as the leaders from the key AmeriHealth Mercy functional areas (such as Member Services, Claims, Facilities and Medical Management). The Executive Director will provide guidance and advice regarding New West and New East specific Business Continuity needs. In the event that the Executive Director or other members of the Management Team are unable to participate due to the nature of the incident, our Executive Team will immediately identify and mobilize a team of personnel to establish contact with local authorities, the state and other relevant emergency contacts.

Table 1: Emergency Management Team

AmeriHealth Mercy Executive Team	
Chief Executive Officer	Chief Legal Counsel
Executive Vice President and Chief Operations Officer	Senior Vice President and Chief Human Resources Officer
Chief Financial Officer	Senior Vice President, Chief Mission Integration Officer
On Call Recovery Executive – Senior Vice President of Operational Initiatives	Chief Medical Officer

Business Recovery Management Team	
VP of Corporate Communications and Marketing	New West and New East Executive Director
Regional President	Vice President of Clinical Services
Vice President of Information Solutions	Senior Vice President of Enterprise Operations
Director of Government Relations	Director of Facilities

Business Continuity and Disaster Recovery Plan Overview

The AmeriHealth Mercy Business Continuity and Disaster Recovery program enables us to quickly return to operating capacity in the event of an emergency, inclement weather, pandemic, technology failure, fire or other catastrophic scenario. Our program combines our plans to recover systems, networks, workstations, applications in the event of a disaster (disaster recovery), assisting with evaluations, with plans to expeditiously restore all operational functions (business recovery).

We have designed our Program to:

- Prepare employees to respond to a crisis, emergency or disaster in a safe manner
- Help control risks and exposures to members, employees and providers
- Provide methods and decision guidance for preventive measures, where appropriate
- Provide the ability to efficiently respond to a business or technology interruption to resume critical business operations and limit the operational downtime and costs
- Minimize delays and improve guidance for decision-making during an interruption/disaster
- Provide a connection between county, state, and federal information (senders) and members, employees, and providers (receivers)
- Prepare AmeriHealth Mercy to continue to deliver critical business functions if employees are impacted due to influenza, other infectious diseases, or other disasters
- Re-integrate members and providers into the community

Our Business Continuity and Disaster Recovery planning methodology begins with categorizing types of disasters, the business severity and priority levels for each type of severity level and an assessment of the Business Impact Analysis (BIA) of critical functions. Each of these critical elements is summarized prior to describing how we will manage the disaster and restore operations.

Disaster Categorization

Our plan for responding to a disaster begins by classifying the disasters into three categories: minor, major, and catastrophic. The disaster recovery categories are summarized in Table 2.

Table 2: Disaster Recovery Categories

Disaster Type	Definition
Minor Disaster Time Frame: 24 hours or less	A minor disaster is an operational disruption that generally does not require a declaration process. However, it does require incident management. A minor disaster usually involves an outage duration anticipated to be one day less. Damage due to a minor disaster is not extensive. It may consist of component failure, minor damage, or unavailability of hardware, software, or supporting electrical equipment. Partial or total loss of hardware for a period of several hours. Recoverable loss of critical data; full recoverability in twenty-four hours or less. Loss of an important computer application. Temporary loss of services such as power or network. No foreseeable impact on the covered population, providers, or employees.
Major Disaster Time Frame: From 24 hours to 7 days	A major disaster is an outage that is likely to be greater than one day but not more than seven calendar days. Damage due to a major disaster may be more severe than that associated with a minor disaster and operations can be restored within seven calendar days. Damage to infrastructure and/or facility. Major impact on the covered population, providers, or employees. Damage to hardware resulting in downtime of more than 24 hours. Loss of services (air conditioning, electrical power, etc.) Recoverable loss of critical data; full recovery taking more than 24 hours. Loss of network caused by severe weather.
Catastrophic Disaster Time Frame: Greater than seven days	A catastrophic disaster is one in which the outage is anticipated to be more than seven calendar days. Damage due to a catastrophic disaster is usually severe and could involve total destruction of data center facilities requiring major replacement of equipment and/or facility and/or major renovation of the data center facility. Serious damage or total destruction of the data center facilities and/or equipment.

Disaster Type	Definition
	Widespread impact on the covered population, providers, or employees with some loss of knowledge of their whereabouts. Loss of operations center staff due to uncontrollable factors (e.g. outbreak of epidemic disease.) Major telecommunications failure. Unrecoverable loss of critical data. Total loss of a facility or workplace.

Business Severity and Priority Level

In addition to classifying the categories of disaster, we have also defined business severity and priority levels. The BIA is used to gather information and assign criticality, recovery point objectives, recovery time objectives, daily business process steps, accompanying resources, applications, tools, dependencies and manual work-around procedures. The BIA is used to identify the extent and timescale of the impact on different levels of our organization. The BIA not only assesses the current activities but also the effect of disruption on major business changes. Table 3 summarizes how we categorize business severity and priority levels.

Table 3: Business Severity and Priority Levels

Business	
Critical or Severity Level	**Four**
Priority Level	No Business Impact
Business Impact	Minimal to no business impact, this indicates the problem causes little impact on operations or that a reasonable circumvention to the problem has been implemented.
Critical or Severity Level	**Three**
Priority Level	Low (Some Business Impact)
Business Impact	A department or individual's ability to perform a job function may be impacted or inconvenienced, but can continue business as normal operations. Public transportation disruption (strike). Inclement weather storm. Threat of a pandemic, epidemic. Threat of a bomb scare. Threat of inclement weather.
Critical or Severity	**Two**

Business	
Level	
Priority Level	Medium (Significant Business Impact)
Business Impact	A department or individual's ability to perform a mission critical function is in jeopardy or unavailable but a workaround is or can be established within a reasonable time. Severe Inclement Weather (Hurricane, Nor'easter, Ice Storm.) Partial loss of a facility (structural damage.) Loss of services or utilities (power, gas, water, HVAC, air and water contamination – 3 to 24 hours.) Food Services Unavailable. Increase in absenteeism (Pandemic, Epidemic.) Disgruntled employee, workplace violence.
Critical or Severity Level	**One**
Priority Level	High (Critical Business Impact)
Business Impact	Business processes are adversely affected resulting in a major impact in business operations. The impact of the problem causes a complete loss of service and work cannot reasonably continue. Severe Weather (State of emergency/state shut down.) Total Loss of a Facility/Workplace (Fire, Flood Plains, Regional Power Outage, collapsed building, regional disaster lasting greater than 24 hours.) Hazardous materials spill (Area roads shut down.) Transportation Accidents (Area roads shut down, airplane crash.) Employee Walkout/Loss of Internal Personnel. Total Loss of Workforce (Pandemic, Epidemic, Walkout.)

Business Impact Analysis (BIA) of Critical Functions

After we classify the types of disasters and the impact to the business, we identify the critical business functions needed to assist us in recovering from the disaster and to commence the continuation of our business.

We use an Employee Impact Analysis to evaluate all functions performed by an employee to determine their impact on the organization should they become unavailable for work. Employees with highly specialized skill sets that will immediately impact the business if unavailable are identified as Critical Associates. Those who perform a business function that will impact the business if unavailable are identified as Essential Associates.

Each quarter, every business area is required to review its Employee Impact Analysis. Additionally, the business function requirements and recovery time objectives are reviewed by each business area each year.

Each business function annually reviews and updates its business continuity needs through a formal Business Impact Analysis program managed by AmeriHealth Mercy's Enterprise Business Continuity Program Management Office (BCPMO). We use the results of this review to perform a "gap analysis" that identifies potential areas of improvement for our continuity plans. The business areas will address any significant gaps and revise the continuity plans accordingly.

Disaster Management

The next important part of our Business Continuity and Disaster Recovery plan is how to manage crises or disaster. Our crisis management methodology ensures a controlled and managed response to an incident/problem or crisis event by identifying resources needed to respond to a significant incident or crisis. In addition to our general approach to disasters, we have a specific response plan for hurricane or pandemic crises outlined in this section.

Our incident management process begins with the detection of a problem as outlined in Figure 1. We may become aware of a problem from a variety of sources, such as a potential weather event, an event occurring in a facility, a report from an associate or a technology error. However, the root cause of the problem may originate from unexpected sources. We use a "crisis management" approach to quickly help us identify and address the root cause of the problem.

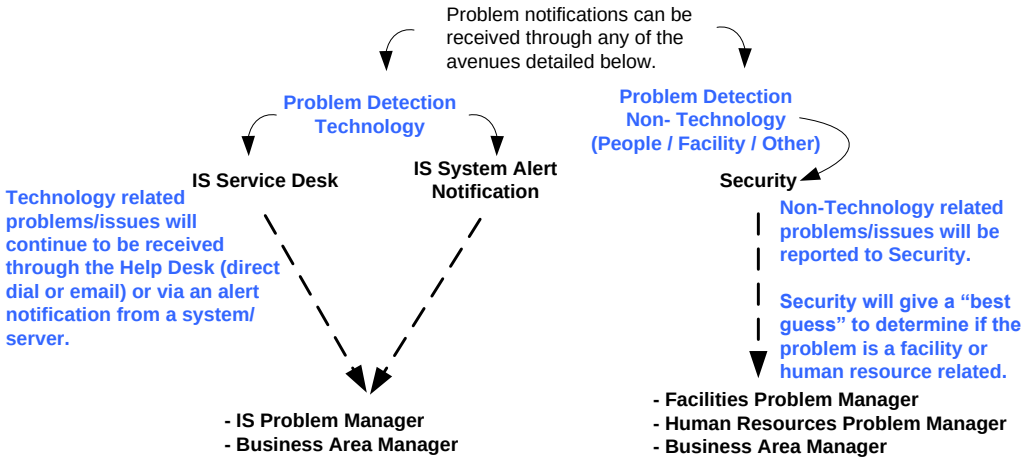

Figure 1: Problem Detection and Notification Procedure

The leader of our Business Continuity and Disaster Recovery Office facilitates an applicable subject matter expert to serve as the "Problem Manager." The Problem Manager assesses the impact of the problem and ensures that the problem is managed to resolution. For example, if the problem is technological in nature, we have predetermined who will serve as the Problem Manager. The Problem Manager adheres to our Problem Management process, which includes diagnosing the root cause of problems and critical incidents. If a problem escalates to a critical incident, the Problem Manager will escalate the incident to the designated Recovery Executive and triggers the Incident Command/Crisis Management System/Team. Figure 1 shows our incident detection and notification system. This system is designed to quickly evaluate the

problem, rank its severity, and begin the process of informing the necessary individuals and teams throughout the organization.

Pandemic Crisis

Another important part of our Business Continuity and Disaster Recovery program involves how to address a pandemic crisis. The pandemic action plan uses five stages to monitor changes in demand for services and our capacity to meet that demand. We have identified essential business functions, critical skills and strategies to manage essential business activities up to and during the declaration of a pandemic. Each department has identified changes they will implement in their business processes to address increased demand and/or decreased capacity. Our local office will have direct access to AmeriHealth Mercy's enterprise-wide resources of trained professionals to assure the ability to respond to increased demand and decreased availability of local staff in the event of a disease outbreak. Key strategic partnerships with select vendors give us the ability to expand capacity quickly to meet the demand.

Contingency Plans

In the event a disaster affects staff, physical buildings, or other portions of the business, we have contingency plans in place that allow us to continue operations while minimizing down time. Because AmeriHealth Mercy is a national organization with facilities in other states, we are able to rapidly shift operations as necessary to other affiliate locations. Our IS infrastructure is shared throughout the organization, member services, provider services, and medical management employees in other regions can be quickly granted permission to access AmeriHealth Mercy member and provider data, making the transition seamless to the caller. All data will be stored at an off-site location and backed up regularly. In the event of a physical disaster, AmeriHealth Mercy's data can be retrieved by other affiliate locations and used to resume operations elsewhere.

Employee Education and Awareness Training

AmeriHealth Mercy uses several methods to keep employees aware of the critical role that they play in preparing for any potential disruption or incident. Our primary methods include recovery tests, tabletop exercises, building evacuation (i.e., fire drills) and regular employee communications. Employees from key areas are included in all testing and exercises.

Recovery Tests

The first method used to assure our employees are aware of our business continuity strategies is testing responses to disaster scenarios. Our recovery tests are designed to enhance our ability to perform necessary procedures and critical business function as well as to identify opportunities to improve our plans. Successive tests are typically performed by different employees to increase the number of people who are familiar with the recovery procedures. Testing also builds organizational acceptance that the business and technology recovery strategies satisfy the organization's business requirements. Testing includes but is not limited to:

- Technical tests from primary to secondary work locations
- Application and data recovery tests
- Business process tests and execution performed by the end users

At a minimum, testing is generally conducted on an annual schedule. Problems, issues and lessons learned identified during testing are rolled up into the maintenance phase and retested during the next test cycle.

Table-top Exercises

Table-top exercises are simulated scenarios designed to test the response capability of an organization to a given event. Examples of table top exercises conducted by AmeriHealth Mercy include identifying safe locations during a tornado watch. Our table-top scenarios require a coordinated response to a realistic situation that develops in real time with participants gathered to formulate responses to each development. This is a facilitated group analysis of an emergency situation in an informal, stress-free environment. The Table-top Exercise allows us to examine our operational plans, identify problems, and conduct in-depth problem solving.

Building Evacuation (Fire Drills)

Each AmeriHealth Mercy location has an evacuation plan and procedure designed for the unique requirements of their area. Our evacuation plans are evaluated regularly by the Business Continuity Program Management Office. All of our employees receive evacuation training that provides an understanding of their own responsibilities during an emergency situation. In addition, we provide each work station or office with directions of how to evacuate the building.

All employees will be required to complete the online training course once each year and new employees will complete the course as part of the new hire orientation. The evacuation awareness and education training course prepares employees for a safe and efficient building evacuation with defined roles and responsibilities for employees, and visitors/vendors. Designated Floor Marshals, Floor Captains and Security team members are appointed to assist with evacuation. We also educate employees on how to assist and account for all persons with disabilities, including employees, visitors and vendors. The course concludes with a ten question assessment of the employee's specific knowledge.

Communications with Employees, Members, Providers, and Suppliers

AmeriHealth Mercy's communication infrastructure provides a framework to:

- Receive critical community and company information and accurately decide on the scope of the event and the need to expand a response
- Communicate and escalate the critical incident or emergency situation to the appropriate crisis management team structure and the AmeriHealth Mercy executives who are the key decision makers
- Obtain support and assistance from other Incident Command/Crisis Management Support Teams

Employee Communications

We communicate regularly with our employees to keep them mindful of the actions they need to take in the event of a disaster. We distribute messages through several different outlets, as outlined below:

- **Business Continuity Program Brochure -** We use a tri-fold brochure that explains and illustrates the program in detail to make sure that any new employees are familiar with the components of our business continuity program. We distribute the introductory brochure to new hires as part of their welcome kit.
- **iNSIGHT** (Internal employee website) **-** Used to share information, updates and tools about our Business Continuity Program. The site allows us to easily and efficiently share information regarding business continuity planning. Specific information such as crisis

management (emergency notification, evacuation, and inclement weather), business continuity planning (planning and software tools, business recovery, and glossary terms), disaster recovery (disaster recovery test information) and pandemic awareness (flu information and inter-office communications) are also available on this site.

- **e-News -** Our periodic employee email newsletter, to disseminate important information about evacuations, inclement weather, our emergency notification system information, or to create general awareness of our business continuity program. For instance, during the flu season months, employees across all AmeriHealth Mercy locations receive awareness communications about flu prevention, recommendations for proper hand sanitation and other flu-related information and awareness. When extreme weather emergencies are predicted, eNews alerts encourage employees to monitor local radio and television news programs for information on evacuation directives.
- **AlertFind** - We implemented an automated tool, AlertFind (Emergency Notification System) to assist us to quickly communicate in a crisis. AlertFind notifies internal crisis management team members, senior management and employees of issues that may affect our operations. Employees receive AlertFind notifications in one of six ways:
  - Incoming call on a company-supplied Blackberry
  - Incoming call on an office work phone
  - Incoming e-mail to Microsoft Outlook
  - Text message to a company-supplied Blackberry
  - Incoming call to a personal cell phone
  - Incoming call to a home phone (used after hours and on weekends only)

These notifications provide instructions, ask questions and/or collect responses. If AlertFind is not able to make contact with the first device in the list above, it automatically moves on to the next device. AlertFind continues through the list until AlertFind receives a confirmation from the associate, leaves a voicemail or an e-mail or exhausts all device options. Associates must reply to any one of the AlertFind message to confirm receipt of the message. AlertFind is also used to provide updates, additional instructions or information to business continuity coordinators and employees related to business recovery.

The contact information used by the AlertFind system is collected directly from our PeopleSoft Human Resources application. Periodically employees are reminded to update their contact information in PeopleSoft to maintain a current list.

- **Emergency Notification Reference Pack –** Distributed to new hires as a part of our Welcome Kit, this pack contains a reference guide and magnet which explain and illustrate the AlertFind system, in detail, to ensure all employees are familiar with this business continuity protocol. (see Attachment 1)

Members, Providers, and Suppliers Communications

AmeriHealth Mercy utilizes existing technology to "push" information services to members, providers and suppliers through our website, toll free 800 numbers and text messaging. Through these communication channels we will provide information, updates, current impact, best practices, care recommendations, schedules of preventive activities (such as immunizations), and in the event of larger and longer lasting events, instructions, methods to access care, pandemic instructions, and instructions to distant providers in the care of our members. This proactive

method of delivering information helps to keep them aware of any emergency situation and impacts on our internal business operations.

Our plan also includes an educational program for members to assure that, upon joining AmeriHealth Mercy, we provide them with information in an understandable format, using various media formats. We supply educational information on a variety of topics, such as:

- Weather emergency preparedness
- Seasonal flu and pandemic flu
- Environmental emergencies
- Evacuation pathways
- Sources of information seasonally and prior to an anticipated event

The ultimate goal of these communication programs is to assist our members, providers, employees and suppliers respond to events that may affect their health, health care, safety, resilience, and recovery. We will partner with providers locally and remotely to ensure access to quality and safe care for our members, regardless of their location.

Plan to Ensure Continuity of Services

Maintaining a constant flow of information with all members, providers, suppliers and employees is key to managing continuity of services during an emergency. During an emergency, the state, counties, and the federal government will release information that is of direct benefit to our stakeholders. We will gather and distribute this information through multiple communication vehicles, including websites, telephone, email and text messages to all groups to assure they receive timely, accurate updates and instructions.

We will provide information on encouraged prophylaxis, road closures in external emergencies, immunization recommendations, or other pertinent other topics. Following a disaster, we will also distribute information to help members reintegrate to the community of providers and to provide community safety and wellness information. Additionally, we will gather and distribute information generated by governmental entities related to wellness or the re-establishment of primary care and other covered care.

AmeriHealth Mercy will use Emergency Contracting Specialists to assure that our members – whether they are in Pennsylvania or out-of-state – receive needed care from providers. During a declared public health emergency, a presidentially declared emergency, and/or a Stafford Act Disaster declaration, we will closely coordinate with DPW and any other state or federal regulatory authorities to make sure all members and providers obtain necessary details. To fully support primary, urgent, and emergent care needs of our members, we will consider and use, as necessary, contracts, Memorandums of Agreement (MOA), Memorandum of Understanding (MOU) and other aggressive contracting methods with providers and in states where our members have relocated. The use of Electronic Health Records and Member Clinical Summaries will facilitate the continuity of service for our most fragile members who receive extensive services.

Our ability to rapidly resume normal business operations in support of our members is of great importance and major priority. To improve our ability to resume operations, we also plan to distribute information to our employees to help them maintain health and wellness after significant events so that they can quickly return to normal operations or alternative work sites if necessary.

Special Needs Populations

AmeriHealth Mercy has a particular concern for the portion of the covered population with additional functional or access needs. These needs are especially acute if these members require additional resources to participate in an organized and timely evacuation. These members may require special transportation, such as a wheelchair car, ambu-van, ambulance, or other special vehicle. This population may, based on functional and access needs, require a destination specifically capable of providing special services, such as dialysis, chemotherapy or related care.

Emergency Plan Testing

AmeriHealth Mercy has developed a detailed testing strategy which includes at a minimum, an annual system test to assure full recovery of our operations at our contacted recovery facility. The overall goals for the tests are:

- Enhance AmeriHealth Mercy's ability to perform necessary procedures and critical business functions in the event of a disaster
- Identify areas of potential improvement in the plans
- Problems, issues and lessons learned which are identified during testing are rolled up into the maintenance phase and retested during the next test cycle

The Disaster Recovery Plan and Business Area Continuity Plans will be tested during our annual test to ensure the adequacy of the Business Continuity and Disaster Recovery Plans such as technical recovery procedures, recovery teams' contact information, communication, recovery of all critical system and critical vendor information (e.g., names, phone numbers, escalation process, etc.) Our annual test is a simulation of a disaster and recovery of all of our critical systems at our contracted recovery location. This ensures critical systems will be available to meet the recovery time objectives and business requirements.

In parallel with the Disaster Recovery technology recovery activities, the business recovery activities will also be tested. Some of the types of tests that will be built into the exercise are as follows:

Crisis Management Component Test

Table-top walk-through test(s) of the Crisis Management Action Plan to determine if team members are aware of their assigned activities, if the document is complete and accurate, and if the communication among teams is appropriate.

- Notification test of the On-Call Recovery Executive
- Establishment of a Crisis Command Center is to determine if On-Call Recovery Executive can set up a location from which to control the crisis and recovery effort
- Notification test of Crisis Management Team members and other support staff members as needed
- Notification test of the Business Recovery Coordinator and Disaster Recovery Coordinator
- Notification test of the Senior Executive Management Team

Business Recovery Activation Component Test

Table-top walk-through test(s) of the Business Continuity Activation Plan to determine if team members are aware of their assigned activities, if the document is complete and accurate, and if the communication among teams is appropriate.

- Notification test of business continuity coordinator
- Notification test of critical employees, and/or outside vendors and services

Business Recovery Component Test

Table-top walk-through tests of the Business Area Continuity Plans to determine if team members are aware of their assigned activities, if the document is complete and accurate, and if the communication among teams is appropriate.

- A test of defined resources to support specific team tasks. These are typically such items as manual procedures to be used only if the automated support is not available, pre-defined alternate work locations, specific procedures required to recover "work in progress" lost during the disaster, or any other measurable resource required by a recovery team.

II-1. Statement of the Problem – New West Zone

Contents

STATEMENT OF THE PROBLEM – NEW WEST ZONE

Vista Health Plan, Inc. ("Vista") and AmeriHealth Mercy Health Plan ("AmeriHealth Mercy") are pleased to submit this proposal to the Commonwealth of Pennsylvania, Department of Public Welfare (DPW) to operate the HealthChoices Physical Health managed care program in the New West Zone.

Together we bring unparalleled experience to the development and operation of managed care programs serving Medicaid consumers and other low income populations in both urban and rural communities. We have provided managed care services to Medicaid consumers and other low income populations in Pennsylvania and throughout the country for nearly 30 years, and AmeriHealth Mercy is proud to be ranked the #22 Medicaid Health Plan in America by the National Committee for Quality Assurance.

Our past performance shows our commitment to executing the DPW's goals for the Medicaid program, and for this procurement specifically:

Vista and AmeriHealth Mercy improve access to medically necessary services through a coordinated network of specialists, facilities and other healthcare providers.

- AmeriHealth Mercy and its affiliate, Keystone Mercy Health Plan, serve one-third of all Pennsylvania Medicaid managed care consumers. Our expansive provider networks and the quality of care and service we provide to our members have made our health plans the "plans of choice" in each program we serve, as demonstrated by our market share.
- We offer comprehensive provider networks in the Lehigh/Capital Zone and in Northeastern Pennsylvania, comprised of 28 in-zone hospitals and 73 participating hospitals in total; nearly 1,300 primary care providers; 9,800 specialists (including out-of-area specialists not available in the service area); and more than 900 ancillary providers.
- Our provider recruitment efforts are already underway, and we are confident that, building upon our success in our current service area, we will develop a robust network of participating providers in the New West Zone.

We improve the quality of care and health outcomes for Medicaid consumers by proactively managing and continually measuring the care they receive, ensuring that the care we deliver meets or exceeds the highest nationally accepted standards and benchmarks.

- AmeriHealth Mercy's Integrated Care Management Program uses predictive modeling to proactively identify members at highest risk for adverse health outcomes, enabling us to focus our most intensive interventions on our highest risk members. We rank in the 90th Medicaid HEDIS percentile for >81% of expected prenatal visits and for well-child visits in the first 15 months of life. Additionally, we rank in the 75th percentile on several measures, including prenatal care in the first trimester; mammography screenings for women ages 42-69; and for controlling high blood for persons ages 15-85 with hypertension.
- AmeriHealth Mercy identifies Care Gaps for all members and integrates alerts into all of our information systems so that every employee who touches a member can reinforce the need for specific health services and assist in coordinating needed care – making every contact count. This information is also shared with providers through our secure Provider Portal for print or download into the Electronic Medical Record.

- AmeriHealth Mercy integrates medical and pharmacy data to identify pharmacy related gaps in care. Related achievements include a 14% increase in the number of members with acute coronary events receiving guideline recommended medication.
- AmeriHealth Mercy's Provider Incentive Program measures performance outcomes and rewards providers for quality improvements against established benchmarks. In 2010, our program included financial incentives for improvements in ER utilization rates, access to care, and following HEDIS measures: breast and cervical cancer screening; diabetes care; blood pressure control for members with cardiovascular disease; appropriate use of medications for members asthma; and adolescent well care.

We improve the stability and predictability of Medicaid spending while sustaining quality health outcomes and appropriate benefit levels for Medicaid consumers.

- AmeriHealth Mercy's care management model and aligned provider incentive program continuously deliver benefits to members and to the Commonwealth and its taxpayers. In calendar year 2010, we achieved a 6% reduction in ER utilization, and we have realized a 4.3% reduction in inpatient utilization over the past two years. In 2010, inpatient admissions decreased 47% for members with heart failure, 23% for diabetic members, and 17% for members with chronic obstructive pulmonary disease.
- Our cost containment initiatives have avoided millions of dollars for the Commonwealth. For example, AmeriHealth Mercy's application of clinical edits to professional and outpatient facility claims has saved more than $7 million since 2009, and we are expecting $11 million in savings annually from new enhancements to our fraud, waste and abuse program.

Our programs are person-centered and encourage self-sufficiency and personal responsibility in all health-related and other personal welfare decisions.

- AmeriHealth Mercy's care management programs use a person-centered approach to empower consumers to exercise personal accountability for their health. We take a holistic approach that addresses all areas of social welfare, understanding that social welfare needs directly impact health outcomes. These programs are coupled with consumer incentives, such as gift cards for preventive care screenings and completion of prenatal and postpartum care. These approaches have allowed us to reach the 90th Medicaid HEDIS percentile for the frequency of prenatal care.

We will remain flexible and adaptable to meet the needs of Pennsylvania's Medicaid consumers and providers, DPW, and the Commonwealth's taxpayers. We will continue to offer new, creative solutions for the existing managed care program and we are prepared to offer new service delivery models for Medicaid populations and/or services that are not included in managed care today. We also are prepared to collaborate with DPW on new person-centered benefit designs.

Vista and AmeriHealth Mercy value our collaborative relationship with the Department of Public Welfare, and we are proud to have played a role in the success of the HealthChoices Program. We look forward to building upon our long-standing partnership to expand our programs to the New West Zone.

II-2. Prior Experience – New West Zone

Contents

INTRODUCTION

Vista Health Plan, Inc. (the Offeror) and AmeriHealth Mercy Health Plan (the prime subcontractor to Vista), together with our corporate parents and affiliates, bring unparalleled experience to the development and operation of Medicaid managed care systems. Together, we have been providing managed care services to Medicaid recipients in Pennsylvania and throughout the country for nearly 30 years.

With premier operational and health care capabilities, AmeriHealth Mercy Health Plan ("AmeriHealth Mercy") and its affiliated companies is one of the country's largest Medicaid organizations, serving almost 800,000 members in Medicaid managed care plans in three states, including 106,000 enrollees in the HealthChoices Lehigh/Capital and voluntary managed care programs, and 317,803 enrollees in the HealthChoices Southeast program through our Keystone Mercy Health Plan affiliate. AmeriHealth Mercy also offers other services such as pharmacy benefits management, behavioral health care, and management of medical care to an additional 3.2 million Medicaid, Medicare, and CHIP beneficiaries in 12 states. In addition, we provide expertise in customer service, informatics, information systems, claims management, enrollment, and 24/7 nurse triage support.

AmeriHealth Mercy provides members with access to quality health care through our network providers and through our own health management programs. Our experience serving adults and children in urban and rural areas, and in ethnically diverse communities, provides us with a first-hand opportunity to identify and build upon best practices throughout the country. Our mission of caring for underserved, at-risk populations gives us the advantage of being able to customize our systems and processes to best serve their needs. We have been awarded an Excellent accreditation status from the National Committee for Quality Assurance (NCQA) and we are ranked the #22 Medicaid Health Plan NCQA. Additionally, AmeriHealth Mercy and two of our affiliated health plans are among only six companies nationwide to become early adopters of the Multicultural Health Care (MHC) Distinction program from NCQA.

CORPORATE BACKGROUND

In addition to relevant prior work done by your company, experience shown should include relevant work done by specific individuals who will be assigned to the New West and/or the New East Zones.

a. Corporate Background. *The Offeror must describe the corporate history and relevant experience of the Offeror and any subcontractors. This section must detail information on the ownership of the company (names and percent of ownership), the date the company was established, the date the company began operations, the physical location of the company, and the current size of the company. The Offeror must provide a corporate organizational chart as part of this section. The Offeror must submit, as an appendix, its organization's Articles of Incorporation. If its Articles of Incorporation does not include all the information in Appendix J. Ownership Structure and Related Information, this information must also be provided.*

Offerors must identify any current contracting or subcontracting relationship(s) that may result in a conflict of interest with the requirements of this RFP. Offerors must also abide by the Department's conflict of interest standards identified in ***Appendix E,*** *Standard Terms and Conditions for Services and* ***Appendix F****, Department of Public Welfare Addendum to Standard Terms and Conditions.*

RESPONSE TO CORPORATE BACKGROUND

Vista Health Plan ("Vista") is the Offeror under this proposal. Vista is a licensed Pennsylvania HMO, and an indirect, wholly-owned subsidiary of Independence Blue Cross, the leading health insurer in southeastern Pennsylvania, providing coverage to nearly 3.1 million people. Vista is a current HealthChoices Physical Health contractor in the HealthChoices Lehigh/Capital and Southeast Zones, and in the voluntary managed care program. Vista provides coverage in the Lehigh/Capital Zone through AmeriHealth Mercy Health Plan, and through Keystone Mercy Health Plan in the HealthChoices Southeast Zone.

Through an integrated delivery system agreement, Vista Health Plan will delegate to AmeriHealth Mercy Health Plan all responsibilities under RFP #20-11, except for family planning services and member complaints and grievances.

AmeriHealth Mercy Health Plan ("AmeriHealth Mercy") is a Pennsylvania general partnership wholly owned through subsidiaries by BMH LLC. BMH LLC, a recently formed company, is owned 61.26% by Independence Blue Cross, through its subsidiaries and affiliates, and 38.74% by Blue Cross Blue Shield of Michigan.

AmeriHealth Mercy traces its roots to Mercy Health Plan, which was established in 1982 to serve Medicaid recipients in West Philadelphia. Between 1982 and 1992, Mercy Health Plan expanded to serve Medicaid recipients throughout Philadelphia County and into Berks, Bucks, Chester, Delaware, Lancaster, Lehigh, and Montgomery counties. AmeriHealth Mercy assumed responsibility for the existing operations of Mercy Health Plan in Berks, Lancaster and Lehigh counties in 1997. Today, AmeriHealth Mercy serves more than 106,000 members in the HealthChoices Lehigh/Capital Zone and in five counties in the Voluntary Managed Care Program.

Please see Tables 1 and 2 below for the following information on Vista and AmeriHealth Mercy:

- Ownership (names and %)
- Date established
- Date operations began
- Physical location
- Current size

Table 1: Ownership of the Offeror

Offeror	Vista Health Plan, Inc.
Ownership	Indirect, wholly-owned subsidiary of Independence Blue Cross
Date Company Established	Vista was incorporated on December 18, 1985 and was acquired by Independence Blue Cross on September 21, 1990
Date Company Began Operations	July 1, 2004
Physical Location	Philadelphia, PA
Current Size	423,470 members

Table 2: Ownership of the Prime Subcontractor

Prime Subcontractor	AmeriHealth Mercy Health Plan
Ownership	Partnership of Independence Blue Cross (IBC) and Blue Cross Blue Shield of Michigan (BCBSM). IBC, through its subsidiaries and affiliates, holds a 61.26% ownership interest in BMH LLC, which is the entity that owns AmeriHealth Mercy. BCBSM holds a 38.74% share in BMH LLC.
Date Company Established	1996
Date Company Began Operations	1997
Physical Location	Corporate Headquarters in Philadelphia, PA Regional Office in Harrisburg, PA
Current Size	106,470 members

Please see Attachment 1 for our corporate organizational charts depicting the ownership structure of Vista Health Plan and of AmeriHealth Mercy Health Plan.

The Vista Health Plan Articles of Incorporation are provided in Attachment 2.

The information required in Appendix J, Ownership, Structure and Related Information is provided at the end of this section.

Vista Health Plan and AmeriHealth Mercy Health Plan do not have any current contracting or subcontracting relationships that may result in a conflict of interest with the requirements of RFP #20-11. As a current HealthChoices contractor, we currently comply, and will continue to comply, with DPW's conflict of interest standards identified in Appendix E, Standard Terms and Conditions for Services and Appendix F, Department of Public Welfare Addendum to Standard Terms and Conditions.

CORPORATE EXPERIENCE

b. Corporate Experience. *The Offeror must describe its experience providing similar services, including the name, address, and telephone number of the responsible*

official of the customer, company, or agency who may be contacted. This section of the proposal must include a description of the Offeror's:

i. Qualifications and experience with Medicaid managed care systems;
ii. Qualifications and experience operating any managed care medical program; and
iii. Experience with other Commonwealth agencies.

The Offeror must also submit ***Appendix G****, Offeror's Managed Care Experience. If the Offeror has no prior experience as referenced above, explain what qualification or past experiences may serve as a substitute.*

RESPONSE TO CORPORATE EXPERIENCE

Qualifications and Experience with Medicaid Managed Care Systems

AmeriHealth Mercy, together with our corporate parents and affiliates, brings unparalleled experience to the development and operation of Medicaid managed care systems. Together, we have been providing managed care services to Medicaid recipients in Pennsylvania and throughout the country for nearly 30 years.

AmeriHealth Mercy's experience with Medicaid managed care systems is described immediately below, followed by a summary of the Medicaid managed care experience of AmeriHealth Mercy's affiliates in Table 4. The information requested in Appendix G, Offeror's Managed Care Experience, is provided in Attachment 3.

AmeriHealth Mercy Health Plan

AmeriHealth Mercy first began serving Pennsylvania's Medicaid population in 1982 through our predecessor, Mercy Health Plan. From our beginnings in Lancaster, Berks and Lehigh counties, we have expanded to serve 106,000 Medicaid consumers in the HealthChoices Lehigh/Capital Zone and five voluntary managed care counties in northeastern Pennsylvania (Carbon, Lackawanna, Luzerne, Monroe, and Pike).

As a testament to the strength of the services and programs we offer to our members and providers in the HealthChoices Lehigh/Capital Zone, our membership has more than tripled since 2001 and our provider network has grown dramatically to keep pace with our increased membership. Currently, AmeriHealth Mercy enrolls 33 percent of the total HealthChoices eligible population in the Lehigh/Capital Zone. Our HealthChoices Lehigh/Capital and voluntary managed care members benefit from our comprehensive provider network comprised of 28 area hospitals and 73 participating hospitals in total; nearly 1,300 primary care providers; 9,800 specialists (including out-of-area specialists not available in the service area); and more than 900 ancillary providers. Our network relationships with children's hospitals and major tertiary facilities are particularly important in caring for our most medically complex members.

AmeriHealth Mercy serves many of the most medically fragile members in the HealthChoices program. We currently provide home and community-based shift nursing services to more than 231 children in the HealthChoices Lehigh/Capital and voluntary managed care programs. More than 1,700 AmeriHealth Mercy members are enrolled in our Care Coordination program through which they receive guidance and support in managing the following conditions: Asthma; Diabetes; Cardiovascular Disease (Health Failure/Heart Risk); HIV/AIDS; Sickle Cell; Hemophilia; and Pregnancy with co-morbid conditions. Members with multiple chronic illnesses are enrolled in our Intensive Case Management Program where they receive intensive interventions through an interdisciplinary team consisting of our Care Managers, Medical Director, pharmacists, and practicing physicians. External agencies involved in the members' care also participate on the care team as needed.

AmeriHealth Mercy uses state-of-the-art technology to identify members at-risk for future adverse health events and engage them in our Care Coordination Program. Looking even deeper, we use technology proactively to identify care gaps that if not addressed, could result in an otherwise avoidable ER admission or hospitalization. We have taken these efforts outside our own organization with our deployment of the Member Clinical Summary (MCS) to participating

hospital ERs. The MCS is a web-based electronic medical record that integrates claims data, pharmacy data, and care gap data, and presents the information in a usable format to the treating physician or provider. We also make this electronic medical record available to our participating ERs, so that the treating ER physician is better able to care for our members, minimizing the likelihood of a repeat ER visit.

AmeriHealth Mercy is fully integrated in the communities we serve. Recognizing that healthcare is local, we have maintained our centrally located office in Harrisburg since 2001. We perform all medical management, provider network management, and health education and outreach functions from this location. We staff this office with associates who live in communities throughout the counties we serve, and by virtue of living and working in the region, are familiar with regional differences in healthcare delivery and the needs of the community. Our Provider Contracting and Community Outreach Representatives spend the majority of their time in the field, meeting with our members and providers. Our Medical Management team members also spend considerable time in the community, meeting with participating providers and working directly with our members, completing home visits and even accompanying members to medical appointments. If awarded new contracts to serve the New West and New East Zones, we will supplement our existing staff with provider contracting representatives and outreach representatives who live and work in these additional counties.

From January to December 2011, AmeriHealth Mercy provided more than 170 community-based health education workshops in the HealthChoices Lehigh/Capital Zone. These self-empowerment educational workshops cover chronic conditions that are part of the DPW's MCO Pay-for-Performance program, and our Provider Pay-for-Performance program, including asthma, diabetes, heart health, women's health, maternity education, and poison prevention (including lead poisoning), and childhood obesity, medication safety, teen health and youth sports safety.

We understand the unique cultural and linguistic landscape of the regions we serve, and have implemented health education and outreach programs to promote health equity. For example, our Healthy Hoops program uses basketball as a platform to educate young asthmatics and their families in African-American communities about asthma management. This innovative program received the 2006 NCQA CLAS award for Recognizing Innovation in Multi-Cultural Healthcare. Likewise, we offer our Women's Wellness program and our Healthy You, Healthy Me childhood obesity program through partnerships with community organizations, community health centers, and school-based clinics primarily serving African-American and Hispanic members.

AmeriHealth Mercy's experience as a current contractor under the HealthChoices Lehigh/Capital Program also provides us with the practical experience necessary to meet all DPW contract requirements and DPW's expectations, from day-one of the new Agreement period. We have an excellent record of meeting DPW's requirements and expectations in the following areas:

- Claims processing timeliness
- Encounter data reporting
- Provider network access standards
- Member services hotline (average speed of answer and abandonment rate)
- Member enrollment procedures
- Timeliness of utilization review decisions
- Timely processing of member complaints and grievances
- Compliance with state reporting requirements

Finally, we make every effort to establish and maintain a collaborative working relationship with DPW. We strive to provide high quality customer service by offering timely, accurate and complete responses to all inquiries and information requests, and by keeping DPW apprised of important developments.

AmeriHealth Mercy's expansion into the New West and New East Zones will be led by a highly experienced team of Medicaid managed care professionals who currently manage our HealthChoices Lehigh/Capital and voluntary managed care programs. Perhaps most importantly, our Executive Director for AmeriHealth Mercy, and our Chief Medical Officer, have extensive managed care experience.

Marge Angello, RN, is the Executive Director of AmeriHealth Mercy and will lead our expansion into the New West and New East Zones. Ms. Angello led utilization management and patient care management departments at AmeriHealth Mercy and Keystone Mercy, our southeast Pennsylvania affiliate, for more than ten years. Ms. Angello has nearly 30 years of managed care experience working for health plans.

Eric Berman, DO, is the Chief Medical Officer for AmeriHealth Mercy. Dr. Berman has served in this role since 2009. Dr. Berman has more than 11 years' experience serving as a Medical Director in a variety of health plan settings.

Please see Section II-3. Personnel for more information about the highly experienced team that will lead AmeriHealth Mercy's expansion into the New West and New East Zones.

Agency Official to Contact for further information on AmeriHealth Mercy:
Gary Alexander
Secretary, Pennsylvania Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17120
(717) 787-2600

Medicaid Managed Care Experience of AmeriHealth Mercy Affiliates

The following table summarizes the qualifications and experience of other AmeriHealth Mercy affiliates related to Medicaid managed care programs.

Table 4: Qualifications and Experience of AmeriHealth Mercy Affiliates

AmeriHealth Mercy Health Plan Affiliate	Agency/Customer to Contact
Keystone Mercy Health Plan Keystone Mercy Health Plan, through its predecessor Mercy Health Plan, has served Medicaid recipients in what is now the Southeast Zone since 1983. Keystone Mercy currently serves more than 317,000 Medicaid recipients in Pennsylvania through the HealthChoices Southeast Program. Keystone Mercy has an Excellent accreditation status from NCQA and is rated the #25 Medicaid Health Plan in America.	Gary Alexander Secretary, Pennsylvania Department of Public Welfare P.O. Box 2675 Harrisburg, PA 17120 (717) 787-2600
PerformRx, LLC PerformRx provides comprehensive pharmacy benefit management services for more than 3.2 million covered lives	Patricia Tanquary, MPH, PhD Chief Executive Officer 595 Center Avenue, Suite 100

AmeriHealth Mercy Health Plan Affiliate	Agency/Customer to Contact
nationwide, with unique expertise in Medicaid and Medicare Part D. PerformRx programs include network management, audit service, utilization management, formulary design, rebate management, prior authorization, call center, mail pharmacy, and specialty pharmacy. PerformRx is among the first companies to have received accreditation under URAC's Pharmacy Benefit Management Standards.	Martinez, CA 94553 (925) 313-6004
Community Behavioral Health Network of Pennsylvania (CBHNP) CBHNP is a full-service behavioral health managed care company that supports over 1 million members nationwide through specialized behavioral health and human service programs in the public and private sector. CBHNP currently serves approximately 200,000 Medicaid recipients in 12 counties in Pennsylvania through the HealthChoices Behavioral Health Program. CBHNP has been awarded full accreditation by the National Committee for Quality Assurance (NCQA), which is the highest level of NCQA accreditation.	Scott Suhring CEO, Capital Area Behavioral Health Collaborative 2300 Vartan Way, Suite 206 Harrisburg, PA 17110 (717) 671-7289
Passport Health Plan AmeriHealth Mercy has provided administrative services for Passport Health Plan, the Medicaid HMO of University Health Care in 16 counties in the Louisville region of Kentucky, since November 1, 1997. Passport manages the delivery of health care services for 140,000 TANF, TANF-related and SSI members through Kentucky's mandatory Medicaid managed care program. In addition, Passport provides services to CHIP members and sponsored a Dual Eligible Special Needs Plan through December 31, 2011. NCQA has awarded Passport an Excellent accreditation status and has rated it the #13 Medicaid health plan in America. PerformRx also provides pharmacy benefit management services for Passport.	Mark Carter Chief Executive Officer Passport Health Plan 5100 Commerce Crossings Drive Louisville, KY 40229 (502) 585-8580
Select Health of South Carolina Select Health, a wholly owned subsidiary of AmeriHealth Mercy Health Plan, provides Medicaid managed care services to 225,000 TANF, SSI and CHIP members in South Carolina. Select Health has earned an Excellent Accreditation status from NCQA and is one of the first six plans in the nation to be awarded NCQA's Multicultural Healthcare Distinction.	Anthony Keck Director, Dept. of Health and Human Services P.O. Box 8206 Columbia, SC 29202 (803) 898-3929
MDwise Hoosier Alliance	Charlotte MacBeth,

AmeriHealth Mercy Health Plan Affiliate	Agency/Customer to Contact
MDwise Hoosier Alliance provides managed care services for 140,000 Indiana Medicaid members in partnership with MDwise, Inc.	President, MDwise, Inc. 1200 Madison Avenue Suite 400 Indianapolis, IN 46225 (317) 822-7116

Qualifications and Experience Operating any Managed Care Medical Program

Together with our owners and affiliates, AmeriHealth Mercy has extensive experience managing CHIP programs in and outside of Pennsylvania, as well as programs for the uninsured in Pennsylvania (adultBasic) and Indiana. Our affiliated health plans also have managed Medicare Advantage D-SNP programs, and our Pharmacy Benefit Management company, PerformRx, manages Medicare Part D pharmacy programs. Table 4 above includes a description of our affiliated health plans' experience serving CHIP, and Medicare Advantage D-SNP members, and also describes the managed care experience of our Pharmacy Benefit Management company, PerformRx. The managed care experience of Vista and its corporate parents and affiliates, and the experience of BCNEPA and its affiliates, is also described above in the Introduction and Corporate Background sections of our response.

Experience with Other Commonwealth Agencies

Through our participation in the Pennsylvania Medicaid Program, AmeriHealth Mercy has developed strong, effective partnerships with Commonwealth agencies that share our mission of helping people get care, stay well, and build healthy communities. These include other offices within DPW, such as the Office of Income Maintenance and the County Assistance Offices, the Office of Children, Youth and Families, and the Office for Developmental Programs. We also work with the Department of Education through the school districts to coordinate care for children with special needs and to offer programs on asthma and childhood obesity. We work with the Department of Aging to coordinate PDA Waiver Services and with the Department of Health and local health departments on a variety of health promotion activities.

- **Office of Children, Youth and Families (OCYF) -** AmeriHealth Mercy works closely with the OCYF within our region to coordinate care for our members. Our Special Needs Unit affords OCYF a single point of contact to make it easy for them to communicate with us. The Special Needs Unit also maintains regular contact, provides trainings upon request, and works with County Children and Youth Agencies as needed for member-specific coordination of care. In addition to coordinating screenings and immunizations, our staff coordinate dental, behavioral health, shift nursing, maternity care, infant wellness, and other health needs. Our staff also frequently assists OCYF staff and foster parents with obtaining out-of-area care for members who have been placed outside of the Lehigh/Capital Zone, but who have not yet been disenrolled from AmeriHealth Mercy. In addition, we help educate OCYF staff and foster parents about covered benefits and how to use Medicaid managed care services.
- **Office of Developmental Programs (ODP) -** We work with the ODP to facilitate waiver services for eligible members. These waiver programs provide the opportunity for members to receive additional benefits, resources, and community supports to remain in the

community and in their home. We make a particular effort to make appropriate transitions for members who will be "aging out" of the EPSDT program, since shift nursing services are not covered for members age 21 and older under the Medicaid Program. We communicate with caregivers and providers, arrange for an assessment to make sure the member can still stay in a community setting safely, and arrange services so that members have a smooth transition into waiver programs.

- **Department of Health -** We work with the state Department of Health and local health departments to share information on blood lead screening, and we collaborate with local health departments on a variety of priority health issues, including but not limited to diabetes, childhood obesity, dental screening, and more.
- **Department of Aging -** We work with the Area Agencies on Aging to coordinate Options Assessments for members who may qualify for the PDA Waiver Program, allowing them to receive services in their homes instead of in nursing facilities.
- **Department of Education -** AmeriHealth Mercy works with individual school districts to coordinate care for children with special needs, especially those who require shift nursing during school hours. We also have partnered with schools to offer asthma education and training for school nurses, and to develop and implement programs to combat childhood obesity. Additionally, we frequently partner with Head Start Agencies to provide health education programs for our members and their parents.

"This partnership with AmeriHealth Mercy is going to change the health for our students and generation to come. The team has been kind, professional, and a blessing to our school."
*- **Ms. Anne Clark**, Title One parent advisory council member for Pennsylvania Department of Education.*

- **Office of Income Maintenance/County Assistance Offices (CAOs) -** AmeriHealth Mercy works closely with the CAOs in the Lehigh/Capital Zone to help guide members through the eligibility re-determination process. Our collaboration in this area is led by our Member Retention Unit, which is staffed by former cash assistance recipients. In speaking with our members and the CAOs, we learned that many members lose Medicaid eligibility temporarily only because they do not complete their Medicaid re-determination packages on time. Also, we learned that the re-determination documents can be daunting, especially for members with limited English proficiency. Our Member Retention Unit works with our members and the CAOs to facilitate the timely completion of this process, which will eliminate eligibility gaps that result in gaps in care.

REFERENCES

c. References. *The Offeror must provide a list of at least three (3) relevant contracts within the past three (3) years to serve as corporate references. This list shall include the following for each reference:*

i. *Name of contractor*
ii. *Type of contract*
iii. *Contract description, including type of service provided*
iv. *Total contract value*
v. *Contracting officer's name and telephone number*
vi. *Role of subcontractor(s) (if any)*
vii. *Time period in which service was provided*

The Offeror must submit ***Appendix H,*** *Corporate Reference Questionnaire****,*** *directly to the contacts listed. The references should return completed questionnaires in sealed envelopes to the Offeror. The reference individual should sign their name over the seal.*

The Offeror must include these sealed references with its proposal.

RESPONSE TO REFERENCES

AmeriHealth Mercy Health Plan has solicited corporate references from the individuals listed in Attachment 4. Copies of the completed Appendix H, Corporate Reference Questionnaires are provided in Attachment 5. Please also see Attachment 6 for copies of letters of support for AmeriHealth Mercy from participating providers and community agencies.

RFP ATTACHMENT J – OWNERSHIP STRUCTURE AND RELATED INFORMATION

The Offeror must include, at a minimum, the following:

1. **Narrative explanation of its ownership structure**
   Vista Health Plan, Inc. ("Vista"), as the licensed managed care company, is the Offeror under this proposal. Vista is a for-profit, licensed managed care company writing business and domiciled in the Commonwealth of Pennsylvania. All outstanding shares of Vista are owned by AmeriHealth HMO, Inc., which is a wholly-owned subsidiary of AmeriHealth Integrated Benefits, Inc., which is a wholly owned subsidiary of AmeriHealth, Inc. Vista's ultimate parent is Independence Blue Cross.

   Vista will delegate all responsibilities under this proposal, with the exception of member complaints and grievances and family planning services, to AmeriHealth Mercy Health Plan.

   AmeriHealth Mercy Health Plan ("AmeriHealth Mercy") is a Pennsylvania general partnership wholly owned through subsidiaries by BMH LLC. BMH LLC, a recently formed company, is owned 61.26% by Independence Blue Cross, through its subsidiaries and affiliates, and 38.74% by Blue Cross Blue Shield of Michigan.

   Organizational charts depicting the ownership structure of Vista and AmeriHealth Mercy and are provided in Attachment 1.

2. **A description of any anticipated merger and the impact on ownership structure.**

   There are no anticipated mergers.

3. **A copy of any executed merger agreement.**

   Not applicable.

4. **A copy of the Articles of Incorporation.**

   A copy of the Vista Articles of Incorporation is provided in Attachment 2.

5. **All related organizational documents.**

   A copy of Vista's bylaws in provided in Attachment 7.

6. **A copy of any guaranty agreement.**

   A copy of Independence Blue Cross' Parental Financial Guarantee of certain portions of Vista business is provided in Attachment 8.

7. **Copy of contractual or other arrangements with any affiliate (including Parent, and other affiliates) to which Offeror is bound and/or which imposes fees on Offeror to affiliate.**

   Copies of contractual or other arrangements with Vista affiliates to which Vista is bound and/or which imposes fees on Vista to an affiliate are provided in Attachment 9. Please also see our response to Question 17 below.

8. Breakdown of financial statement amounts due to and from Offeror's affiliates.

The following is a breakdown of financial statement amounts due to and from Vista's affiliates:

As of September 30, 2011, the amount due from parents, subsidiaries, and affiliates was $131. This amount represents the receivable for support services provided by QCC Insurance Company.

As of September 30, 2011 the amounts due to affiliates was $222,626,982. This primarily represents funds due from the Department of Public Welfare for capitation and the Health Quality Care assessment program, net of the gross receipts tax that is due to Keystone Mercy Health Plan and AmeriHealth Mercy Health Plan upon receipt. This balance also includes money owed to Keystone Health Plan East, an affiliate of Vista, and represents family planning claims paid by Keystone Health Plan East, charged to Vista, and then billed back to AmeriHealth Mercy Health Plan and Keystone Mercy Health Plan. The smaller amounts owed to Independence Blue Cross and AmeriHealth HMO are for some of the supporting services that are performed for AmeriHealth Mercy Health Plan and Keystone Mercy Health Plan.

9. Copies and explanations of any payments made to Offeror's affiliates.

The amounts referenced in our response to Question 8 are short term balances incurred in the normal course of operations and are settled on a monthly or quarterly basis. There are no other payments or long term debt obligations reflected in these balances.

10. Narrative of any trust arrangement.

There is no trust arrangement.

11. Disclosure of prior suspensions or debarment by state or federal or any other government involving the proposer of any affiliate.

Neither Vista and its affiliates, nor AmeriHealth Mercy and its affiliates, have ever been suspended or debarred by any state or federal or any other government entity.

12. Narrative on any pending lawsuits or investigations involving the Offeror or any affiliate.

Below is a narrative of each material pending lawsuit that could affect Vista or the Medical Assistance program and any investigation that could affect Vista or its affiliates. Any other pending lawsuits are not material and arise in the ordinary course of business.

Avrum Baum vs. Keystone Mercy Health Plan and AmeriHealth Mercy Health Plan, Philadelphia Court of Common Pleas, January Term 2011, No. 003876. Putative Class Action alleging negligence and breach of Pennsylvania unfair trade practice/consumer protection law for alleged disclosure of personal health information (PHI). Case was recently removed to Federal Court (U.S.D.C., E.D. Pa, Case Number 2:11-CV-01261-AB) and a Motion to Dismiss the Complaint was filed on March 2, 2011. (In-house reserves established.) Complaint seeks statutory damages (based upon Pennsylvania Law) as well as compensatory damages in excess of Fifty Thousand Dollars ($50,000).

Teresa Sims v. Passport Health Plan, Jefferson Circuit Court, Kentucky. Plaintiff is a former AmeriHealth Mercy Health Plan employee hired to support Passport Health Plan, a Kentucky

Medicaid health plan for which AmeriHealth Mercy Health Plan provides certain administrative and management services pursuant to an administrator agreement. Plaintiff is claiming she was unlawfully terminated due to her disability and that AmeriHealth Mercy Health Plan failed to accommodate her disability under Kentucky law. She is seeking compensatory damages along with front and back pay and benefits. (In-house reserves established.)

PharmMD v. Denise Kehoe and PerformRx, LLC, Davidson County, Tennessee, No. 11-331-IV. This Complaint was filed in Tennessee State Court (it was subsequently removed to Federal Court - Middle District of Tennessee) by the former employer of Denise Kehoe who was an employee of PerformRx at the time the suit was filed. The suit seeks to enforce an employment agreement Ms. Kehoe signed with PharmMD which contained non-disclosure, non-solicitation and non-competition covenants. The Complaint seeks equitable remedies and unspecified damages. (In-house reserves established.)

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

13. Information which identifies any parent corporation ownerships and relationship status (direct or indirect).

Please see our response to Question 1. An organization chart depicting the ownership structure is provided in Attachment 1.

14. Amounts on first quarter filing with Department of Labor.

We understand this question requests filings with the United States Department of Labor. Vista does not make any such filings. On a monthly basis, AmeriHealth Mercy Health Plan reports to the Bureau of Labor and Statistics the number of AmeriHealth Mercy Health Plan employees as of the 12th day of that month. The most recent filing by AmeriHealth Mercy Health Plan, indicates that there were 94 AmeriHealth Mercy Health Plan employees in the Lehigh/Capital Zone.

15. Information on intermediary subsidiary which holds Offeror's stock (indirect only).

All outstanding shares of Vista are owned by AmeriHealth HMO, Inc., which is a wholly-owned subsidiary of AmeriHealth Integrated Benefits, Inc., which is a wholly-owned subsidiary of AmeriHealth, Inc. Vista's ultimate parent is Independence Blue Cross. For additional information regarding Vista's ownership structure, please refer to Questions 1 and 13 above.

16. Statement on whether any affiliates will be a subcontrator.

Vista will delegate all responsibilities under this proposal, with the exception of member complaints and grievances and family planning services, to AmeriHealth Mercy Health Plan. Responses to Questions 1 and 13 above describe the affiliated relationship between Vista and AmeriHealth Mercy Health Plan.

AmeriHealth Mercy will subcontract pharmacy benefit management services to its wholly-owned subsidiary PerformRx, LLC.

17. Identification of the affiliate(s) receiving management fees and copies of any such contractual arrangements.

In addition to the arrangements described in our responses to Questions 7, 8 and 9 above, Vista remits payments to AmeriHealth Mercy Health Plan for the administration of all responsibilities under the HealthChoices New West Program, with the exception of member complaints and grievances and family planning services, which are not delegated by Vista. Vista retains a portion of the payments it receives from the Department of Public Welfare for the administration of the member complaints and grievances process and for the provision of family planning services.

A copy of the Integrated Delivery Systems Agreement between Vista and AmeriHealth Mercy is provided in Attachment 10.

II-3. PERSONNEL

CONTENTS

INTRODUCTION

AmeriHealth Mercy understands that success in managing the delivery of health care services is contingent upon the implementation of a strong, effective organizational structure made up of experienced, talented professionals. A broad set of technical and managerial skills is required to deliver an effective, high-quality Medicaid managed care program. In addition, key personnel must truly understand the unique requirements of the Medicaid Program and the people it serves.

AmeriHealth Mercy has a strong, experienced executive management team and key administrative personnel in place to manage our existing HealthChoices Lehigh/Capital and contract and our proposed expansion in the New West and New East Zones.

EXECUTIVE MANAGEMENT

a. Executive Management (Section V.M of the draft Agreement)

Full time positions for executive management as described in V.M. of the draft Agreement mean full time positions dedicated to the Medicaid Managed Care Program in Pennsylvania.

For the Chief Executive Officer, Chief Operations Officer, Chief Financial Officer, Chief Medical Officer, Pharmacy Director, HealthChoices Program Manager and the Chief Information Officer, please provide the following information for each position:

1. *Describe the executive's role in the organization.*
2. *During the most recent 36 months, how many months was this position not filled by an employee permanently assigned to the position? During the most recent 36 months, how many different people filled this position?*
3. *Describe the level of effort he/she provides related to each of the major program areas of contract management, financial management, quality management, utilization management, data management, consumer services and provider utilization.*

For all management positions specifically identified in your proposal, including the executive management positions listed above, provide:

- *Résumés of the management personnel already employed by the organization as an appendix to your proposal.*
- *A job description for each management position for the proposed organizational structure for the HealthChoices NW and/or NE programs.*
- *Specify where management personnel will be physically located during the time they are engaged to work.*

RESPONSE TO EXECUTIVE MANAGEMENT

Table 1 provides the names of the persons holding the Executive Management positions outlined in Section V.M of the draft Agreement, as well as the information requested in Section II-3.a of the RFP. Resumes and job descriptions for these individuals are provided in Attachment 1.

Please note in our responses below that AmeriHealth Mercy combines the Chief Executive Officer/Administrator and the Chief Operating Officer/HealthChoices Program Manager as one position, under the leadership of Marge Angello, RN, Executive Director of AmeriHealth Mercy Health Plan.

Table 1: Executive Management

Chief Executive Officer/Administrator	Marge Angello, RN
Role	Ms. Angello is responsible for planning, oversight, and operational management of AmeriHealth Mercy's Pennsylvania HealthChoices and voluntary managed care contracts. Ms. Angello is charged with the oversight and management of hospital, physician and ancillary contracting; community relations and public affairs; utilization management, care coordination, and quality management.
Past 36 months	Ms. Angello has held this position on a full-time basis since April 2010.
Level of effort related to each major program area	100% of Ms. Angello's time is focused exclusively on our Pennsylvania Medical Assistance lines of business.
Location	Harrisburg, PA

Note: AmeriHealth Mercy does not have a separate Chief Operating Officer/HealthChoices Program Manager position. These roles are combined under the CEO/Administrator role held by Marge Angello, RN, Executive Director of AmeriHealth Mercy Health Plan.

Chief Financial Officer	Open
Role	The Chief Financial Officer (CFO) is responsible for managing all of the financial aspects of our Pennsylvania Medical Assistance contracts, including contract and rate negotiations with the Department of Public Welfare. The CFO also ensures that all written financial policies are updated as needed and monitors budget compliance to assure that operational performance results are achieved. The CFO coordinates all financial information with the Regional President of the Corporate finance department.
Past 36 months	The CFO position was held on a full-time basis by Russell. Gianforcaro from December 2006 – July 2010. Mr. Gianforcaro assumed the Chief Accounting Officer position in our corporate office in July 17, 2010, but has maintained his responsibility as the acting CFO for our Pennsylvania Medical Assistance contracts while we conduct a national search to identify his successor, who will be 100% dedicated to our Pennsylvania Medical Assistance lines of business.
Level of effort related to each major program area	100% of the CFO's time is dedicated to our Pennsylvania managed care contracts. As noted above, we are engaged in a national search to identify a successor to Mr. Gianforcaro to fill this position on a full-time basis, exclusively dedicated to our Pennsylvania Medical Assistance lines of business.
Location	Philadelphia, PA

Chief Medical Officer	Eric Berman, D.O.
Role	Dr. Berman is directly responsible for the Medical Management division of our Pennsylvania Medical Assistance business, including medical management initiatives such as utilization, quality, care management, and disease management.
Past 36 months	Dr. Berman has held this position on a full-time basis since February 2009. Prior to Dr. Berman's tenure, this position was filled with one other individual, Dr. Jay Feldstein, in the past 36 months. Dr. Feldstein has since accepted the position of Regional President, Northern Division, for AmeriHealth Mercy.
Level of effort related to each major program area	100% of Dr. Berman's time is focused exclusively on our Pennsylvania Medical Assistance lines of business.
Location	Philadelphia, PA

Pharmacy Director	Jeffrey Kreitman, Pharm. D.
Role	Dr. Kreitman oversees and monitors all aspects of AmeriHealth Mercy's Pharmacy operations, including the agreement with PerformRx to perform Pharmacy Benefit Management Services. He collaborates with medical affairs to conceive, design, and implement quality improvement and cost containment pharmacy initiatives to more effectively manage overall member care. He monitors drug utilization trends and supports pharmacy prior authorization activities for complex members. Dr. Kreitman also plans and implements provider and member education initiatives.
Past 36 months	Mr. Kreitman has held this position with AmeriHealth Mercy since July 2006.
Level of effort related to each major program area	100% of Mr. Kreitman's time is focused exclusively on our Pennsylvania Medical Assistance lines of business.
Location	Harrisburg, PA

Information Systems Coordinator	Gail Gatto
Role	Gail Gatto is responsible for enterprise wide planning, operations, and delivery of information technology services for AmeriHealth Mercy's Pennsylvania plans. She leads technology efforts to support administrative and medical management initiatives; efforts to improve efficiency, effectiveness and collaboration through technology; and coordinates with all corporate applications, data center, solution development, architecture, help desk, electronic commerce, telecommunications, data warehouse, and information reporting.
Past 36 months	Ms. Gatto has occupied this position since April of 2011. Prior to that time, oversight for the PA plans was the responsibility of the corporate Chief Information Officer, Michael O. Willis, in conjunction with the management team of the corporate Information Solutions department. In April of 2011, the department was reorganized and a new Business Engagement area was created. It is through this team that the PA plans are now receiving full-time support through a dedicated coordinator.
Level of effort related to each major program area	100% of Ms. Gatto's time is focused exclusively on our Pennsylvania Medical Assistance lines of business.
Location	Philadelphia, PA

KEY ADMINISTRATIVE POSITIONS

b. Key Administrative Positions (Section V.N of the draft Agreement)

In this section, the Offeror must identify the name and position of the person authorized to finalize an Agreement with the Department, and the name and position of the person who will have ultimate responsibility and accountability for the Agreement should one be entered into.

In addition, for each of the key administrative positions/functions listed below, provide the following information:

1. *Attach a job description that includes minimum education for each staff position identified in the offeror's proposal for the proposed organizational structure for the HealthChoices NW and/or NE program.*
2. *Specify where these personnel will be physically located during the time they are engaged to work.*

Key Administrative Positions/Functions

- *Quality Management Coordinator*
- *Utilization Management Coordinator*
- *Full-Time (FT) Special Needs Coordinator*
- *FT Government Liaison*
- *Maternal Health/EPSDT Coordinator*
- *Member Services Manager*
- *Provider Services Manager*
- *Complaint, Grievance and Department Fair Hearing Coordinator*
- *Claims Administrator*
- *Contract Compliance Officer*
- *Other key personnel identified by Offeror*

For ease of reference, Offerors may use the chart in Appendix I, Executive Staff and Key Administrative Personnel Checklist, to ensure that their response provides all the documents and information pertaining to the Executive Management and Key Administrative positions and functions discussed in this section.

Board Members

The Offeror must describe the role of board members in governance and policy making and specify the manner in which MA consumers are to be represented in an advisory and/or decision making capacity for the HealthChoices NW and/or NE Zones. In accordance with Pennsylvania Department of Health regulations, one-third of the board's membership must be "subscribers" of the MCO.

RESPONSE TO KEY ADMINISTRATIVE POSITIONS

Steven Udvarhelyi, MD, President and Chief Executive Officer of Vista Health Plan, is authorized to finalize an Agreement with the Department and has ultimate responsibility and accountability for an Agreement, should one be entered into.

Table 2 provides the names and work locations of the persons holding the key administrative positions outlined in RFP #20-11. Resumes and job descriptions for these individuals are provided in Attachment 2.

Table 2: Key Administrative Positions

Key Administrative Position	Person Holding Position	Physical Location
Quality Management Coordinator	Lori McNew, RN, MHA, MBA	Harrisburg, PA
Utilization Management Coordinator	Jessica Yasher, RN, BSN	Harrisburg, PA
Full Time Special Needs Unit Coordinator	Danielle Thompson, MSW	Harrisburg, PA
Full Time Government Liaison	Ellan Baumgartner	Philadelphia, PA
Maternal Health/EPSDT Coordinator	Sharon Griffiths, RN, BC, CCN	Harrisburg, PA
Member Services Manager	Sandra Duffy	Philadelphia, PA
Provider Services Manager	Steve Orndorff	Harrisburg, PA
Complaint, Grievance and Department Fair Hearing Coordinator	Stephanie Curtis, RN	Philadelphia, PA
Claims Administrator	Sandra Duffy	Philadelphia, PA
Contract Compliance Officer	Laura Herzog	Philadelphia, PA

Board Members

AmeriHealth Mercy is governed by a Partnership Board whose members are appointed by AmeriHealth Mercy's partners. The Partnership Board's exclusive commitment is to the Medical Assistance members enrolled in AmeriHealth Mercy. It is responsible for ensuring that the AmeriHealth Mercy management team operates in accordance with the missions of our founding organizations. The President and Chief Executive Officer of AmeriHealth Mercy Health Plan reports to the Partnership Board on all areas of AmeriHealth Mercy's performance, including the provision of medical services, operational support functions, quality management, financial management, and regulatory compliance.

Medicaid consumers are represented in an advisory capacity to AmeriHealth Mercy and the Partnership Board through our Health Education Advisory Committee (HEAC). The HEAC is a

diverse panel of community leaders, health care providers and Pennsylvania Medicaid consumers. The HEAC meets quarterly to help ensure promotion of the mission of AmeriHealth Mercy, The findings and recommendations of the HEAC are reported to the Partnership Board.

As required by Department of Health regulations, one-third of the Vista Health Plan Board will be members.

ORGANIZATION

The Offeror must submit a current or proposed org chart so that a determination can be made as to whether the overall organizational structure reflects usual and customary business practices consistent with other managed care programs operating in the Commonwealth. Offerors need not duplicate but may cross-reference org charts provided elsewhere in the proposal.

RESPONSE TO ORGANIZATION

Operational Structure

AmeriHealth Mercy's organizational structure has been developed in alignment with the strategic direction that guides all of our affiliate plans, and in conjunction with the specific requirements of the DPW contract. This organizational structure is illustrated below. This structure highlights the functions that will be performed at the local, regional, and corporate levels. AmeriHealth Mercy's proven business processes, technology platform, and operational policies and procedures will be crucial to the success of the new Pennsylvania Zones. In addition to our strong existing team in the Harrisburg market, our regional and corporate resources, as part of our dedicated implementation team, will provide training and support to ensure a smooth implementation.

Local Office

In keeping with our strategy of an "enterprise reach with a local touch," AmeriHealth Mercy's core member-and-provider-facing functions are performed at the local level in each of our markets. For the New West and New East HealthChoices Zones, we will continue to build on our existing operational presence in Harrisburg. Figure 1 below shows the existing AmeriHealth Mercy Health Plan organizational chart that will be expanded with the addition of new members from the New West and New East Zones. Following Figure 1 in Table 3 is a full listing of all of the functions that are and will continue to be performed at the local office.

AmeriHealth Mercy Health Plan
Organizational Chart

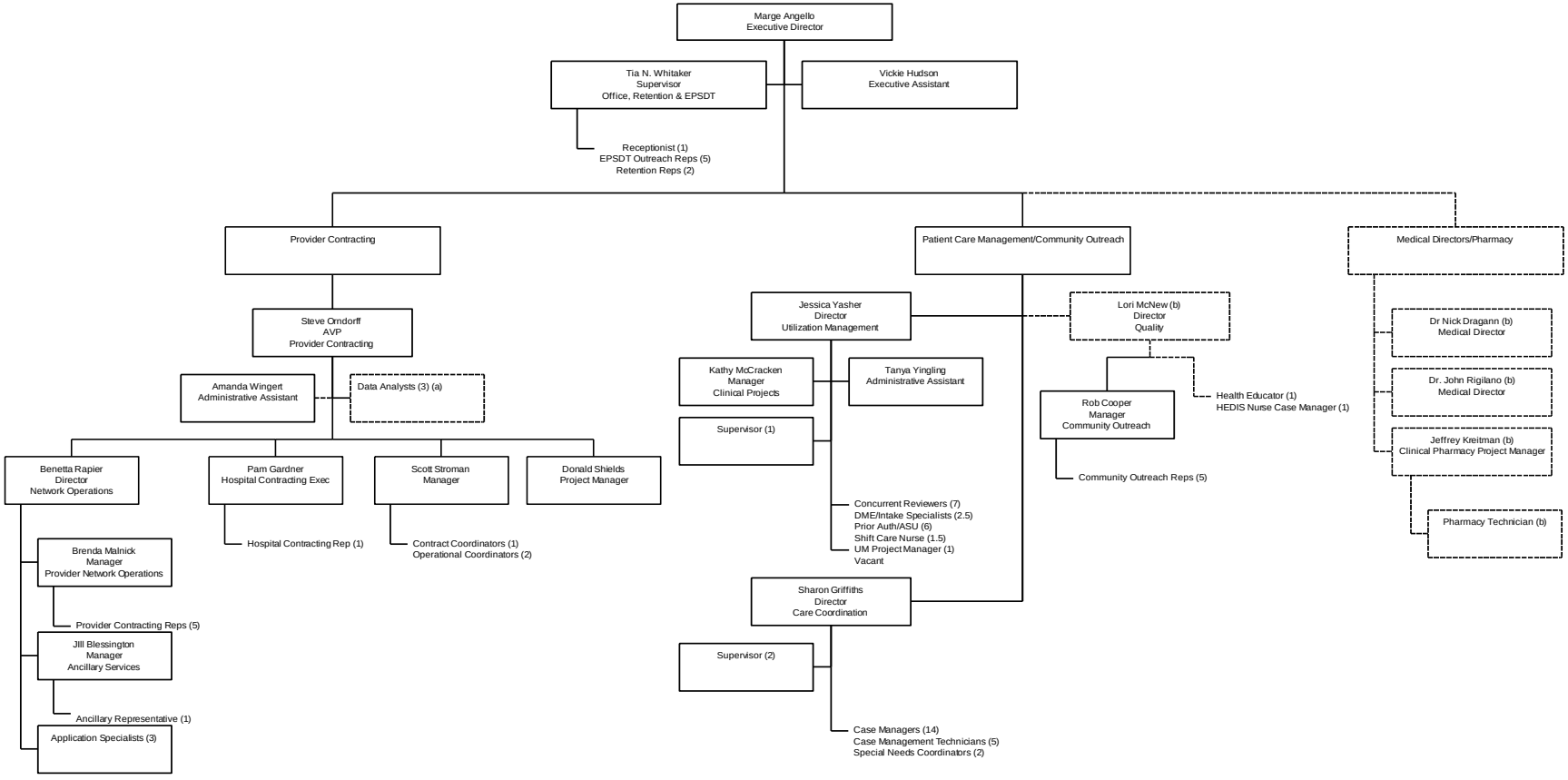

Figure 1: Organizational Structure – Local Office

Table 3: Functions to be performed at the Harrisburg Office

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

Regional Office

AmeriHealth Mercy's regional office structure offers a second level of support for the Pennsylvania plans based on the concept of shared functions for those areas that require less direct contact with members, providers, and other external parties. Functions managed at the regional level will include credentialing, utilization management, and our unique Rapid Response team that serves as an immediate contact point for enrollees with medical, transportation, or other social needs. This Rapid Response team also serves as a connector point for enrollees with providers, social agencies, and other community resources. Additional regional functions include Finance, Government Affairs, and Human Resources. The organizational chart in Figure 2 below depicts the assignment of resources at the regional level for these functions, and Table 4 contains a detailed list of the functions to be performed at the Regional level.

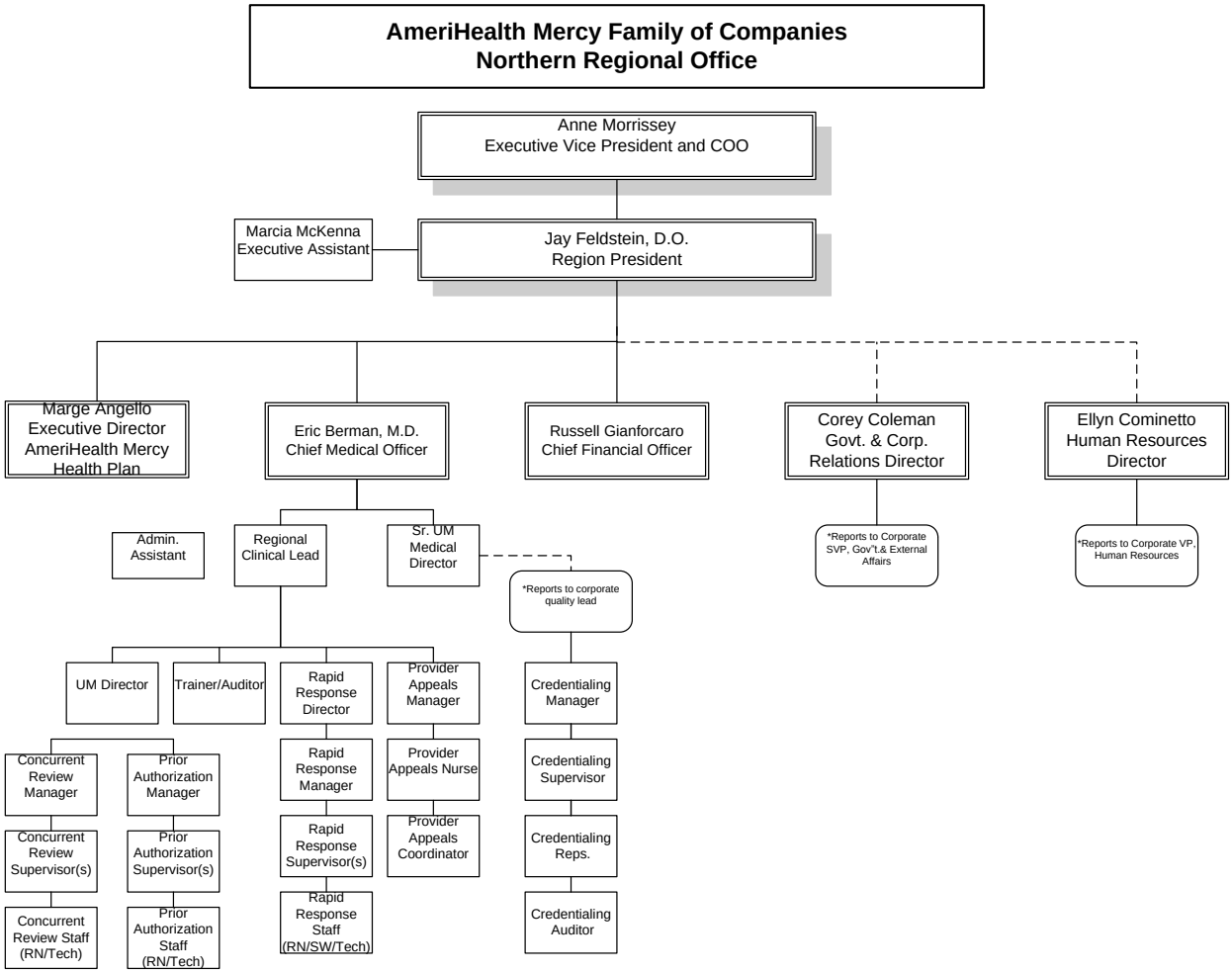

Figure 2: Organizational Structure – Regional Office

Table 4: Functions to be performed at the Northern Regional Office

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

Corporate Office

AmeriHealth Mercy's service delivery model includes a direct connection to a robust set of corporate functional areas that provide support to affiliated plans in all markets nationwide. This structure ensures that the local plans reap the benefits of efficiently managed back office functions such as the Member Contact Center, provider support, enrollment, claims processing, and information technology. In addition, AmeriHealth Mercy provides enterprise oversight and strategic direction for our Provider Network Management, Medical Management, Finance, Mission and Values, Human Resources, Government Relations, and Legal/Compliance functions that operate at the local and regional levels. The organizational charts in Figures 3 - 5 below highlight this corporate-level support, with corporate functions listed in Table 5.

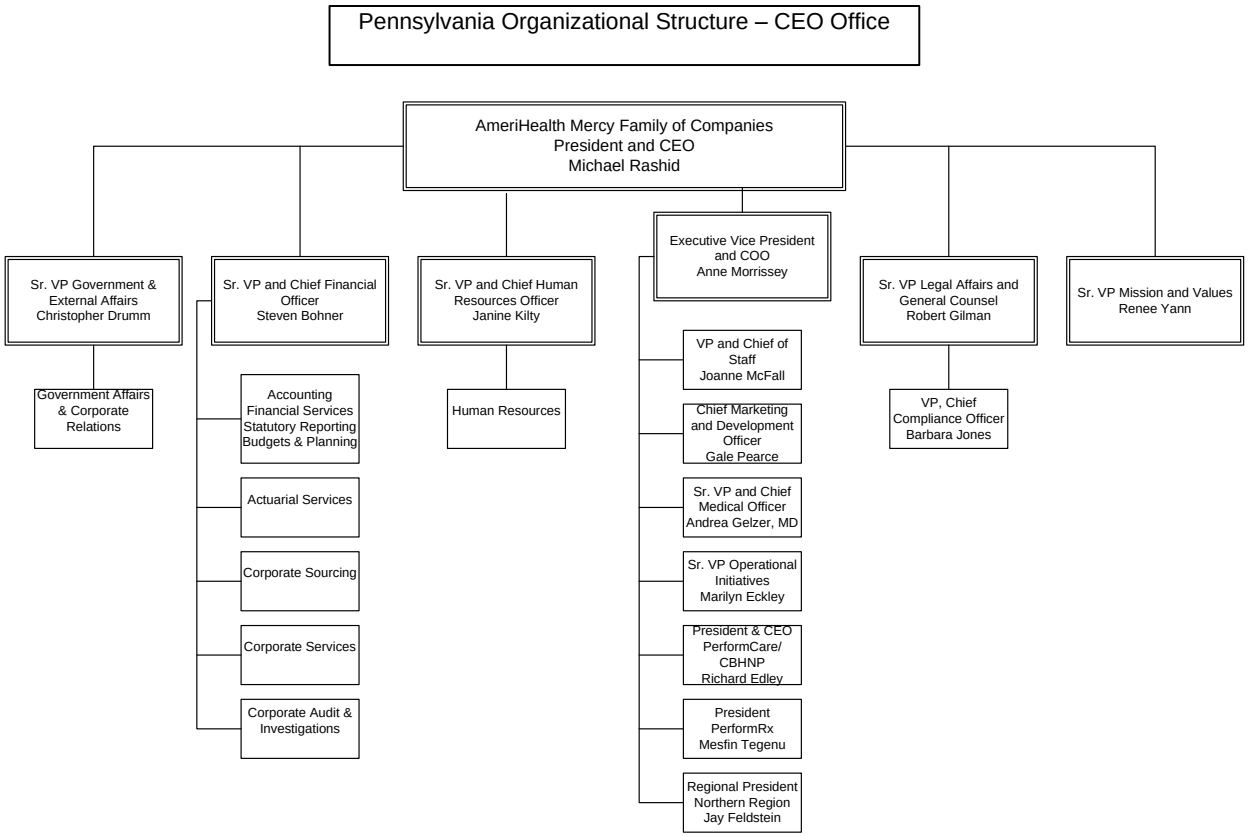

Figure 3: Organizational Structure – Corporate CEO Office

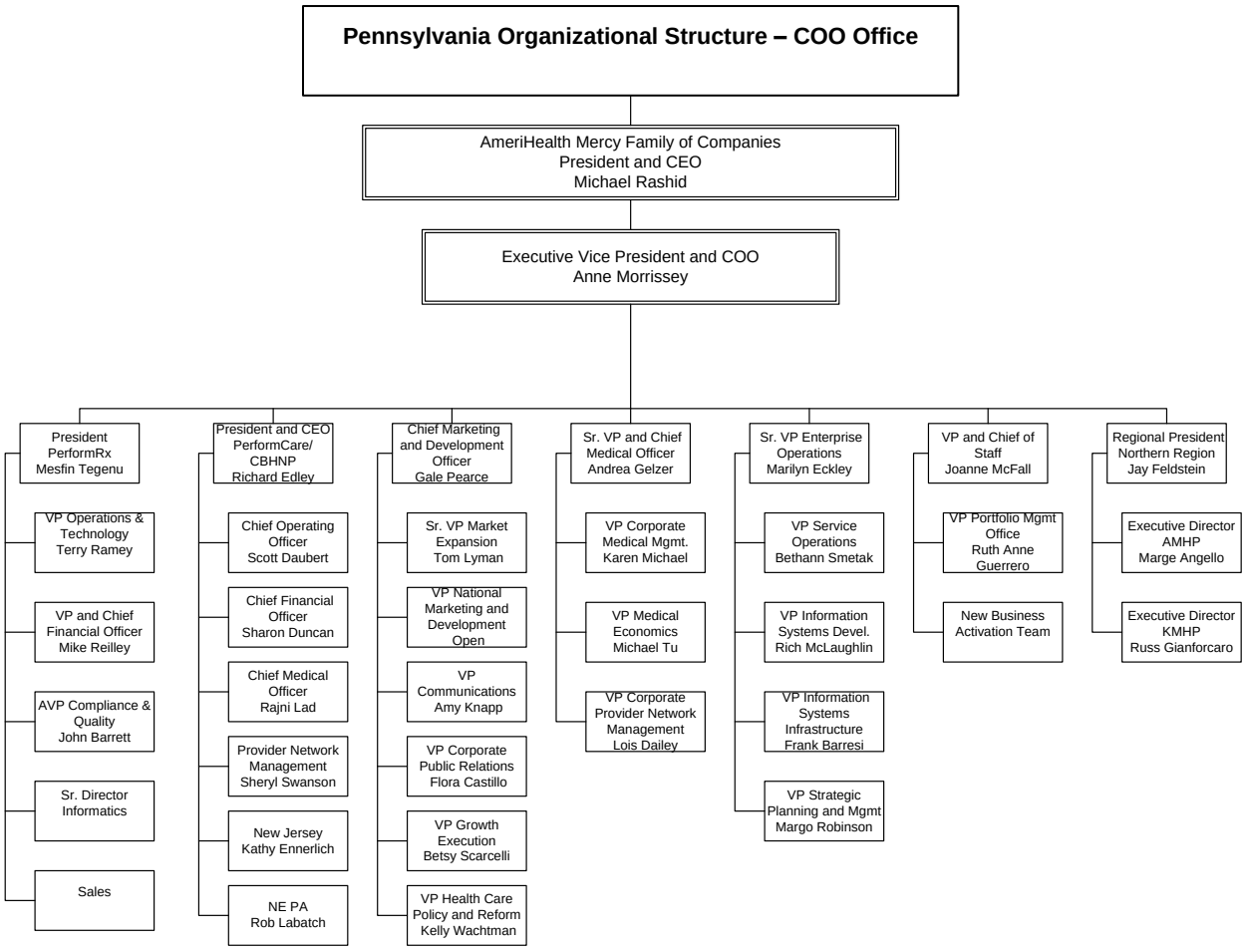

Figure 4: Organizational Structure – Corporate COO Office

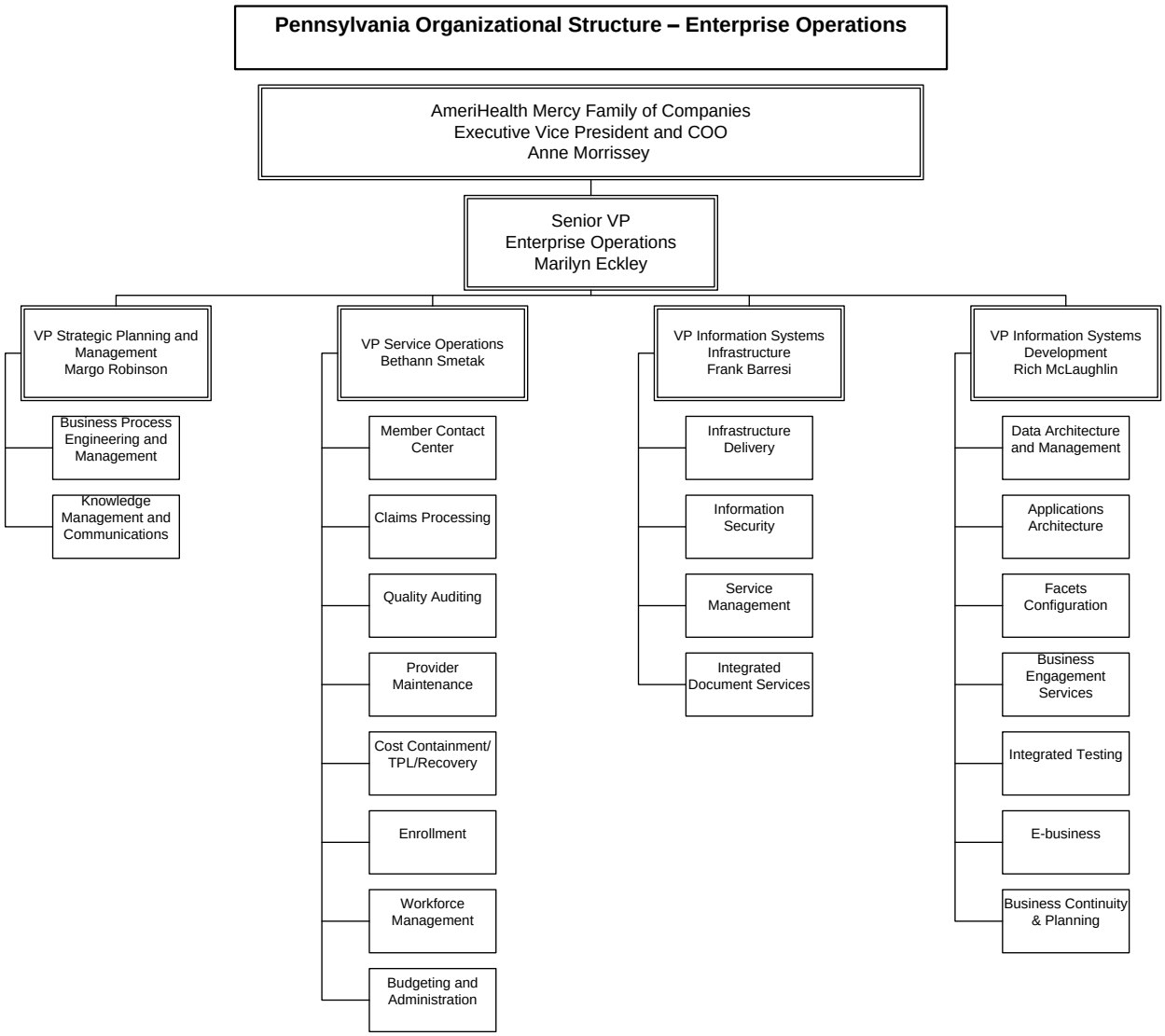

Figure 5: Organizational Structure – Enterprise Operations

Table 5: Functions to be performed at the AmeriHealth Mercy Corporate Office

Administration	Human Resources
▪ Corporate oversight and management ▪ Corporate P&L responsibility ▪ Government relations – state and federal ▪ Mission and values ▪ Strategy implementation ▪ Operational oversight and risk management ▪ Portfolio Management (PMO) ▪ New business activation	▪ HR strategy ▪ HR policies and procedures ▪ Compensation and benefits ▪ HR systems ▪ Talent management – recruiting, hiring, staff development ▪ Associate relations and business support ▪ Learning and organizational effectiveness
Finance	**Integrated Care Management**
▪ Accounting ▪ Financial services and systems ▪ Statutory reporting ▪ Budgets and planning ▪ Actuarial services ▪ Corporate sourcing ▪ Corporate services ▪ Corporate Audit and Investigations - fraud, waste and abuse program	▪ Integrated care management strategy development ▪ Clinical quality oversight ▪ Medical policy development and oversight ▪ Utilization management strategy and oversight ▪ Medical loss review ▪ Care management systems
Legal & Compliance	**Mission and Values**
▪ Corporate legal oversight ▪ Corporate compliance program	▪ Integration of the AmeriHealth Mercy mission and values into all aspects of the business
Provider Network Management	**Data Management**
▪ Provider Network Management strategy and systems ▪ Payment policy development and oversight ▪ Network management policies and procedures ▪ National contracting ▪ Provider incentive program strategy	▪ Production reporting ▪ Data management and governance ▪ Strategic business intelligence ▪ Quality and medical analytics ▪ Network and ancillary analytics ▪ Data management systems
Service Operations/IS	**Government Affairs**
▪ Service level oversight, reporting and monitoring ▪ Member and provider services – contact center ▪ Claims processing, research and analysis ▪ Enrollment and eligibility ▪ Operations support ▪ Facets configuration and testing ▪ Cost containment, TPL and recovery ▪ Quality auditing	▪ Liaison to federal and state legislators and regulators for legislative affairs, policy development, and regulatory affairs

▪ Provider data maintenance ▪ Business continuity and planning ▪ Vendor management ▪ Information systems ▪ Business engagement ▪ Security ▪ Infrastructure delivery ▪ Data architecture and management, e-business ▪ Encounter data management ▪ Applications development ▪ Service management	
Marketing and Development	
▪ Market expansion ▪ Product development ▪ Health care reform/regulatory oversight ▪ Marketing and communications ▪ Strategic planning	

STAFFING PLANS

The Offeror must include a comprehensive statement of its proposed staffing plan demonstrating how it will provide adequate staffing to address all requirements found in the RFP and the draft Agreement. Include comprehensive org charts that detail the number of staff and positions for each existing or proposed department within the MCO.

RESPONSE TO STAFFING PLANS

As a current HealthChoices contractor, AmeriHealth Mercy already has the organizational and management structure needed to support the requirements of RFP #20-11. We have staffing models for all positions directly supporting our Pennsylvania Medicaid business, and we will use these tested models to augment our staff based on our anticipated membership in the New West and New East Zones to meet and exceed the performance standards set forth in the draft Agreement.

AmeriHealth Mercy believes that maintaining a consistent presence in the communities we serve is essential to understanding and addressing the needs of our members and our network providers. To this end, we recruit and hire provider network representatives and community outreach representatives who live in the counties we serve and spend nearly all of their time working directly in the community as our "feet on the street." In 2011, this team completed more than 5,800 visits and since 2010 have connected with more than 34,000 people in the communities. They have been to provider offices to supply the staff with health education materials and training on available health education programs, community agencies and support organizations. They collaborate with faith-based settings, provide general member/community education and attend health fairs in the communities we serve. They have presented more than 170 workshops to educate and empower the community to take care of their health. These health education programs include asthma, diabetes, heart health, childhood obesity, poison prevention, medication safety, teen health, women's health, maternity education and youth sports safety.

Staffing for these positions is dictated by the geographic and demographic characteristics of the region, rather than specific staffing models. The effectiveness of this consumer-centric and provider-centric approach is evidenced by the excellent relationships we enjoy with our enrollees, community agencies, and participating providers. Our community agencies are equally enthusiastic about our services. Please see Attachment 3 for letters of support we have received from community agencies and participating providers for AmeriHealth Mercy's proposed expansion to the New West and New East Zones.

As part of our service delivery model described in the Organizational Structure section above, key functional areas at the Local, Regional and Corporate level will require enhanced staffing to meet the expanded membership from the New West and New East Zones. These areas represent those most directly connected to our hands-on approach to member and provider relationship management and are described in Table 6 below.

Table 6: AmeriHealth Mercy Staffing Projections for New West and New East HealthChoices Zones

Local Harrisburg Office	
New West – Projected Membership 40,000	*New East – Projected Membership 70,000*
Community Outreach Representatives – 3	Community Outreach Representatives - 2
Manager, Community Outreach - 1	Manager, Community Outreach – N/A
Provider Representatives – 2	Provider Representatives – 4
Hospital Representative – 1	Hospital Representative – 1
Hospital Account Executive – 1	Hospital Account Executive – N/A
DME Representative - 1	DME Representative – N/A
Manager, Provider Contracting - 1	Manager, Provider Contracting – N/A
CPP Program (EPSDT/Retention) - 4	CPP Program (EPSDT/Retention) - 2
Application Specialist - 1	Application Specialist – N/A
Case Management Nurses – 4	Case Management Nurses – 7
Total Positions - 19	Total Positions - 16
Regional Office	
New West – Projected Membership 40,000	*New East – Projected Membership 70,000*
UM Nurses – 4	UM Nurses – 7
Rapid Response Team - 2	Rapid Response Team - 3
Appeals Team - 1	Appeals Team - 2
Concurrent Review Team - 4	Concurrent Review Team - 7
Total Positions - 11	Total Positions - 19
Corporate Office	
New West – Projected Membership 40,000	*New East – Projected Membership 70,000*
Member Services/Provider Services – 4.3	Member Services/Provider Services – 10.3
Provider Claims Services – 1.2	Provider Claims Services – 3.3
Claims Processing – 3	Claims Processing – 5.5
Research and Analysis – 2.2	Research and Analysis – 4.3
Team Lead – 1	Team Lead – N/A
Supervisors – 2	Supervisors – N/A
Enrollment Rep - 1	Enrollment Rep – N/A
Claims Payment Research – 0.75	Claims Payment Research – 2
Data Analysis/System Enhancement – 0.25	Data Analysis/System Enhancement – 0.5

Facets Configuration – 0.5	Facets Configuration – 0.5
Provider Maintenance & Reporting – 0.25	Provider Maintenance & Reporting – 0.75
Quality Auditing – N/A	Quality Auditing – 2
Recovery/TPL – 0.5	Recovery/TPL – 1
Total Positions – 16.95	Total Positions – 30.15

Note: At the Corporate level, other areas including, but not limited to, Legal, Finance, Information Solutions, and Administration will be able to absorb the expanded membership without adding staff. This also applies to the Credentialing function performed at the Regional level.

SUBCONTRACTS

Provide a description of each subcontractor with responsibilities related to the provision of services to consumers, including but not limited to the provision of medical services, consumer services, and administrative support including but not limited to claims processing along with an organizational synopsis of services to be provided by each of these subcontrators. Provide a separate response for each subcontract (limit to 2 pages for each subcontract). Note that if the subcontract provides for financial risk, the HealthChoices MCO will be required to comply with the subcontracting requirements set forth in Section XIII of the draft Agreement.

RESPONSE TO SUBCONTRACTS

AmeriHealth Mercy utilizes subcontractors to manage the following:

- Vision services – Davis Vision
- Dental services – DentaQuest, LLC (formerly Doral Dental USA, LLC)
- 24/7 Nurse Call Line– Connextions Health
- Neonatal intensive case management services – ProgenyHealth Inc.
- Management of Medical Imaging Services – MedSolutions, Inc.
- Document scanning, data entry and imaging – ACS Commercial Solutions, Inc.
- Subrogration – ACS Recovery Services Inc.
- TPL/COB program support - Health Management Systems
- Pharmacy claims processing – Argus Health Systems
- Pharmacy benefit management - PerformRx

Information on these subcontractors, including a description of the responsibilities delegated to each, is provided below.

Davis Vision

Davis Vision is AmeriHealth Mercy's subcontractor for vision care services. Founded in 1964, this Plainview, New York-based company is one of the country's leading managed care vision and eyewear providers, serving more than 19 million people throughout the country through a national network of 11,000 vision care professionals. In addition to serving managed care organizations like AmeriHealth Mercy, Davis also serves municipalities, union trust funds, insurance companies, and corporations. Davis is known for the quality of its management, which is run under Total Quality Management (TQM) principles.

Under our contract with Davis Vision, Davis is responsible for arranging for the provision of vision care services to AmeriHealth Mercy members, as defined by AmeriHealth Mercy's vision benefit. Davis serves all AmeriHealth Mercy members. AmeriHealth Mercy has delegated provider credentialing and re-credentialing, utilization management, quality management, claims management, financial services, and informal member dispute responsibilities to Davis. AmeriHealth Mercy has retained the member services function, although Davis is actively involved in the investigation and resolution of member concerns relating to vision services.

DentaQuest, LLC

DentaQuest (formerly Doral Dental) is AmeriHealth Mercy's dental benefits management subcontractor. Founded in 1993, the Wisconsin-based company is the largest multi-state Medicaid dental administrator in the country, serving four million Medicaid members. In addition to providing these services to numerous managed care organizations in twenty states, DentaQuest also administers the Medicaid dental program for the state of Illinois. Supporting DentaQuest's network of 8,000 dental provider sites is proprietary software installed in provider offices that features advanced reporting capabilities that foster nearly error-free data reporting and reduced overhead costs.

Under our contract with DentaQuest, DentaQuest is responsible for arranging for the provision of dental services to AmeriHealth Mercy members, as defined by AmeriHealth Mercy's dental benefit. DentaQuest serves all AmeriHealth Mercy members eligible for the dental benefit. AmeriHealth Mercy delegates the following responsibilities to DentaQuest: provider credentialing and re-credentialing, claims management, utilization management, quality

management, financial services, and informal member disputes. AmeriHealth Mercy has retained the member services function, although DentaQuest is actively involved in the investigation and resolution of member concerns relating to dental services.

Our dental providers are paid on a fee-for-service basis; AmeriHealth Mercy reimburses DentaQuest for claims paid by DentaQuest. In addition, DentaQuest receives an administrative fee from AmeriHealth Mercy.

Connextions Health

Under the contract with AmeriHealth Mercy, Connextions conducts 24/7 nurse triage services (AmeriHealth Mercy's Nurse Call Line). Using member and provider files supplied by AmeriHealth Mercy, Connextions responds to calls from AmeriHealth Mercy members, using AmeriHealth Mercy-approved algorithms. The Nurse Call Line is staffed by registered nurses. The services are provided to assist members in identifying the appropriate level and source of care based on symptoms reported and/or health care questions asked during the call. Members also have access to the Connextions Audio Health Library through the Nurse Call Line. Additional elements of this service include the ability to conduct "warm transfers" (the Connextions agent stays on the line with the caller until the call is accepted by an AmeriHealth Mercy agent) to AmeriHealth Mercy's Member Services Department; reporting Nurse Call Line contacts to the member's PCP; and the reporting of all Nurse Call Line encounters to AmeriHealth Mercy. Services (including the Audio Health Library) are offered in English and Spanish, and they can also be provided in other languages via the AT&T Language Line, and via TTY for hearing-impaired members.

ProgenyHealth Inc.

AmeriHealth Mercy contracts with ProgenyHealth for the provision of neonatology management services pursuant to ProgenyHealth's evidence-based clinical management guidelines, which have been reviewed and approved by AmeriHealth Mercy. AmeriHealth Mercy contracts with ProgenyHealth to achieve a number of goals, including: management of the delivery of neonatology services consistent with national standards of quality and utilization; assurance of appropriate member outcomes and improved health status; and provision of access by AmeriHealth Mercy to neonatology clinical expertise. ProgenyHealth is accredited by URAC in Health Utilization Management.

ProgenyHealth's service model is primarily care management and facilitation with an emphasis on a strong case management program. ProgenyHealth begins working with AmeriHealth Mercy members the moment they are notified that an infant has been admitted to the intensive care nursery following birth. ProgenyHealth's team of neonatologists, pediatricians, and NICU-experienced/pediatric nurses begin by collaborating with the hospital professional staff to coordinate the health care needs of the neonate. ProgenyHealth's model stresses comprehensive care management to meet the health care needs of the infant. For those infants requiring a higher level of intervention, ProgenyHealth has an intensive case management program dedicated to supporting and enhancing the Medical Home throughout the first year of life.

Specific neonatal medical management services that ProgenyHealth provides include: concurrent review approvals and denial recommendations of NICU admissions through discharge; discharge planning; ongoing case management services; family education; and medical necessity reviews of specialized pharmaceuticals for newborns. AmeriHealth Mercy has not delegated utilization review denial determinations to ProgenyHealth, and ProgenyHealth is

further required to obtain AmeriHealth Mercy's authorization before approving certain high-cost services. ProgenyHealth surveys member families and providers who have respectively received and provided services covered under our contract, to assess satisfaction with ProgenyHealth's services.

MedSolutions, Inc.

AmeriHealth Mercy contracts with MedSolutions, Inc. for utilization management services for certain outpatient diagnostic imaging services. MedSolutions, Inc. provides a physician-supportive, patient-centric approach to achieve enhanced patient care. MedSolutions, Inc. applies clinical algorithms to improve the quality and efficiency of radiology modality choices by ordering physicians, while providing AmeriHealth Mercy and our participating physicians with information on overall radiology ordering practices.

Under this contract, AmeriHealth Mercy has formally delegated to MedSolutions, Inc. the implementation and management of a utilization review/management program for specified outpatient diagnostic imaging procedures. MedSolutions, Inc. maintains a call center in order to accept telephonic requests for prior authorization from AmeriHealth Mercy's participating providers. MedSolutions, Inc. also offers password-protected near-real-time Internet access, through its proprietary software application, which providers can use to obtain updated information on authorization status. In addition, MedSolutions, Inc. is responsible for conducting provider education programs relating to its utilization management services, and for surveying provider satisfaction. AmeriHealth Mercy and MedSolutions, Inc. work closely together in the context of a local advisory committee to ensure consistency between our policies and procedures and MedSolutions, Inc.'s utilization management program. MedSolutions, Inc.'s nationwide reach allows it access to comprehensive data against which to measure utilization and assist AmeriHealth Mercy in establishing appropriate benchmarks for performance improvement.

ACS Commercial Solutions

AmeriHealth Mercy contracts with ACS Commercial Solutions, Inc. (ACS), through the contract of its affiliate Keystone Mercy Health Plan, for data processing and related services. This Dallas-based company offers innovative outsourcing solutions around the world. ACS' capabilities and expertise include business process outsourcing, information technology outsourcing, systems and integration and e-solutions. ACS was formerly known as ACS Shared Services, Inc.

ACS provides support to AmeriHealth Mercy for a number of functions where ACS is better suited to leverage its resources. Specifically, ACS provides mailroom and data entry services for health claim forms. This process involves the conversion of paper claims into an electronic format that AmeriHealth Mercy can then import to its claims system for more efficient electronic adjudication and payment. ACS provides similar scanning and electronic conversion functions for paper referral forms; data captured from referral forms is entered directly to AmeriHealth Mercy's claims processing system.

ACS has a rigorous quality control process in place to monitor the timeliness and accuracy of its services under this contract; AmeriHealth Mercy receives frequent reports from ACS so that we can detect and correct performance deficiencies before they become significant problems. Performance expectations are high, in accordance with the vital nature of the services being performed.

ACS Recovery Services Inc.

ACS Recovery Services (ACSRS) is AmeriHealth Mercy's recovery vendor of choice to support Subrogation-related overpayment recoveries. With AmeriHealth Mercy oversight, ACSRS performs the primary function of Worker's Compensation case identification, communication, recovery and reporting. To accomplish this, AmeriHealth Mercy sends monthly paid Claims data to ACSRS, along with Eligibility, Provider and Third Party Liability data. ACSRS analyzes this data in an effort to identify those claims for which AmeriHealth Mercy has paid as primary, but that may be for a work-related injury. When this analysis identifies potential Worker's Compensation cases, ACSRS sends a survey to the identified Members in order to ascertain whether or not their claims are related to injuries that may be the responsibility of a Worker's Compensation carrier. Since surveys are helpful but often are not returned or are returned, but with gaps, ACSRS utilizes a variety of methods, tools, and techniques to obtain the necessary information, such as outgoing telephone calls, court docket searches, Internet searches for contact information, ISO ClaimSearch lookups, or requests for emergency services and/or police records.

With this research, cases confirmed to be Worker's Compensation-related and with recovery potential, are followed-through by ACSRS. Communication with Attorneys is typical in this process, especially with respect to liens, and this is also handled by ACSRS. ACSRS monitors progress of all open cases and provides reports to keep AmeriHealth Mercy informed on progress and results to-date. As cases are closed, recoveries obtained are provided to AmeriHealth Mercy and compensation for services is remitted to ACSRS upon invoice.

Healthcare Management Systems

AmeriHealth Mercy contracts with Health Management Systems (HMS), through the contract of its affiliate Keystone Mercy Health Plan, to support our third party liability (TPL) and Coordination of Benefits identification and recovery efforts. HMS leads the nation in cost-containment, coordination of benefits and program integrity services for government healthcare programs. Using information technology and data mining techniques, HMS identifies other insurance coverage, coordinates benefits and recovers overpayments.

For more than 20 years, HMS has worked throughout the U.S. with Medicaid programs specifically. HMS helps its clients recover more than one billion dollars annually, and helps them save comparable amounts through cost avoidance. HMS helps AmeriHealth Mercy meet the mandate that Medical Assistance be the payer of last resort. HMS provides AmeriHealth Mercy with files twice monthly that identify TPL and COB resources for our members. AmeriHealth Mercy's operating system extracts information from these files where a TPL or COB resource has been identified for a member but where our file does not contain that resource. The responsible insurance carrier is thus identified for these members.

Argus Health Systems

AmeriHealth Mercy contracts with Argus Health Systems to process and adjudicate pharmacy claims. Founded in 1983, Argus is a leading independent prescription claims processor for pharmacy benefit administration. One of the largest providers of independent data processing and related services for the pharmacy benefit administration industry, Argus processed 510 million claims for 26 million recipients throughout the country in 2010. Argus serves a wide variety of customers, including large insurance carriers, managed care organizations, and chain drug stores.

Argus provides a direct point-of-sale interface at AmeriHealth Mercy's participating pharmacies for real-time claims processing and adjudication. This claims processing system facilitates and supports concurrent drug utilization review (DUR) functions that allow for the review and monitoring of the cost-effectiveness, interaction and resulting therapeutic implications of various drugs. By incorporating AmeriHealth Mercy's formulary guidelines and parameters into the Argus system, AmeriHealth Mercy is better able to effectively administer the formulary, and to ensure appropriate pharmaceutical products and services are being provided to our members.

Through remote connectivity to the Argus system, AmeriHealth Mercy is able to conduct its own ad hoc claim review and other data analysis. AmeriHealth Mercy is able to query the Argus system and export data to other applications so that the data can be analyzed as necessary in response to individual business needs. This is in addition to the standard set of reports that Argus produces on a routine basis.

Argus also supports AmeriHealth Mercy's manufacturer rebate reporting. AmeriHealth Mercy is further able to access Argus' "wrap-around" pharmacy network as needed to meet access requirements, and to access Argus' pharmacy call center as a back-up to our own internal pharmacy provider call center in emergency situations to maintain business continuity.

PerformRx, LLC

PerformRx was originally formed in 1999 as a business unit of AmeriHealth Mercy, as a way to deal directly with the complex administrative, operational and regulatory challenges inherent in providing Medicaid pharmacy benefits. PerformRx has met this challenge in providing the "next generation" of PBM services in the Medicaid marketplace; this same philosophy has driven PerformRx's expansion into the Medicare Part D and commercial marketplaces. PerformRx, LLC (a Pennsylvania limited liability company) is a member of the AmeriHealth Mercy Family of Companies (AmeriHealth Mercy). PerformRx, LLC has been operating as a wholly-owned subsidiary of AmeriHealth Mercy Health Plan since January 1, 2010; prior to that date, PerformRx operated as a business unit of AmeriHealth Mercy.

As a pharmacist-led organization, PerformRx understands the importance of maintaining a clinically focused staff with specific experience in managed care. In fact, more than 60 percent of PerformRx's staff is credentialed either as pharmacists or as certified pharmacy technicians – which means that we have the clinical experience and knowledge to effectively manage your pharmacy program.

We explore issues from multiple angles, looking for every possible way –conventional and unconventional – to identify clinical intervention opportunities. Our proven and time-tested clinical solutions were born from our experience serving millions of managed care members since 1999.

PerformRx's uniqueness lies in its focus on providing PBM services for the managed health care sector. We specialize in providing pharmacy benefits management services for members of Medicaid managed care organizations, state Medicaid plans, and Medicare Part D plans.

PerformRx is a transparent organization and has no ownership ties to drug manufacturers. This enables us to create innovative clinical solutions for our customers and their members without the conflicts of interest that impact other PBMs.

The PerformRx business model does not allow us to benefit from any undisclosed rebates, discounts or spread advantage. Not only do we offer our clients a commitment to transparency, we are also willing to fully comply with an independent third-party audit process.

II-6. Objections and Additions to Standard Contract Terms and Conditions

Contents

OBJECTIONS AND ADDITIONS TO STANDARD CONTRACT TERMS AND CONDITIONS

The Offeror will identify which, if any, of the terms and conditions (contained in **Appendices A, E and F**) it would like to negotiate and what additional terms and conditions the Offeror would like to add to the agreement. The Offeror's failure to make a submission under this paragraph will result in its waiving its right to do so later, but the Department may consider late objections and requests for additions if to do so, in the Department's discretion, would be in the best interest of the Commonwealth. The Department may, in its sole discretion, accept or reject any requested changes to the standard contract terms and conditions. The Offeror shall not request changes to the other provisions of the RFP, nor shall the Offeror request to completely substitute its own terms and conditions for **Appendices A, E and F**. All terms and conditions must appear in one integrated Agreement. The Department will not accept references to the Offeror's, or any other, online guides or online terms and conditions contained in any proposal.

Regardless of any objections set out in its proposal, the Offeror must submit its proposal on the basis of the terms and conditions set out in **Appendices A, E and F**. The Department will reject any proposal that is conditioned on the negotiation of the terms and conditions.

Inasmuch as the terms and conditions set out in **Appendices A, E and F** of the RFP are substantially the same as the terms and conditions that govern Vista Health Plan's existing relationship with the Department of Public Welfare under current HealthChoices contracts, Vista agrees to these terms and conditions. We look forward to working with the Department of Public Welfare to address and resolve inconsistencies between the terms and conditions in the RFP and those in our current contracts.

RESPONSE TO OBJECTIONS AND ADDITIONS

Inasmuch as the terms and conditions set out in Appendices A, E and F of the RFP are substantially the same as the terms and conditions that govern Vista Health Plan's existing relationship with the Department of Public Welfare under current HealthChoices contracts, Vista agrees to these terms and conditions. We look forward to working with the Department of Public Welfare to address and resolve inconsistencies between the terms and conditions in the RFP and those in our current contracts.

COORDINATION OF CARE

CONTENTS

QUESTION 1

Describe the procedures and processes you have in place for coordination of care to ensure a smooth transition for MA consumers who transfer between delivery systems during the initial enrollment and auto assignment period, as well as throughout the ongoing program. (This includes the current ACCESS Plus Program)

(Limit to two pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy has established policies and procedures to ensure a smooth transition for MA consumers who transfer between delivery systems during the initial enrollment and auto assignment period, and on ongoing basis.

Coordination during the Initial Enrollment and Auto Assignment Period

AmeriHealth Mercy's approach to coordinating seamless transitions for members during the initial enrollment and auto-assignment period is informed by our experience during the initial implementation of the HealthChoices Program in the Lehigh/Capital Zone, and the experience of our southeast Pennsylvania affiliate during the HealthChoices Southeast implementation. From this experience, we understand that seamless transitions can be achieved through the following key steps:

- Developing a comprehensive provider network to minimize the need for newly enrolled members to change providers.
- Providing timely, accurate updates to our provider network to facilitate plan selection and PCP assignments.
- Educating members and providers about the continuity of care provisions afforded to transitioning members that allow members to continue an ongoing course of treatment with a non-participating provider.
- Completing new member welcome calls to ensure that new members received a welcome packet and their identification card with their PCP assignment.
- Completing a Health Risk Assessment on new members to identify those with continuing or unmet needs and connecting them to our Rapid Response Team for immediate intervention, and/or to our Care Management Program.
- Engaging in extensive education and outreach in the community, with appropriate DPW approvals, to help members and community partners understand our plan and provide information on who to call for assistance.
- Working closely with Children and Youth agencies to education their staff about our provider network and facilitate the selection of participating PCPs and specialists.

Ongoing Coordination of Care

To facilitate seamless care transitions on an ongoing basis, we rely on the same key steps taken during the initial selection and auto-assignment process, and supplement those with our proven systems and processes to support data sharing and information exchange.

Our Member Clinical Summary (MCS) helps to ease transitions by capturing a claim-based medical history including pharmacy and medical management data sets, and any Care Gaps. The MCS is accessible through our secure Provider and Member Web Portals for print or download into an electronic medical record. Available to Members, PCPs, specialists and emergency room providers, the MCS provides key information for a physician who is seeing a member for the first time, and thereby reduces gaps in care, and duplication of services and prescriptions.

Our Rapid Response team is always available to facilitate immediate interventions to achieve seamless transitions, from assisting members in getting prescription drug orders and medical records transferred to new pharmacies or providers, to quickly meeting any needs for equipment and supplies that could otherwise be interrupted while transitioning between systems.

In addition, we routinely use the DPW Member Transfer Coordination of Care Form (Interplan Transfer Form) to provide the receiving delivery system with a snapshot of the transferring member's care coordination needs.

Looking Ahead

As part of our continual effort to improve our information sharing capabilities with providers, AmeriHealth Mercy actively participates in Pennsylvania's Health Information Exchange (HIE) projects at a statewide and local levels participating with the state PAeHC's development of their strategic plan for HIE through active involvement on the Business Operations and Finance committees, and the Southeast PA Health Information Organization, a collaborative effort with the Delaware Valley Healthcare Council. We also bring HIE experience working with other states, namely the Kentucky HIE, where we are delivering a Continuity of Care Document of health plan information (medications, admissions, office visits, etc.) to providers through the exchange.

During 2012, our ongoing efforts to improve integration between our Integrated Care Management platform and our Member and Provider Web portals will allow sharing of assessments and care plans through our secure portal sites.

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QUESTION 2

Describe the procedures and processes you have in place to ensure continuity of care whenever a MA consumer transitions between and among delivery systems. (This includes the current ACCESS Plus Program)

(Limit to two pages)

RESPONSE TO QUESTION 2

AmeriHealth Mercy has several processes and procedures to ensure continuity of care for transitioning members. Working with both the member and our health plan counterparts, we share health information relevant to the member's current plan of care, preventing any gaps in ongoing treatment that could otherwise result in negative and costly health outcomes.

Previously Approved Services

We encourage newly enrolled members to complete a Health Risk Assessment (HRA) through our new member welcome packet, and through our telephonic outreach. The data collected includes information on the member's current providers and services the member is receiving. We use this information to proactively identify the need for continued treatment from a non-participating provider and continued authorization of covered services. Our Utilization Management team coordinates entry of information on previously approved services into our claim system, and coordinates with out-of-network providers to ensure continuity of care, as appropriate. As needed, our network management team will intervene to negotiate a one-time payment rate for care that is being continued with a non-participating provider.

Continuity of Care

AmeriHealth Mercy takes necessary steps to ensure continuity of care for all newly enrolled members in an ongoing course of treatment with a non-participating provider, and for members in an ongoing course of treatment with a provider who has been terminated from AmeriHealth-Mercy's network for reasons that are not "for cause." Newly enrolled members who are pregnant on the effective date of enrollment with AmeriHealth Mercy may continue to receive ongoing treatment from a non-participating Obstetrician (OB) or Midwife through delivery and the completion of post-partum care related to the delivery.

Requests for continued treatment from a non-participating provider can be submitted by the member, the new PCP or the non-participating provider. Our Utilization Management team works with the provider, the member, and our Network Management team to enter information on the ongoing care and payment arrangements into our authorization system to enable the provider's claims to pay smoothly.

Transitioning to a Participating Provider

We assign all members receiving care from a non-participating provider to a Care Manager. The Care Manager works with the member and the non-participating provider to identify an appropriate point to move the member's care to an AmeriHealth Mercy participating provider. We will continue to approve ongoing care from the non-participating provider for an extended period of time if there is not sufficient expertise within the network to assume the member's care, or if transitioning to a participating provider would cause undue hardship for the member. In those situations, we will document the approved services and payment in writing, so the provider is clear on what services will be covered.

Collaboration with Other Delivery Systems

AmeriHealth Mercy routinely makes contact with other delivery systems in our market to facilitate collaboration for members who move from one system to another. As requested, we complete the Member Transfer Coordination of Care, also known as the Interplan Transfer Form, to provide the new delivery system with information on the member's care plan and utilization

history. We also have a detailed Member Clinical Summary, discussed below, that can be shared with the new delivery system and/or any new physicians seeing the member.

Our Special Needs Coordinator proactively reaches out to the member's prior Medical Assistance Delivery System for information on members with special care needs and obtains a copy of the prepared transfer summary.

Member Clinical Summary

Members who are transitioning from AmeriHealth Mercy can access and print a Member Clinical Summary (MCS) from the Member Web Portal prior to their termination date. The MCS is a claim-based medical history compiled from information in our claim and medical management data sets. In addition to PCP and demographic information, the MCS lists the member's chronic conditions, medications, recent inpatient, emergency room and physician visits and current care gaps. Care gaps are services that are recommended according to nationally-accepted clinical guidelines for which there is no record of the member having the service. A copy of our Member Clinical Summary is included as Attachment 1.

The Medication history on the MCS identifies the medication name, dose, date filled, number of days supply, prescribing physician and name of the pharmacy for medications filled in the last six months. The inpatient and emergency room section identifies the facility, the primary diagnosis and the dates of service. The physician visit section includes the name of the physician, the diagnosis, the date and the physician's specialty. With the member's permission, we will send a copy of the MCS to a new physician or Medical Assistance delivery system if the member transfers from AmeriHealth Mercy.

Looking Ahead

As part of our continual effort to improve our information sharing capabilities with providers, AmeriHealth Mercy has an active role in Pennsylvania's Health Information Exchange (HIE) projects at a state and local levels. AmeriHealth Mercy participated with the Pennsylvania e-Health Collaboratives (PAeHCs) development of their strategic plan for HIE through active involvement on the Business Operations and Finance committees. We are also involved at the local level in supporting the Southeast PA Health Information Organization (HIO), a collaborative effort with the Delaware Valley Healthcare Council which represents the major hospitals in the area and the Health Care Improvement Foundation. We also bring HIE experience working with other states, namely the KYHIE, where we are delivering a Continuity of Care Document of health plan information (medications, admissions, office visits, etc.) to providers through the exchange.

QUESTION 3

Describe the procedures and processes you will have in place for coordination of care with all current Pennsylvania waiver services and programs (listed and described in Appendix A, "Draft HealthChoices Agreement," Exhibit O, "Description of Facilities and Related Services," and Exhibit P, "Out-of-Plan Services."

(Limit to two pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy has nearly 30 years of experience, including 14 years in the HealthChoices program, working with Medical Assistance populations and coordinating care with Pennsylvania agencies and programs, such as the HIV/AIDS Waiver Program, the HIV/AIDS Targeted Case Management Program, the Healthy Beginnings Plus Program, and the Pennsylvania Department of Aging Waivers. We also provide continuous coordination of care for members receiving out-of-plan benefits and non-Medical Assistance covered services provided by other community programs and residential facilities, including Nursing facilities; Intermediate Care facilities; residential treatment facilities; acute, extended and/or extended-acute psychiatric facilities; Juvenile Detention Centers; and Early Intervention Services. We coordinate care and facilitate access to health care services for members in substitute care settings, including adoption assistance programs, foster care programs and transitional care homes, as well as for members who are part of any of Pennsylvania's Home and Community Based Waiver Programs.

We identify members involved in the above programs through flags on their eligibility record and our new member assessment process. Our Care Managers, being familiar with the member's health status and needs, review the services provided by the waiver or other programs and determine if the member has any treatment gaps or duplications in services. A comprehensive, coordinated care plan is developed in collaboration with the member's PCP, member/family or member representative, Waiver Case Manager (when applicable) and other service or support providers/representatives. See Attachment 2 for a narrative description of how AmeriHealth Mercy coordinates with waiver services programs.

Building on the foundation of our existing community partnerships with the programs and agencies serving the Pennsylvania Medicaid population, AmeriHealth Mercy has begun to create new relationships with the staff and agencies associated with the New West and New East Zones. As appropriate, we will provide program and agency representatives with access to the member's Member Clinical Summary (MCS) and care plan. These tools allow the agency/program representative to view information on the member's medications, chronic conditions, care gaps, inpatient admissions, emergency room visits and office visits. The MCS is an excellent source of information for a new substitute care/medical foster care caregiver. An EPSDT version of the MCS, containing information on immunization history and EPSDT screening services, is also available for children under age 21.

Ongoing Input

In addition, AmeriHealth Mercy will invite key members from the above program/agency community to participate in our Health Education Advisory Committee (HEAC). The HEAC serves as a mechanism for stakeholders to have a voice in our programs and policies. The HEAC is chaired by our Manager of Community Outreach and meets every other month. The HEAC provides valuable input on health education programs, specifically as they relate to public health priorities and the goal of empowering members to take responsibility for their health. AmeriHealth Mercy recognizes the importance of collaborating with the waiver programs and out-of-plan agencies to effectively serve this population and is committed to working closely with representatives in coordinating and communicating about the members we all serve.

Looking Ahead

As defined, waivers allow the states to cover home and community-based services for specific populations to avoid institutionalization. Waivers may increase optional and additional Medicaid

services, such as, respite care, environmental modifications and family training. As such, it is AmeriHealth Mercy's experience that tremendous overlap exists within the scope of services provided by each of the engaged delivery systems. The result is fragmentation, and diminished efficiencies, reducing members' ability to control their own care and presenting an unneeded burden on state and county budgets.

Through our work with HealthChoices members who are also receiving services through a waiver program, we have seen numerous instances of duplication of services and resources, causing frustration for the member, and unnecessary strain on the state's Medicaid delivery system. In most cases, these members are served by two, sometimes three care managers – one from the HealthChoices plan, one from the waiver program and possibly one from the Behavioral Health MCO. In addition, each program has a separate oversight team – whether through the Office of Medical Assistance Programs (OMAP), the Office of Developmental Programs (ODP) or the Office of Mental Health and Substance Abuse Services (OMSAS).

We would welcome the opportunity to partner with the DPW to pilot a system of care approach to the delivery of public welfare services to these vulnerable populations. Our success using this model to deliver behavioral health and developmental services in New Jersey has shown value through decreased medical and administrative costs and the improvement in care delivery that comes with coordinated, un-fragmented care. This type of coordination is a hallmark of a successful Medicaid program, allowing members to make educated decisions about their care, allowing the health plan to monitor and control cost and quality, and allowing the state to provide an efficient and streamlined system of care to its residents.

JP is an 18 year-old male with Cerebral Palsy, mental retardation, blindness, seizure disorder, who is non-verbal, non-ambulatory, incontinent of bowel and bladder, dependent for all activities of daily living (ADLs) and fed through a tube into his stomach. He lives at home with family and receives skilled nursing and home health aide services through his HealthChoices benefit plan, as well as additional home health aide services through the Office of Mental Retardation. Multiple entities control a portion of his care, including two Pennsylvania agencies, physical and behavioral health managed care organizations, a waiver coordinator and home health providers who are billing separate payors, depending on which benefit is covering the service. JP's care would benefit from a system of care approach with one entity coordinating all of his care and services.

QUESTION 4

What are your processes for transitioning and coordinating care for membership 21 years and under as they age into adult categories of assistance that may provide less service coverage? Describe your strategy moving forward to improve coordination of care.

(Limit to two pages)

Response to Question 4

AmeriHealth Mercy has extensive experience transitioning and coordinating care for members who age into adult categories of assistance that provide less service coverage. Our process focuses on early and clear communication to set expectations and active coordination to identify and pursue other options for services for these members whose benefit package changes when they become 21 years old. These pediatric members, who are medically fragile, are often receiving persistent in-home services due to chronic health care needs. These services, also called "shift care services," consist of hourly in-home skilled nursing, medical day care, and/or home health aide services, provided by an external nursing agency.

Clear Communication

We begin the communication process well in advance of the 21st birthday to allow the member and family adequate time to prepare for the transition and to provide the lead time necessary to navigate the waiver application process for members with complex service needs. The member's pediatric care manager sends a letter to the member/member's caregiver three months before member's 18th birthday to explain the transition that will occur when the child turns 21 and outline the process. The letter explains the difference in services available through the HealthChoices program and the Office of Long Term Living (OLTL) waiver. The letter is followed by a call from the care manager within three weeks to answer any questions and explain the process.

Active Coordination

Our care managers take a hands-on role to ensure that the member is connected to appropriate community and waiver services well in advance of the 21st birthday. The care managers complete the Resource Facilitation Team (RFT) forms and forward them to the Bureau of Managed Care Operations (BMCO) Human Service Program Specialist, currently Eric Ulsh. The care managers actively monitor the case to ensure that the Independent Enrollment Broker (IEB) interview occurs at least six months before the child's 21st birthday. Our care managers stay in close communication with BMCO staff to identify and address any barriers that arise during the process.

Three months before the 21st birthday, the care managers obtain and forward an updated Letter of Medical Necessity from the treating physician, along with a current service plan and care notes from the agencies providing the member's care. The care managers remain in close contact with the parent/caregiver and help clarify any questions about the new service plan. Once the waiver services are in place, the care managers follow up with the member/caregiver to determine whether the services are being delivered to the member/caregiver's satisfaction.

Transition to an Adult PCP

We also take an active role in the transition from a pediatric PCP to an adult PCP for children receiving shift care services and for other children who have special needs that do not require in-home services. We know from our extensive experience working with this population that many parents/caregivers have a strong relationship with their pediatric practitioner and are reluctant to transfer to a physician who does not know their child's history and care needs. Additionally, it can be difficult to identify adult practitioners who are able to meet the needs of young adults with special needs.

To ease this process, we survey our network to identify adult practitioners who are comfortable treating medically fragile young adults. Our care managers use the survey results to assist the members/caregivers to identify a suitable adult practitioner. We also established a special payment code that allows the adult practitioner to evaluate the member while the member was still assigned to the pediatric PCP. This system allows the member/caregiver and adult PCP to meet and discuss the member's care needs, making both parties more comfortable with the transition.

"N", a child in need of 24-hour a day personal care, was living in a pediatric long term care facility due to her chronic health care needs, including Mental Retardation (MR), Cerebral Palsy, Blindness, Microcephaly, and Dwarfism.

The AmeriHealth Mercy care management team contacted the member's case worker at the facility, and ascertained quickly that he was unaware that the member's coverage would change when she turned 21. The member's guardian was the county MH/MR agency, who also had not yet started working on funding for the member's ongoing care needs after she turned 21. "N" had no available family.

AmeriHealth Mercy's care manager stayed in close contact with the MH/MR social worker over the next year prompting her to submit the required paperwork necessary for services after "N" turned 21. After numerous meetings between the facility, the MH/MR social worker, and our care manager, it was determined that the best option for "N" was funding that would allow her to remain in a 24/7 skilled facility as opposed to a home-based waiver program.

AmeriHealth Mercy's care manager contacted the Association for Retarded Citizens (ARC) in "N's" county and worked to get the member an advocate through their program. She connected the ARC advocate with the MH/MR social worker and Human Services Program Specialist from the Division of Quality and Special Needs Coordination at DPW to coordinate efforts for this member. Our care management team continued to follow this case closely and was able to help find the member a place in an adult long term care MR facility.

Through this follow-up, the care manager became aware that the MH/MR social worker had not submitted the admission application to the MR facility. Our care manager contacted the Disability Rights Network to obtain a legal advocate for the member. Only with the continued coordination and follow up by our care managers were these wheels kept in motion for this member. With so many agencies involved, this member was poised to "slip through the cracks" as she had no family advocate and everyone had adopted an "it's not my problem" approach to finding her appropriate placement. Because of AmeriHealth Mercy's efforts, the member was placed in the facility, at age 21, and will remain there. Our role as an advocate for this profoundly retarded child with no voice of her own, ensured that she was appropriately and safely placed where all her needs will be met for the rest of her life.

QUESTION 5

Describe your plan to create, maintain, and continuously improve collaboration with HealthChoices Behavioral Health Managed Care Organizations (BH-MCO). Include a description of methods you will use to exchange information relevant to ensuring care coordination using behavioral health utilization data provided by the Department.

(Limit to two pages)

RESPONSE TO QUESTION 5

AmeriHealth Mercy has worked closely with Behavioral Health Managed Care Organizations (BH-MCOs) since the beginning of the HealthChoices Program to ensure coordination of care for our members with co-morbid behavioral health and physical health diagnoses.

Our Care Managers use an evidenced-based tool to screen members during initial assessment for multiple behavioral health conditions, including depression, anxiety, trauma exposure, suicide risk, substance abuse and autism (for children). We create referral pathways for members to connect them with clinical and behavioral health resources for further assessment and intervention. This screening process also includes pregnant members and is repeated during the new mother's postpartum period to identify new at-risk members and gauge improvement in previously identified participants.

We encourage members with co-morbid behavioral health issues to be part of our Chronic Care Program. Our Care Managers (registered nurses and social workers) sit at the center of the team and coordinate the participation of our Medical Director, pharmacists, and practicing physicians with expertise in the disease state to develop and monitor care plans. Advocacy groups, waiver providers, school district staff, behavioral health providers, and government agencies (for example, the Office of Children, Youth and Families, the Juvenile Probation Office, and the Guardian ad Litem/Child Advocacy) also participate on the care team as needed. The team collaboratively creates a plan of care to address the needs of participating members.

Behavioral health providers collaborate with AmeriHealth Mercy as a result of the Coordination Agreements. We currently have existing Coordination Agreements with the BH-MCOs serving the majority of the counties in the New West and New East Zones, and we are actively pursuing a coordination agreement with remainder. In addition to the coordination agreement required by the DPW HealthChoices contract, we also work jointly with the BH-MCOs to create cost-sharing agreements so that appropriate services are delivered without dispute over whether the service is purely "medical" or "behavioral."

Our efforts to coordinate care with the BH-MCOs in the New West and New East Zones will be tailored from our success in other zones. We will begin by building collaborative relationships between our employees and the administrators of residential treatment facilities. We will also develop Regional Behavioral Health Workgroups to collaborate with the BH-MCOs on various care coordination and data sharing initiatives. Collaborations in our current HealthChoices zones include programs on medication use (e.g. Selective Serotonin Reuptake Inhibitors – SSRIs) and adolescent suicide risk communication to practitioners; communication to PCPs on the identification of autism; development of an autism brochure for families, a joint Physical Health-Behavioral Health (PH-BH) medication formulary document; and a joint PH-BH medication prior authorization form.

For example, we worked with the Capital Area Behavioral Health Collaborative to develop practice guidelines for the appropriate use of Suboxone or Subutex in the treatment of opiate dependence. These efforts led to an initiative to use behavioral health MCO reinvestment dollars for the Recovery, Advocacy, Service, and Empowerment (RASE) Project to improve access to counseling services for patients with opiate dependence. We also worked with Magellan Behavioral Health in Bucks, Montgomery, and Delaware Counties to implement the Serious Mental Illness Innovation Project.

Information Exchange

AmeriHealth Mercy complies with all of the current requirements to exchange information with BH-MCO's, and would welcome the opportunity to have further discussions regarding ways to improve outstanding issues regarding information exchange between PH-MCOs and BH-MCOs. AmeriHealth Mercy currently shares pharmacy data with our behavioral health counterparts via electronic file exchange. AmeriHealth Mercy transmits a pharmacy paid claims file to the Department at least twice monthly in accordance with a predetermined schedule. Upon receipt of the files, DPW posts the data to a private website corresponding to the appropriate BH-MCO for each County.

In 2007-2008, AmeriHealth Mercy participated with DPW in efforts to find solutions for the sharing of BH utilization data with the physical health MCOs. Unfortunately, legal concerns governing confidentiality of information prohibited the sharing of most information. However, we are prepared to quickly integrate such data if it is provided by DPW in the future. We would use this data to support care plans, predictive modeling, programs for members with developmental disabilities and neurological conditions, and improved gaps-in-care analysis. Many programs already operating in conjunction with BH-MCOs will also benefit from this data, especially in terms of enhanced outcomes measurement.

Looking Ahead

AmeriHealth Mercy looks forward to collaborating with its behavioral health counterparts in the New West and New East Zones as we do today in the other HealthChoices zones. Ideally, we wish to extend the lessons learned from the other zones and continue the programs with our county partners in the new zones, improving our techniques and processes for information sharing and joint care management for members with behavioral health co-morbidities. Additionally, we will support and work with the Pennsylvania Psychiatric Society's Outreach Consultation Project, Psychiatrists on Call, which organizes volunteer psychiatrists to offer informal phone consultation for PCPs who need advice or guidance about a patient.

A hospital case manager contacted AmeriHealth Mercy on behalf of Mary, a member with multiple chronic health conditions, including asthma, emphysema, seizure disorder, migraines, and osteoporosis, who repeatedly overused the ER. Our Special Needs Unit contacted Mary and helped her coordinate neurology and orthopedic appointments and even accompanied her to an appointment. Our care manager identified that Mary was a victim of domestic violence and referred her to appropriate resources. Mary is now receiving regular outpatient behavioral health services, is engaged in our Care Management Program, and has had no recent ER visits.

QUESTION 6

Describe the process you will use to coordinate with County Offices of Children, Youth, and Families to ensure that Children in Substitute Care receive necessary services.

(Limit to two pages)

RESPONSE TO QUESTION 6

Children in Substitute Care

AmeriHealth Mercy has a strong track record of meeting the challenge of connecting children in substitute care with timely and appropriate care. In our two existing Pennsylvania HealthChoices plans, we work closely with the staff from the county Offices of Children, Youth and Families to ensure seamless care coordination for children in foster care, including children placed in medical foster care. We make a special effort to ensure that children in substitute care have a consistent Medical Home and plan of care. If awarded a contract to serve the New West and New East Zones, we will replicate the successful procedures we use today in the new zones.

AmeriHealth Mercy has identified a staff liaison within each of the PA Offices of Children, Youth and Families (OCYF) in our current service areas to facilitate care coordination. We also assign an AmeriHealth Mercy care manager as the single point of contact in our organization for OCYF office to facilitate communication. The designated AmeriHealth Mercy Care Manager maintains regular contact with the OCYF liaison, helping to navigate all AmeriHealth Mercy policies and procedures, and the physical health delivery system in general. The AmeriHealth Mercy care manager provides education and training for OCYF offices upon request, and works with OCYF as needed to address member-specific needs. Our efforts to coordinate care commonly focus on:

- Coordinating abuse screenings within mandated timeframes
- Managing adherence to EPSDT guidelines through the coordination of preventive services
- Educating OCYF staff and foster parents about covered benefits and how to use available health benefits
- Arranging dental and other specialty care services
- Coordinating behavioral health services, including home-based wrap-around services
- Coordinating shift nursing services
- Arranging for blood lead screenings
- Coordinating maternity care and infant wellness
- Helping OCYF staff and foster parents coordinate benefits with primary insurers

We are already initiating outreach to identify liaisons in the OCYF offices in the New West and New East counties to begin the process of developing relationships.

Drawing from our experience managing the implementation of the HealthChoices Lehigh/Capital and Southeast Zones, we will work very closely with the OCYF offices in the new zones to facilitate the selection of participating PCPs for members in substitute care, especially during the initial implementation phase. In addition, we will work together to share information about participating specialists and ancillary providers, and develop continuity of care plans for children in substitute care who select AmeriHealth Mercy, but are engaged in an ongoing course of treatment with a non-participating provider. We will comply with all DPW contract requirements related to continuity of care for members engaged in an ongoing course of treatment with a non-participating provider.

Another important area of care coordination for children in substitute care is working to ensure they receive all EPSDT screening services. AmeriHealth Mercy provides the OCYF Offices in our current service area with a monthly report identifying all children in substitute care who are

missing or overdue for an EPSDT screening. We will produce this same report for all OYCF Offices in the New West and New East Zones.

A final important area of focus in developing our relationship with OCYF Offices will be finding solutions to ensure that our written member materials get to the individuals caring for our members in substitute care. Again, based on our experience in our existing service area, we learned that OYCF staff members incur difficulties in delivering much of the written communication we sent to our members. Material that is critical to accessing care - Member ID Cards, for example - were mailed to the central OYCF address provided on the DPW enrollment file. Because of high case loads and over-worked staff, it is almost impossible for OCYF staff to ensure that health plan mailings are distributed in a timely manner to the member's placement agency and then on to the member's foster family. We want to work with OYCF to determine how we find solutions to this important problem.

Our southeast Pennsylvania affiliate, Keystone Mercy, has established procedures with interested OCYF offices to mail supplies of written materials directly to OCYF contracted placement agencies. The agencies provide the information directly to the foster families. Keystone Mercy supplies the agencies with New Member Welcome Kits (comprised of the Member Handbook, Notice of Privacy Practices, a co-pay schedule, a quick-reference benefits grid and information on what to do in an emergency) and Member Newsletters. Because these materials are not addressed to any specific member, this process is compliant with privacy rules. We will encourage the OCYF Offices in the New West and New East Zones to adopt similar processes with us.

Through the processes and procedures described above, and our ongoing communication and relationship building, AmeriHealth Mercy will form the strong connections necessary to ensure the seamless coordination of care for children in substitute care in the New West and New East Zones.

The relationship between Keystone Mercy [AmeriHealth Mercy's affiliated plan in Southeast Pennsylvania] and Delaware County has been, and continues to be, a great collaboration. Delaware County Children and Youth has been fortunate enough to have developed an ongoing relationship that has allowed us to trouble shoot on problems that arise regarding the children that we serve. Keystone Mercy continues to inform us of new programs that could benefit the children in our area. In the past we have brought to Keystone's attention that the bulk mailing was overwhelming and most likely would not reach the clients. In an effort to problem solve this, Keystone Mercy and Children and Youth Services came together and prioritized which information our foster parents are to receive and the best way to disseminate this information to the clients.

*- **Denise Stone**, MSW, Supervisor, HealthChoices/Education, Delaware County, Children and Youth Services*

QUESTION 7

Describe your process for care coordination to ensure that members receive adequate in-home services to divert them from entering long term care facilities.

(Limit to two pages)

RESPONSE TO QUESTION 7

AmeriHealth Mercy has a strong track record of supporting members with complex needs in the home setting. We are currently coordinating care for close to 1,000 HealthChoices enrollees who receive ongoing in-home services, ranging from caregiver support to nursing and ventilator care. Our approach includes aggressive planning, creative service delivery and ongoing monitoring and care management to minimize delays in service that often lead to poor health and costly hospital admissions.

Coordinating Service Planning and Delivery

Our planning process begins with a review of the member's health information. We identify all prior health care issues and past services, including services rendered immediately prior to any hospital admission.

Information gathered from the member Care Coordination Survey included in our New Member Welcome Packet and completed during new member welcome outreach calls (see Clinical Performance Measures Attachment 10), and other care management tools, provides a template of the member's needs and available supports, while data gathered from the member's treating physician, hospital social worker, and other involved healthcare professionals, provide a blueprint of care needs.

For high-volume hospitals, Transition Managers are placed onsite to help assess discharge needs and assists with arranging post-discharge care and physician appointments for those members needing long term in-home care. After a discharge date has been established, we facilitate communication of the member's clinical condition and plan of care to the identified home health, durable medical equipment and specialty home care providers. For members who need services not covered through the HealthChoices program, such as home modifications, we actively assist the member and caregiver to obtain the needed services through community agencies or additional programs.

Meeting Complex Home Health Needs

AmeriHealth Mercy Care Managers assemble each member's personal support network, encompassing the services needed for the member to remain in the comfort of their own homes regardless of complex needs. Skilled nursing facilities, home health agencies, DME suppliers, and other healthcare providers each fill a crucial role. As with the other HealthChoices zones we serve, we are committed to maintaining a robust network of home service providers. We are already contracted with Bayada, the largest home health provider in the state.

We are prepared to collect and report staffing and missed home health shifts in the mandatory DPW Monthly Missed Shift Report that we use today in our current HealthChoices zones.

Ongoing Monitoring and Care Management

AmeriHealth Mercy conducts follow-up phone calls to those members receiving in-home services. Following a hospital discharge, our Care Managers contact members who are currently in a care management program, while our Rapid Response team contacts all other members. Staffed by care managers and non-clinical Care Connectors, our Rapid Response team is a specialized unit dedicated to assisting members to identify and overcome healthcare barriers through facilitation and empowerment.

These follow-up calls focus on medication reconciliation, checking the status of ordered home services, confirming physician appointments and determining how well the member and caregivers understand physician instructions. Through this outreach, we work to make sure the member has the tools they need to progress in the recovery phase of their care and are prepared and able to use them.

All members receiving ongoing in-home care are enrolled in our Complex Care Management program. These members receive comprehensive and condition-specific assessments and reassessments, along with the development of short-term and long-term goals and an individual plan of care, created with input from the member, caregiver, physician, home service provider, and, when applicable, waiver program care manager.

Looking Ahead

The barriers associated with home health care are unique and need to be addressed creatively. Our analysis of the New West and New East Zones reveals that transportation for in-home caregivers is likely to be an issue, especially in remote areas such as Bradford and Tioga Counties. Our plan is to work with agencies when needed to provide additional reimbursement to cover travel costs for members who need care in remote areas, just as we do within our existing HealthChoices zones.

We will extend our Shift Care & Skilled Nursing Performance Incentive Program, specifically developed for the purpose of providing monetary incentives to improve the staffing of home-based shift care and skilled nursing services, to the New West and New East Zones. This DPW funded program allows us to distribute funds through action grants. Home Care Agencies submit proposals outlining programs to improve quality of care and/or reduce the incidence of missed home nursing shifts. Hiring bonuses, on-call nurses, and specialized education curriculums are examples of such proposals.

Avoiding Nursing Home Placement

"J." is a 44-year-old male who became eligible for Medicaid following a massive stroke. He had no prior medical coverage and had a feeding tube, tracheostomy, and multiple medications at the time of discharge. The AmeriHealth Mercy care manager assisted his family in coordinating skilled nursing and home health aide visits so he could return home, arranged for ambulance transportation to physician appointments after discharge, and worked closely with his provider prior to discharge to discuss his ongoing needs.

After speaking with our care manager, his provider agreed to complete a home visit to follow up, evaluate and coordinate his care. Our care manager also referred J. to a community agency to evaluate his needs and determine what type of services would be beneficial. As a result of this referral, his sisters have been designated as his primary caregivers and are being paid by the community agency to provide personal care services. Also with this referral, an application for his enrollment in the Independence Waiver (Pennsylvania) was completed and approved. With these supports, J. has successfully been cared for in his home since discharge.

QUESTION 8

Describe the procedures and processes you will have in place to comply with Department requirements related to the Enhanced Medical Home (EMH) model (as described in Appendix A, "Draft HealthChoices Agreement," Exhibit M(1), "QM/UM Program," under Standard V, Letter F).

(Limit to two pages)

RESPONSE TO QUESTION 8

AmeriHealth Mercy is a national Medical Home Pioneer and was founded on the principles of the Medical Home Model. In 1983, the staff of our founding plan, Mercy Health System, noticed that many of its Medicaid patients were using the emergency room for their primary care. They worked with DPW, and in response to this very expensive and inefficient delivery model, we created what became known as a Patient-Centered Medical Home (PCMH).

True to our roots, AmeriHealth Mercy has remained in the forefront as this concept evolved into the more intensive Enhanced Medical Home (EMH). As defined, this model of care places the primary care practitioner (PCP) at the center of our members' care, working with us to provide and coordinate a centralized spectrum of services to include acute, chronic, specialized treatment. In many cases, behavioral, nutritional, and dental services may be available and Electronic Medical Records are utilized.

AmeriHealth Mercy is already participating in each of the four pillars of the EMH model as described in Exhibit M(1) of the Draft Heath Choices Agreement and is prepared to expand our best practices into the New West and New East Zones.

Pillar 1: Embedded Care Managers in High Volume Practices (HVP)

Our southeastern Pennsylvania affiliate, Keystone Mercy, began using embedded care managers in Pennsylvania in 2009 with a care manager embedded in a clinical practice. In 2010, Health Affairs chose the program for presentation to the Centers for Medicare and Medicaid Services during November's Health Innovations Conference. The pilot, which was also selected by the Medicaid Health Plans of America (MPHA) for its 2011 Innovation Award, significantly reduced inpatient admissions and readmissions. See Attachment 3 for MHPA and Health Affairs articles for additional information on this award-winning program.

Pillar 2: Working With HVP(s) to Achieve Medical Home Quality

Our vast experience in the Medical Home realm is easily passed on to providers seeking NCQA Medical Home accreditation. Thoroughly trained Provider Network Representatives are a knowledgeable resource to practices working toward compliance, and access to NCQA certification standards is available through the provider portion of our website. Attachment 4 provides specific details of our efforts to facilitate NCQA accreditation in the following areas:

- Access and Communication
- Patient Tracking and Registry Functions
- Care Management
- Performance Reporting and Improvement

Pillar 3: Transition of Care (TOC) Nurses to Work with High Volume Health Systems

Our Transition Managers work collaboratively with the emergency room and hospital staff to assess members for discharge needs, assist with arrangements, and arrange post-discharge physician appointments. The Transition Managers explore the events leading up to unplanned hospital care and work with the member and AmeriHealth Mercy resources to address issues.

This function is particularly relevant in the New West and New East Zones, where rural localities make accessing care more difficult.

Pillar 4: Participation with Regional Learning Network Collaboratives

As part of the first phase of Pennsylvania's Chronic Care Initiative, AmeriHealth Mercy participated in Learning Collaboratives held between practices, the Department of Health (DOH), and commercial and Medicaid payers on a quarterly basis between 2008 and 2011. The purpose was to share best practices and challenges to implementation, execution and reporting requirements. During Phase II of this initiative, we will participate in learning collaboratives with a multitude of medical practices including 26 located in the Northeast region.

Looking Ahead

As we expand our service area to the New West and New East Zones, we are prepared to execute a comprehensive strategy consistent with our contractual obligations to the four pillars of the EMH model.

Working with DPW, it is our intention to begin identifying high volume practices in the each zone to identify the best locations for embedded care managers. We are prepared to begin the selection and implementation process upon our receiving an award in this procurement.

For those practices seeking NCQA Medical Home recognition we are prepared to assist with Baseline Assessments and calculations. Our affiliates are developing Medical Home reimbursement strategies to provide a financial incentive for practices to achieve NCQA Medical Home certification. This reimbursement strategy pilot program combines traditional fee-for-service, with a per member per month (PMPM) management fee, and has a discrete fee schedule to cover services not typically on a state Medicaid fee schedule. These services, like telephonic and online consultations and team conferences are consistent with Medical Home practices.

We are seeking facility partners to engage an initiative that will place Transition of Care Managers at high-volume hospitals in the New West and New East Zones to help coordinate care for members who are in the emergency room or on an inpatient unit.

We will continue to participate in Pennsylvania's Chronic Care Initiative for the second three year phase. As one of the participating health plans, we will attend the Learning Collaborative meetings and complete any requested Inter-Session assignments. We look forward to participating in the DOH-identified workgroups to address quality improvement opportunities in the state. We will also assist the participating practices through data sharing, system resources and practice education, as appropriate.

QUESTION 9

What methods do you use to ensure the quality of care delivered by out-of-network providers? Describe any potential barriers and the resolution process.

(Limit to two pages)

RESPONSE TO QUESTION 9

AmeriHealth Mercy's philosophy is to develop and maintain an extensive provider network to support easy access to high-quality providers for our members, while at the same time promoting high quality and cost-effective services through our network management, care management, and quality improvement activities. Even so, at times we find it necessary to authorize and coordinate out-of-network care, particularly for certain specialty/subspecialty care that is in short supply or does not exist in the region. We also coordinate care through non-participating providers to ensure continuity of care for newly enrolled members who are in an ongoing course of treatment with a non-participating provider. Though out-of-network providers are used infrequently, we have internal controls to ensure that we use only appropriately licensed, Medicaid-approved providers, and that all quality of care issues that may be identified retrospectively are handled in accordance with the same policies and procedures that we use to investigate and resolve quality of care concerns related to participating providers.

Procedures to Ensure Use of Licensed Out-of-Network Providers in Good Standing

When a member requires medically necessary care from a provider who is not represented in our network, the AmeriHealth Mercy Care Management staff work collaboratively with the member's referring physician and with the member to identify the right non-participating provider to serve the member. With limited exceptions, such as emergency services, we require prior approval of services obtained through out-of-network providers. The prior-approval process enables us to obtain necessary information to facilitate information sharing and care coordination with the member's PCP.

AmeriHealth Mercy uses only licensed providers when approving out-of-network services. Providers must submit their medical license number before services can be authorized. Transplant facilities must be licensed and Medicare certified. In addition, prior to authorizing care, we determine whether the provider has a Pennsylvania Medical Assistance (PROMISe) provider number, verify that the provider is not on the Medicheck list, and query our own quality of care database to verify that we have no record of past quality of care incidents related to the provider.

Monitoring the Quality of Out-of-Network Care

AmeriHealth Mercy's Prior Authorization Unit coordinates out-of-network care. All quality-of-care concerns that may occur after authorization are handled exactly as if the provider were in our network, with the concern forwarded to our Quality Management Department for investigation through a peer review process. Potential quality of care issues are reviewed by the physician-members of our Quality Assessment and Performance Improvement (QAPI) committee, which is comprised of several physicians from a variety of specialty backgrounds. The QAPI committee reviews each referral to determine whether the provider used acceptable standards of care in treating the member. The QAPI committee advises AmeriHealth Mercy's Medical Director of its findings, and appropriate follow-up action is taken in accordance with our policies and procedures for quality of care issues. Follow-up actions may include provider education or reporting to quality databanks.

Since requests for non-emergent out-of-network services require authorization, each request is entered into our Utilization Management information system. This allows us to track the use of

out-of-network providers at the member-level, as well as report and analyze data on an aggregate basis to identify and investigate trends.

Addressing Potential Barriers to Coordinating Out-of-Network Care

The most common challenge we face in coordinating out-of-network care is negotiating a mutually acceptable rate for the services to be provided. We attempt to address this issue by entering into participating provider contracts with out of area specialists that are not available in the service area, and with nearby children's hospitals located outside of the service area. For example, AmeriHealth Mercy currently contracts with the Children's Hospital of Philadelphia and with Nemours Medical Center in Delaware to facilitate access to specialty care that is not available in the Lehigh/Capital Zone. Furthermore, while it is not always feasible to enter into participating provider agreements with out of network providers, we are often able to negotiate a non-participating provider agreement with providers who are unwilling to open their practice fully to the Medicaid population, but are willing to accept special cases.

AmeriHealth Mercy reviews the frequency with which members are using non-participating providers on a quarterly basis and attempts to contract with those most frequently utilized.

Our robust contracting efforts, coupled with our tested quality monitoring and investigation processes allows our members to receive the same high level of quality from out-of-network provides as from our contracted providers.

CLINICAL PERFORMANCE MEASURES

CONTENTS

QUESTIONS 1-14

Questions 1-14 (answers to be provided using Appendix K (1), K (2), or K (3)

Provide HEDIS® rates for the following 14 measures:

1. *Controlling High Blood Pressure*
2. *Comprehensive Diabetes Care: HbA1c Poorly Controlled*
3. *Comprehensive Diabetes Care: LDL Control <100*
4. *Prenatal Care in the First Trimester*
5. *Frequency of Ongoing Prenatal Care:>81 Percent of the Expected Number of Prenatal Care Visits*
6. *Breast Cancer Screening (Ages 42-69)*
7. *Cervical Cancer Screening (Ages 24 to 64 years)*
8. *Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Controlled<100*
9. *Annual Dental Visits (Ages 2-21 years)*
10. *Well-Child Visits in the First 15 Months of Life*
11. *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
12. *Adolescent Well-Care Visits*
13. *Lead Screening in Children*
14. *Emergency Department Utilization*

RESPONSE TO QUESTION 1-14

HEDIS® REPORTING FORM

This Appendix is to be used by Offerors currently participating in the HealthChoices Program who have been participating in the HealthChoices Program since prior to April 1, 2010. Offerors must provide 2009 and 2010 HealthChoices HEDIS® rates for the HEDIS® performance measures displayed in this Appendix.

	HEDIS® PERFORMANCE MEASURE	2009 HealthChoices HEDIS® Rate	2010 HealthChoices HEDIS® Rate
1	Controlling High Blood Pressure	64.84	66.58
2	Comprehensive Diabetes Care: HbA1c Poorly Controlled	35.40	33.03
3	Comprehensive Diabetes Care: LDL Control <100	40.15	42.15
4	Prenatal Care in the First Trimester	89.89	90.28
5	Frequency of Ongoing Prenatal Care: >81 Percent of the Expected Number of Prenatal Care Visits	78.96	83.06
6	Breast Cancer Screening (Ages 42-69 years)	61.49	61.39
7	Cervical Cancer Screening (Ages 24 to 64 years)	70.43	71.84
8	Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Controlled <100	53.35	52.00
9	Annual Dental Visits (Ages 2-21 years)	44.96	50.27
10	Well-Child Visits in the First 15 Months of Life	70.73	72.70
11	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	78.05	74.65
12	Adolescent Well-Care Visits	57.78	56.08
13	Lead Screening in Children	72.02	73.72
14	Emergency Department Utilization	86.68	80.85

QUESTION 15

Describe your proposed strategy for controlling high blood pressure in members who reside in a rural service delivery area who are ages 18 to 85 years old and have been diagnosed with hypertension.

(Limit to two pages)

RESPONSE TO QUESTION 15

Cardiovascular disease (including Hypertension) is the leading cause of mortality in Pennsylvania, accounting for 33% of all deaths in the Commonwealth in 2007. AmeriHealth Mercy's approach to improving blood pressure control has demonstrated success in our two Pennsylvania plans. Both plans exceed the state Medical Assistance average, with AmeriHealth Mercy ranking in the 75th national Medicaid percentile. The following section outlines our strategies for controlling high blood pressure in a rural population. Our strategies can be grouped into the following categories and are reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information. We expect that using technology to remotely support our members with high blood pressure will improve member adherence to care plans, resulting in improved blood pressure control.

Telehealth

AmeriHealth Mercy will offer a Telehealth program for rural members with high blood pressure. Members with high blood pressure will receive a wireless digital blood pressure monitor for home use. The monitor automatically stores and sends the member's health information to designated medical professionals (e.g. their PCP) and to the AmeriHealth Mercy Care Manager. This process alerts the PCP and the AmeriHealth Mercy care management team to fluctuations in the member's blood pressure, allowing for timely intervention that may prevent an ER visit or hospital admission.

24/7 Nurse Line

Our 24/7 Nurse Line provides members with access to symptom counseling and healthcare guidance by a registered nurse. This is particularly helpful for a rural population, as clinical counseling is made available at all times to any member with access to a telephone. A summary of the member's interaction with the 24/7 Nurse Line is faxed to the PCP and to AmeriHealth Mercy's Rapid Response team. Our Rapid Response Care Connectors subsequently contact the member to assess any additional needs and to help reconnect the member with the PCP, if appropriate.

Member and Provider Portal

Currently, members and providers have access to our secure Web Portals which contain detailed information on care gaps and medication history. Care Gaps are recommended services supported by evidence-based clinical practice guidelines (such as LDL-C and blood pressure testing) for which there is no claim evidence that the member received the service. Providers receive an alert identifying patient-specific Care Gaps when the member's ID is entered in the portal.

In addition to providing care gap prompts, our Web Portals provide accurate, up-to-the-minute information on medications the member has received. The medication information provided through the portal allows the provider to see whether the member has filled the prescribed

medications and alerts the provider to medications the member is taking that were prescribed by a different provider.

This information is crucial in the management of hypertension. In some cases, members report that they are taking the prescribed dose of medication because they want to appear compliant, while the medication history indicates otherwise. This information can make the difference between prescribing unnecessary higher doses or additional medications and performing additional assessment and counseling related to the drivers of the member's medication non-adherence.

Both the provider and the member can view the member's care gaps and medication history through the Member Clinical Summary section of the respective Web Portals.

Community Outreach

Our extensive experience with the Medicaid population in rural markets demonstrates to us the importance of engaging members where they reside, and in a manner that fosters respect and trust. To that end, we sponsor and participate in over 1,000 local health-related events annually to bring health care directly to the communities we serve.

To support blood pressure management, these events offer blood pressure testing, nutrition counseling, medication adherence counseling, as well as a connection to our Integrated Care Management team, should a member need greater support in closing their care gaps and following their care plan.

To improve the rate of blood pressure control in the rural areas of the New West and New East HealthChoices Zones, we will use our Health Navigator infrastructure to deliver educational programs focusing on healthy heart habits and blood pressure control using our Heart Health and "Know your Numbers" outreach programs. To support our rural counties, Health Navigators, a type of Community Health Worker (CHW), will be stationed in each of the New West and New East counties. Through their familiarity with the county's population and local gathering spots, the Health Navigators will identify appropriate venues for delivery of these programs.

Member Education

We have found that for members to feel empowered to make behavioral changes, they first must be educated on the appropriate manner to make those changes. To that end, we utilize CHWs to provide culturally appropriate health education and information; empower people to obtain the care that they need; provide informal counseling and guidance on health-related behaviors; and advocate for individuals and community health care needs.

Provider Engagement

The relationship between the provider and the member is one of the strongest tools we possess for changing member behavior. In rural areas with low PCP density, we will expand access to care by contracting with pharmacies to provide counseling services for members with high blood pressure that fall within the pharmacists' scope of practice, but go beyond traditional medication counseling. We will also ensure that all providers have accurate and up-to-date data on member medications and offer Pay-for-Performance incentives for achievement of HEDIS completion rates.

QUESTION 16

Describe your proposed approach to achieve appropriate HbA1c control and cholesterol management for members with diabetes who reside in a rural service delivery area.

(Limit to two pages)

RESPONSE TO QUESTION 16

People with diagnosed diabetes have medical expenditures that are, on average, approximately 2.3 times higher than those without diabetes. AmeriHealth Mercy exceeds the state Medical Assistance average for HbA1c and cholesterol screening, as well as HbA1c poor control and cholesterol management (LDL <100 mg/dl). We anticipate achieving the same results in the rural counties belonging to the New West and New East Zones. The following section outlines our strategies for controlling blood glucose and cholesterol levels in a rural population. Our strategy can be grouped into the following categories and is reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information. We expect that using technology to support our members with diabetes will improve adherence to care plans, resulting in improved HbA1c control and cholesterol management.

Telehealth

To support rural members with diabetes, we will offer a Telehealth program. This program will provide cell-phone connected glucometers to high-risk diabetic members for daily uploading of blood glucose levels. This process alerts the PCP and AmeriHealth Mercy care management team to fluctuations in the member's blood sugar, allowing for timely intervention that may prevent an ER visit or hospital admission. Our affiliate, Keystone Mercy Health Plan, piloted this program in an underserved area of Philadelphia, and saw a decrease of 8.6 percent in HbA1c and a 13.5% decrease in emergency room visits among participants.

Home Test Kits

AmeriHealth Mercy recently entered into an agreement to provide home HbA1c and LDL test kits. The kits contain easy-to-use instructions and materials for collection of a finger-stick blood sample that is mailed to a certified laboratory for processing, saving the member from a separate trip to a laboratory site. The data collected from these at-home test kits are shared with the member's PCP and the AmeriHealth Mercy Care Manager.

24/7 Nurse Line

Our toll-free 24/7 Nurse Line provides members with access to symptom counseling and healthcare guidance by a registered nurse. This is particularly helpful for a rural population, as clinical counseling is made available at all times to any member with access to a telephone. A summary of the member's interaction with the 24/7 Nurse Line is faxed to the PCP and to AmeriHealth Mercy's Rapid Response team. Our Rapid Response Care Connectors subsequently contact the member to assess additional needs and reconnect the member with the PCP, if appropriate.

Member and Provider Portals and Dissemination of Care Gaps

Currently, members and providers have access to our secure Web Portals which contain detailed information on care gaps and medication history. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as HbA1c testing and control and LDL-C testing and control for diabetes) for which there is no claim evidence that the member received

the service. Providers receive an alert identifying patient-specific care gaps when the member's ID is entered in the portal. Both the provider and the member can view the member's care gaps and medication history through the Member Clinical Summary section of the respective Web Portals.

This information can be particularly helpful for rural members by ensuring that all required preventive care is completed during provider interactions. Members can use the information in the portal to track completion of recommended services. In addition to receiving alerts for members who need recommended services, providers gain insight into the member's behavior. For example, a member whose information in the Web Portal indicates an HbA1c result greater than eight percent, missing refills for diabetic testing supplies and has no refills for their oral hypoglycemic medication needs a different approach than a member who has an elevated HbA1c result and is compliant with blood glucose testing and medications.

Community Outreach

Our experience with the Medicaid population in rural markets demonstrates to us the importance of engaging members where they reside. To that end, we sponsor and participate in more than 1,000 local health-related events annually to bring health care directly to the communities we serve. To specifically support HbA1c and cholesterol control, these events offer blood draws, nutrition counseling, medication adherence counseling, as well as a connection to our Integrated Care Management team, should a member need greater support.

To improve HbA1c and cholesterol management in the rural areas of the New West and New East HealthChoices Zones, we will use our Health Navigator infrastructure to identify appropriate venues in the community and deliver educational programs focusing on healthy habits, medication adherence, and PCP communication. Health Navigators, a type of Community Health Worker (CHW), will be stationed in each of the New West and New East counties.

Member Education

We use CHWs to provide culturally appropriate health education, counseling, and guidance on health behaviors, as well as advocate for health care needs. Our successful Promotora program in the Lehigh/Capital Zone uses specially trained CHWs to provide educational sessions on healthy living with diabetes to Spanish-speaking members with diabetes and their families. The sessions, which are delivered in Spanish, address a wide range of topics including healthy eating and recipes. Participants receive the Platillos Latinos !Sabrosos y Saludables! (Delicious Heart Healthy Latino Recipes) cookbook. The program culminates with a "graduation" celebration. Please see Attachment 1 for an example of written material used to educate members about warning signs of diabetes, risk factors, and the availability of our Diabetes Program.

Provider Engagement

The relationship between the provider and the member is one of the strongest tools we possess for changing member behavior. In rural areas with low PCP density, we will expand access to care by contracting with pharmacies to provide counseling services for members with diabetes that fall within the pharmacists' scope of practice, but go beyond traditional medication counseling. We will also ensure that our providers have accurate and up-to-date data on member care gaps and prescription history. We currently include HbA1c and LDL-C measures in our Pay-for-Performance programs and will extend that program into the New West and New East Zones. See Attachment 2 for more information on our provider incentives.

QUESTION 17

Describe the proposed approach you will use to care manage pregnant women in rural service delivery areas to ensure they receive prenatal care in the first trimester and to ensure they receive "81% or greater" of the expected number of prenatal care visits.

(Limit to two pages)

RESPONSE TO QUESTION 17

We know that a preterm infant costs 10 times more than a healthy one.[1] AmeriHealth Mercy exceeds the state Medical Assistance average for Prenatal Care in the First Trimester and Frequency of Prenatal Care (>81% of expected visits), achieving the 75th and 90th national Medicaid percentiles, respectively. The following section outlines our strategies for ensuring pregnant women receive prenatal care in the first trimester and that they receive "81% or greater" of the expected number of prenatal care visits in a rural market. Our strategy can be grouped into the following categories and is reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information. We have seen improvements in prenatal care in the first trimester and prenatal care completion rates by remotely supporting members and their adherence to care plans.

We expect that using technology to remotely support our pregnant members will improve member adherence to care plans, resulting in improved prenatal and postpartum outcomes.

Early Pregnancy Identification

Adequate prenatal care starts with early identification of pregnant members. We accomplish this by analyzing claims and utilization data seeking pregnancy identifiers, including Logical Observation Identifiers Names and Codes (LOINC). LOINC are a data set of universal identifiers for laboratory and other clinical observations that facilitate communication of clinical results, including pregnancy. We ask members about their pregnancy status as part of the new member assessment and we encourage providers to alert us to new pregnancies and reimburse them for completing pregnancy risk assessment forms.

24/7 Nurse Line

Our toll-free 24/7 Nurse Line provides members with access to symptom counseling and healthcare guidance by a registered nurse. This is particularly helpful for a rural population, as clinical counseling is made available at all times to any member with access to a telephone. A summary of the member's interaction with the 24/7 Nurse Line is faxed to the PCP and to AmeriHealth Mercy's Rapid Response team. This allows us to follow-up with members who report symptoms related to a new pregnancy to ensure that they are connected to prenatal care and enrolled in our WeeCare (maternity management) program.

Text-4-Baby

We promote and encourage our members to participate in the nationally-recognized Text-4-Baby program, a no-cost text message education service. Launched by the National Healthy Mothers and the Healthy Babies Coalition, Text-4-Baby is a public health campaign which promotes good health for expectant mothers and babies. Members who sign up receive weekly text messages with prenatal care reminders.

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1 About Prematurity. March of Dimes. As viewed on the world wide web at http://www.marchofdimes.com/prematurity/21198_10734.asp on 12/9/2011.

Community Outreach and Member Education

To support our prenatal care goals, our Community Health Workers (CHWs) educate our members on the need for, and importance of, early and ongoing prenatal care, risk factors for premature birth, and more. To encourage early identification of pregnancies, we distribute pregnancy test kits at community events containing the toll-free phone number for our WeeCare department. Members who test positive and contact our WeeCare department are assisted in making a prenatal care appointment and coordinating needed transportation, and are enrolled in our WeeCare maternity program.

Our WeeCare program provides educational information to pregnant members and reminders about upcoming prenatal appointments. All members receive education on healthy pregnancy habits, smoking and alcohol cessation, choosing a pediatrician and the importance of immunizations and infant medical care during the first two years of life. Please see Attachment 3 for examples of written educational materials related to pregnancy.

All pregnant members are educated about the importance of dental care during pregnancy to reduce the risk of pre-term labor. We work with our OB/GYN providers to raise awareness of, and adherence to, dental care during pregnancy through our Smiling Stork program. We provide pregnant members who are in their first or second trimester with educational mailers and follow-up reminder calls to schedule dental appointments (see Attachment 3). In the first year of our Smiling Stork Program, we doubled the number of women who received dental care during pregnancy.

Members identified as high-risk receive individual care management through a team of WeeCare Care Managers (registered nurses experienced in maternity) and Care Connectors (non-clinical staff). Care Managers coordinate care and address various issues throughout the member's pregnancy and post-partum period. We screen all pregnant members for depression and coordinate behavioral health services as needed.

Dental Care during Pregnancy

Member Incentive Programs

AmeriHealth Mercy offers two member incentives to increase adherence to prenatal care. Our Community Baby Showers are held in local community venues. Women receive "shower gifts" in the form of baby supplies for attending prenatal care education sessions. Additionally, through our WeeCare Incentive Program members who complete their recommended prenatal care and post-partum care visits receive a gift card.

Provider Engagement

The relationship between the provider and the member is one of the strongest tools that we possess for changing member behavior. To that end, in rural areas with low PCP density, we contract with nurse midwives to increase access. Recently, our partner in the New East Zone, Blue Cross and Blue Shield of Northeastern Pennsylvania, funded a project with Maternal & Family Health Services' Nurse Family Partnership Program, supporting 200 new families throughout the region. Additionally, we recognize that in many rural areas, Family Practitioners perform deliveries. We will contract for those services accordingly.

QUESTION 18

Describe the approach you will use in a rural service delivery area to ensure access to mammograms to screen for breast cancer for women ages 42-69 years old.

(Limit to two pages)

RESPONSE TO QUESTION 18

The following section outlines our strategies for ensuring member access to mammograms in a rural population. AmeriHealth Mercy exceeds the state Medical Assistance average for breast cancer screening and is ranked in the 75th national Medicaid percentile. Our strategy can be grouped into the following categories and is reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information. We expect that using technology to remotely support our members will increase mammography screenings for women ages 42-69 years old.

Member and Provider Portals and Dissemination of Care Gaps

Currently, members and providers have access to our secure Web Portals which contain detailed information on care gaps and medication history. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as mammography for breast cancer screening) for which there are no claim evidence that the member received the service. Providers receive an alert identifying the care gap when the member's ID is entered in the portal. Both the provider and the member can view the member's care gaps through the Member Clinical Summary section of the respective Web Portals.

This information is particularly helpful for rural providers by serving as a point-of-care reminder to address the need for a mammogram with the member during the encounter. Members use the information in the portal to track completion of recommended services.

Customer Service Support

Care Gaps are integrated with all of our internal information systems, providing a pop-up alert to any AmeriHealth Mercy staff person that enters the member's ID number into our Member Service or Care Management systems. Care Management and/or Member Service staff members talking with the member address the care gap, following a role-specific protocol to connect the member to the recommended care. For instance, a Member Service Representative who receives an alert for a woman who is overdue for a mammogram will initiate a scripted exchange with the member designed to allow the representative to move the call to a Care Connector who will assist the member in making an appointment and coordinating transportation as needed.

Community Outreach

We sponsor and participate in over 1,000 local health-related events annually to bring health care directly to the communities we serve. These events offer education on women's health issues including the importance of mammograms, Pap tests, nutrition counseling, medication adherence counseling, and provide a connection to our Care Management team, should a member need greater support in connecting with a provider.

Gift for Life

AmeriHealth Mercy will implement the Gift for Life program, established by our Keystone Mercy affiliate, which engages, educates and empowers members who have not had a mammogram in the past two years. During the member outreach, members are encouraged to dedicate time to themselves and to give their families the "gift" of their own life through

preventive care screenings. To support their completion of the mammogram, we will provide transportation and arrange for screenings in the neighborhoods where our members live, shop, or seek medical care, leveraging Mobile Mammograms and Provider block schedules (discussed below). These strategies are particularly valuable in the rural market. Prior to the event, outreach team members will make reminder calls to maximize participation, and following the mammogram, members will receive a gift card incentive for their participation.

Mobile Mammography

To facilitate access in rural areas, we bring a mobile mammography unit to neighborhood locations, reaching out in advance to members to schedule mammograms. We work with the Lackawanna Mobile Diagnostic Services in the HealthChoices Lehigh/Capital Zone, and have started discussions with them to reserve dates for the New West and New East Zones, should we be awarded a contract.

Member Education

We use Community Health Workers (CHWs) to provide culturally appropriate health education and to educate members as to why they need mammograms. To support our rural counties, Health Navigators, a type of CHW, will be stationed in each of the New West and New East counties. Through their familiarity with the county's population and local gathering spots, the Health Navigators will identify appropriate venues for delivery of these programs. Please see Attachment 4 for an example of written material used to educate members and encourage them to get a mammogram.

Member Incentive Programs

AmeriHealth Mercy has often found that successful behavior change comes from combining actionable information with incentives. To that end, AmeriHealth Mercy offers a Gift Card incentive to members who participate in the Gift for Life program and complete their mammogram screening.

Provider Engagement

As discussed above, providers have access to our secure Provider Portal, which provides alerts and reports on members who have not had recommended screening mammograms. The closure of mammography care gaps is further supported our provider Pay-for-Performance program that rewards providers for their performance related to the HEDIS breast cancer screening (mammography) measure. See Attachment 2 for more information on our provider incentive.

Our partner in the New East Zone, Blue Cross and Blue Shield of Northeastern Pennsylvania, recently funded a project to provide digital mammography and diagnostic ultrasound screenings for 85 underserved individuals served through the Blue Mountain Health System.

Dedicated Schedule Blocks

As access can be an issue in rural settings, we partner with local providers to reserve blocks of time for our members to receive breast cancer screenings, and we work with our members to ensure that they keep their appointments. We help our members schedule the appointments and coordinate transportation if needed, and we follow up to remind them of upcoming appointments. We have started discussions with providers about scheduling mammography screening blocks in the New West and New East Zones should we be awarded a contract.

QUESTION 19

Describe the approach you will use in a rural service delivery area to ensure access to Pap tests to screen for cervical cancer for women ages 24-64 years old.

(Limit to two pages)

RESPONSE TO QUESTION 19

The following section outlines our strategies for ensuring member access to Pap tests in a rural population. AmeriHealth Mercy exceeds the state Medical Assistance average for Cervical Cancer Screening (Pap tests). Our strategy can be grouped into the following categories and are reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information. We expect that using technology to remotely support our members will increase our cervical cancer screening rate for women ages 24-64 years old.

Member Portal and Submission of Care Gaps

Currently, members and providers have access to our secure Web Portals which contain detailed information on care gaps and medication history. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as Pap testing for cervical cancer screening) for which there is no claim evidence that the member received the service. Providers receive an alert identifying the care gap when the member's ID is entered in the portal. Both the provider and the member can view the member's care gaps through the Member Clinical Summary section of the respective Web Portals.

This information is particularly helpful for rural providers by serving as a point-of-care reminder to address the need for a Pap test with the member during the encounter. Members use the information in the portal to track completion of recommended services.

Customer Service Support

Care Gaps are integrated with all of our internal information systems. This integration provides an alert to an AmeriHealth Mercy staff person that enters the member's ID number into our Member Service or Care Management systems. Care Management and/or Member Service staff members talking with the member address the care gap, following a role-specific protocol to connect the member to the recommended care. For instance, a Member Service Representative who receives an alert for a woman who is overdue for a Pap test will initiate a scripted exchange with the member designed to allow the representative to move the call to a Care Connector who will assist the member to make an appointment for the test. The Care Connector will assist the member with transportation arrangements, as necessary. The protocols contain decision and escalation points, providing staff with the ability to transfer the call directly to a clinical Care Manager if the member has questions of a clinical nature.

Community Outreach

We sponsor and participate in over 1,000 local health-related events annually to bring health care directly to the communities we serve. These events offer education on women's health issues including the importance of Pap tests, mammograms, nutrition counseling, medication adherence counseling, and provide a connection to our Care Management team, should a member need greater support in connecting with a provider.

Member Education

We have found that, for members to feel empowered to make behavioral changes, they first must be educated on the appropriate manner to make those changes. To that end, we utilize Community Health Workers (CHWs) to provide culturally appropriate health education and to educate members as to why the need Pap tests. To support our rural counties, Health Navigators, a type of CHW, will be stationed in each of the New West and New East counties. Through their familiarity with the county's population and local gathering spots, the Health Navigators will identify appropriate venues for delivery of these programs. Please see Attachment 4 for an example of written material used to educate members and encourage them to get a Pap test.

Member Incentive Programs

AmeriHealth Mercy has often found that successful behavior change comes from combining actionable information with incentives. To that end, AmeriHealth Mercy will offer a DPW-approved Gift Card incentive to members who complete a Pap test. To support their completion of the Pap test, we provide transportation and screenings in the neighborhoods where our members live, shop, or seek medical care leveraging Provider block scheduling (discussed below). These strategies are particularly valuable in the rural market. Prior to the event, outreach team members make reminder calls to maximize participation, and following the Pap test, members will receive the gift card incentive for their participation.

Provider Engagement

The relationship between the provider and the member is one of the strongest tools that we possess for changing member behavior. To that end, in rural areas with low PCP density, we contract with Nurse Practitioners to provide support for women's health needs as well as preventive care contracts with Planned Parenthood Facilities. We will also ensure that all providers have accurate and up-to-date data on member care gaps and include Pap test performance in our Pay-for-Performance provider incentive program. As discussed above, providers have access to our secure Provider Portal, which provides alerts and reports on members who have not had recommended screening Pap tests. The closure of the Pap test care gaps is further supported by our provider Pay-for-Performance program that rewards providers for their performance related to the HEDIS cervical cancer screening (Pap test) measure. The care gap information, coupled with the provider Pay-for-Performance incentive (See Attachment 2), is particularly helpful for rural providers who wish to ensure that all required preventive care is completed during member interactions.

Dedicated schedule blocks

As access can be an issue in rural settings, we partner with local providers to reserve blocks of time for our members to receive Pap tests, and we work with our members to ensure that they keep their appointments. We help our members schedule the appointments and coordinate transportation if needed, and we follow up to remind them of upcoming appointments.

We have started discussions with providers about scheduling blocks in the New West and New East Zones, should we be awarded a contract.

QUESTION 20

Describe the plan you propose to use in a rural service delivery area to provide disease management services for members with cardiovascular disease; including but not limited to cholesterol management.

(Limit to two pages)

RESPONSE TO QUESTION 20

The following section outlines our strategies to provide disease management services for members with cardiovascular disease in a rural population. AmeriHealth Mercy exceeds the state Medical Assistance average for cholesterol (LDL-C) screening and management. Our strategy can be grouped into the following categories and is reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information. We expect that using technology to remotely support our members with cardiovascular disease will improve member adherence to care plans, resulting in improved cholesterol management.

Home Test Kits

Convenient access to laboratory facilities is one barrier that can impede adequate cholesterol management. To address this issue, we provide members with cardiovascular disease with home LDL test kits. The kits contain easy-to-use instructions and materials for collection of a finger-stick blood sample that is mailed to a certified laboratory for processing. Collection of the blood sample involves the same type of finger-stick that individuals with diabetes use for home glucose monitoring. All collected data from the at-home test kits are shared with the member's PCP and AmeriHealth Mercy Care Management, should additional follow-up be needed.

24/7 Nurse Line

Our toll-free 24/7 Nurse Line provides members with access to symptom counseling and healthcare guidance by a registered nurse. This is particularly helpful for a rural population, as clinical counseling is made available at all times to any member with access to a telephone. A summary of the member's interaction with the 24/7 Nurse Line is faxed to the PCP and to AmeriHealth Mercy's Rapid Response team. Our Rapid Response Care Connectors subsequently contact the member to assess any additional needs and to help reconnect the member with the PCP, if appropriate.

Member and Provider Portals and Dissemination of Care Gaps

Currently, members and providers have access to our secure Web Portals which contain detailed information on care gaps and medication history. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as LDL-C testing and control for cardiovascular disease) for which there is no claim evidence that the member received the service. Providers receive an alert identifying the care gap when the member's ID is entered in the portal. Both the provider and the member can view the member's care gaps and medication history through the Member Clinical Summary section of the respective Web Portals.

Members use the information in the portal to track completion of recommended services. In addition to receiving an alert for members who need recommended services, providers gain insight into the member's behavior. For example, a member whose information in the Web Portal indicates care gap alerts for a LDL-C result greater than 100 mg/dl and no refills for their antilipidemic medication in the last two months needs a different approach than a member who has an elevated LDL-C result and is compliant with prescribed medications.

Community Outreach

We sponsor and participate in over 1,000 local health-related events annually to bring health care directly to communities. To specifically support cardiovascular disease management, these events offer blood pressure testing, blood draws, nutrition counseling, medication adherence counseling, as well as a connection to our Care Management team, should a member need greater support in closing their Care Gaps and adhere to their medications.

Member Education

We have found that education empowers members to make appropriate changes. To that end, we utilize Community Health Workers (CHWs) to provide culturally appropriate health education, counseling, and guidance on health behaviors, as well as advocate for health care needs.

To improve cardiovascular disease management in the rural areas of the New West and New East HealthChoices Zones, we will use our Health Navigator infrastructure to deliver educational programs focusing on healthy habits, medication adherence, and PCP communication. Health Navigators, a type of CHW, will be stationed in the New West and New East counties. Through their familiarity with the county's population and local gathering spots, the Health Navigators will identify appropriate venues for delivery of these programs. Please see Attachment 5 for an example of written material used to educate members about ways to maintain a healthy heart.

Integrated Care Management

Our Integrated Care Management (ICM) program, discussed in greater detail in the Coordination of Care section, provides a member with a single point-of-contact for all of their healthcare needs. Members are selected for ICM through our own data stratification process or though provider or member referral. Within our ICM program we provide intensive focus on complex members who have comorbidities with their cardiovascular disease. Depression screening and smoking cessation counseling are standard pillars of our comprehensive ICM program.

Provider Engagement

The relationship between the provider and the member is one of the strongest tools we possess to change member behavior. In rural areas with low PCP density, we will expand access to care by contracting with pharmacies to provide counseling services for members with cardiovascular disease that fall within the pharmacists' scope of practice, but go beyond traditional medication counseling. We will also ensure that providers have accurate and up-to-date data on member care gaps and prescription history. We currently include LDL-C performance measures in our provider Pay-for-Performance program (see Attachment 2), and will extend that program into the New West and New East Zones.

QUESTION 21

Describe your proposed strategy to ensure access to a dentist for an annual dental visit for 2 to 21 year olds who reside in a rural service delivery area.

(Limit to two pages)

RESPONSE TO QUESTION 21

Our strategies for ensuring access to an annual dental visit for 2 to 21 year olds, who reside in rural areas of the New West and New East Zones, focus on promoting the adoption of healthy behavior and increasing access to dental services. We use a combination of technology-driven and high-touch processes to connect members to dental care and services.

Our programs and approaches have successfully raised dental rates in our rural Lehigh/Capital HealthChoices population over the last three years. Since March of 2009 when we implemented a new dental fee schedule, we aggressively expanded our dental specialist network and improved access rates by double digits.

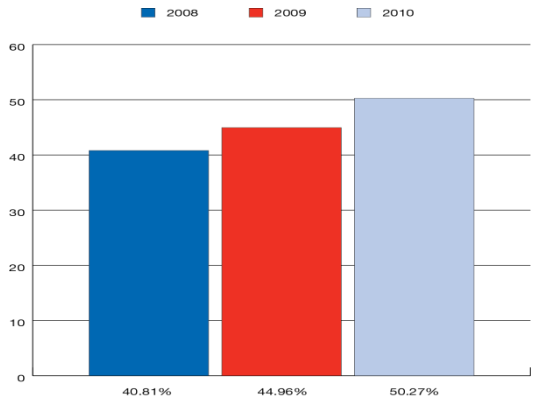

Figure 1: Dental Care Improvements Lehigh/Capital Zone

We know from conversations with multiple stakeholders in the New West and New East Zones, including Ron Errett, President and CEO of the Community Action Partnership in Mercer County, that access to dental care in those counties is a serious issue, more so than in the existing HealthChoices zones. Mr. Errett cited the high rate of missed appointments by Medicaid consumers and one reason why the few dentists in the New West and New East are reluctant to participate in HealthChoices.

We will leverage several intersecting strategies to improve dental access in the New West and New East Zones, including mobile dental vans, scheduling assistance, PCP engagement, care gap dissemination and educational outreach.

Expanding Access

We have identified and will coordinate with dental vans that service the New West and New East Zones to provide services for our members. Our Health Navigators, health plan outreach staff located in each of the counties, will identify locations within the communities to host the van. We use the mobile dental van strategy successfully today in the Lehigh/Capital Zone.

Our partners in the New East portion of this proposal, Blue Cross and Blue Shield of Northeastern Pennsylvania, recently funded the expansion of Tioga Dental Services' pediatric preventive dental program to reach an additional 370 children in the region.

Scheduling Assistance

For members who need help with scheduling dental visits, our nurses, Care Connectors and Member Services Representatives assist members in making an appointment with a dental provider. Our employed dental hygienist assists members with special needs who require special services, including anesthesia, as part of their dental care.

PCP Engagement

AmeriHealth Mercy encourages PCPs to screen patients for dental needs, and we pay PCPs to apply fluoride varnishes in the physician practice. Additionally, we will facilitate collaboration between dentists and PCPs to develop professional relationships that will support the referral of patients in need of dental and physical health care.

Care Gap Dissemination

Care gaps are recommended services supported by evidence-based clinical practice guidelines for which there is no claim evidence that the member received the service. We evaluate claim data at least monthly for all members. Care gap algorithms exist for a full range of preventive services and chronic disease states, including annual dental care. In the event there is no claim for a dental examination in the last 12 months, the system automatically generates a care gap.

Care gap data are loaded into our internal information systems and appear as an alert when a member ID number or name is entered. Care Management and/or Member Service staff members talking with the member are alerted to the need for a dental examination and offer to assist the member in making an appointment. Protocols in our system trigger a follow-up call to remind the member of the appointment and assess for transportation needs.

Care gaps are also used to conduct outreach campaigns. Members who are missing or overdue for recommended dental examinations are contacted, educated on the recommendation, and assisted with obtaining appointments for care. We segment our outreach to coordinate with planned visits of the dental van, contacting members who live in the area but have not had their annual examination.

Educational Outreach

Our approach to member outreach focuses on the three “E”s: Engagement, Education, and Empowerment. The primary goal of this strategy is to provide members with the educational programs and resources necessary to encourage self-management of care to the degree that each individual member is capable. Continuously available self-management resources, such as the 24/7 Nurse Line and Rapid Response call center assist members on a more individualized basis. Please see Attachment 6 for an example of written material used to educate members about important dental care issues for infants and young children.

Looking Ahead

We know from our experience in the Lehigh/Capital and Southeast Zones that access to dental care is a challenging issue in Pennsylvania. In addition to the proven strategies described above, we will implement a dental measure in our pay-for-performance program, similar to the one we are implementing in the Lehigh/Capital Zone this month.

QUESTION 22

Describe how you will ensure access to well-child visits in the first 15 months of life for those who reside in a rural service delivery area.

(Limit to two pages)

RESPONSE TO QUESTION 22

Our Pediatric Preventive Health Care program is designed to improve the health of members from birth to age 21 by increasing adherence to EPSDT and well-child visit guidelines. We have successfully improved well-child visit rates in the first 15 months of life. AmeriHealth Mercy's rates for this HEDIS measure are in the 90th national Medicaid percentile.

The following section outlines our strategies for ensuring that well-child visits occur in the first 15 months of life in a rural market. Our strategy can be grouped into the following categories and are reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information.

Member and Provider Portals

Members currently have access to our secure Member Portal, providing members a tool to help them understand and follow their care plan. This information can be particularly helpful for parents keeping track of all EPSDT requirements, including well child visits. Parents can view and print an EPSDT Clinical Summary listing the well child visits and other EPSDT services the child has received and the recommended frequency, assisting them to take responsibility for their child's care. Providers can view this same summary for any pediatric member they are treating.

Automated Outreach

Children need several well child visits and screenings during the first 15 months of life. To assist parents in making appointments, we program our automated phone outreach system to call the parent one month prior to the next needed visit. Calls are made at different times of the day and different days of the week. Parents receiving the call have the option to acknowledge the message or to be transferred to one of our Care Connectors for assistance scheduling an appointment.

To augment our reminder outreach, we mine claim data to identify children ages 6 months to one year who do not have any claims for well child care. Our Rapid Response team contacts the parent/guardian of these children to educate them on the need for well child care and help them to make an appointment. The appointment date is entered into our medical management system where it creates a reminder task for the Rapid Response team to contact the parent prior to the appointment to assess for any barriers and confirm transportation arrangements. We maintain contact with these parents/guardians to ensure that future appointments are made in accordance with the Periodicity schedule.

Making Every Contact Count through Family Link

Our care management and customer service systems also allow our staff to quickly access care gaps for other family members in one click by accessing the Family Link functions in our system. This allows a Care Connector or Member Service Representative to assist the parent/guardian to address the well-child care needs of all of the children during one call.

Community Outreach

We sponsor and participate in over 1,000 local health-related events annually to bring health care directly to communities. Events like the Poison Prevention and Health Me, Healthy You programs support parents and offer education on required child wellness care, nutrition counseling, general advice on child rearing and a connection to our Care Management team, should a member need additional support in completing a child's EPSDT services.

Emily Daly, Community Resources Coordinator for Pocono Services for Families and Children, a Head Start agency, has stated "AmeriHealth Mercy and its employees improve the health and lives of the children and families Monroe County Head Start serves. The Poison Prevention and Health Me, Healthy You programs visit our preschool classrooms and talk with the children about the dangers of poisonous substances and the importance of exercise and healthy eating habits. These programs have proven to be invaluable to our Head Start program."

Transportation

Our Rapid Response team assists parents with coordinating transportation as needed to complete appropriate well-child visits.

Member Education

For members to feel empowered to make behavioral changes, they first must be educated on the appropriate manner in which to make those changes. To that end, we utilize Community Health Workers (CHWs) to provide culturally appropriate health education and information; empower people to obtain their needed care; provide informal counseling and guidance on health-related behaviors; and advocate for individuals and community health care needs. Please see Attachment 7 for an example of written material used to educate members about the importance of EPSDT services and well-child visits.

WeeCare (Maternity Management)

To get parents started on the right foot, we begin our education on the importance and schedule for well child visits during the last trimester of pregnancy. Pregnant mothers are assisted with selecting a PCP for the baby, and given information on EPSDT services and screenings, including well-child check-ups. As part of the post-partum follow-up, our WeeCare staff contact the member to schedule a post-partum visit and to make sure that the infant has started receiving the required well-child visit.

Provider Engagement

The relationship between the provider and the member is one of the strongest tools we possess for changing member behavior. To that end, in rural areas with low PCP density, we partner with local schools, Head Start and Healthy Beginnings programs to increase access. We will also ensure that all providers have accurate and up-to-date data on member EPSDT requirements and include well-child visits in our Pay-for-Performance provider incentive program.

As discussed above, providers have access to our secure Provider Portal, which provides alerts and reports on members who have not had recommended EPSDT screens, including well-child visits. The EPSDT screening information, coupled with the provider Pay-for-Performance incentive, is particularly helpful for rural providers who wish to ensure that all required preventive care is completed during member interactions.

QUESTION 23

Describe how you will ensure access to well-child visits in the third, fourth, fifth, sixth years of live for those who reside in a rural service delivery area.

(Limit to two pages)

RESPONSE TO QUESTION 23

Our Pediatric Preventive Health Care program improves the health of members from birth to age 21 by increasing adherence to EPSDT and well-child visit guidelines, including well-child visits in the third, fourth, fifth, sixth years of life. In the Lehigh/Capital Zone, AmeriHealth Mercy's rates for well child care are higher than the state Medical Assistance average and in the 75th percentile nationally.

The following section outlines our strategies for ensuring that well-child visits occur in the third, fourth, fifth, sixth years of life in a rural market. Our strategy can be grouped into the following categories and are reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information.

Member and Provider Portals and Dissemination of Care Gaps

Currently, members and providers have access to our secure Web Portals, which contain detailed information on care gaps. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as well child visits) for which there is no claim evidence that the member received the service. Providers receive an alert identifying the care gap when the member's ID is entered in the portal. Both the provider and the member can view the member's care gaps through the Member Clinical Summary section of the respective Web Portals.

This information can be particularly helpful for rural members by ensuring that all required preventive care is completed during provider interactions. Parents can use the information in the portal to track completion of preventive care. Parents and providers can also view and print an EPSDT clinical summary, which lists the well child visits, screenings and immunizations the child received.

Care gaps are integrated with all of our internal information systems, providing a pop-up alert to any AmeriHealth Mercy staff person that enters the member's ID number into our Member Service or Care Management systems. Care Management and/or Member Service staff members talking with the member address the care gap, following a role-specific protocol to connect the member to the recommended care. For instance, a Member Service Representative who receives an alert for a child who has not had a well-child visit will initiate a scripted exchange with the member designed to allow the representative to move the call to a Care Connector who will assist the member to make an appointment and coordinate transportation for the visit.

Making Every Contact Count through Family Link

Our Care Management and Customer Service systems also allow our staff to quickly access care gaps for other family members in one click by accessing the Family Link functions in our system. This allows a Care Connector or Member Service Representative to assist the parent/guardian to address the well-child care needs of all of the children during one call.

Community Outreach

We partner with many organizations and agencies to help in our efforts to increase well-child visits, such as local Head Start offices, schools, the Healthy Beginnings program, YMCAs, homeless shelters, and faith-based organizations. We also sponsor and participate in over 1,000 local health-related events annually to bring health care directly to the communities we serve. Events that support parents offer education on required child wellness care, nutrition counseling, general advice on child rearing and a connection to our Care Management team, should a member need additional support in completing a child's EPSDT services.

Transportation

In coordination with our Rapid Response team, we also ensure that parents have access to whatever transportation they need to complete appropriate well-child visits.

Member Education

We have found that, for members to feel empowered to make behavioral changes, they first must be educated on the appropriate manner to make those changes. To that end, we utilize Community Health Workers (CHWs) to provide culturally appropriate health education and information; empower people to obtain needed care; provide informal counseling and guidance on health-related behaviors; and advocate for individuals and community health care needs.

To encourage member completion of EPSDT screenings, we mail birthday cards to members under 21 years of age that remind members of the importance of screenings and well visits. These cards also provide the phone number for our EPSDT unit. Please see Attachment 8 for a sample birthday card. Please also see Attachment 7 for an example of written material used to educate members about the importance of EPSDT services and well-child visits.

QUESTION 24

Describe how you will ensure access to primary care practitioners for well-care for 12-19 year old who reside in a rural service delivery area.

(Limit to two pages)

RESPONSE TO QUESTION 24

Our Pediatric Preventive Health Care program improves the health of members from birth to age 21 by increasing adherence to EPSDT and well-care visit guidelines. The following section outlines our strategies for ensuring that well-care occurs for 12-19 year olds in a rural market. Our strategy can be grouped into the following categories and are reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information.

Member and Provider Portals and Dissemination of Care Gaps

Currently, members and providers have access to our secure Web Portals which contain detailed information on Care gaps. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as adolescent well child visits) for which there is no claim evidence that the member received the service. Providers receive an alert identifying the care gap when the member's ID is entered in the portal. Both the provider and the member can view the member's care gaps through the Member Clinical Summary section of the respective Web Portals.

This information can be particularly helpful for rural members by ensuring that all required preventive care is completed during provider interactions. Parents can use the information in the portal to track completion of preventive care. Parents and providers can also view and print an EPSDT clinical summary, which lists the well care visits, screenings and immunizations the teenager received.

Care gaps are integrated with all of our internal information systems, providing a pop-up alert to any AmeriHealth Mercy staff person that enters the member's ID number into our Member Service or Care Management systems. Care Management and/or Member Service staff members talking with the member address the care gap, following a role-specific protocol to connect the member to the recommended care. For instance, a Member Service Representative who receives an alert for a teenager who has not had a well-care visit will initiate a scripted exchange with the member designed to allow the representative to move the call to a Care Connector who will assist the member to make an appointment and coordinate transportation for the visit.

Making Every Contact Count through Family Link

Our care management and customer service systems also allow our staff to quickly access care gaps for other family members in one click by accessing the Family Link functions in our system. This allows a Care Connector or Member Service Representative to assist the parent/guardian to address the well-care needs of all of the children during one call.

Community Outreach

We partner with many organizations and agencies to help in our efforts to increase well-child visits, such as schools, YMCAs, homeless shelters, and faith-based organizations. We also sponsor and participate in over 1,000 local health-related events annually to bring health care directly to the communities we serve. Events that support parents offer education on required

child wellness care, nutrition counseling, general advice on child rearing and a connection to our Care Management team, should a member need additional support in completing a child's EPSDT services.

Transportation

In coordination with our Rapid Response team, we also ensure that parents have access to whatever transportation they need to complete appropriate well-care.

Member Education

We have found that for members to feel empowered to make behavioral changes, they first must be educated on the appropriate manner to make those changes. To that end, we utilize Community Health Workers (CHWs) to provide culturally appropriate health education and information; empower people to obtain needed care; provide informal counseling and guidance on health-related behaviors; and advocate for individuals and community health care needs.

To encourage member completion of EPSDT screenings, we mail birthday cards to members under 21 years of age that remind members of the importance of screenings and well visits. These cards also provide the phone number for our EPSDT unit. Please see Attachment 8 for a sample birthday card. Please also see Attachment 7 for an example of written material used to educate members about the importance of EPSDT services and well-child visits.

Member Incentive Programs

AmeriHealth Mercy has often found that successful behavior change comes from combining actionable information with incentives. To that end, AmeriHealth Mercy provides network providers with movie tickets to give to adolescent members for completing EPSDT requirements. As this serves as an incentive for both the child and the parent, this is a step in educating children in managing their own healthcare.

QUESTION 25

Describe how you will ensure that children who reside in a rural service delivery area receive one or more capillary or venous lead blood tests for lead poisoning by their 2nd birthday.

(Limit to two pages)

RESPONSE TO QUESTION 25

The following section outlines our strategies to ensure that children who reside in a rural service delivery areas receive one or more capillary or venous lead blood tests for lead poisoning by their 2nd birthday. We have demonstrated consistent improvement in the lead screening rate in the Lehigh/Capital Zone since 2007, moving from a rate of 66% to 73%. Our strategy can be grouped into the following categories and is reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information.

Finger Stick Lead Tests

Convenient access to laboratory facilities and the difficulty performing a venipuncture on a small child are two barriers that can impede adequate lead testing. To address these issues, we have contracted with Medtox, a laboratory that provides finger stick lead screening kits to provider offices. The kits allow providers, including Federally Qualified Health Centers and Rural Health Centers, to collect the lead screen blood sample in the office, avoiding the need for the parent to make a separate laboratory appointment and sparing the child a venipuncture.

Member and Provider Portals and Dissemination of Care Gaps

Members and providers have access to our secure Web Portals, which contain detailed information on Care gaps. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as blood lead screening) for which there is no claim evidence that the member received the service. Both the provider and the member can view the care gaps through the Member Clinical Summary section of the respective Web Portals.

This information can be particularly helpful for rural members by ensuring that all required preventive care is completed during provider interactions. Parents and providers can also view and print an EPSDT clinical summary, which lists the child's blood lead screening, as well as any well child care, screenings and immunizations the child received.

Care gaps are integrated with all internal information systems, providing a pop-up alert to any AmeriHealth Mercy staff person that enters the member's ID number into our Member Service or Care Management systems. Care Management and/or Member Service staff members talking with the member address the care gap, following a role-specific protocol to connect the member to the recommended care. For instance, a Member Service Representative who receives an alert for a child who has not had a blood lead screen will initiate a scripted exchange with the member designed to allow the representative to move the call to a Care Connector who will assist the member to make an appointment with the PCP and coordinate transportation for the visit.

Making Every Contact Count through Family Link

Our care management and customer service systems also allow our staff to quickly access care gaps for other family members in one click by accessing the Family Link functions in our system. This allows a Care Connector or Member Service Representative to assist the parent/guardian to address the well-child care needs of all of the children during one call.

Community Outreach

We sponsor and participate in over 1,000 local health-related events annually to bring health care directly to the communities we serve. Where possible, we sponsor finger stick lead screening at the event.

Transportation

In coordination with our Rapid Response team, we also ensure that parents have access to whatever transportation they need to complete blood lead screening.

Member Education

We have found that for members to feel empowered to make behavioral changes, they first must be educated on the appropriate manner to make those changes. To that end, we utilize Community Health Workers (CHWs) to provide culturally appropriate health education and information; empower people to obtain needed care; provide informal counseling and guidance on health-related behaviors; and advocate for individuals and community health care needs. Please see Attachment 9 for an example of written material used to educate members about lead poisoning, risk factors, prevention, and the importance of testing for blood lead levels.

WeeCare (Maternity Management)

To get parents started on the right foot, we begin our education on the importance of EPSDT screenings, including blood lead levels, during the last trimester of pregnancy. Pregnant mothers are assisted with selecting a PCP for the baby, and given information on EPSDT services and screenings, including blood lead testing. As part of the post-partum follow-up, our WeeCare staff contact the member to schedule a post-partum visit and to make sure that the infant has started receiving the required well-child care and screenings.

Provider Engagement

Another key to success in getting children under age two screened for blood lead levels is ensuring providers will actively instruct parents/guardians to get the test. The current Pennsylvania Medical Assistance recommendation for screening every child under age two is more stringent than the American Academy of Pediatrics (AAP) guideline to screen only if certain risk factors are present. We know from numerous conversations with pediatricians and PCPs in Pennsylvania that many physicians do not see the need to screen all children, and instead follow the AAP guidelines. We provide ongoing education to providers on the Medical Assistance lead testing requirements in provider newsletters, quarterly information packets delivered to the provider's office and the Provider Web Portal.

As discussed above, providers have access to our secure Provider Portal, which provides alerts and reports on members who have not had recommended EPSDT services, including lead testing. The care gap information, coupled with the provider Pay-for-Performance incentive and convenience of the Medtox finger stick kits, is particularly helpful for rural providers who wish to ensure that all required preventive care is completed during member interactions.

QUESTION 26

Describe the initiatives you will implement in a rural service delivery area to educate members and providers about the appropriate use of hospital emergency departments.

(Limit to two pages)

RESPONSE TO QUESTION 26

Receiving non-urgent care in the Emergency Room (ER) setting lends itself to fragmented care, lack of continuity of medical history, duplicate testing, and inadequate post-ER follow up. Over the last two years, our successful approach resulted in a 6% decrease in the Emergency Room utilization rate in the Lehigh/Capital Zone.

The following section outlines the initiatives we will implement in the rural service delivery areas of the New West and New East Zones to educate members and providers about the appropriate use of hospital emergency departments. Our strategy can be grouped into the following categories and is reviewed in greater detail below:

1. Technology
2. Community Outreach
3. Member Education
4. Provider Engagement

Technology

Technology offers an alternative way of reaching members and providers in rural areas by increasing the flow of information.

Targeted Member Outreach

We analyze claim data to identify frequent ER users. Identified members are contacted by our care management team to offer education and assistance on using the correct care setting, including urgent care centers (UCCs). We also ask members during the new member assessment if "anyone in the household has been to the ER 4 times or more in the last 6 months?" Members who respond "yes" are flagged in the system and contacted by our Rapid Response team to connect them to a more appropriate level of care. We also encourage providers to alert us to members they know to be inappropriate high users of the ER.

24/7 Nurse Line

Our toll-free 24/7 Nurse Line provides members with access to symptom counseling and healthcare guidance by a registered nurse. This is particularly helpful for a rural population, as clinical counseling is made available at all times to any member with access to a telephone. A summary of the member's interaction with the 24/7 Nurse Line is faxed to the PCP and to AmeriHealth Mercy's Rapid Response team. Our Rapid Response Care Connectors subsequently contact the member to assess any additional needs and to help reconnect the member with the PCP, if appropriate. The 24/7 Nurse Line is an especially important tool for reducing unnecessary ER use, as it provides a resource for members needing guidance in how to manage an urgent health need when their PCP office is closed.

Automated Emergency Room Outreach Surveys and Discharge Outreach Surveys

Part of encouraging appropriate use of the ER in the future is to connect a member to appropriate follow-up care post discharge from the ER. The automated outreach and discharge surveys administered by AmeriHealth Mercy remind members about scheduling follow-up appointments with their PCP. If a member needs any additional support in connecting to care, they are connected to a Rapid Response Care Connector, who will address any identified barriers to care.

Community Outreach

We sponsor and participate in over 1,000 local health-related events annually to bring health care directly to the communities we serve. To specifically support appropriate ER utilization, these events offer education on when and where to get care. For example, our '4 Your Kids Care"

education program provides hands-on education for parents on how to care for sick children, effective home treatments, and when to seek medical or emergency care. Each participant is given a linguistically appropriate reference book that describes symptoms and recommended care for common childhood illnesses, and a thermometer. The Rapid Response Team follows-up with a telephone call to address identified health care barriers.

Member Education

We have found that education empowers members to make appropriate changes. For example, our new member Welcome Packets, available in English and Spanish (see Attachment 10), include an easy-to-read flow chart to educate members on the appropriate use of the ER. Additionally, our Rapid Response and Outreach Team contacts members who have recently been to the ER to reconnect them with their PCP for follow up appointments. Please see Attachment 11 for examples of written material used to educate members about how and where to get care for urgent medical needs.

Our chronically ill members are engaged in our Integrated Care Management (ICM) program, discussed in greater detail in the Coordination of Care section. The ICM program provides members with a single point-of-contact for all of their healthcare needs. Members are selected for ICM through our data stratification process or though provider or member referral. Our ICM program provides intensive focus on complex members, working to strengthen the member's self-management skills and decrease the incidence of avoidable episodes of care and exacerbations which could lead to an ER visit.

Provider Engagement

The relationship between the provider and the member is one of the strongest tools we possess to change member behavior. In rural areas with low PCP density, we will encourage providers through Pay-for-Performance incentives to be available for evening and Saturday hours. Additionally, we send information on UCC locations to members in the surrounding areas.

We also evaluate the PCP offices to determine compliance with access and availability standards. If we find a provider to be out of compliance, we will educate the PCP on our availability requirements and assist the PCP to develop a workable solution for the office.

Transition Managers

We also place care management resources in the Emergency Rooms of our high-volume facilities. Through personal contact with ER users during the ER event, we eliminate problems relating to inaccurate contact information and are able to assess in person any barriers and drivers that led the individual to the ER. We also use this opportunity to strengthen the Care Management relationship with the member, make an appointment with their PCP, and forward the ER discharge summary to the PCP office.

EMERGENCY PREPAREDNESS

CONTENTS

EMERGENCY PREPAREDNESS

Throughout our experience in operating Medicaid managed care plans in Pennsylvania and other states, we have responded to hurricanes, fires, floods, snow storms and technology failures. Our practical experience through lessons learned, combined with our use of industry best practices, makes AmeriHealth Mercy uniquely equipped to respond quickly and efficiently to any emergency. AmeriHealth Mercy's comprehensive Enterprise Business Continuity and Disaster Recovery plan serves as the foundation for the New West and New East plan.

AmeriHealth Mercy's Business Recovery Management Team

AmeriHealth Mercy has a Business Continuity Program Management Office (BCPMO). The full focus of the BCPMO is not only to quickly respond to any types of crises that need to be managed, but also to plan for such events and to coordinate the response. The team works closely with all functional areas across the company to facilitate the development and testing of preparedness plans.

The Business Recovery Management Team is responsible for making all critical decisions and directing the recovery process for all AmeriHealth Mercy affiliates and offices. The management team members will include the New West and New East Executive Director, as well as the leaders from the key AmeriHealth Mercy functional areas (such as Member Services, Claims, Facilities and Medical Management). The Executive Director will provide guidance and advice regarding New West and New East specific Business Continuity needs. In the event that the Executive Director or other members of the Management Team are unable to participate due to the nature of the incident, our Executive Team will immediately identify and mobilize a team of personnel to establish contact with local authorities, the state and other relevant emergency contacts.

Table 1: Emergency Management Team

AmeriHealth Mercy Executive Team	
Chief Executive Officer	Chief Legal Counsel
Executive Vice President and Chief Operations Officer	Senior Vice President and Chief Human Resources Officer
Chief Financial Officer	Senior Vice President, Chief Mission Integration Officer
On Call Recovery Executive – Senior Vice President of Operational Initiatives	Chief Medical Officer

Business Recovery Management Team	
VP of Corporate Communications and Marketing	New West and New East Executive Director
Regional President	Vice President of Clinical Services
Vice President of Information Solutions	Senior Vice President of Enterprise Operations
Director of Government Relations	Director of Facilities

Business Continuity and Disaster Recovery Plan Overview

The AmeriHealth Mercy Business Continuity and Disaster Recovery program enables us to quickly return to operating capacity in the event of an emergency, inclement weather, pandemic, technology failure, fire or other catastrophic scenario. Our program combines our plans to recover systems, networks, workstations, applications in the event of a disaster (disaster recovery), assisting with evaluations, with plans to expeditiously restore all operational functions (business recovery).

We have designed our Program to:

- Prepare employees to respond to a crisis, emergency or disaster in a safe manner
- Help control risks and exposures to members, employees and providers
- Provide methods and decision guidance for preventive measures, where appropriate
- Provide the ability to efficiently respond to a business or technology interruption to resume critical business operations and limit the operational downtime and costs
- Minimize delays and improve guidance for decision-making during an interruption/disaster
- Provide a connection between county, state, and federal information (senders) and members, employees, and providers (receivers)
- Prepare AmeriHealth Mercy to continue to deliver critical business functions if employees are impacted due to influenza, other infectious diseases, or other disasters
- Re-integrate members and providers into the community

Our Business Continuity and Disaster Recovery planning methodology begins with categorizing types of disasters, the business severity and priority levels for each type of severity level and an assessment of the Business Impact Analysis (BIA) of critical functions. Each of these critical elements is summarized prior to describing how we will manage the disaster and restore operations.

Disaster Categorization

Our plan for responding to a disaster begins by classifying the disasters into three categories: minor, major, and catastrophic. The disaster recovery categories are summarized in Table 2.

Table 2: Disaster Recovery Categories

Disaster Type	Definition
Minor Disaster Time Frame: 24 hours or less	A minor disaster is an operational disruption that generally does not require a declaration process. However, it does require incident management. A minor disaster usually involves an outage duration anticipated to be one day less. Damage due to a minor disaster is not extensive. It may consist of component failure, minor damage, or unavailability of hardware, software, or supporting electrical equipment. Partial or total loss of hardware for a period of several hours. Recoverable loss of critical data; full recoverability in twenty-four hours or less. Loss of an important computer application. Temporary loss of services such as power or network. No foreseeable impact on the covered population, providers, or employees.
Major Disaster Time Frame: From 24 hours to 7 days	A major disaster is an outage that is likely to be greater than one day but not more than seven calendar days. Damage due to a major disaster may be more severe than that associated with a minor disaster and operations can be restored within seven calendar days. Damage to infrastructure and/or facility. Major impact on the covered population, providers, or employees. Damage to hardware resulting in downtime of more than 24 hours. Loss of services (air conditioning, electrical power, etc.) Recoverable loss of critical data; full recovery taking more than 24 hours. Loss of network caused by severe weather.
Catastrophic Disaster Time Frame: Greater than seven days	A catastrophic disaster is one in which the outage is anticipated to be more than seven calendar days. Damage due to a catastrophic disaster is usually severe and could involve total destruction of data center facilities requiring major replacement of equipment and/or facility and/or major renovation of the data center facility. Serious damage or total destruction of the data center facilities and/or equipment.

Disaster Type	Definition
	Widespread impact on the covered population, providers, or employees with some loss of knowledge of their whereabouts. Loss of operations center staff due to uncontrollable factors (e.g. outbreak of epidemic disease.) Major telecommunications failure. Unrecoverable loss of critical data. Total loss of a facility or workplace.

Business Severity and Priority Level

In addition to classifying the categories of disaster, we have also defined business severity and priority levels. The BIA is used to gather information and assign criticality, recovery point objectives, recovery time objectives, daily business process steps, accompanying resources, applications, tools, dependencies and manual work-around procedures. The BIA is used to identify the extent and timescale of the impact on different levels of our organization. The BIA not only assesses the current activities but also the effect of disruption on major business changes. Table 3 summarizes how we categorize business severity and priority levels.

Table 3: Business Severity and Priority Levels

Business	
Critical or Severity Level	**Four**
Priority Level	No Business Impact
Business Impact	Minimal to no business impact, this indicates the problem causes little impact on operations or that a reasonable circumvention to the problem has been implemented.
Critical or Severity Level	**Three**
Priority Level	Low (Some Business Impact)
Business Impact	A department or individual's ability to perform a job function may be impacted or inconvenienced, but can continue business as normal operations. Public transportation disruption (strike). Inclement weather storm. Threat of a pandemic, epidemic. Threat of a bomb scare. Threat of inclement weather.
Critical or Severity	**Two**

Business	
Level	
Priority Level	Medium (Significant Business Impact)
Business Impact	A department or individual's ability to perform a mission critical function is in jeopardy or unavailable but a workaround is or can be established within a reasonable time. Severe Inclement Weather (Hurricane, Nor'easter, Ice Storm.) Partial loss of a facility (structural damage.) Loss of services or utilities (power, gas, water, HVAC, air and water contamination – 3 to 24 hours.) Food Services Unavailable. Increase in absenteeism (Pandemic, Epidemic.) Disgruntled employee, workplace violence.
Critical or Severity Level	**One**
Priority Level	High (Critical Business Impact)
Business Impact	Business processes are adversely affected resulting in a major impact in business operations. The impact of the problem causes a complete loss of service and work cannot reasonably continue. Severe Weather (State of emergency/state shut down.) Total Loss of a Facility/Workplace (Fire, Flood Plains, Regional Power Outage, collapsed building, regional disaster lasting greater than 24 hours.) Hazardous materials spill (Area roads shut down.) Transportation Accidents (Area roads shut down, airplane crash.) Employee Walkout/Loss of Internal Personnel. Total Loss of Workforce (Pandemic, Epidemic, Walkout.)

Business Impact Analysis (BIA) of Critical Functions

After we classify the types of disasters and the impact to the business, we identify the critical business functions needed to assist us in recovering from the disaster and to commence the continuation of our business.

We use an Employee Impact Analysis to evaluate all functions performed by an employee to determine their impact on the organization should they become unavailable for work. Employees with highly specialized skill sets that will immediately impact the business if unavailable are identified as Critical Associates. Those who perform a business function that will impact the business if unavailable are identified as Essential Associates.

Each quarter, every business area is required to review its Employee Impact Analysis. Additionally, the business function requirements and recovery time objectives are reviewed by each business area each year.

Each business function annually reviews and updates its business continuity needs through a formal Business Impact Analysis program managed by AmeriHealth Mercy's Enterprise Business Continuity Program Management Office (BCPMO). We use the results of this review to perform a "gap analysis" that identifies potential areas of improvement for our continuity plans. The business areas will address any significant gaps and revise the continuity plans accordingly.

Disaster Management

The next important part of our Business Continuity and Disaster Recovery plan is how to manage crises or disaster. Our crisis management methodology ensures a controlled and managed response to an incident/problem or crisis event by identifying resources needed to respond to a significant incident or crisis. In addition to our general approach to disasters, we have a specific response plan for hurricane or pandemic crises outlined in this section.

Our incident management process begins with the detection of a problem as outlined in Figure 1. We may become aware of a problem from a variety of sources, such as a potential weather event, an event occurring in a facility, a report from an associate or a technology error. However, the root cause of the problem may originate from unexpected sources. We use a "crisis management" approach to quickly help us identify and address the root cause of the problem.

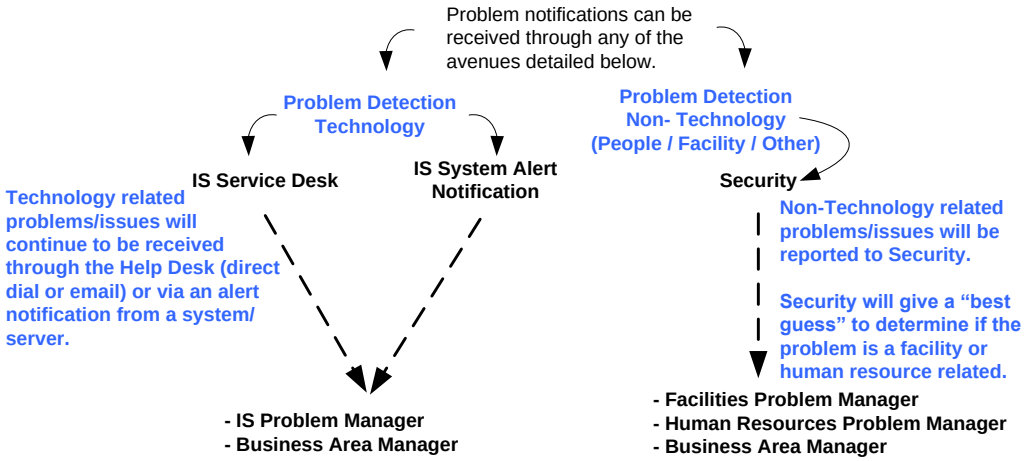

Figure 1: Problem Detection and Notification Procedure

The leader of our Business Continuity and Disaster Recovery Office facilitates an applicable subject matter expert to serve as the "Problem Manager." The Problem Manager assesses the impact of the problem and ensures that the problem is managed to resolution. For example, if the problem is technological in nature, we have predetermined who will serve as the Problem Manager. The Problem Manager adheres to our Problem Management process, which includes diagnosing the root cause of problems and critical incidents. If a problem escalates to a critical incident, the Problem Manager will escalate the incident to the designated Recovery Executive and triggers the Incident Command/Crisis Management System/Team. Figure 1 shows our incident detection and notification system. This system is designed to quickly evaluate the

problem, rank its severity, and begin the process of informing the necessary individuals and teams throughout the organization.

Pandemic Crisis

Another important part of our Business Continuity and Disaster Recovery program involves how to address a pandemic crisis. The pandemic action plan uses five stages to monitor changes in demand for services and our capacity to meet that demand. We have identified essential business functions, critical skills and strategies to manage essential business activities up to and during the declaration of a pandemic. Each department has identified changes they will implement in their business processes to address increased demand and/or decreased capacity. Our local office will have direct access to AmeriHealth Mercy's enterprise-wide resources of trained professionals to assure the ability to respond to increased demand and decreased availability of local staff in the event of a disease outbreak. Key strategic partnerships with select vendors give us the ability to expand capacity quickly to meet the demand.

Contingency Plans

In the event a disaster affects staff, physical buildings, or other portions of the business, we have contingency plans in place that allow us to continue operations while minimizing down time. Because AmeriHealth Mercy is a national organization with facilities in other states, we are able to rapidly shift operations as necessary to other affiliate locations. Our IS infrastructure is shared throughout the organization, member services, provider services, and medical management employees in other regions can be quickly granted permission to access AmeriHealth Mercy member and provider data, making the transition seamless to the caller. All data will be stored at an off-site location and backed up regularly. In the event of a physical disaster, AmeriHealth Mercy's data can be retrieved by other affiliate locations and used to resume operations elsewhere.

Employee Education and Awareness Training

AmeriHealth Mercy uses several methods to keep employees aware of the critical role that they play in preparing for any potential disruption or incident. Our primary methods include recovery tests, tabletop exercises, building evacuation (i.e., fire drills) and regular employee communications. Employees from key areas are included in all testing and exercises.

Recovery Tests

The first method used to assure our employees are aware of our business continuity strategies is testing responses to disaster scenarios. Our recovery tests are designed to enhance our ability to perform necessary procedures and critical business function as well as to identify opportunities to improve our plans. Successive tests are typically performed by different employees to increase the number of people who are familiar with the recovery procedures. Testing also builds organizational acceptance that the business and technology recovery strategies satisfy the organization's business requirements. Testing includes but is not limited to:

- Technical tests from primary to secondary work locations
- Application and data recovery tests
- Business process tests and execution performed by the end users

At a minimum, testing is generally conducted on an annual schedule. Problems, issues and lessons learned identified during testing are rolled up into the maintenance phase and retested during the next test cycle.

Table-top Exercises

Table-top exercises are simulated scenarios designed to test the response capability of an organization to a given event. Examples of table top exercises conducted by AmeriHealth Mercy include identifying safe locations during a tornado watch. Our table-top scenarios require a coordinated response to a realistic situation that develops in real time with participants gathered to formulate responses to each development. This is a facilitated group analysis of an emergency situation in an informal, stress-free environment. The Table-top Exercise allows us to examine our operational plans, identify problems, and conduct in-depth problem solving.

Building Evacuation (Fire Drills)

Each AmeriHealth Mercy location has an evacuation plan and procedure designed for the unique requirements of their area. Our evacuation plans are evaluated regularly by the Business Continuity Program Management Office. All of our employees receive evacuation training that provides an understanding of their own responsibilities during an emergency situation. In addition, we provide each work station or office with directions of how to evacuate the building.

All employees will be required to complete the online training course once each year and new employees will complete the course as part of the new hire orientation. The evacuation awareness and education training course prepares employees for a safe and efficient building evacuation with defined roles and responsibilities for employees, and visitors/vendors. Designated Floor Marshals, Floor Captains and Security team members are appointed to assist with evacuation. We also educate employees on how to assist and account for all persons with disabilities, including employees, visitors and vendors. The course concludes with a ten question assessment of the employee's specific knowledge.

Communications with Employees, Members, Providers, and Suppliers

AmeriHealth Mercy's communication infrastructure provides a framework to:

- Receive critical community and company information and accurately decide on the scope of the event and the need to expand a response
- Communicate and escalate the critical incident or emergency situation to the appropriate crisis management team structure and the AmeriHealth Mercy executives who are the key decision makers
- Obtain support and assistance from other Incident Command/Crisis Management Support Teams

Employee Communications

We communicate regularly with our employees to keep them mindful of the actions they need to take in the event of a disaster. We distribute messages through several different outlets, as outlined below:

- **Business Continuity Program Brochure -** We use a tri-fold brochure that explains and illustrates the program in detail to make sure that any new employees are familiar with the components of our business continuity program. We distribute the introductory brochure to new hires as part of their welcome kit.
- **iNSIGHT** (Internal employee website) **-** Used to share information, updates and tools about our Business Continuity Program. The site allows us to easily and efficiently share information regarding business continuity planning. Specific information such as crisis

management (emergency notification, evacuation, and inclement weather), business continuity planning (planning and software tools, business recovery, and glossary terms), disaster recovery (disaster recovery test information) and pandemic awareness (flu information and inter-office communications) are also available on this site.

- **e-News -** Our periodic employee email newsletter, to disseminate important information about evacuations, inclement weather, our emergency notification system information, or to create general awareness of our business continuity program. For instance, during the flu season months, employees across all AmeriHealth Mercy locations receive awareness communications about flu prevention, recommendations for proper hand sanitation and other flu-related information and awareness. When extreme weather emergencies are predicted, eNews alerts encourage employees to monitor local radio and television news programs for information on evacuation directives.
- **AlertFind** - We implemented an automated tool, AlertFind (Emergency Notification System) to assist us to quickly communicate in a crisis. AlertFind notifies internal crisis management team members, senior management and employees of issues that may affect our operations. Employees receive AlertFind notifications in one of six ways:
  - Incoming call on a company-supplied Blackberry
  - Incoming call on an office work phone
  - Incoming e-mail to Microsoft Outlook
  - Text message to a company-supplied Blackberry
  - Incoming call to a personal cell phone
  - Incoming call to a home phone (used after hours and on weekends only)

These notifications provide instructions, ask questions and/or collect responses. If AlertFind is not able to make contact with the first device in the list above, it automatically moves on to the next device. AlertFind continues through the list until AlertFind receives a confirmation from the associate, leaves a voicemail or an e-mail or exhausts all device options. Associates must reply to any one of the AlertFind message to confirm receipt of the message. AlertFind is also used to provide updates, additional instructions or information to business continuity coordinators and employees related to business recovery.

The contact information used by the AlertFind system is collected directly from our PeopleSoft Human Resources application. Periodically employees are reminded to update their contact information in PeopleSoft to maintain a current list.

- **Emergency Notification Reference Pack –** Distributed to new hires as a part of our Welcome Kit, this pack contains a reference guide and magnet which explain and illustrate the AlertFind system, in detail, to ensure all employees are familiar with this business continuity protocol. (see Attachment 1)

Members, Providers, and Suppliers Communications

AmeriHealth Mercy utilizes existing technology to "push" information services to members, providers and suppliers through our website, toll free 800 numbers and text messaging. Through these communication channels we will provide information, updates, current impact, best practices, care recommendations, schedules of preventive activities (such as immunizations), and in the event of larger and longer lasting events, instructions, methods to access care, pandemic instructions, and instructions to distant providers in the care of our members. This proactive

method of delivering information helps to keep them aware of any emergency situation and impacts on our internal business operations.

Our plan also includes an educational program for members to assure that, upon joining AmeriHealth Mercy, we provide them with information in an understandable format, using various media formats. We supply educational information on a variety of topics, such as:

- Weather emergency preparedness
- Seasonal flu and pandemic flu
- Environmental emergencies
- Evacuation pathways
- Sources of information seasonally and prior to an anticipated event

The ultimate goal of these communication programs is to assist our members, providers, employees and suppliers respond to events that may affect their health, health care, safety, resilience, and recovery. We will partner with providers locally and remotely to ensure access to quality and safe care for our members, regardless of their location.

Plan to Ensure Continuity of Services

Maintaining a constant flow of information with all members, providers, suppliers and employees is key to managing continuity of services during an emergency. During an emergency, the state, counties, and the federal government will release information that is of direct benefit to our stakeholders. We will gather and distribute this information through multiple communication vehicles, including websites, telephone, email and text messages to all groups to assure they receive timely, accurate updates and instructions.

We will provide information on encouraged prophylaxis, road closures in external emergencies, immunization recommendations, or other pertinent other topics. Following a disaster, we will also distribute information to help members reintegrate to the community of providers and to provide community safety and wellness information. Additionally, we will gather and distribute information generated by governmental entities related to wellness or the re-establishment of primary care and other covered care.

AmeriHealth Mercy will use Emergency Contracting Specialists to assure that our members – whether they are in Pennsylvania or out-of-state – receive needed care from providers. During a declared public health emergency, a presidentially declared emergency, and/or a Stafford Act Disaster declaration, we will closely coordinate with DPW and any other state or federal regulatory authorities to make sure all members and providers obtain necessary details. To fully support primary, urgent, and emergent care needs of our members, we will consider and use, as necessary, contracts, Memorandums of Agreement (MOA), Memorandum of Understanding (MOU) and other aggressive contracting methods with providers and in states where our members have relocated. The use of Electronic Health Records and Member Clinical Summaries will facilitate the continuity of service for our most fragile members who receive extensive services.

Our ability to rapidly resume normal business operations in support of our members is of great importance and major priority. To improve our ability to resume operations, we also plan to distribute information to our employees to help them maintain health and wellness after significant events so that they can quickly return to normal operations or alternative work sites if necessary.

Special Needs Populations

AmeriHealth Mercy has a particular concern for the portion of the covered population with additional functional or access needs. These needs are especially acute if these members require additional resources to participate in an organized and timely evacuation. These members may require special transportation, such as a wheelchair car, ambu-van, ambulance, or other special vehicle. This population may, based on functional and access needs, require a destination specifically capable of providing special services, such as dialysis, chemotherapy or related care.

Emergency Plan Testing

AmeriHealth Mercy has developed a detailed testing strategy which includes at a minimum, an annual system test to assure full recovery of our operations at our contacted recovery facility. The overall goals for the tests are:

- Enhance AmeriHealth Mercy's ability to perform necessary procedures and critical business functions in the event of a disaster
- Identify areas of potential improvement in the plans
- Problems, issues and lessons learned which are identified during testing are rolled up into the maintenance phase and retested during the next test cycle

The Disaster Recovery Plan and Business Area Continuity Plans will be tested during our annual test to ensure the adequacy of the Business Continuity and Disaster Recovery Plans such as technical recovery procedures, recovery teams' contact information, communication, recovery of all critical system and critical vendor information (e.g., names, phone numbers, escalation process, etc.) Our annual test is a simulation of a disaster and recovery of all of our critical systems at our contracted recovery location. This ensures critical systems will be available to meet the recovery time objectives and business requirements.

In parallel with the Disaster Recovery technology recovery activities, the business recovery activities will also be tested. Some of the types of tests that will be built into the exercise are as follows:

Crisis Management Component Test

Table-top walk-through test(s) of the Crisis Management Action Plan to determine if team members are aware of their assigned activities, if the document is complete and accurate, and if the communication among teams is appropriate.

- Notification test of the On-Call Recovery Executive
- Establishment of a Crisis Command Center is to determine if On-Call Recovery Executive can set up a location from which to control the crisis and recovery effort
- Notification test of Crisis Management Team members and other support staff members as needed
- Notification test of the Business Recovery Coordinator and Disaster Recovery Coordinator
- Notification test of the Senior Executive Management Team

Business Recovery Activation Component Test

Table-top walk-through test(s) of the Business Continuity Activation Plan to determine if team members are aware of their assigned activities, if the document is complete and accurate, and if the communication among teams is appropriate.

- Notification test of business continuity coordinator
- Notification test of critical employees, and/or outside vendors and services

Business Recovery Component Test

Table-top walk-through tests of the Business Area Continuity Plans to determine if team members are aware of their assigned activities, if the document is complete and accurate, and if the communication among teams is appropriate.

- A test of defined resources to support specific team tasks. These are typically such items as manual procedures to be used only if the automated support is not available, pre-defined alternate work locations, specific procedures required to recover "work in progress" lost during the disaster, or any other measurable resource required by a recovery team.

MEMBER MANAGEMENT

CONTENTS

QUESTION 1

Describe what innovative approaches your MCO will take to promote personal responsibility among MA consumers by involving them in managing their own healthcare benefits and providing incentives that encourage wellness and healthy lifestyles.

(Limit to 2 pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy shares DPW's goal of encouraging independence and personal responsibility to promote positive health outcomes and control program costs. Our strategy focuses on empowerment through engagement and education, and is interwoven in all components of our clinical programs. This is coupled with innovative and award-winning community-based wellness programs and member incentives to engage members in taking control of their health. Our prominent programs and incentives are described below.

Integrated Care Management

AmeriHealth Mercy's Integrated Care Management model actively engages members in care planning to empower them to take responsibility for their care. Our engagement strategy begins with asking the member to identify personal goals rather than "health care" goals. By focusing on the member's concerns, like wanting to walk a child to school or climb stairs, the Care Manager can address items such as dietary changes required for healing a diabetic member's foot wound or proper use of asthma medication. Once plans are in motion to address the member's personal goals, the Care Manager works toward addressing additional issues revealed in health assessment findings and utilization data. For each intervention, the Care Manager focuses the discussion on how the particular intervention will benefit the member.

Members who are able to actively participate in the care plan are assigned 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 help members maintain an open, active dialogue that leads to improved care.

Member Web Portal

To help members manage their healthcare, the Member Web Portal gives members the ability to view their Care Gaps. Care Gaps are services that are recommended by nationally-accepted clinical guidelines for which there is no claim evidence that the member received the service. Members are also able to see detailed information about medications they received within the past six months and their recent visits to the doctor, hospital and emergency room. This information is available as a printable Member Clinical Summary that members can take to their physician appointments. AmeriHealth Mercy will print and mail the Member Clinical Summary to members who do not have access to a computer or printer.

Our Member Web Portal also provides state-of- the-art interactive tools to perform self-service for specific activities and includes a robust Health and Wellness section, with information on preventive care, wellness strategies and management tips for living with a chronic condition.

Member Wellness Programs and Incentives

AmeriHealth Mercy effectively engages members in their own health by partnering with them, and with community leaders, faith-based organizations and agencies already trusted in the community. By establishing a relationship of mutual trust, we help the member become an active participant in their care. A key component to all of our programs is a specific and clear call to action, defining a path for the member to use in addressing the target behavior or care need. Several of our programs are described below and in more detail in the Member Management Attachments.

- **Healthy Hoops® -** Our NCQA award-winning program uses basketball to educate pediatric members with asthma and their families about asthma management and obesity prevention.
- **Lose-to-Win -** Our URAC award-winning program uses a contest format loosely mirrored on TV's "Biggest Loser" to educate and engage members with type-2 diabetes and obesity on nutrition and exercise.
- **Women's Health Ministry 40-Day Journey -** This NCQA-recognized program focuses on improving the health of African-American women and their families through a multi-week educational series emphasizing nutrition, exercise, medication compliance and water intake.
- **Know Your Numbers -** This program stresses the importance of knowing key health numbers, including blood pressure, cholesterol level and blood sugar level.
- **Prepare For Your Visit** -This personal responsibility program provides an easy-to-use guide to help a member ask the right questions during their doctor's visit.
- **4 Your Kid's Care -** Our newest program, 4 Your Kid's Care provides young mothers with hands-on training and education on how to care for a sick child at home. Focused on reducing inappropriate emergency room utilization, this program offers educational sessions in local community venues and train-the-trainer sessions for community-based organizations.
- **Smoking Cessation and Nutritional Support** - All AmeriHealth Mercy members are eligible for 70 tobacco cessation counseling sessions per calendar year without referral or prior authorization. Members who are eligible for pharmacy services can get tobacco cessation drug medicines like bupropion and the generic nicotine patch. We also provide our members with access to registered dieticians and nutritional counselors.

AmeriHealth Mercy uses health incentives to increase members' motivation and willingness to change and maintain healthy lifestyles. We adjust our member incentive programs over time based on our retrospective evaluation of the effectiveness of each incentive, and ensure that incentives target those areas most in need of improved outcomes. Some of the member incentives we use today or have used in the past are listed below.

- Gift cards for completed mammograms, pap tests, and prenatal care visits
- Movie Tickets for adolescents who complete an Adolescent Well Care visit
- Baby "onesie" for new mothers who complete a timely post-partum visit

Looking Ahead

AmeriHealth Mercy is ready to seek DPW approval to launch new member incentive programs to encourage members to engage in specific health related activities. For example,

- **Reward Points** - Members earn points for joining the online portal, completing a health risk assessment and for obtaining preventive care services, such as mammogram, annual physical exam (adult and child), prenatal visits, post-partum visit and LDL/HgbA1c tests (diabetics). Points can be redeemed for gift cards to a selection of vendors.
- **Over-the-Counter Products** – Members receive over-the counter products for completing wellness and chronic condition monitoring care related to pregnancy (prenatal and post-partum care), hypertension (controlled blood pressure) and diabetes (HgbA1c and LDL measurement; dilated retinal exam).

As another way to engage members in their own care, AmeriHealth Mercy will begin sending an Explanation of Benefits to members to communicate the actual cost of the care they receive to promote a more aware and educated consumer.

QUESTION 2

Describe any experience your MCO has in using state of the art technology to provide your members with resources for managing their own healthcare benefits (including the use of incentives or "smart accounts.")

(Limit to two pages)

RESPONSE TO QUESTION 2

AmeriHealth Mercy uses several technology strategies to provide members with resources for managing their own healthcare benefits, including our Member Web Portal, technology programs and participation in smart accounts. Some of the incentive programs we have used are described in Question 1 of this section.

Member Web Portal

Our Member Web Portal provides members with state of the art interactive tools to perform self-service for specific activities. For example, the portal gives members the ability to view demographic information about their doctor, including languages spoken, or find a new PCP using a link to the online Provider Directory. The portal also contains a robust Health and Wellness section, with information on preventive care, wellness strategies and management tips for living with a chronic condition. To help members manage their healthcare, the Member Web Portal gives members the ability to view their Care Gaps. Care Gaps are services that are recommended by nationally-accepted clinical guidelines for which there is no claim evidence that the member received the service. Members are also able to see detailed information about medications they received within the past six months including the date prescribed, medication name, dosage and prescribing physician. Members also are able to view their recent visits to the doctor, hospital and emergency room. Each of these sections can be printed individually, or together as a Member Clinical Summary (MCS) document. We encourage members to take a copy of the MCS to their physician appointments as a tool to discuss their healthcare needs with their physician.

Our Member Web Portal uses best practice designs based on the US Government's Web Guidelines on usability to ensure that members can easily find information and services that AmeriHealth Mercy provides. All the features and offerings on the website meet or exceed the Section 508 of the Americans with Disabilities Act Requirements 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.

Other Technology Programs

AmeriHealth Mercy uses other technological programs to enhance members' ability to manage their health conditions. Examples are summarized below.

- **moms2b -** We engage pregnant members in prenatal healthy behaviors through our moms2b social media program. The moms2b Club utilizes a social media and a mobile technology platform to promote prenatal and post-partum care. Through a partnership with a mobile phone service provider, OB/GYN providers, community partners and our WeeCare maternity program, moms2b engages high-risk pregnant members to keep them connected to our WeeCare Care Managers and their available services.
- **Cell phones for pregnant women** - Free phones with 250 free monthly voice minutes are offered to pregnant members for a 12 month period. In addition to the free voice minutes, members receive free text messages containing healthy reminders and other pregnancy-related messages, as well as phone calls from AmeriHealth Mercy.

- **Home Monitoring - Heart Failure and Diabetes -** High risk members receive remote patient monitoring (RPM) equipment to monitor and report blood pressure, blood sugar and weight.
- **Cell phone-connected glucometers** – Our southeastern Pennsylvania affiliate, Keystone Mercy Health Plan, provided 93 high risk members belonging to one of three practices in an underserved area of Philadelphia with cell phone-connected glucometers. Participants saw a decrease of 8.6 percent in HgbA1c and a decrease of 13.5 percent in emergency room visits.

Smart Accounts

Through our Indiana affiliate, we participate in the state's Healthy Indiana Plan (HIP), which provides healthcare benefits to uninsured individuals who do not qualify for Medicaid. HIP members have a POWER account that is jointly funded by the state and the member (on an income-based sliding scale) for use in covering the cost of healthcare services the member receives. If the member receives the required preventive care services and POWER account dollars remain at the end of the year, the remaining dollars rollover to the next year and can be used to decrease the member's payment into the POWER account for the next year. AmeriHealth Mercy welcomes the opportunity to discuss this innovative approach with DPW.

Looking Ahead

We will actively work with DPW to identify and implement technology-supported services to provide members with resources and incentives to manage their own healthcare. For the New West and New East Zones, we will provide our interactive Member Web Portal, and a free cell phone program for pregnant women.

To better serve members in the rural areas of the New West and New East Zones, AmeriHealth Mercy has begun discussions with Logistics Management Consultants Inc. (LMC) on a Telemedicine Preventative Health Care Program to provide direct care to the member at their various locations in the community. LMC's interactive health kiosks can be provided at fixed locations throughout underserved communities or made available through mobile trailers. With doctor and nurse connectivity, the system is able to monitor blood pressure, weight, oximetery, temperature, and blood glucose and cholesterol. Data is shared with member's Primary Care Provider (PCP) and prescriptions can be printed at the kiosk.

This program, which is Electronic Medical Record-compatible, has the ability to service 150 members within eight hours and complies with all HIPAA fraud prevention standards. Especially helpful in the most remote areas of the Commonwealth, the system is not affected by poor cell phone reception or internet connectivity.

QUESTION 3

Describe the management techniques, policies, procedures or initiatives you have implemented to promote health care equity for your members. Please provide evidence of success. Describe your strategy moving forward to improve performance in this area.

(Limit to six pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy is a national leader in the design and implementation of programs and initiatives to promote healthcare equality for the members we serve. Our award-winning programs are based on our understanding of the cultural norms of our members. AmeriHealth Mercy and two of our affiliated health plans are among only six companies nationwide to become early adopters of the Multicultural Health Care Distinction Program from the National Committee for Quality Assurance (NCQA). All three health plans scored 100% to earn this Distinction.

Embedded in all of our efforts is a culturally and linguistically appropriate approach to the delivery of health care services. We foster cultural awareness both in our staff and in our provider community. Additionally, we leverage race, ethnicity, and language data to ensure that the cultures prevalent in our membership are reflected to the greatest extent possible in our provider network. We routinely examine Access to Care Standards for both the general population and the population who speak a primary language other than English. In addition, every edition of the provider newsletter includes a pertinent article on addressing cultural or language issues.

Every six months, we analyze member demographic trends, and we review our HEDIS and CAHPS data annually to compare results across the population by available race, ethnicity, and language categories. These data allow us to identify the subpopulations within our membership whose health outcomes are not as favorable as the general population. Results of this analysis are used to guide our Performance Improvement Projects and Integrated Care Management initiatives.

Our 2011 Disparity Analysis of health outcomes for our HealthChoices Lehigh/Capital members found no evidence of health disparities between our African American and Caucasian members on the following measures:

- Frequency of Ongoing Prenatal Care: >81 % of the Expected Number of Prenatal Care Visits
- Child-Adolescent Access to Care (Ages 12-19 years)
- Cervical Cancer Screening (Ages 24 to 64 years)
- Breast Cancer Screening (Ages 42-69 years)
- Annual Dental Visits (Ages 7-10 years and ages 15-18 years)

Our analysis of outcomes for Hispanic/Latino and non-Hispanic/Latino members found that members of Hispanic/Latino ethnicity have consistently better outcomes on HEDIS measures than there non-Hispanic/Latino counterparts.

Central Pennsylvania Healthcare Disparity Initiatives

Because AmeriHealth Mercy's Lehigh/Capital Zone population is largely African American and Hispanic, we have made a concerted effort to address the disease states that affect these populations disproportionately.

- **Type 2 Diabetes Program for Latinos -** In partnership with Edgardo G. Maldonado MD, Medical Director, Centro de Salud and Community Health and Wellness Center in Allentown, AmeriHealth Mercy implemented a Type 2 Diabetes program among Latinos, providing health education, implementation of preventive practices, and increased access to

health care services. Program interventions included Spanish-language educational materials, a Promotora program to train community members as healthy diabetes advocates/lay educators and distribution of a Platillos Latinos ¡Sabrosos y Saludables! (Delicious Heart-Healthy Latino Recipes) cookbook. AmeriHealth Mercy Care Managers work directly with diabetic members in the area to enroll them in the program. Program results showed improved diabetic testing scores and significantly lowered HbA1C levels, a key clinical indicator in diabetes control. Detailed analysis showed a significant improvement for both LDL and HbA1C management measures for the Latino population in Allentown region.

- **Go Red for Women Heart Health Program for Latinas -** Similarly, AmeriHealth Mercy has worked with the American Heart Association to sponsor an annual *Go Red for Women* Latina Community Luncheon. This event is both social and educational, designed to encourage women in the Latina community to become champions of their own health. The program is held at a popular restaurant and includes Spanish-speaking lecturers, health screenings with bi-lingual health professionals, cooking demonstrations that teach women how to reduce fat and salt in their favorite recipes, and salsa dancing to promote the importance of exercise. The event is attended by over 150 women each year and is open to the public.
- **African American Women's Wellness Empowerment Program -** AmeriHealth Mercy partners with African American faith-based community leaders, like those at The Bright Side Baptist Church in Lancaster, to address health disparities in the African American community. AmeriHealth Mercy has held four Women's Wellness Empowerment Fairs in partnership with faith-based organizations in the Lehigh/Capital Zone.
- **Healthy You, Healthy Me Childhood Obesity Program -** Our Healthy You, Healthy Me Program, modeled after the CATCH (Coordinated Approach to Child Health) Kids Curriculum, helps children and their parents and caregivers combat and prevent obesity. This curriculum provides activities and programs that encourage improved nutritional choices and increased physical activity in children ages 5 to 13. The six-week Healthy You, Healthy Me program is implemented in partnership with summer or after-school programs to bring health information to underserved youth in our service area, primarily in African American communities.

Healthcare Disparity Initiatives in other Markets

In our Southeastern Pennsylvania affiliate, two of our programs to improve healthcare disparities were recognized by NCQA. AmeriHealth Mercy intends to bring these award-winning programs to the New West and New East Zones, and to our HealthChoices Lehigh/Capital members.

- **Healthy Hoops® -** Our NCQA award–winning program uses basketball as a mechanism to engage pediatric members with asthma and their families in education on asthma management and obesity prevention.
- **Women's Health Ministry 40-Day Journey -** This NCQA-recognized program focuses on improving the health of African-American women and their families through a multi-week educational series emphasizing nutrition, exercise, medication compliance, and water intake.
- **Community Baby Shower Program -** This program received the 2011 Outreach Award by the Medicaid Health Plans of America (MPHA) for its impact on reaching into racial/ethnic minority communities. Through this program, we partner with community agencies and invite pregnant members and their families to attend festive community baby showers. Care Management nurses and social workers are present to complete clinical assessments on the

pregnant women (many of whom are teens), identify possible high-risk conditions, and offer health care guidance throughout the duration of the women's pregnancy for a healthy delivery. The community baby showers have also included mobile dental vans to provide the pregnant women with routine dental exams, stressing the importance of dental hygiene during pregnancy in relation to the infants' development. The community baby showers also include fun activities, nutritious food, and baby shower gifts donated by our employees. The goal of the community baby showers is to increase pregnant women's awareness of the importance of prenatal care and how to access those health care services.

Culturally Competent Approach

Another key to AmeriHealth Mercy's ability to address health care disparities among our membership is our focus on cultural competency for our staff and within our provider community. We begin with a diverse workforce, hiring staff from the communities that we serve, including those hired through our Contractor Partnership Program. Our outreach phone unit is staffed by Welfare-to-Work participants who live in the same neighborhoods as our members and have unparalleled insight into our members' challenges and perspectives.

AmeriHealth Mercy employees take part in training on diversity and Culturally and Linguistically Appropriate Services (CLAS) principles, and we educate our providers on the same. CLAS principles are reinforced during semi-annual Provider Symposiums and are included in all quarterly provider education packets. A provider attending our CLAS presentation at a Provider Symposium recently invited us to present to the entire provider office staff.

In addition, we routinely sponsor conferences to assist providers in becoming more aware of cultural differences and how they impact patient care.

"Your seminar was unique and combined together two very important aspects of our lives: culture and health care. Given that we live in such a multicultural society, it is crucial that we as health care providers understand the culture from which each of our patients comes from, and how this culture affects their oral health. Only by gaining cultural competency can we establish a trusting relationship with our patients, and provide them with excellent dental care as well as with proper preventive measures. "
– Dr. Albert Aloian

Looking Ahead

Using Census Bureau data and information from the Center for Rural Pennsylvania, we have identified that African Americans and Hispanics comprise the prominent racial and ethnic minorities in the New West and New East Zones, which is consistent with our experience in the Lehigh/Capital Zone and in the five voluntary managed care counties where we currently operate. We are confident that the programs and initiatives we have established to serve our current African American and Hispanic members will provide a strong platform for addressing healthcare disparities in the new zones, and we look forward to adjusting our existing approaches as needed to address the more rural communities in the New West and New East Zones. To assist in our efforts, we have identified several opportunities to partner with local agencies in the new zones to improve health equity for Medicaid consumers. Some of these are described below.

Pennsylvania Area Health Education Centers (AHECs)

AHECs are known nationally for linking community services in rural and urban settings with teaching hospitals and health centers. They have a special focus on recruiting and retaining PCPs and allied health professionals, particularly individuals from minority and underserved communities and populations, to provide care in underserved areas. They also develop effective

community-based health promotion programs. A solid relationship with the Pennsylvania AHEC holds the potential for strong, locally-focused initiatives in health equity, smoking cessation, and domestic violence.

AmeriHealth Mercy staff has experience working within the AHEC framework. Currently, AmeriHealth Mercy hosts medical students participating in the New Jersey AHEC for two week rotations every year, and a staff member with our southeastern Pennsylvania affiliate, Keystone Mercy Health Plan, previously served as the director of the regional AEHC for Northeast Florida.

Building Local Partnerships to Address Health Disparities

In preparing for expansion into the New West and New East Zones, we have been working with local community agencies and leaders to identify health care needs unique to this region. We have identified a particularly promising opportunity for addressing health disparities through our conversation with Andy Glass, Director of the Erie County Department of Health. Mr. Glass shared information about PartnerSHIP for a Healthy Community, the local affiliate "State Health Improvement Plan" partner for the Pennsylvania Department of Health. The key objectives of the initiative are to reduce and ultimately eliminate health care disparities, to increase access to care, and to improve the health status of everyone. Mr. Glass also informed us of a partnership that the Erie Department of Health has established with the Erie County Medical Society to address health literacy. We are very enthusiastic about the opportunity to work with Mr. Glass and the PartnerSHIP for a Healthy Community, and the Erie County Medical Society to address health disparities in Erie County, and to extend the successes here to other New West Zone counties.

The increased prevalence of diabetes is a common area of concern expressed by nearly everyone we have met in the New West and New East Zones. This was echoed in our conversations with Amy Woods, Executive Director of the United Way of Crawford County and Jim Minksy, Executive Director of the United Way of Mercer County. It is evident from these conversations that AmeriHealth Mercy's Lose to Win and Healthy You, Healthy Me programs would be welcomed opportunities for collaboration with their respective organizations and the local YMCAs. In the New East Zone, Sojourner Truth Ministries (Williamsport) is also particularly interested in AmeriHealth Mercy's diabetes education programs and our preventive care programs.

One other theme from our conversations with local agencies and community groups is that access to care, especially primary care, is problematic in these regions for Medicaid recipients generally, and perhaps more acutely for minority populations. AmeriHealth Mercy has a strong record of improving access to care for our members in the Lehigh/Capital Zone and in the voluntary managed care program, especially in Hispanic communities. We offer enhanced compensation to encourage PCPs to open their practices to new patients, and we offer enhanced compensation for extended office hours. Additionally, our efforts to educate members about keeping their appointments and our assistance in coordinating transportation for members has positively impacted no-show rates, which providers tell us is a key reason they do not accept Medicaid patients.

One of our important community partners in the Lehigh/Capital region, Ngozi Inc., will be opening three new wellness centers in Northumberland County. Our strong ties to this organization, which primarily serves the African American population, will be instrumental in improving access to care for members in this area.

QUESTION 4

Describe the management techniques, policies, procedures or initiatives you have in place to effectively and appropriately control avoidable hospital admissions. Describe your strategy moving forward to improve performance in this area.

(Limit to two pages)

RESPONSE TO QUESTION 4

Effectively managing avoidable hospital admissions requires moving from a reactive, episodic healthcare system to a proactive model that promotes care coordination and evidence-based medicine through information sharing. This is the cornerstone of AmeriHealth Mercy's approach to managing our members' care, as described below, and it has contributed to our continued 4.3percent decrease in inpatient utilization over the past two years. Our success in this area is one of our many contributions to improving health outcomes for our members and lowering taxpayer costs for the Medicaid program.

- **Utilization Management (Prior Authorization, Concurrent Review, and Discharge Planning) -** Our Utilization Management (UM) program is designed to ensure that members receive the right care, at the right time, in the appropriate setting. We require prior authorization for all elective admissions to maximize the delivery of care in the most cost-effective setting. Our concurrent review nurses assess every admission for conformance to evidence-based medicine protocols, and our discharge planners work with every hospitalized member to coordinate home services and referrals to Care Coordination to avoid future admissions or re-admissions.

Integrated Care Management

Our Integrated Care Management model blends traditional Disease Management with complex case management. We offer programs for the following chronic health conditions that if left unmanaged, result in poor health outcomes and high rates of hospitalization: diabetes, asthma, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure, HIV, sickle cell disease, and hemophilia. We also offer our WeeCare Maternity Case Management Program to manage high-risk pregnant members, and a Pediatric Preventive Care Program that targets children ages 0 -2 to ensure compliance with EPSDT services.

Members are identified for enrollment in our Integrated Care Management program through predictive modeling and through referrals from internal AmeriHealth Mercy staff, members or providers. We use Verisk Health's Diagnostic Cost Groups and predictive modeling system ("DxCG") to identify members at highest risk for future admissions, based on the Prospective Risk Score (indication of future risk for avoidable care) and the Likelihood of Hospitalization Score (predictor of future inpatient hospital care), and we focus our most intensive care management efforts on this group.

- **Member Clinical Summaries and Care Gap Identification** - AmeriHealth Mercy facilitates improved care coordination with providers by sharing a Member Clinical Summary, which is a claim-based medical history including pharmacy and medical data, and identified Care Gaps, through our secure Provider Web Portal. Sharing of Care Gap data is especially helpful in identifying issues that if not addressed, could lead to deteriorations in health status resulting in avoidable hospitalization. For example, Care Gap data identifies diabetic members who are overdue for HbA1c testing and members with heart failure who are not on the guideline-recommended "triple-therapy" medications.
- **Pharmacy Coordination -** AmeriHealth Mercy focuses on pharmacy compliance and appropriateness to help our members stay well and avoid deteriorations in health status that can lead to hospitalization. Our care managers have desktop access to the medication profiles of all members enrolled in our Integrated Care Management Program, allowing them to make

timely reminders and assist members in understanding how to take their medications as directed. Our Regional Clinical Pharmacist conducts daily rounds with our Care Managers.

- **Member Health Education and Wellness Programs -** AmeriHealth Mercy is known both locally and nationally for our comprehensive health education programs. We held over 400 programs in the Lehigh/Capital Zone last year. Our programs empower members to take control of their own health and seek to increase member compliance with their care plans. Our Know Your Numbers Program helps members recognize problems, such as blood pressure, cholesterol, or high glucose, early and seek care promptly. Please see our response to Member Management Question 1 for more information about our health education and wellness programs.
- **Telemedicine -** AmeriHealth Mercy is partnering with home care agencies and other vendors to deploy telemedicine technology, especially in rural communities. We are prepared to coordinate remote blood pressure monitoring using a digital blood pressure monitor within the member's home, and remote glucose monitoring using cell phone-connected glucometers. The remote monitors transmit results to the PCP and the AmeriHealth Mercy care manager, alerting both to fluctuations that may require immediate intervention.

Looking Ahead

- **Provider Shared Savings Contracts -** AmeriHealth Mercy has a strong provider Pay for Performance model that aligns provider compensation with desired health outcomes. Moving forward, an analysis of encounter and claims data will identify targets for proactive partnerships, including the possible implementation of our hospital shared savings program. This program enables hospitals to share in savings derived from a reduction in hospital readmissions and ER utilization, and we will seek to include reductions in avoidable readmissions as well. Our southeastern Pennsylvania affiliate, Keystone Mercy Health Plan, has successfully introduced shared savings contracts in that region, and we are confident that we can build upon that success in the New West and New East Zones, and in our existing Lehigh/Capital service area.
- **Embedded Care Management -** Our southeastern Pennsylvania affiliate, Keystone Mercy Health Plan, piloted a program placing Care Managers in provider offices, working with the staff and interacting with plan members during their visits. The embedded Care Manager shared information on filled prescriptions, Care Gaps, emergency room visits and inpatient admissions with the office staff to prepare for the member's office visit. The Care Manager also addressed the members' social concerns such as transportation and child care, and provided coaching on self-care issues such as medication adherence and preventive care measures. In addition, the Care Manager assessed each member for ongoing needs and coordinated care management services for the member in between visits.

  The Care Manager also facilitated proactive outreach to members of the practice who had not had a visit in the last year or who were missing key recommended services (Care Gaps). Among other improvements, the program resulted in a 10 percentdecrease in hospital admissions.

  AmeriHealth Mercy will work to partner with providers in the New West and New East program to bring this successful program to these regions.

QUESTION 5

Describe the management techniques, policies, procedures or initiatives you have in place to effectively and appropriately manage the Transition of Care (TOC) for members being discharged and control hospital readmissions. Describe your strategy moving forward to improve performance in this area.

(Limit to two pages)

RESPONSE TO QUESTION 5

Inpatient care is the largest component of any Medicaid Managed Care Organization's budget. Implementing sound transition of care policies and procedures to control preventable readmissions are paramount to managing members' health outcomes and overall program costs. AmeriHealth Mercy's approach to transition of care management for hospital discharges, and for controlling hospital readmissions, includes the following components:

- A best-in-class integrated data platform to inform care planning
- A collaborative transition of care team and on-site acute care transition managers in high-volume hospitals
- Post-discharge follow-up and Rapid Response team support
- Robust data analytics using the 3M Health Information Systems algorithms
- Shared savings models with hospitals

Our comprehensive approach to managing transitions of care resulted in a decrease in potentially preventable readmissions at AmeriHealth Mercy and all of our affiliated health plans between 2009 and 2010. Our results have been using algorithms developed by 3M Health Information Systems.

AmeriHealth Mercy's Integrated Care Management platform provides a complete member profile showing diagnostic information, medical and pharmacy utilization history, and social data such as family and support system availability. The data included in this system provide the foundation for transition of care planning and all efforts to control avoidable readmissions.

When a member is hospitalized, our care managers use the information contained in our Integrated Care Management system develop a successful, person-centered discharge plan. A plan is developed in collaboration with the member and/or caregiver, treating physicians, and hospital social worker, to align all parties with the transition goals. As discharge approaches, the AmeriHealth Mercy care managers coordinate home health services, specialty care and DME services to ensure a seamless transition and prevent any gaps in ongoing treatment that could result in negative health outcomes and costly readmissions.

AmeriHealth Mercy places acute care transition managers on site at certain high-volume hospitals, to help coordinate care for hospitalized members. The transition managers visit hospitalized members, assessing their discharge needs, coordinating post-discharge physician appointments, and arranging needed equipment and supplies. The transition manager also alerts the Integrated Care Management Team when a member is nearing discharge and will arrange for ongoing support from the team. The transition manager serves as a liaison for the facility and activates resources and services provided by the health plan to support the member.

Post-discharge, our transition of care team follows up with discharged members at regular intervals based on the individual plan of care and the member's ongoing needs. The team assists members with self-management techniques and helps eliminate barriers to achieving better health, like overcoming health literacy issues that impede a member's understanding of the plan of care and contribute substantially to member non-compliance resulting in readmission.

Staff can address questions concerning how to obtain medications, supplies or medical equipment, offer assistance in finding a specialist, and how to get help with making physician appointments. Ongoing medication monitoring assures the member is meeting their responsibility of remaining up-to-date with prescriptions, while those found to be noncompliant

are given a call to action and guidance on obtaining all needed medications. It is not unusual for AmeriHealth Mercy to arrange for home delivery of medication for those members rendered homebound after a hospital stay.

AmeriHealth Mercy continuously monitors the following key measures for all acute care hospital discharges:

- Physician visits within seven and 30 days of discharge
- Readmissions within 30 days of discharge
- Potentially Preventable Readmissions (Using 3M Health Information Systems' methodology)

Results of our evaluation drive improvement and performance goals, both internally and for under-performing facilities. For example, members who do not complete a follow up physician visit post discharge receive targeted outreach from AmeriHealth Mercy, including an offer of assistance in scheduling a follow up appointment.

Avoiding Re-Admission

C is a 60 year-old with female with a history of heart failure, COPD, diabetes, hypertension, gastro esophageal reflux, coronary artery disease, gait imbalance, and two cardiac stents, who was discharged from the hospital after being admitted with chest pain. We contacted C the next day to review her discharge instructions, verify that she had her medications and a follow-up PCP appointment and identify any barriers to following her plan of care.

C identified that she did not have her glucometer anymore. We arranged for delivery of a new glucometer and marked C's case for a follow-up. During the follow-up call, the Care Connector verified that the glucometer arrived. However, in discussing her follow-up PCP appointment, C identified a need for transportation assistance. We initiated the process to connect C to the county transportation service, making multiple phone calls to the PCP office, C and the transportation provider to complete the necessary paperwork so she could use the Medical Assistance Transportation Program to get to her appointment.

Looking Ahead

As we expand the scope of our HealthChoices participation, our transition of care strategy has been shaped by both past experience and research of the New West and New East Zones. In addition to carrying on the aforementioned protocols, we look forward to partnering with DPW to identify facilities with the highest readmission rates in these counties. An analysis of encounter and claims data will identify targets for proactive partnerships, including the possible implementation of our hospital shared savings program, which enables hospitals to share in savings derived from a reduction in hospital readmissions and ER utilization.

In addition, we will seek to engage local agencies in our ongoing efforts to address health literacy issues. We look forward to partnering with people like Andy Glass, Director of the Erie County Department of Health, and providers in the new zones, on health education and literacy programs to help empower our members to take control of their health.

QUESTION 6

Describe how you encourage provider usage of electronic medical records.

(Limit to four pages)

RESPONSE TO QUESTION 6

Electronic Medical Records (EMR) is a required standard for 2015. More importantly, it provides a vehicle to improve patient care, saves time, reduces fraud and helps control costs. AmeriHealth Mercy's ongoing multi-faceted EMR plan encourages our partners and providers to more quickly implement and better utilize EMR along with Pennsylvania's Health Information Exchange (HIE).

Introduction

AmeriHealth Mercy has encouraged implementation of Electronic Medical Records (EMR) in coordination with Pennsylvania's HIE to:

- Improve our members' overall healthcare experience
- Improve member care by allowing providers instant access to members' medical history, so providers can act faster and more efficiently
- Reduce admissions time allowing for faster medical attention
- Reduce medical errors
- Reduce fraud, waste and abuse
- Enhance reporting capabilities and patient tracking to facilitate better member care
- Reduce duplication of tests and delays in treatment
- Improve accuracy of medical records
- Reduce office space, paper filing, storage and other costs due to hard copy files
- Reduce 'lost' charts where files are misplaced or not available to provider at the time of service
- Improve synergies between providers
- Improve disaster relief efforts since records are no longer 'lost' when catastrophic events occur

These improvements in care are mutually beneficial to members, who benefit from improved care coordination leading to better health outcomes, and to the Commonwealth its taxpayers, who benefit from medical and administrative cost reductions resulting from increased efficiencies and better coordinated care. For these reasons, AmeriHealth Mercy is a strong proponent of the use of EMR within our provider network.

Data Integration with Provider EMRs

AmeriHealth Mercy makes an individual Member Clinical Summary available to participating providers for print or download into the provider's electronic medical record via our secure Provider Portal. The Member Clinical Summary is a claim-based medical history including pharmacy and medical management data sets, and any Care Gaps. The Member Clinical Summary is a valuable tool to ensuring appropriate coordination of care.

Provider Education

AmeriHealth Mercy routinely informs providers of funding from various entities for EMR acquisition and implementation through our provider website, our provider newsletter, and our provider education packets (distributed three times a year).

For example, our provider website currently has a notice about the federal incentives and state subsidized assistance available to providers for implementing and using electronic medical

records through the Pennsylvania Regional Extension and Assistance Center for HIT (REACH). We inform providers that the federal incentive program is open to all Pennsylvania providers.

Participation in State and Regional Initiatives

AmeriHealth Mercy is actively involved in Pennsylvania's Health Information Exchange (HIE) projects. We have participated with the Pennsylvania E-Health Collaborative (PaeHC) in the development of their strategic plan for HIE through active involvement on the Business Operations and Finance committees. We have also been involved at the local level in supporting the Southeast PA Health Information Organization (HIO), a collaborative effort with the Delaware Valley Healthcare Council, which represents area hospitals, and the Health Care Improvement Foundation. We also bring HIE experience working with other states, namely the Kentucky HIE, where we are delivering a Continuity of Care Document of health plan information (medications, admissions, office visits, etc.) to providers through the HIE.

Looking Ahead

AmeriHealth Mercy understands that providers may be reluctant to invest in expensive, time consuming and complex EMR technologies. Providers may not have the money, time or expertise to select, implement, and covert current systems and train their staff. Change itself is also a barrier since any process change can disrupt operations.

In response to these concerns, AmeriHealth Mercy is introducing incentives to providers for improving quality performance and utilizing EMR software. This incentive will become part of our existing Provider Incentive Program.

QUESTION 7

Describe your plan's approach to utilization management, including:

- *Lines of accountability for utilization policies and procedures and for individual medical necessity determinations;*
- *Data sources and processes to determine which services require prior authorization and how often these requirements will be re-evaluated;*
- *Process and resources to develop utilization review criteria;*
- *Prior authorization processes for Members requiring services from non-participating providers or for members who require expedited prior authorization review and determination due to conditions that threaten the Member's life or health; and*
- *Processes to ensure consistent application of criteria by individual clinical reviewers.*

(Limit to six pages)

RESPONSE TO QUESTION 7

The most effective approach to controlling healthcare costs and managing utilization is providing the right care, at the right time, delivered by the right provider. Medicaid members are disproportionately impacted by chronic disease, and while we have systems in place that emphasize care for the chronically ill, our approach to utilization management is designed to assist all members - not just those in our case and disease management programs - in getting and staying healthy. Our Utilization Management (UM) program marries technology and decision support systems with a quality focus to promote member responsibility and self-management and minimize the administrative burden for providers.

Our UM program is a comprehensive, systematic, and ongoing effort that is based on nearly 30 years of experience coordinating care for our diverse membership. The UM program employs nationally recognized guidelines, regular and ongoing evaluations, and a thorough employee training program to ensure that members receive high quality, medically necessary care. We will use this proven UM program as a foundation to ensure that our members receive the most sound, efficient, and effective care available.

AmeriHealth Mercy will not structure compensation to individuals or entities that conduct utilization management activities in such a way as to provide incentives for the individual, AmeriHealth Mercy employees or subcontractors to deny, limit or discontinue medically necessary services to any members.

Lines of Accountability for Utilization Policies and Procedures

Our Board of Directors provides strategic direction for the UM Program and retains ultimate responsibility for ensuring that the UM Program is managed, monitored, and evaluated in accordance with accrediting bodies, State, and CMS regulations. Operational responsibility for the development, implementation, monitoring, and evaluation of the UM Program is delegated by the Board of Directors through the Regional President, the Health Plan Executive Director, and our Quality Assessment and Performance Improvement committee (QAPI). The Medical Director reports to the Executive Director and Regional Chief Medical Officer and facilitates communication between regional and local leadership and the Board.

The Medical Director is responsible for the development, implementation, and oversight of all aspects of the UM program. The Utilization Management Director works in concert with the Medical Director and is responsible for oversight of all operational aspects of the UM program. The UM Director, Manager and Supervisor have responsibility for the managerial oversight of the UM program and for ensuring that the basic components of utilization management are established and effectively operating.

A complete set of policies and procedures outline the processes and decisions-support guidelines for the UM Program. UM policies, procedures and medical necessity guidelines are reviewed and approved by the QAPI committee, which includes participating practitioners as voting members.

Staff Roles and Responsibilities

The role of each staff member is clearly defined, documented, and implemented to ensure that all aspects of the UM process fully support care coordination efforts. All care coordination efforts are designed and implemented to support quality administration of health care benefits, in

accordance with all State requirements, state and federal laws and regulations, and accreditation guidelines.

Requests for benefit coverage or Medical Necessity determinations are made through staff, supervised by a Registered Nurse. Decisions to approve coverage for care may be made by UM staff when falling within written guidelines applicable to this program.

Licensed physicians support the staff within the UM Department. Together they provide clinical review of medical information and/or peer-to-peer contacts with attending/treating physicians and/or other healthcare practitioners when there is conflicting medical information or there are questions about appropriate application of Medical Necessity guidelines. Any decision to deny, alter or approve coverage for an admission, service, procedure or extension of stay in an amount, duration, or scope that is less than requested is made by the Medical Director.

Data sources and processes to determine which services require prior authorization

AmeriHealth Mercy uses well-defined and tested algorithms to assess the utility of an authorization process for selected outpatient, medical equipment, supplies, and inpatient services, including monthly review of prior authorization requests. Our written policies and procedures for processing requests for initial and continuing authorization of services meet DPW and NCQA standards. In all cases, we will follow DPW requirements as to which services require prior authorization.

In addition to volume and cost, we look at frequency of denial, potential for abuse, and local market characteristics as indicators for review. For example, one of our affiliated health plans experienced a chronically high level of tonsillectomies in comparison to the Medicaid mean. Although tonsillectomies do not require authorization for most of our health plans, our affiliated health plan nonetheless performs clinical review of these requests in order to better understand and manage utilization.

The Prior Authorization Governance team, consisting of representatives from our Medical Management, Operations and Provider Network Management departments, meets monthly to review data on service utilization and requests for changes to the list of services that require prior authorization. Data on the relative volume of requests (requests per member), the cost of the service, the potential for safety issues or adverse outcomes and the percentage of requests found to be outside of medical necessity guidelines are reviewed. The Governance team can decide to add or remove services from the prior authorization list. In order to have an authorization for services added to the grid, the proposed action must be supported by a rationale (such as a State mandate or an unexplained increase in utilization) and an anticipated return on investment. Additions and deletions are reviewed and approved by the QAPI and DPW.

Process and Resources to develop Utilization Review Criteria

AmeriHealth Mercy uses the nationally-recognized InterQual guidelines for its UM program. We review and update our criteria for at least annually – or more often if needed – during our Quality Assessment and Performance Improvement committee (QAPI) meeting, which includes external physicians as members with voting privileges. The criteria currently in use include:

- InterQual Adult ISD (Intensity of Service, Severity of Illness & Discharge Screens) Criteria
- InterQual Pediatric ISD (Intensity of Service, Severity of Illness & Discharge Screens) Criteria

- InterQual Outpatient Therapy Criteria
- InterQual Home Care Criteria
- InterQual Outpatient Procedures Criteria
- InterQual DME Criteria

As needed, AmeriHealth Mercy develops internal criteria to supplement InterQual. We use the following information sources during the development process:

- Results of the Hayes Incorporated technology assessment report
- Information from appropriate government regulatory bodies, such as the Food and Drug Administration or the DPW Technology Assessment Group
- Published scientific evidence
- Publicly available reference information (including web/online resources)
- Information from a board-certified consultant(s) familiar with the specialty or technology area under review

The final criteria are reviewed and approved by the QAPI committee which will be responsible for the annual review and approval as part of our Quality Assessment and Performance Improvement Program. Practitioners that serve on this committee will provide input in the development and revision of these criteria.

Any request that is not addressed by, or does not meet, the guidelines set forth in the above criteria is referred to a Physician Reviewer for a decision. Medical Necessity decisions are based on DPW's definition of Medical Necessity, in conjunction with the member's benefits, the reviewer's medical expertise, applicable criteria, and/or published peer-review literature. At the discretion of the Physician Reviewer, input to the decision may be obtained from participating board-certified physicians from an appropriate specialty. The Physician Reviewer makes the final decision subject to applicable appeal and grievance procedures.

Prior Authorization for Non-Participating Providers and Expedited Prior Authorization

We have well-defined policies and procedures to follow when a member needs to access care from a non-participating provider or needs an expedited prior authorization determination. Our UM criteria, and the process used for criteria development, are used for both participating providers and non-participating providers. AmeriHealth Mercy also has mechanisms in place to ensure consistent application of review criteria for authorization decisions, and procedures for consultation with the requesting provider when appropriate.

Process for Non-Participating Providers

Although we will make every effort to provide a comprehensive network of providers, there will be occasions when a member needs services from a non-participating provider. We will consider the use of a non-participating provider to be medically necessary in the following situations:

Continuity of Care

Members who are engaged in an ongoing course of treatment with an out-of-network provider can continue to receive services from that provider in the following situations:

- **Newly enrolled Members** may continue an ongoing course of treatment with a nonparticipating Practitioner or Provider for up to sixty (60) days from the date of enrollment with the Plan.

- **Newly enrolled Members who are pregnant** on the effective date of enrollment may continue to receive ongoing treatment from a non-participating Obstetrician or Midwife through delivery and the completion of post-partum care related to the delivery.
- **Current Members** may continue an ongoing course of treatment with a Practitioner whose contract is terminated with the Plan (either by the Plan or by the Practitioner) for up to ninety (90) days from the date that the Member is notified by the Plan of the termination or pending termination.
- **Current Members** may continue an ongoing course of treatment with a Provider whose contract is terminated by the Plan for up to sixty (60) days from the date that the Member is notified by the Plan of the termination or pending termination.
- **Current Members who are pregnant** on the date that the Member is notified by the Plan of their provider's termination or pending termination may continue an ongoing course of treatment with a non-participating Obstetrician or Midwife through the completion of post-partum care related to the delivery.

Services are Unavailable from Participating Specialist/Provider

Prior authorization will be granted for medically necessary out-of-network services if the requested services are not available within the AmeriHealth Mercy network or if participating specialists/providers do not have the necessary expertise/training to provide the services.

Expedited UM Determinations

AmeriHealth Mercy has a process in place to handle expedited or urgent medical requests, separately from non-urgent requests that comply with DPW requirements. The determination is based on what will drive the best outcome for the member.

Members and/or their practitioner or provider can request an expedited review of an authorization request via phone or fax. Expedited requests are flagged as "Urgent" in our Medical Management Information system, alerting the UM staff to the need to follow expedited processing rules and timeframes. The urgent flag also allows UM leadership to monitor and report timeliness of expedited determinations.

Expedited determinations are made and verbal or electronic notification is provided as expeditiously as the Member's health condition requires, at least orally, within 24 hours of receipt of the request unless additional information is needed. If additional information is requested by AmeriHealth Mercy to make a determination, the decision is made and verbal or electronic notification is provided within 24 hours of receipt of the additional information or the date when the additional information was to have been received, whichever is sooner. Both the Member and the Health Care Provider receive verbal or electronic notification of all determinations. Written notification of denial determinations is made within 24 hours of the verbal notification of the decision.

Consistent Application of Criteria

Our training and ongoing education programs for our UM team are based on our proven programs. The programs are designed to help the UM employees understand the delivery of health-related services to our members, as well as to ensure the consistent application of medical necessity criteria. Our multi-layered approach ensures that the goals of the HealthChoices program around stabilizing Medical Assistance spending while sustaining quality health outcomes and appropriate benefit levels are met.

Certified Trainers

We maintain a team who are certified as instructors for InterQual Medical Necessity criteria. Annually, this team goes through training and instructor update certification. Our instructors deliver training on changes and updates to the criteria to our UM staff. We have four (4) RN staff members who are being certified as InterQual Instructors. Initial training on proper application of our criteria is provided during new employee training.

New Employee Training

New employees are educated and trained on job duties by the department manager and program trainer. For a UM nurse, this training includes use of applicable medical necessity criteria and guidelines. Utilization review skills are taught using scenarios that mimic the coverage needs of the Medicaid population and focus on commonly encountered requests. Basic system navigation and documentation of criteria use is taught in the classroom.

Inter-rater Reliability

In addition, UM staff members involved in the application of medical necessity criteria participate in an Inter-Rater Reliability (IRR) process twice per year. This process involves reviewing blind 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 (or disapproval) if criteria appear to have not been met. Physician reviewers also participate in an IRR process twice per year. The IRR process helps to identify if clarification or recommendations for modifying criteria are needed, or if additional individual or group training is indicated. Action plans are developed to address identified variances. Performance results and action plan results are communicated to staff via individual sessions, team meetings and department communications and reported to the QAPI committee.

Individual Coaching

UM cases, including information collection, criteria application, documentation, timeliness and notification, are audited on an ongoing basis. Monthly, a supervisor reviews the results with the individual employee responsible for the case and evaluates 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 care management issues, and also serves as an educational forum to share information, resources and example-based education.

MANAGEMENT TO CONTROL COSTS

CONTENTS

QUESTION 1

Demonstrate how you monitor the performance of your subcontractors to ensure all Agreement responsibilities are met. Provide sample reports showing any actions taken to improve performance and ensure positive results. Describe any sanctions or penalties that apply if the subcontractor fails to perform up to the expectations of your organization. Attach sample performance monitoring reports.

(Limit to two pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy will only delegate activities to organizations meeting the requirements defined in 42 CFR Part 438. We evaluate the prospective subcontractor's ability to perform the delegated activities. After the potential subcontractor demonstrates acceptable capability, a written agreement specifying the delegated activities, required performance standards, reporting responsibilities and contractual remedies related to performance issues, is executed. AmeriHealth Mercy contractually retains the right to investigate and audit a subcontractor at any time; to require corrective action plans; and to implement increased monitoring to meet standards. Subcontractor requirements are based on AmeriHealth Mercy's requirements, the requirements of the RFP, Federal or State regulatory authorities, and applicable accrediting agencies. Oversight of subcontractors includes validating all required certificate(s) of insurance prior to contract implementation and that all such standards are maintained throughout the term of the agreement.

We monitor the performance of our subcontractors through a formal contract-based quality oversight program performed by staff dedicated to this function. Performance measures are monitored through monthly reports submitted by the subcontractor. In addition, annual onsite audits are conducted during which regulatory compliance and performance is reviewed and documented. Monthly subcontractor performance reports and the results of annual on-site audits are reviewed by an AmeriHealth Mercy quality review committee, which meets monthly. Recommendations for any necessary corrective action plan, along with the target completion date(s), are presented to the committee. Based on the committee's decision, the subcontractor is approved or disapproved for continued operation. If a corrective action plan is imposed, the results of the corrective action and subsequent monitoring are brought back to the committee.

Table 1: Sample Performance Monitoring Report - December 2011

Metric	Contractual or RFP Requirement	Actual Performance
Clean Claim (Electronic) Paid in 21 days	98%	100%
Clean Claim (Paper) Paid in 30 days	98%	100%

Sample Report for Performance Improvement

This is a sample of a subcontractor that was not performing consistently with the contract. In this instance, the subcontractor was required to pay clean claims within established time frames 98 percent of the time. The standards were measured in four categories:

- Paper UB-04: 98% of clean claims must be paid within 30 days of receipt
- Paper CMS 1500: 98% of clean claims must be paid within 30 days of receipt
- Electronic UB-04: 98% of clean claims must be paid within 21 days of receipt
- Electronic CMS 1500: 98% of clean claims must be paid within 21 days of receipt

Issue

Subcontractor missed the goal in January 2011 for Paper UB-04 claims due to several issues, and was projected to miss the goal for the first quarter of 2011 for Paper UB-04 claims because of the low rate in January and the fact that this category historically has a low level of claims submitted.

Root Cause Analysis

Several issues were quickly discovered and the Subcontractor Claims and IT Departments continued their root cause analysis to identify all the causes. The overall root cause was attributed to Subcontractor processes not containing a measure of validation that all claims to pay were completely adjudicated and processed.

Table 2: Planned Corrective Actions

Intervention	Date/Status	Comments
Complete root cause analysis to determine issues	01.27.2011: ongoing	
Fix eCura defect	01.27.2011: pending with eCura vendor, InfoMC	Is on high priority status
Implement manual workaround	01.27.2011: manual workaround implemented	Claims staff are manually running a report after every check run to ensure that all claims completed the entire process

QUESTION 2

Describe your method and process for capturing third party resource and payment information from your claims system for use in reporting cost-avoided dollars and provider-reported savings to the Department. Explain how you will use such information. Describe the process you use for retrospective post-payment recoveries of health-related insurance as well as your process for adjudicating a claim involving an auto accident.

(Limit to four pages)

RESPONSE TO QUESTION 2

AmeriHealth Mercy has nearly 30 years of experience in cost avoidance and collection of third party resources (TPR). For calendar year 2010, the AmeriHealth Mercy avoided inappropriate payment of *$67.7 million* across all its affiliated Medicaid risk plans. The capture of TPR is critical to ensuring that Medicaid remains available to those who need it most and that Medicaid is the payer of last resort. Our system has virtually unlimited capacity to capture TPR data from other carriers, agencies and relevant sources.

Method and Process for Capturing Third Party Resources and Payment Information

AmeriHealth Mercy captures TPR information regularly received from many sources, including Explanation of Benefits (EOB) forms sent with provider claims, enrollment files, third-party liability (TPL) files received from the state and through telephone calls from providers and members who self-identify TPR coverage.

AmeriHealth Mercy's dedicated Recovery department identifies and obtains third party payer information, including Medicare, commercial insurance and/or accident-related coverage, and administers the collection and adjudication of TPL information, while meeting all federal and state requirements. The three units of the Recovery department are:

- **Cost-Containment** – Execution of a cost containment strategy, which identifies recovery-related projects (over- and under-payments) ranging in scope from small to large
- **Third Party Liability (TPL)** – Responsible for maintaining and identifying our members' additional insurance carrier information. This includes identifying and flagging records for dual eligible (Medicaid/Medicare) and commercial carriers
- **Subrogation** - Responsible for identifying, tracking and monitoring casualty-related claims for potential recovery

We exercise all applicable full assignment rights and make every reasonable effort to determine third parties to pay for services rendered to members and cost avoid and/or recover any such liability for the third party.

Reporting Cost Avoided Dollars and Provider Reported Savings

AmeriHealth Mercy complies with the State requirement to treat funds recovered from third parties as offsets to claims payments. In addition, we report all cost avoidance values to DPW in accordance with applicable federal guidelines and include the collections and claims information in encounter data submitted to DPW (including any retrospective findings via encounter adjustments). We also report third party collection in the aggregate as required by DPW, and post all third party payments to claim level detail by member. AmeriHealth Mercy will cooperate with DPW and its recovery vendor(s) in any manner as may be requested by DPW. At a minimum, we will report TPR information identified to DPW within two weeks of its receipt. The information will be made available in the appropriate format and media determined by DPW.

We understand that we may retain amounts recovered by third parties, but that these amounts must be reported monthly to DPW. In addition, we understand and acknowledge that DPW is solely responsible for estate recovery activities and will retain any and all funds recovered through these activities. We work with DPW to establish appropriate TPR-related systems and

processes for members who are made retroactively eligible for Medicare and pursue TPR with respect to such members until waiver of enrollment occurs.

As evidence of the successful application of the protocols described in this section, AmeriHealth Mercy reported over $5 million in cost avoided dollars and $3.7 million in Coordination of Benefits (COB) savings to DPW as a result of TPR/COB coordination efforts during the 2010 contract year.

How We Use the Information

AmeriHealth Mercy uses the TPR data to coordinate benefits using the methods of cost avoidance and post-payment recoveries. We utilize cost avoidance methodology whenever there is a verified third party resource.

After the TPR data are loaded, it is immediately available to all Facets (eligibility and claim system) users, including claim examiners, customer service representatives, provider service representatives, enrollment employees, medical management employees, and recovery employees. This information supports specific reporting requirements and enables the Claim department to process COB claims appropriately by using "flags" established within the Facets system. The flags assure that TPR information is considered prior to finalizing claim adjudication.

Our claims processing system automatically routes all claims containing EOBs from other insurance carriers to claim examiners for further examination. A claim examiner reviews the EOB and claim image information captured during claim submission. The COB module in Facets captures and displays line-level data of AmeriHealth Mercy and the alternate insurer(s) allowed amounts. This information is fully available for use in reporting cost-avoided dollars and provider-reported savings to DPW.

In the event the TPR information on the EOB does not match the TPR information documented in the system, the claim is routed via an automated workflow process to the Recovery department. The Recovery department verifies TPR 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 and payment.

Process for Retrospective Post Payment Recoveries of Health-Related Insurance

AmeriHealth Mercy is well-positioned to perform post payment recoveries. We have the capability to perform TPL-related overpayment recoveries directly from liable third party payers through Health Management Systems (HMS). HMS supports our retrospective post payment recoveries of health-related insurance as well as the identification and validation of additional TPR data. HMS maintains a proprietary national database containing TPR information for many of the major commercial carriers, as well as government program information.

We send eligibility information to HMS on a monthly basis, which is compared to HMS's national data sources to determine if other insurance exists for the member. Any information previously unknown to us is routed back for evaluation and appropriate action. This additional TPR information is automatically compared to existing data and, as appropriate, is loaded into our claims processing system via an automated file load process. Any updated information is included in the information sent to the State.

HMS also identifies TPR-related overpayments and is able to generate and transmit secure billing files to responsible third party payers. These payers process the billing files and submit payments to a plan-specific lockbox, which HMS reconciles. Lockbox deposits are routinely monitored by our Finance department. HMS also provides detailed billing and posting files to ensure we are informed of all claims for which a recovery was attempted and for which a recovery was realized.

Claim and line level claim denials are sent to the provider on the EOB. Our claim processing system has the capability to provide the TPR data to the provider so they can submit the claim to the appropriate carrier for payment, and will provide all such information as required by DPW.

AmeriHealth Mercy understands and complies with the State requirement that, notwithstanding any specific measures taken with respect to TPR identification and collection, if the probable existence of a TPR cannot be established the MCO must adjudicate the claim and thereafter utilize its post-payment recovery process. Upon the award of the contract, AmeriHealth Mercy will meet with the State and its vendor to define a processing and reporting protocol to conduct the post-payment reviews; if DPW wants a different process than we currently perform.

Process for Adjudicating an Auto Accident Claim

AmeriHealth Mercy manages all subrogation-related activities including identification of diagnosis for trauma, through ACS. ACS is one of the nation's largest subrogation vendors. Through years of subrogating claims, it has designed criteria and developed queries and algorithms to successfully mine paid claim data and identify potential recoveries. Claim data are processed to identify recovery potential using an algorithm which takes into account a number of detection variables including diagnosis codes, procedure codes and external cause codes found in claims information. ACS's data mining criteria include:

- An automated analysis of claim data based on review of ICD-9-CM diagnosis codes as well as the cost of treatment, demographics associated with an individual, and any related claim matters.
- Review of claim information to determine potential overpayment as it relates to accidents, slip and fall, or other worker's compensation.
- Review of membership eligibility information using a variety of tools and logic such as mandatory Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) Section 111 reports, and the use of real-time commercial eligibility information to prevent the improper payment of claims.
- Identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) and any other applicable trauma codes, including but not limited to E Codes, in accordance with 42 CFR 433.138(e).

AmeriHealth Mercy forwards a claim file each month to ACS containing information related to paid claims and enrollment data. ACS utilizes sophisticated data mining tools to identify potential accident-related claims. The analysis focuses on TPR, automobile medically related coverage, and no fault workers' compensation.

Once a potential subrogation case is identified, ACS will mail a letter and questionnaire to the member to determine whether the incident which generated the claim was accident-related. Three attempts are made to contact the member. If the member does not respond to the mail inquiries, ACS reviews additional resources using ISO ClaimSearch, official court records (court dockets) and other online research sources to further investigate whether a subrogation claim

exists. ISO ClaimSearch is the only comprehensive all-claims database and system for claims processing and fraud detection — serving property/casualty insurers, self-insured organizations, third party administrators, and many state workers compensation insurance funds. Additionally, cases may be opened manually by an ACS investigator when a member, provider, or attorney provides the incident information required to open and investigate a case.

When a case is verified and opened, ACS communicates with members on an "as needed" basis, communicates regularly with attorneys, coordinates with AmeriHealth Mercy on litigation options and settlement negotiations, and follows the case through to closure. We receive regular status reports on open and closed cases.

All cases will be pursued regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by AmeriHealth Mercy outside of the claims processing system will be treated as offsets to medical expenses for the purposes of reporting.

QUESTION 3

Describe any other cost-saving programs/initiatives you have implemented in the last 36 months and provide information on cost-savings realized related to these programs/initiatives. Please identify cost-savings plans you have planned, but not implemented.

(Limit to four pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy has integrated cost savings initiatives and program improvements into our daily approach. We are committed to continuous improvement in quality and in operational and cost efficiency in our local health plan and throughout our corporate enterprise. Over the past 36 months, AmeriHealth Mercy and our affiliated health plans have implemented several initiatives aimed at reducing unnecessary utilization, reducing provider unit costs, administrative cost reductions through operational efficiencies, and activities to deter fraud, waste and abuse. These initiatives are described below.

AmeriHealth Mercy Health Plan Initiatives

Single Source Specialized DME Supplier

AmeriHealth Mercy recently entered into a single-source contract with J&B Medical Supplies to offer full service, drop-ship incontinence supplies. Full implementation will be complete February 28, 2012. We expect to achieve savings of $1 million annually.

Claims Clinical Editing

AmeriHealth Mercy claim payment policies are based on guidelines from established industry sources such as the National Correct Coding Initiative, Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies and medical specialty professional societies. In making claim payment determinations, AmeriHealth Mercy 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 and the International Statistical Classification of Diseases and Related Health Problems (ICD) manual. Our application of iHealth Technology edits to professional and outpatient facility claims has saved more than $7 million since 2009.

Emergency Room Initiatives

AmeriHealth Mercy has a PCP incentive program that rewards PCPs for cost-effecting, high-quality care. Practices are rewarded for achieving lower than average non-emergent ER utilization. We also offer PCP incentives for expanded office hours. In calendar year 2010, we achieved a six percent reduction in ER utilization, which generated savings of appropriately $1 million.

90-Day Program

In 2011, we implemented a 90-day prescription program for select generic medications where the dispensing fee paid to the pharmacy for months two and three exceed the cost of the medication provided.

By providing all of the medication for a single dispensing fee, we are able to save the two additional dispensing fees. This program is especially advantageous for our members with limited means of transportation because it allows them to make fewer trips to the pharmacy for their medication. Since the program began, nearly 14,000 claims have been filled for a 90-day prescription resulting in savings of approximately $200,000. These savings will continue increase as more members are transitioned into the program.

Fraud and Abuse

AmeriHealth Mercy currently utilizes HMS for TPL identification and recovery. We submit full membership files to HMS, which in turn identifies additional sources of TPL information. The

additional information is transmitted back to AmeriHealth Mercy and is automatically loaded into our healthcare system. HMS also recovers claims paid where the member had TPL via billing of the primary carrier(s). Claims paid due to retroactive TPL and/or those that fall under regulatory "pay and chase" requirements are referred to HMS for pursuit from the primary carrier. Through identification, recovery, and cost avoidance activities, AmeriHealth Mercy has saved more than $7.3 million since 2009.

AmeriHealth Mercy has extended its partnership with HMS to include retrospective data mining services and forensic editing post adjudication, and pre-pay prospective fraud, waste and abuse. We expect that this additional support from HMS will result in savings of $11.2 million annually.

AmeriHealth Mercy Family of Companies Corporate Initiatives

Contact Center Initiatives

Enterprise-wide, the AmeriHealth Mercy Family of Companies realized $2.5 million in savings in 2011 through more efficient configuration of call center technologies, workflows and staffing models. Specifically, AmeriHealth Mercy Health Plan has realized a portion of these savings through a reduction in back office fees.

Claims Process Improvements

In addition to call center savings, the AmeriHealth Mercy Family of Companies also realized $1.4 million in savings in 2011 due to claims processing workflow improvements. A portion of these savings are also passed through to AmeriHealth Mercy Health Plan via back office fee reductions.

Looking Ahead

Dental Insourcing

AmeriHealth Mercy Health Plan currently subcontracts dental services to DentaQuest (formerly Doral Dental). Our southeast Pennsylvania affiliate, Keystone Mercy Health Plan, recently in-sourced dental benefit management in an effort to improve quality and utilization and reduce the cost of dental care. Keystone Mercy expects to save $1 million in 2011 as a result. AmeriHealth Mercy anticipates saving approximately $300,000 annually, based on the relative size of our membership.

MANAGEMENT INFORMATION SYSTEMS

CONTENTS

QUESTION 1

Provide a general systems description, including:

- *A systems diagram that describes each component of the management information system and all other systems that interface with or support it;*
- *How each component will support the major functional areas of HealthChoices (In-Plan Services; Coordination of Care; Member Services; Maternity Care Payments; Complaint, Grievance and Fair Hearings; Pharmacy; Special Needs; Provider Network; Provider Services; Service Access; Quality Management/Utilization Management (QM/UM); Claims Payment and Processing, and; Encounter Data Reporting System).*

(Limit to ten pages, including the diagram)

RESPONSE TO QUESTION 1

System Diagram

The diagram below describes each component of the management information system (MIS) and all other systems that interface with or support the functional areas of HealthChoices. The core functional areas supported by AmeriHealth Mercy's healthcare management systems include:

Medical Management

In plan services, care coordination, special needs, utilization management (UM), quality management (QM)

Network Management

Provider Network development (provider contracting, credentialing), provider services (performance management and oversight, education), service access (provider access)

Facets Claims Processing & Eligibility System (Claims Adjudication)

Claims payment and processing, maternity care payments, pharmacy claims processing

Member Contact Center

Member services (eligibility and enrollment) and complaint, grievance and appeal

Encounter Processing and Reporting

Encounter submission, subcontractor encounter submissions and Reporting

Figure 1: Health Care Management Systems

The following matrix provides a cross-reference between PA HealthChoices functional areas and the supporting AmeriHealth Mercy system domains:

Table 1: PA HealthChoices Functional Area – AmeriHealth Mercy System Domain

PA HealthChoices Functional Area	AmeriHealth Mercy System Domain
Medical Management	
In-Plan Services	ZeOmega Jiva
Coordination of Care	ZeOmega Jiva, Verisk DxCG, E-Health Clinical Alerts
Special Needs	ZeOmega Jiva
Quality Management/Utilization Management (QM/UM)	ZeOmega Jiva, McKesson CERME/InterQual®, Treo Solutions

PA HealthChoices Functional Area	AmeriHealth Mercy System Domain
Provider Network Management	
Provider Network	Portico, Visual Cactus, Networx Pricer, Networx Modeler
Provider Services	NaviNet Provider Portal
Service Access	GeoAccess GeoCoder, by Ingenix Suite®, DirectoryExpert®, by Ingenix Suite
Claims Adjudication	
Claims Payment and Processing	TriZetto Facets, EXP MACESS™/Workflow and Imaging, iHealth Technology (iHT)
Maternity Care Payments	TriZetto Facets
Pharmacy	Argus
Member Contact Center	
Member Services	EXP MACESS/Call Documentation/Workflow, Streamline, Member Portal
Complaint, Grievance and Fair Hearings	EXP MACESS/Call Documentation/Workflow
Encounter Processing & Reporting	
Encounter Data Reporting	Data Exchange Services
Reporting	Data Warehouse, Catalyst Technologies – Quality Spectrum®

Medical Management

AmeriHealth Mercy maintains fully integrated Medical Management and e-Health solutions that help manage the delivery of valuable clinical services and information.

ZeOmega Jiva Care Management

The ZeOmega Jiva (Jiva) Care Management application is a collaborative health care management platform for case and disease management, service coordination, preventive health (EPSDT) and utilization management. Jiva's extensive capabilities, coupled with our robust analytic and data mining capabilities, form a comprehensive Care Management Information System for all members, including those with special needs. Highlights of Jiva's system capabilities include:

Utilization Management

- Defined business rules that automatically evaluate care requests to determine whether the request should be approved or pended for further review
- Clinical rules, based on evidence-based medicine, reference materials, industry-standard best practices and physician expertise, for clinical consistency in care management processes
- Provider portal interface allowing providers to create, update and view information on medical necessity authorizations and determinations

Disease and Case Management

- Identification and stratification of target patients and populations to set appropriate levels of intervention and improvements for a member's care
- Integrated access to medical, pharmacy, lab, and behavioral health data to provide a 360 degree view of the member
- Clinically validated Care Gaps and electronic health records derived from claims and care management data
- A series of care management clinical pathways that enable the efficient implementation of our holistic approach to the management of chronic conditions, pregnancy, pediatric preventive care and quality management initiatives that reduce costs and improve the health outcomes
- Comprehensive outreach pathways that incorporate current member needs, health reminders and missed service strategies
- Robust reporting templates and the ability to create ad hoc reports for care management data

Preventive Health/EPSDT

- Support for health risk assessment
- Integrated access to medical, pharmacy, lab, and behavioral health data to provide a 360 degree view of the member

Verisk Sightlines DxCG Risk Solutions

DxCG Risk Solutions offers risk adjustment and prediction engines, used to analyze and quantify both financial and clinical risk. Built using powerful, validated medical and pharmacy classification systems, as well as proven predictive modeling methodologies. Features, capabilities and benefits of Sightlines are:

- Validated, predictive modeling technology
- Advanced analytics to manage risk, improve health outcomes, and contain costs
- Designed to integrate with third party systems, including home-grown financial and actuarial methodologies
- Assess the illness burden of individuals, groups and populations
- Identify cost drivers and allocate healthcare resource budgets
- Develop risk-based provider payment structures
- Measure and demonstrate the impact of care management programs
- Use predicted costs to set underwriting rates
- Develop risk-based provider payment systems

E-Health Solutions

Our e-Health Suite leverages technology to connect providers and the health plan. This e-Health suite enables better care coordination, improves population health, increases access to care, improves quality outcomes, and helps control costs. The e-Health Suite is successfully utilized by our affiliate Pennsylvania health plans and can be customized to meet New West and New East Zone's needs, and includes the following services:

Clinical Alert Services

This solution delivers the right information, on the right member, at the right time to the provider. Instead of waiting for a provider to "pull" relevant information on the member, this solution "pushes" information to the provider. The clinical alert service delivers information on care gaps to providers when they check eligibility online through the Provider Portal. The alert

capability can be customized to deliver other types of clinical information and can be triggered by any transaction in the secure section of the portal.

Mobile Device Integration

AmeriHealth Mercy is piloting the integration of our Clinical Alert Service with handheld devices used by physicians for e-prescribing, in the Lehigh/Capital HealthChoices Zone. In partnership with NaviNet, we placed integrated hand-held devices with 43 primary care providers in 23 practice sites, covering 3300 of our enrollees. When the provider accesses the enrollee's information during an office visit, any missing or overdue recommended services (Care Gaps) for the enrollee will display. The PCP is asked to enter a response indicating that the care gap was addressed and specify the type of action taken. In the initial three months of the pilot, 112 care gaps were viewed and 62 percent were addressed during the visit.

Panel Reports

A comprehensive reporting engine allows PCPs to create panel-level reports for their assigned enrollees. The panel-level reports can be filtered to include specific conditions or preventive health measures. In addition, the PCP can specify whether the report should display as a print-ready PDF file or as a comma-separated values (CSV) file for use in creating mail merge documents or uploading into a practice management system.

Member Clinical Summary

Our Member Clinical Summary (MCS) is available to provider offices, emergency rooms and enrollees through the secure areas of our Member and Provider Web Portals. The MCS is a claim-based medical history for an individual member. Each MCS offers the user a broad view of the care the member has received across the continuum of providers. It includes a medication list, recent encounters, diagnoses, and Care Gaps. It is particularly useful when the member visits an emergency room, and is referred to a provider that has no prior information on the member or if the member requires out-of-network care. The MCS is available as a print-ready report or a Continuity of Care Document (CCD) for downloading into an electronic medical record.

EPSDT Clinical Summary

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 EPSDT Clinical Summary can be printed or downloaded as a Continuity of Care Document (CCD) for electronic integration into an electronic medical record.

Providers can also pull reports on the EPSDT status of their entire panel – and print or download the information in a MS Excel or CSV file format.

Health Information Exchange

Key elements of our e-Health Suite are available in the Continuity of Care Document (CCD) format. The CCD can be integrated with any Health Information Exchange (HIE) that follows current standards. It can also be delivered for direct download to a provider's Electronic Medical Record (EMR)/Electronic Health Record (EHR) through our Provider Portal.

Providers can request e-Health Suite Training through the Contact Center or speak to their Provider Network Management Account Executive. The Provider Network Management

Account Executives work closely with our vendor NaviNet and our e-business solutions team to provide training to our providers.

McKesson Interqual/CERM(e)

McKesson has paired InterQual Criteria with browser-based technology to provide a user-friendly care management application: CareEnhance® Review Manager (CERM (e)). AmeriHealth Mercy uses CERM (e) to automate the review process. Benefits of CERM (e) are:

- Offers easy access to InterQual criteria as well as extensive medical references, glossaries, discussions of patient management and safety warnings
- Provides a common language and foundation for understanding decision points. This leads to improved quality of care and facilitates communications among staff and between health plans and providers
- Integrates into ZeOmega Jiva application
- Streamlines workflows and enhances consistency with nested decision trees for increased productivity and greater defensibility of care management decisions
- Allows customization of content with the optional Custom Criteria Utility, to reflect our policies and integrate our content alongside InterQual criteria for a unified, comprehensive set of guidelines
- Includes integrated, flexible reports that support compliance with HIPAA privacy regulations and other quality initiatives

Treo Solutions

Treo is a Web-based suite of applications which incorporates the 3M methodology for identifying Potentially Preventable Readmissions (PPRs). Using sophisticated algorithms chains of admission and readmission, events are linked to generate rates of PPR for any hospital or group of hospitals versus the network or any segment of it. Treo also can identify Potentially Preventable Initial Admissions (PPIAs) and Potentially Preventable ER visits. Since the member is the basis for this data, we can also report the data by PCP, in order to identify PCPs with the most PPRs and PPIAs so that improvement opportunities can be explored with primary care providers. In addition TREO is used for analytics related to healthcare cost and quality outcomes at the provider level. The insights gained from the analytics are used to develop provider performance management strategies and hospital provider profiles.

Provider Network Management

The core applications of the Provider Network Management systems assist AmeriHealth Mercy in providing services in the following areas: Provider Contracting, Provider Credentialing, Contract Pricing, Contract Modeling, Provider Data Management, Network Adequacy, and Provider Directory.

Portico

Foundational to managing our provider network is Portico's integrated provider management system, through which we are transforming how we manage provider information with the objective to minimize errors, lower costs, and improve provider performance and health outcomes. Portico consists of three components:

- **Contract Manager** - is a single content source for provider contracting and provides the information transparency and process automation necessary for our affiliates to effectively manage the end-to-end provider contracting process. It automates the way our contracts are created, negotiated, amended, viewed, analyzed, managed, distributed, and audited. Utilizing

its components, we are able to streamline negotiations, manage provider demographics, and provide system-wide visibility into provider network information. Allowing us to track report and update contracts that are expiring, have built in term changes or are undergoing renegotiation.

- **Courier** - enables our employees to securely send contracts and amendments electronically. Providers utilize an easy download process that has the functionality to allow them to sign contracts electronically via an internal eSignature process. The electronic signature capability improves provider relations and reduces the cost of contract distribution. Courier is a web-based application that allows providers to access contracts from any internet connection, with no installation of software or a browser plug-in.
- **Negotiator** - provides our affiliates with the ability to have secure online contract negotiations between the affiliate and providers. The Negotiation Center walks all parties through the entire process and highlights comments from actual negotiation requests. Negotiator logs a complete history of the original and edited versions of the contract, resulting in end-to-end lifecycle tracking of the negotiation process. We track all negotiation requests, capture contract change intent, generate negotiation summary reports, and integrate negotiation requests with contract version control.

Visual Cactus

Visual Cactus (CACTUS) is a Windows-based, desktop application, which maintains provider credentialing and re-credentialing information using electronic interfaces with web-based data repositories and primary verification sources, like Council for Affordable Quality Healthcare (CAQH). The repository maintains a history of all provider attestations downloaded and an intuitive viewer provides a side-by-side comparison of select CAQH and CACTUS data. Data currently imported includes: Provider demographics, Provider IDs, Institutions, Licenses, Affiliations, Insurance, Education, Specialties, Boards, Languages, Groups, and Addresses. The import program will also create a credentialing instance for the provider if they are due for credentialing and an instance does not already exist. The electronic interfaces with web-based data repositories and primary verification sources are:

- **Custom Delegate Importer** - takes the data submitted from multiple delegates from a delimited text file containing the required data elements and populates them into CACTUS. The Office of Inspector General (OIG) Manager sweeps the OIG and Medicaid sanction history against the practitioners in the CACTUS database and flags newly found matches.
- **CACTUS ABMS Direct Connect Select -** receives primary source verified data directly from the American Board of Medical Specialties (ABMS) database which contains board certification information, including effective and expiration dates, as well as historical board certification information.
- **License Expiration Monitoring Module (LEMM)** - monitors updates to providers' medical licensing information on the state and/or DEA level. This module incorporates officially published changes in the provider's licensing information into the CACTUS license record for the provider and posts each status change for us to review.

NetworX Pricer

NetworX Pricer is a java-based application that integrates with our claims system and supports greater contract sophistication, specificity, and processing speed, while eliminating inconsistencies and errors in pricing of providers' claims. Combined with NetworX Modeler,

these capabilities position us to model the financial implications of changes during provider negotiations and those driven by regulatory changes, such as the ICD-10 implementation.

NetworX Modeler

NetworX Modeler helps to forecasts results, negotiate optimized terms, and improve the financial outcome of contracts. It helps to target costly or imprecise contractual provisions before agreements are signed, contributing to improved MLR's. It integrates with NetworX Pricer to move contracts electronically between the two so they can be modeled and moved without needing to rebuild the contract.

Provider Portal (NaviNet)

AmeriHealth Mercy uses NaviNet as its Provider Portal. NaviNet's multi-payer design allows the provider to log in once to access information from multiple payers. AmeriHealth Mercy offers access to all the standard transactions through NaviNet including eligibility and benefits, claim status and referral submission and inquiry, as well as links to provider manuals, forms and other important administrative information. Special features offered though NaviNet include a report query tool that allows providers to access reports that can vary by client and an encounters correction tool that can be accessed by providers to improve encounter submissions.

The Provider Portal also delivers valuable features including eligibility, benefits, claim status, searchable provider directory and others. Additionally, clients benefit from a best practice feature set including:

- Clinical information delivery including member clinical summaries and alerts for overdue health screens
- Provider report center that offers administrative and clinical reports in print and downloadable formats
- Eligibility/Benefit Inquiry
- Care Gap Alerts
- Claim Status Inquiry
- Claim Correction
- Referral Creation and/or Inquiry
- Authorization Creation, Update or Inquiry
- Clinical Reports and Clinical Alert Reports
- Member Clinical Summary/EPSDT Summary
- Continuity of Care Document
- Searchable Provider DirectoryGeoAccess GeoCoder, by Ingenix Suite

GeoAccess GeoCoder, by Ingenix Suite, is a desktop software application that provides the precise analysis and mapping of member access to network providers. GeoAccess is used to assist in the auto-assignment process for PCPs and to monitor network access standards. GeoAccess is also used to understand network disruption in the event of a provider termination.

DirectoryExpert, by Ingenix Suite

DirectoryExpert, by Ingenix Suite, is a Microsoft® Windows-based application for database publishing. DirectoryExpert is used to produce comprehensive, customized provider directories that are made available online through the Member Portal, NaviNet Provider Portal and the health plan's website. The directories offer a variety of search features including detail and proximity zip code searches and return detailed data including information on languages spoken, panel status and accreditation or board-certification status.

Claims Adjudication

AmeriHealth Mercy utilizes the following applications to support medical and pharmacy claim processing functions and maternity care payments.

TriZetto Facets Application

AmeriHealth Mercy uses Facets as our core eligibility and claims administration solution. Facets offers a high degree of automation and data capture, achieving fast, accurate claims processing and high auto-adjudication rates. Facets electronic commerce capabilities are designed to accept external claims submitted electronically from trading partners in the HIPAA compliant 837 transaction set standard format. Facets™ can also send remittance information to trading partners in the HIPAA compliant 835 transaction set standard format.

During the various stages of the adjudication process, Facets interacts with membership eligibility, product benefit parameters (in plan services), provider pricing agreements, medical management requirements and clinical editing information to provide accurate and highly automated adjudication of claim and/or encounter submissions. The Facets system allows for generation of checks to individual providers or the combining of payments into one check at the group or IPA level. The Facets system also captures and reports 1099 tax information.

The claims processing applications within Facets are organized for efficiency and ease-of-use by claims processors, while conforming to CMS 1500 and UB-04 formats which are the industry standards. Numerous edits alert our employees to any inconsistencies during entry, and predefined system warning messages facilitate increased accuracy and productivity.

EXP MACESS/Workflow and Imaging

EXP MACESS tracks and manages the flow of data, documents, and business processes including claim processing throughout our corporate offices and affiliates. EXP's tools for capturing, centralizing, and archiving data and documents help ensure that all of our organization's operations are standardized and integrated. Reporting tools monitor workflow, helping managers identify bottlenecks and increase efficiency.

Claim Edits/iHealth Technologies (iHT)

AmeriHealth Mercy utilizes iHT's system for enhanced clinical and business rule editing for claims. iHT's system applies 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, each affiliate has its own library of customized Medicaid-specific medical policies.

Argus

Argus helps AmeriHealth Mercy realize the greatest net benefit with a comprehensive snapshot of drug spend across all our plans. Pharmacy Claim data from Argus is integrated into our Data Warehouse to allow for complete data reporting to support coordination of care, quality and utilization management, and other data analysis as required by the State. Argus allows a broad range of customized benefit processing and analytical reporting and addresses our compliance concerns by maintaining technological and physical standards for HIPAA regulations. Argus provides a reliable and secure data storage environment. Argus has been supporting NCPDP D.0 standards since December 2010 and supports AmeriHealth Mercy-specific eligibility files and custom outbound file layouts.

Member Services

AmeriHealth Mercy uses the following applications to support contact center activities including Member Services and our complaint Grievance and Fair Hearing processes.

EXP MACESS/Call Documentation/Workflow

The SunGard EXP MACESS is utilized by our Member Services and Care Management staff to support automation of internal processes including image storage, documenting 100 percent of all telephonic contacts that come in from a member or provider, and routing requests for information between departments. Our EXP System also utilizes common indexes that facilitate high performance search functions associated with a common event, or transaction such as a complaint, grievance or fair hearing request across all records pertaining to members and providers. EXP MACESS call documentation is used in our Quality Auditing process to ensure that we provide the correct level of service to our members and providers.

Streamline

We implemented Streamline, a custom-designed front-end graphical user interface that allows our employees to enter member demographic updates into our Facets system, request member ID cards, and request member materials, and change their PCP. The Streamline interface simplifies the data entry process and eliminates the need for an end user to access multiple pages in Facets. Updates to Streamline are transmitted to Facets in real time.

Member Portal

Our online Member Portal is designed to meet the unique needs of the Medicaid population. The Member Portal features secure and convenient self-service applications enabling members to quickly reset passwords and unlock their own account. The Member Portal delivers valuable health care features including information on:

- Clinical information delivery such as member clinical summaries and alerts for overdue health screens
- Member health resources and information tailored to the specific needs and comprehension levels of the our membership
- PCP Information
- Medication List
- Care Gap Report
- Member Clinical Summary
- EPSDT Clinical Summary
- Request an ID Card
- Request a Handbook
- Send secure email
- Health Risk Assessment

Public Website

AmeriHealth Mercy has its own public website that delivers up-to-date information to members and providers through the use of web pages, PDFs, applications and videos. This includes an NCQA-compliant searchable provider directory, provider and member handbooks, health and wellness resources, and a wealth of other information about our services and procedures. Our websites are optimized for easy access from Google and other external search engines as well as fully searchable from within the site. Information contained on the public web site also includes:

- Provider newsletters, handbooks and other communications
- Information on health management programs
- Health education materials (members) and Clinical Practice Guidelines (providers)

Encounter Data Processing and Reporting

Data Exchange

AmeriHealth Mercy has implemented standards-based data interfaces to facilitate the exchange of information about enrollments, eligibility, encounters, claims and payments with our customer and provider organizations. The data exchange solution includes:

- The ability to transmit, receive, process, update and send replies in HIPAA-compliant and/or proprietary formats;
- The ability to exchange data through secure file transfer protocol (FTP) over a secure virtual private network (VPN);
- The ability to exchange data for a point in time (e.g., daily, weekly, monthly) or for a real-time transaction; and
- The logging and archiving of all data exchanges for future reference, if needed.

Data Warehouse

DataStage®, by IBM-Ascential Software Inc. ™, provides an extract, transform, and load (ETL) function to populate business intelligence data into our Data Warehouse. Data are extracted from our business systems databases (such as Facets) and loaded to our Oracle Data Warehouse. This data is then utilized by our reporting programs to support our Enrollment, Eligibility, Encounters, and Claim Payment processes.

Catalyst Technologies – Quality Spectrum

Quality Spectrum Insight (QSI) is a NCQA-certified HEDIS reporting software by Catalyst Information Technologies, Inc., a standalone tool that derives performance measure results which adhere to the annually updated NCQA HEDIS guidelines.

QSI calculates HEDIS results from internal and external data for reporting to NCQA, state Medicaid agencies, or for supporting internal quality improvement studies, including encounters. Ready-to-run HEDIS measures are included with each yearly updated version. Source files are loaded monthly into a dedicated data repository used for HEDIS reporting, provider profiling and the generation of "care gap" intelligence. Catalyst is NCQA-certified for HEDIS reporting. Benefits include:

- Full HEDIS reporting capability to easily produce the NCQA Data Submission Tool import template, CMS patient-level detail file, and CAHPS survey sample frame files
- Drill-down analysis tools to investigate quickly why a member did, or did not, meet the measure criteria in response to an auditor inquiry
- Eliminates the need for code review during the HEDIS compliance audit
- Integrates with the Medstat Advantage Suite® to simplify data extract and load

QUESTION 2

Describe any modifications or updates to your Management Information System (MIS) within the next year that will be necessary to meet the requirements of this Agreement, and your plan for their completion

(Limit to four pages)

RESPONSE TO QUESTION 2

As a current HealthChoices contractor, AmeriHealth Mercy's systems are fully compliant with existing HealthChoices contract requirements, and are capable of supporting our proposed expansion into the HealthChoices New West and New East Zones. This same platform has supported our successful implementation of Medicaid managed care programs in multiple states, including Pennsylvania, and we are fully confident that we will meet all Department of Public Welfare (DPW) health information system requirements for the expansion region from day one of implementation.

AmeriHealth Mercy routinely reinvests capital for improvement of our technology and data sharing infrastructure to continuously advance the quality of care and services for our members. We are constantly working toward the goal of providing a fully integrated technology solution through which members, providers, and other partners will have access to a full range of information and tools necessary for accessing and sharing the information needed to proactively manage positive health outcomes.

Below, we describe minor updates to configuration and core business systems, and other system enhancements necessary to support AmeriHealth Mercy's proposed expansion.

Updates to Configuration

Having reviewed the draft agreement included with the RFP, we do not foresee the need to perform any major system configuration changes to support expansion. The table below describes the modest configuration changes that we will undertake.

Table 2: Configuration Update

Function	System Configuration Change
Provider Data Management	We will need to load all newly contracted providers into our Provider Data System and configure their provider contracts to facilitate accurate claim payment.
Eligibility/Enrollment	Our systems are configured so that enrollments for members with a county code outside of our service area will error out of our automated eligibility load process for manual evaluation. We will need to configure our automated eligibility and enrollment processing to accept members with county codes for the New West and New East Zones.
Claims Processing	We will need to program new claims processing rules and guidelines based on negotiated provider agreements in the New West and New East Zones

Updates to Core Business Systems

The table below describes core system update that AmeriHealth Mercy will implement in the next 12 to 24 months to adhere to federal and state requirements.

Table 3: Core Business System Updates

Core Business System	Function Performed by System	Reason for Enhancement
Trizetto Facets	Facets is AmeriHealth Mercy's core claims processing Engine	Upgrading to a new HIPPA 5010 compliant version

As part of our routine system upgrade process, we have scheduled an upgrade of our claims processing system for the third quarter of 2012. The upgraded version of Facets will be HIPPA 5010 compliant. We have a detailed upgrade strategy and patch management process to ensure all of the systems remain in compliance with federal and state regulations, as well as resolve any system bugs. AmeriHealth Mercy will notify DPW of any major system upgrades in the future and provide a high-level summary outlining the reason for the upgrade and project timeline. All upgrades follow our normal change management process.

Plan for System Enhancements

AmeriHealth Mercy's change management process facilitates implementation of both planned and unplanned changes across application and infrastructure environments through the management of changes and version and production control activities. This process minimizes the business impact and risk of system-wide changes in an efficient and cost effective manner.

Systems Change Management Process

Ensuring effective change management practices for all AmeriHealth Mercy environments is critical to maintaining stability and high-quality processing. Adherence to these practices by using change management principles from the Information Technology Infrastructure Library (ITIL) enables us to maintain SAS 70 compliance, as well as low occurrences of production turnover defects.

Our Change Management Board (CMB) is comprised of representatives from each IS discipline who meet weekly to review and evaluate submitted changes. The board evaluates each proposed change in the context of other changes requested to ensure proper sequencing and prioritization. Approved changes are managed through version control and scheduled for release to production through our Production Control team. The change activity lifecycle is maintained and tracked through an automated system, called TeamTrack, which provides a single system of record for changes across the organization.

Key components of the AmeriHealth Mercy Change Management program include:

- **Accurate Documentation and Testing** – Ensuring that relevant information for each change is submitted and reviewed (including quality testing outcomes, a critical factor for error free implementations)
- **Continuous Oversight** – Using a disciplined process of evaluating changes to balance the demands of change while evaluating and managing risk to the production environments
- **Formal, Defined Approval Process** – Following an established, multi-level approval process to ensure that all changes are completed as expeditiously as possible, while ensuring complex, high impact changes receive the oversight necessary to guarantee success

There are three types of change management requests: standard, expedited, and emergency. Each request follows the defined change management process; however, non-standard changes require accelerated and elevated review and additional approvals. Our change management discipline enables us to maintain a stable environment. Continuous improvement is a key part of our discipline. We update processes and procedures to improve our success rate using the lessons learned from prior implementations.

Version Control

Version control is a series of processes and corresponding tools that ensures uniformity and accuracy of the components in an implementation package. An implementation package consists of source code, object code, deployment plans, operations execution instructions, and back out procedures. Through our version control tool, all of these components can be centrally accessed and managed. These processes and tools provide us with the ability to retain each version of an implementation package, allowing us to access any previous version of the package, as required. AmeriHealth Mercy utilizes Microsoft Visual SourceSafe (VSS) as its version control tool.

Production Control Operations

Production Control administers and monitors operational and production processing standards for all AmeriHealth Mercy Family of Companies' corporate operations, ensuring that all production cycle requirements are in accordance with individual company standards, as well as State and customer requirements.

Production Control employees provide technical support services 24 hours a day, seven days a week, 365 days a year. Production Control is responsible for executing over 3,700 processes on a daily basis, which are triggered by predetermined calendars, file events, e-mail events, job events, and by operator interaction.

QUESTION 3

What is the current capacity of your MIS/claims processing? Explain your process to readily expand your MIS/claims processing should the capacity of either be exceeded through enrollment of program members.

(Limit to two pages)

RESPONSE TO QUESTION 3

Capacity through Our Technology Platforms

One of AmeriHealth Mercy's key differentiators is our ability to scale our technology platform to meet growth demands. Our scalable and agile systems architecture, comprised of industry-proven applications and hardware infrastructures, has allowed AmeriHealth Mercy to successfully expand our capacity to cover additional Medicaid managed care enrollees in new and existing Medicaid markets.

Scalability to increase capacity is first addressed in a comprehensive approach during the design of our system enhancements and new solutions. Dedicated resources from our Architecture, Infrastructure Delivery, and Data Center Operations teams continuously monitor system utilization to ensure that our baselines and performance are within expected ranges and compliant with state contract requirements. The team looks continuously for opportunities to enhance performance and ensure availability.

A fundamental element of our success is the tight collaboration and experience we have gained with our core technology partners, including:

- TriZetto
- EMC/VMware
- Hewlett Packard (HP) Oracle
- Avaya

Through these industry leaders, AmeriHealth Mercy leverages "best in breed" technology that enables us to easily assume sizable growth. The following provides a brief description of how these technology partners support AmeriHealth Mercy's Medicaid managed care products today and position us to readily and seamlessly expand to serve additional membership.

- TriZetto's Facets system is AmeriHealth Mercy's core claims processing engine. Facets incorporates batch processing and load balancing models to readily resize and process expanded volumes of claims.
- EMC's VMware virtual server environment is the foundation of managing scheduled claim processing growth for the expansion of HealthChoices in Pennsylvania.
- Hewlett Packard's dynamic resource on demand (iCAP) technology enables instant capacity processing and populates business critical systems at maximum configuration. The agility gained allows for short-term and long-term needs to be easily addressed.
- The Oracle Data Warehouse solution is scalable commensurate with our Facets claim processing system. In anticipation of growth, we have sized the storage capacity appropriately.
- The Avaya Single Image Switch is a fully distributed IP-based phone system. This system provides feature transparency across the AmeriHealth Mercy infrastructure and also extends contact center and other telephony applications throughout the enterprise. The main Avaya Communication Manager server resides in Philadelphia, Pennsylvania and supports all AmeriHealth Mercy locations. The secondary standby server is located in a separate location to ensure continuity of service. Since we migrated to the Avaya single image switch platform, all sites are fully capable of providing contact center call handling for any type of situation.

Capability and Capacity Assessment

As a part of the Initiation and Planning phase of our systems development lifecycle, AmeriHealth Mercy reviewed the Department of Public Welfare's requirements and projected volumes in relation to our Information Systems capacity and capabilities and confirmed that our systems have the capability and capacity to exceed all the requirements. The following are the key outcomes of our system capacity and capability assessment:

AmeriHealth Mercy currently processes over 6.5 million Medicaid claims for Pennsylvania per year with >85 percent auto adjudication rate. Our existing infrastructure capacity will accommodate additional business volumes from expansion counties.

The table below shows our current Sybase configuration to support our Medicaid managed care business across the country. To ensure maximum efficiency, we have separated our current books of business into multiple regions. This reduces load times and impacts on system processing. The HP SuperDome we have is designed for instant capacity on demand – we would simply need to license the additional processors as we grow.

Table 4: Current capacity of our current Sybase (Facets) environment by region

Environment	Memory	Engines/Processor
PRD_REG_1	9GB	6
PRD_REG_2	6GB	4
PRD_REG_3	7GB	4
PRD_REG_4	7GB	4

AmeriHealth Mercy is confident in our ability to manage even larger volumes of increased data to support our future growth. We have developed and deployed clear and effective business continuity and disaster recovery procedures, which have been successfully tested in response to recent weather events impacting several of our lines of business.

Finally, we measure our success by trending solution activity, system availability, and our responsiveness to scale environments as needed. On a yearly basis, we complete a full review of the compiled system statistics as part of the organization's annual operating goal development. This information is used as the basis for setting new thresholds for performance, availability, and our ability to meet the business needs of our company and the requirements and expectations of our state regulatory partners, and the Medicaid consumers and health care providers we serve.

QUESTION 4

Explain your process for ensuring your subcontractors meet the same MIS requirements for which you are responsible.

(Limit to three pages)

RESPONSE TO QUESTION 4

Vendor and Subcontractor Management/Oversight

AmeriHealth Mercy understands that it is ultimately accountable for the performance of all services performed by subcontractors. As such, defined strict management information system requirements and related policies, procedures, and protocols, exist to ensure that all subcontractors adhere to Department of Public Welfare (DPW) and AmeriHealth Mercy compliance provisions. Our policies and procedures guide the initial selection of subcontractors and ongoing adherence performance monitoring and oversight. AmeriHealth Mercy requires all subcontractors to have completed, or provide a plan and timeline for completing, their SAS 70 audit.

AmeriHealth Mercy conducts an on-site assessment of a potential subcontractor's ability to meet performance standards prior to executing a subcontract agreement. AmeriHealth Mercy requires subcontractors and vendors to conform to the HealthChoices Management Information System and System Performance Review (SPR) Standards as set forth in the HealthChoices Agreement, including, but not limited to:

- Systems Standardization Requirements
- Data Requirements
- Systems Documentation Requirements
- Claims Processing Requirements (including claims processing support; input validation and control; edit and audit; adjudication and payment; and audit trail requirements)
- Information Retrieval Requirements for operational, program management, surveillance, and utilization review processing
- Capture of Required Data Elements

Service Level Agreements outlining performance standards are incorporated into the written contract with all subcontractors. Defined contract provisions define adherence requirements to performance standards, including provisions for auditing and oversight by AmeriHealth Mercy, corrective action plans, and assessment of penalties up to and including contract termination. Routine oversight and monitoring is performed consistent with industry standards. In addition to routine monitoring and oversight, we perform a formal annual audit of each subcontractor's performance and compliance.

MIS Service Level Agreements

The following is a sample SLA chart demonstrating standards for subcontractors as included in the contract.

Table 5: Sample SLA for Subcontractors

Performance Indicator	Definition	Performance Standard	Performance Goal	Reporting Frequency
Encounter file submission timeliness	The vendor shall submit its encounter data at least monthly, following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount ($0.00) and all encounters for capitation arrangement with a provider.	By 10th of each calendar month	100%	Monthly

Performance Indicator	Definition	Performance Standard	Performance Goal	Reporting Frequency
Encounter submission completeness & accuracy	The vendor shall provide complete and accurate encounter data for all levels of healthcare services provided to include encounter data for specific denied claims as specified by the State.	> 98%	100%	Monthly
Encounter error correction timeliness & accuracy	The vendor shall address any issues that prevent processing of an encounter. Acceptable standards shall be 90% of reported repairable errors are addressed within 30 calendar days, and 99% of reported repairable errors within sixty (60) calendar days. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan may result in monetary penalties.	100% within 60 calendar days	100% within 30 calendar days	Monthly
Encounter requests	Regulatory changes or special requests by AmeriHealth Mercy or State	60 days upon request	30 days upon request	As requested
Issue escalation	The escalation points for VENDOR issues with encounter submissions: 1) AmeriHealth Mercy Encounters Manager 2) AmeriHealth Mercy Vendor Oversight Manager	Notification of issue(s) effecting performanc e standards	Immediate	As needed

These reports are continuously reviewed to evaluate and monitor Service Level Agreement (SLA) metrics, to discover potential areas of weakness, and to target interventions.

Subcontractor Oversight Data Analysis

In addition to using the encounter data to analyze subcontractor performance, each subcontractor is required to submit a monthly performance report to measure their compliance to the contractual terms. This report is distributed to the AmeriHealth Mercy Quality of Service Committee, which is responsible for monitoring compliance and providing recommendations for corrective actions or sanctions, if documented performance goals are not met.

Some of the performance and quality reports that AmeriHealth Mercy receives from subcontractors include:

- Ongoing Monitoring of Sanctions
- Subcontractor Call Center Statistics
- Authorization Denials and Appeals
- Timeliness of Claims Paid
- Accuracy of Claims Paid
- Member Satisfaction
- Provider Satisfaction
- Credentialing Status /Network reports

Other Components of Subcontractor Agreements, Oversight, and Monitoring

File Transfer Protocols

All subcontractors are governed by contract provisions and service level agreements that require adherence to file transfer protocols (FTPs). AmeriHealth Mercy uses secure internal servers,

public external servers, and Connect: Direct for FTP connections to subcontractors. All files sent to subcontractors' FTP sites use a secure virtual private network (VPN), local area network (LAN)-to-LAN tunnel that is HIPAA compliant.

Data Validation/Error Report Handling

Our systems use industry-standard, two-level status validation of all input sources. The level one status check ensures that all inputs match record format criteria, including 1) that all mandatory/ required fields are present; 2) that all date fields contain a valid millennium-compliant date; and 3) that numeric fields contain only numerals.

The level two status check cross-validates that the input source data are what is expected within the record, utilizing defined criteria that include:

- Valid supplied data (e.g., "diagnosis code" is a valid diagnosis based on a predefined format to determine if the diagnosis provided by the PCP truly exists)
- Cross-validation within the application (e.g., the medical claim being loaded is cross-validated to a previously defined valid member)
- Cross-validation for mandatory items (e.g., the hospital/physician/provider is an active provider within the network for provided a valid service)

Encounter Data Reporting

AmeriHealth Mercy requires that all subcontractor encounter files pass Level II X12 compliance prior to submission to the DPW. If any file fails this compliance check, the subcontractor is required to return a corrected encounter file to us within four business days. To support their efforts to meet AmeriHealth Mercy's performance expectations, we provide our subcontractors' with regular updates of DPW's procedure codes, diagnosis codes, and provider data reference files. Also, AmeriHealth Mercy's Delegation Oversight Committee is responsible for monitoring our subcontractors' encounter data performance.

Information Security

We require that all subcontractors sign AmeriHealth Mercy's HIPAA and Code of Conduct agreements, which define acceptable use and policy requirements. All subcontractors are subject to the same internal audit controls as AmeriHealth Mercy employees. These internal controls include intensive LAN and wide area network (WAN) monitoring using URL filtering, intrusion detection and prevention, and native SYSLOG monitoring by the Information Security Department. Subcontractors are also restricted by global group and local policy settings within the active directory environment. Our Information Security Department staff reviews these logs, and any security conduct violations are subject to prompt disciplinary action.

Our Information Security team interrogates all access requests (for all employees, contractors, subcontractors, and other entities) to ensure access is appropriate and compliant with the policy. They track access requests in a problem management system, and access cannot be granted until the request is approved. Additionally, Information Security monitors access requests using various real-time or near real-time tools to ensure compliance with acceptable usage standards. Detailed reports and automated alerts are built in to the process to ensure a timely and systematic incident response in the event of an abnormality.

QUESTION 5

Describe the capability your management will have to access a database of service information to create ad hoc reports for both MCO management and the Department. Include a description of the system and software, an overview of the data that will be held, and the resources and the capability you will have to use large amounts of data to create ad hoc reports.

(Limit to five pages and list of reports)

RESPONSE TO QUESTION 5

AmeriHealth Mercy will leverage our comprehensive business intelligence capabilities to provide the Department of Public Welfare (DPW) and internal AmeriHealth Mercy management with accurate, complete, and timely ad hoc reports. As a long-standing Medicaid contractor in Pennsylvania and several other states, AmeriHealth Mercy brings significant knowledge and expertise to the preparation and secure delivery of such reports. The Medical Economics Department provides leadership, guidance, and support to the improvement of processes that create, disseminate, manipulate, and manage data. This dedicated team is responsible for all statutory, quality, clinical and cost analysis reporting, on both a regularly scheduled and an ad-hoc basis.

Our ad-hoc reporting capabilities include:

- Enterprise Data Management Architecture
- Data Availability for Ad Hoc reporting
- Ad-Hoc Internal and External Reporting Capabilities

Enterprise Data Management Architecture

To support our quality ad hoc reporting and timely delivery of all state management reporting, AmeriHealth Mercy maintains an Enterprise Data Management Architecture that includes a robust Business Intelligence capability. This capability will be leveraged to generate the ad hoc reports required by the internal management team for oversight purposes, as well as to support State-requested reports. Figure 1 depicts the following core components of the enterprise data management architecture

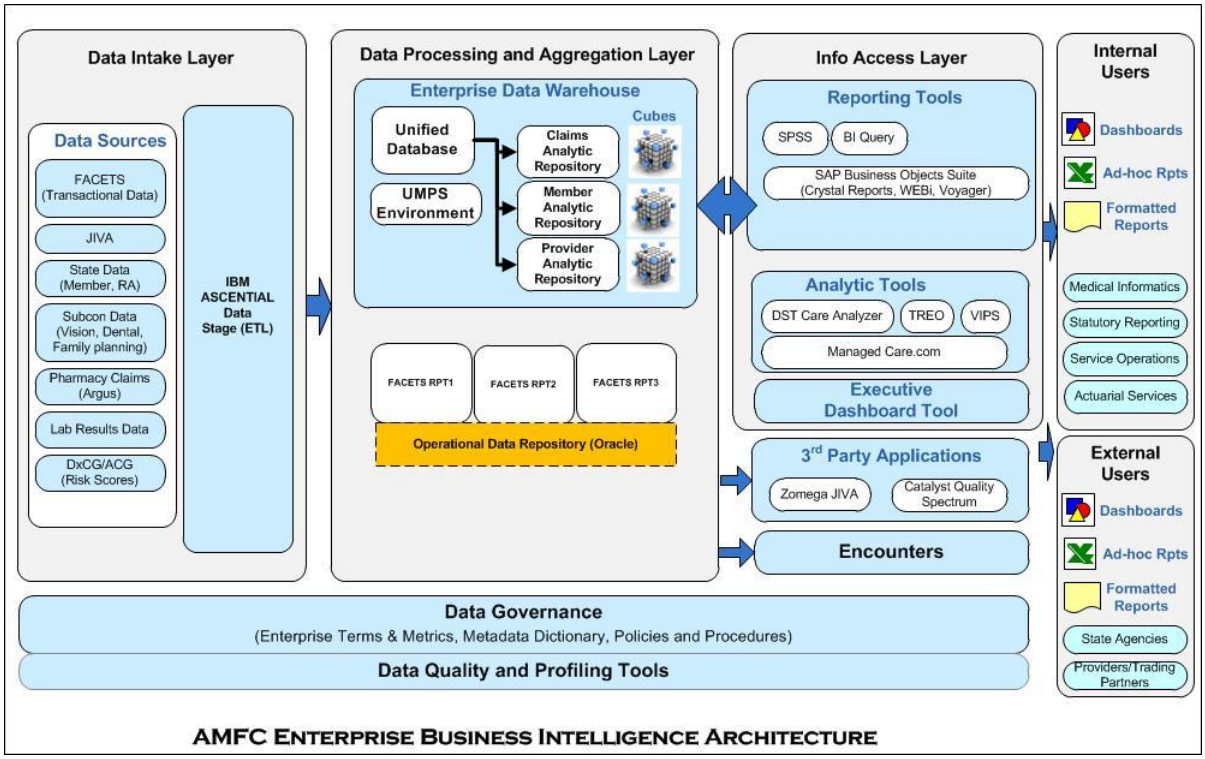

Figure 2: Enterprise Data Management Architecture

The Data Intake Layer collects and cleanses the data extracted from a number of internal and external sources including:

- Claims data from the Facets claims processing system
- Care management data from Jiva
- State data (Member eligibility, Third Party Liability, etc.)
- Subcontractor claims data (Dental, Vision, Family Planning,)
- Pharmacy claims data (Argus)
- Lab results
- DxCG/ACG risk scores

The chart below displays the data sources (production applications or data feeds), the data integration methods (real-time, or batch), and the data integration controls (compliance and validation tools) for ad hoc reporting.

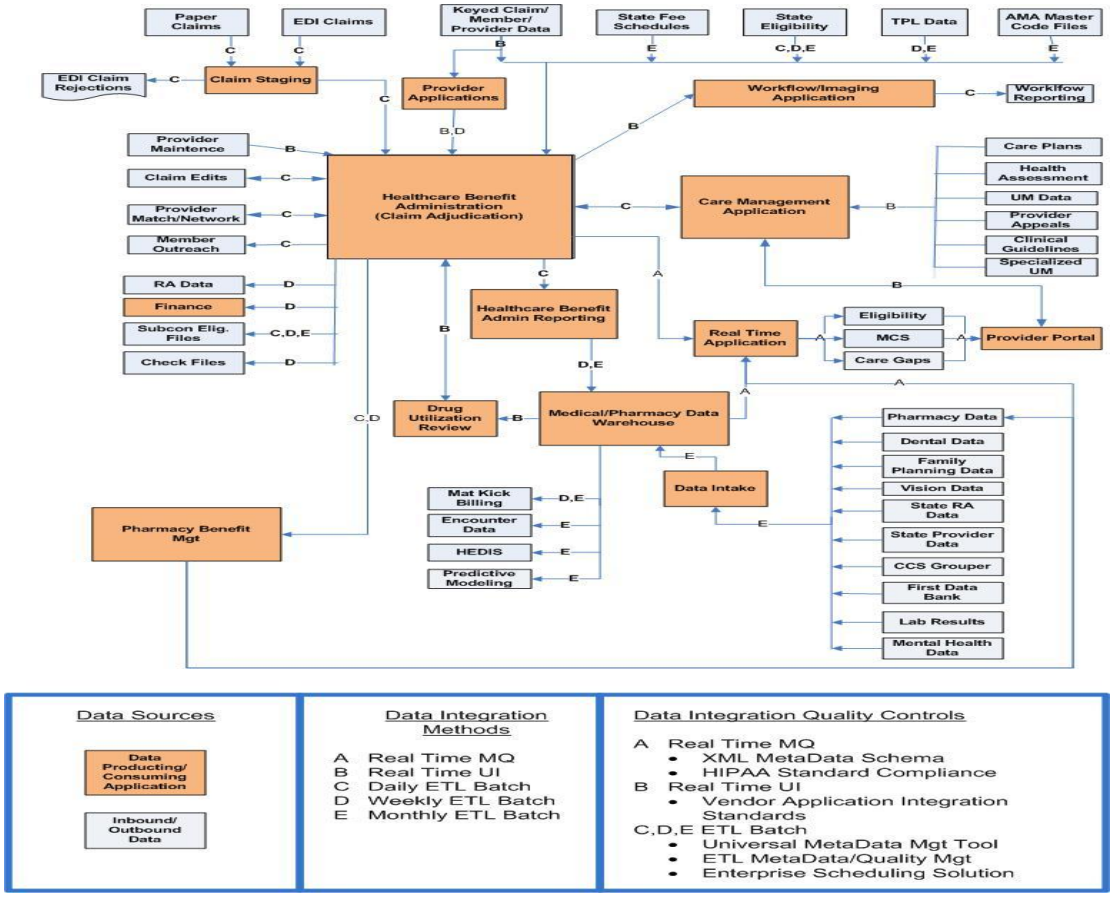

Figure 3: Data Integration

The Data Processing and Aggregation Layer unifies the data obtained from multiple data sources and organizes the data by two primary dimensions: member and provider. In addition, a number of useful business measures are aggregated to aid in analysis and reporting. This unified and integrated view of our members and providers enables us to offer accurate, complete, and timely reports to stakeholders and customers.

The Information Access Layer includes the Business Intelligence tools to transform data into actionable information. These tools are described under Ad Hoc Internal and External User Reporting Capabilities.

The Executive Dashboard capability within the Information Access Layer enables the delivery of information to stakeholders based upon customized, role-appropriate views.

Ad Hoc Internal and External Reporting

AmeriHealth Mercy will access data from our core business systems and the enterprise data warehouse to address its ad hoc reporting needs. The types of data available for reporting include, but are not limited to:

- Membership data
- Provider network data
- Care management data, including health assessments, EPSDT, lab results, care gaps, care plans, disease management and case management data
- Utilization data, authorizations, over/under-utilization
- Encounters and claims (medical, hospital, pharmacy, dental, vision, behavioral health, family planning)
- Payments
- Appeals and grievances
- Outcomes data (e.g., HEDIS, maternity)

Our data retention processes are customizable based on the specific needs of our enrollees, while maintaining compliance with applicable state and federal regulations. Our standard data retention and management practices are described below:

- Claims: The data warehouse stores all historical claims for up to 10 years. The data warehouse claim data is primarily utilized for informatics and analytical needs
- Membership and Provider Data: The data warehouse retains a complete history of all membership and provider data
- Billing and Capitation Data: The data warehouse retains all billing and capitation data for 10 years

A broad portfolio of reporting and analysis tools, robust data quality controls, and secure report delivery processes provide the foundation for us to deliver ad hoc reports upon request, with turnaround times that vary based on the complexity and urgency of the request:

Reporting and Analysis Tools

- Crystal Reports® enable rapid development of flexible, versatile reports from a number of data sources, and integrates them into Web and Windows applications. Crystal Enterprise® (Business Objects™) is used companywide for reporting information from the data warehouse, Facets, our care management system, and other sources. Crystal Reports are often used for medical management reporting on claims, membership, provider, authorization, and care management data.
- SPSS Statistical Reporting® provides statistical data analysis and graphical presentation of data. It is used to analyze survey data, utilization data, cost data, record sampling, and control group vs. test group sampling.
- SAP Business Objects Web Intelligence utilizes multi-dimensional data models to enable business users to interpret business information in order to gain valuable insights for

operational and strategic management. Users can select the business measures of interest and drill through the data at multiple levels of detail.

- HEDIS Services - Quality Spectrum This application (Catalyst Technologies, a premier NCQA-certified software vendor) is used to generate HEDIS and State Performance Measurement data and results. Monthly interim HEDIS rates and data on care gaps are generated on a monthly basis.
- Treo is a Web-based suite of applications which incorporates the 3M methodology for identifying Potentially Preventable Readmissions (PPRs). Using sophisticated algorithms, chains of admission and readmission events are linked to generate rates of PPR for any hospital or group of hospitals compared to the network, or any segment thereof. These data can be used to identify opportunities for improvement of care and for use in pay-for-performance programs. Treo also can identify Potentially Preventable Initial Admissions (PPIAs) and Potentially Preventable ER Visits. Since the basis for this content is member data, we can also report the data by primary care providers (PCP), in order to identify PCPs with the highest rates of PPRs and PPIAs so that improvement opportunities can be explored.

Data Quality Controls

AmeriHealth Mercy's reporting process ensures that reports are developed, tested, and sent as prescribed by DPW. Policies and procedures are in place to ensure that all reports: 1) use the appropriate specifications for creation of the report; 2) are quality-reviewed for data integrity and completeness; and 3) are retained in accordance with AmeriHealth Mercy policy and applicable State and Federal laws and regulations. The dedicated staff in our Reporting Department manages the ongoing reporting process to ensure timely delivery of material to the State.

Secure Delivery of Reports

AmeriHealth Mercy utilizes a secure Provider Web Portal to extend reporting access and services to external entities. We will work with the DPW to establish a safe, secure, and efficient approach to enable DPW staff to access ad hoc reports.

Sample Reports

Examples of ad hoc reports that we have prepared include, but are not limited to:

- Monthly inpatient and outpatient authorization reports
- Summary of Healthcare Activity report (claims-based cost & utilization)
- Member Demographics reports
- Maternity Outcomes report
- EPSDT gaps in care report
- HEDIS
- Over-/Under-Utilization report
- Plan Wide Indicator report
- PCP Profile report
- Case Management/Disease Management Dashboard report

Detailed reporting requirements will be developed in consultation with the DPW.

Standard Reports

Report Management

- Utilization management reporting
- Care management reporting

- Support activity regarding risk adjusted rates and encounter data improvement activities
- Support Market Expansion and new business development
- Provide data to Legal Affairs as needed
- Appeals reporting
- Plan-Wide Indicator Report
- Medical Affairs Operations Reports
- Provider Contracting reporting

Population Analysis and Outcomes

- Member population analysis
- Disease management reporting and outcomes measurement
- Support NCQA accreditation
- Coordinate and submit HEDIS
- Coordinate and submit CAHPS
- Conduct, coordinate and support other surveys and analyses-provider satisfaction
- voluntary disenrollment, PCP change, Physician after-hours accessibility
- Coordinate and support submission of quality indicators for EQRO
- Predictive Modeling
- PCP and Hospital Profiling

Reporting Accomplishments

AmeriHealth Mercy's reporting and analytical capabilities and leadership are nationally recognized:

- Presenter, 2010 National Predictive Modeling Congress
- Quality Profiles, The Leadership Series, 2009, NCQA
- Winner, 2009 Thomson Reuters Healthcare Advantage Award
- Presenter, 2009 Thomson Reuters Healthcare Conference
- Poster Presentation, 2008 Society of General Internal Medicine
- Winner, 2007 Thomson Innovator Award
- Presenter, 2006 Thomson Annual Conference
- Finalist, 2006 Thomson Innovator Award
- Poster Presentation, 2006 AHIP Meeting
- Poster Presentation, 2005 Pennsylvania Public Health Association

In addition to the above presentation and awards, members of our Information Solutions Reporting teams serve in the following capabilities:

- Board member, Pennsylvania Public Health Association
- Member, American Medical Informatics Association
- Reviewer of papers for the AMIA
- Member, American Health Information Management Association
- Member, The Data Warehouse Institute
- Member, Healthcare Financial Management Association
- Member, NCQA HEDIS Policy Panel

QUESTION 6

Describe the capability you will have to access your subcontractor's information to create ad hoc reports for subcontractor oversight and for the Department upon request.

(Limit to three pages)

RESPONSE TO QUESTION 6

AmeriHealth Mercy has service level agreements with our subcontractors defining accurate and timely two-way exchange of encounter data and monthly performance reports to ensure optimal operational performance and customer satisfaction. Subcontractor encounter data is integrated into our Data Warehouse and is available for ad hoc reporting and analysis for a variety of purposes, including but not limited to, subcontractor oversight and care management. This data can be made available to the Department of Public Welfare upon request.

Integration of Subcontractor Data into the Data Warehouse

On a monthly basis, encounter and claim data for pharmacy, dental, vision, laboratory, radiology and family planning services are received from AmeriHealth Mercy's subcontractors. Subcontractor encounter and claim files are received using Secured File Transfer Protocol (SFTP) through the inbound data interface. Results are reviewed by encounter analysts and appropriate action is taken to ensure the data is complete. Data collected from subcontractors is integrated in the AmeriHealth Mercy Enterprise Data Warehouse. The Data Integration Layer organizes and stores the subcontractor data in the Enterprise Data Warehouse. AmeriHealth Mercy's Data Warehouse hosts information from all of our major internal operating systems in addition to external data sources. Therefore, when subcontractor data is loaded to the AmeriHealth Mercy Data Warehouse, it can be readily joined to the data files downloaded from internal processing systems. As such, production and ad hoc reports at the member, provider, or program level can be generated to include data that spans across all categories of service providers.

Ad Hoc subcontractor reporting

Ad-hoc reports for subcontractor oversight are generated by our Medical Economics Department. These are based on the encounter data that subcontractors submit and are available through the Information Access Layer of the AmeriHealth Mercy Business Intelligence Architecture.

Once the data is in the Data Warehouse, we use our standard reporting tools. As shown, the Information Access Layer of the AmeriHealth Mercy Business Intelligence Architecture provides a variety of tools for ad-hoc reporting, including the following:

Crystal Reports

Enables rapid development of flexible, versatile reports against a number of data sources, and integrates them into Web and Windows applications. Crystal Enterprise, by Business Objects, is used throughout the organization for reporting from the data warehouse, Facets, our care management system, and other sources. Crystal Reports is often used for medical management reporting on claims, membership, provider, authorization, and care management data.

SPSS Statistical Reporting

SPSS Provides statistical data analysis and graphical presentation of data. It is used to analyze survey data, utilization data, cost data, record sampling and control group vs. test group sampling.

SAP Business Objects Web Intelligence

SAP Business Objects uses multi-dimensional data models to enable business users to manipulate business information in order to gain valuable insights for operational and strategic management. Users can select the business measures of interest and drill-through the data at multiple levels of detail.

Catalyst Technologies - Quality Spectrum

This application is from Catalyst Technologies, a premier NCQA-certified software vendor. It is used to generate HEDIS and state performance measurement data and results. Monthly interim HEDIS rates and data on care gaps are generated on a monthly basis.

AmeriHealth Mercy has a solid history of providing both internal management and DPW information and data sets on a special-request basis. For example, below is a summary of a recently fulfilled ad hoc request for prior authorization denial information that included data from subcontractors.

Table 6: Summary of Ad Hoc Prior Authorization Denial Information

Physical Health Managed Care Organizations Please provide the prior authorization denial information specified below for FY 2010-11		
Data requested: (Please provide the information in percentage (%) form for questions 1-4)	**KMHP MCO Response**	**AMHP MCO Response**
Overall service denial rate for prior authorization requests (including both partial and full denials)	4.18%	4.49%
Denial rates, specific to the following service types: Pharmacy, including "automatic" denials at point-of-sale based on a lack of prior authorization	47.94%	50.82%
Home health	0.63%	2.11%
Therapies (including Speech, Physical, and Occupational)	2.99%	1.88%
Dental	23.09%	23.28%
Durable medical equipment	5.69%	6.44%
3. Percentage of overall denials in which a grievance *or* fair hearing was requested	75.79%	79.49%
4. Percentage of overall denials reversed, partially or fully, after a grievance was filed or fair hearing was requested.	24.21%	20.51%
5. The total number of denials issued. (absolute number)	70,582	28,491

Subcontractor Oversight Data Analysis

In addition to using the Encounter data to analyze subcontractor performance, each subcontractor is required to submit a monthly performance report to measure their compliance to their contractual terms. This report is distributed to the business owner as well as the Quality Management Department. This information is also reported to AmeriHealth Mercy's Quality of Service Committee, which is responsible for tracking compliance/non-compliance and making a recommendation for corrective action or sanctions if documented performance goals are not met.

Some of the performance and quality reports AmeriHealth Mercy receives from subcontractors, include:

- Credentialing status /Network reports
- Ongoing Monitoring of Sanctions
- Subcontractor Call center Statistics
  - Call Volume
  - Calls per 1000 members
  - Average Speed of Answer
  - Service Level
  - Abandonment Rate
- Authorizations denials and appeals
- Timeliness of claims paid
- Accuracy of claims paid
- Member Satisfaction
- Provider Satisfaction

QUESTION 7

Describe your approach for ensuring complete encounter data is submitted accurately and timely to the Department consistent with required formats.

(Limit to two pages)

RESPONSE TO QUESTION 7

AmeriHealth Mercy has successfully submitted complete, accurate, and timely encounter data to the Department of Public Welfare (DPW) in the appropriate format for 14 years. A cross-functional review of the medical record/claims data is conducted to verify that complete data are being submitted.

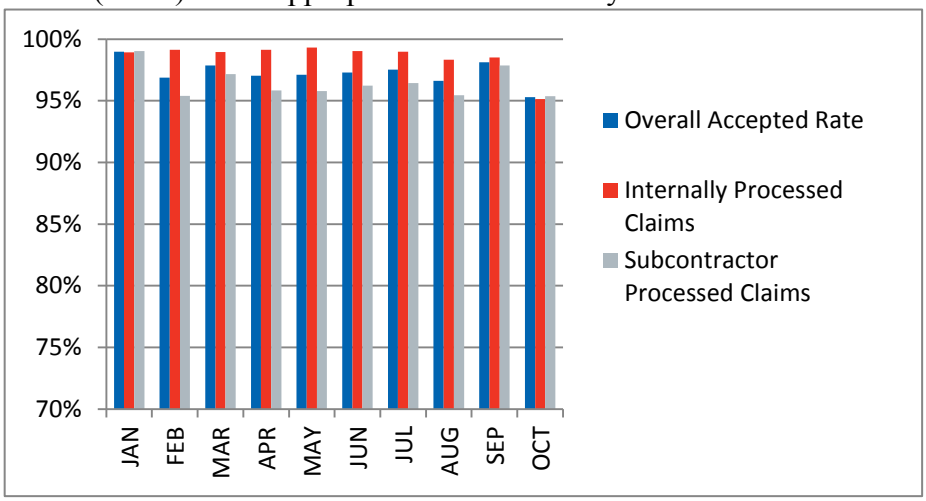

Figure 4: 2011 Encounter Data Submission

Monitoring Data Completeness

Our well-defined and reproducible encounter processes, along with our related reconciliation and operational quality reviews, provide the framework for data completeness.

Claims/encounters are submitted by providers via electronic data interface (EDI) or paper claim form (which is converted to electronic format). A clearinghouse edits specific claim data and returns claims that do not meet editing rules back to the provider. Clean claims are processed through Facets, which verifies the completeness and accuracy of provider numbers, member ID numbers, diagnosis codes, and procedure codes. Claim acknowledgements are sent to providers via the clearinghouse. Discrepancies are identified, investigated, and corrected.

Encounter files are examined for completeness and accuracy prior to submission to DPW. Claim counts and payment amounts are validated between the claims processing system and the data warehouse system. Claim counts and key claim/encounter data and HIPAA compliance validation are verified. All encounter files and claim/encounter records are logged onto an audit file.

Ensuring Accuracy

Encounter accuracy is examined on three levels: 1) when the encounter is loaded into the claims processing system; 2) when the encounter enters our encounter database; and 3) when the 837 file is created to send to the DPW. The claim processing system verifies the completeness and accuracy of the provider numbers, member ID numbers, diagnosis codes, procedure codes, ICD 9 or ICD10, HCPCS codes, and National Correct Coding Initiative standards. Our claims processing system rejects claims with missing or inaccurate information and rejected claims are returned to the providers for correction.

When encounter data are loaded from the claims processing system into the encounter database (from which we prepare encounter data submissions to the State), the data passes through a secondary pre-editing process. This process enables AmeriHealth Mercy to identify, investigate, and correct significant errors before submitting the encounters to the State in the required formats.

To assure file accuracy, all 837 professional and institutional files must pass HIPAA compliance investigations prior to submission to the State. In addition, AmeriHealth Mercy uses an encounter audit table for data validation. After encounter files are created from the data warehouse, we post encounter data at the claim line level to an encounter audit table and audit history table, and mark each encounter with the status of "sent to State." When responses from the State are received, the encounter status is updated to "accepted" or "rejected." Additionally, a monthly status report from the encounter audit table that displays claim counts categorized by each status. This report is used to resolve/resubmit encounters, and to identify non-reparable encounters, such as claims that are exact duplicates. After an update of the response files, we calculate an acceptance percentage based on claims sent and accepted by the State.

Internal Quality audits are performed monthly, and discrepancies are promptly investigated. Quality and independent audits are conducted by sampling claims and encounters processed by AmeriHealth Mercy systems. Queries are written and pre-approved by an auditor. Specific data elements may be requested (e.g., provider NPI, procedure, diagnosis codes, bill amount, payment amount, etc.). Query results are provided to the auditor to verify the samples against AmeriHealth Mercy's internal systems, and against encounter data residing in DPW's databases.

Ensuring Timeliness

Our approach to timely submissions is based on State standards for submitting encounter data on a predefined schedule (e.g. weekly, bi-weekly, or monthly). We have developed automated encounter processes to ensure encounter data is submitted on a consistent time schedule for each period.

To provide predictable and reliable processing, the Tidal Enterprise Scheduler (Cisco) is used to manage the sending and receiving of files between AmeriHealth Mercy and its subcontractors, the State or its agents. The predetermined schedules allow for alerts to be signaled in the event that: 1) a file is not received or sent when expected; 2) the file transfer is not successful; or 3) any processing step fails. These alerts are monitored (24 hours a day, 7 days a week, and 365 days a year) and appropriate steps are taken depending upon the circumstances.

Following the encounter processing by the DPW, the EDI response files received from the DPW is reconciled to the encounter audit file to determine the disposition of the claim. Should AmeriHealth Mercy not receive a response file, the disposition of the claim will be resolved in collaboration with the DPW.

QUESTION 8

The MCO will be required to have a data completeness monitoring program and submit a data completeness monitoring plan as described in the Agreement. Describe your approach to providing this data completeness monitoring plan.

(Limit to three pages)

RESPONSE TO QUESTION 8

AmeriHealth Mercy will ensure that all claims and encounters submitted to us by our providers and subcontractors for transmission to Department of Public Welfare (DPW) are both accurate and timely. Our data completeness monitoring program is realized through a combination of encounter completeness monitoring, internal audits, annual encounter data information survey, annual on-site audits performed by DPW, documented policies and procedures and reporting. In addition data completeness oversight is provided by our Encounter Data Team, Medical Economics and Delegated Oversight units.

Approach

AmeriHealth Mercy will utilize our current Completeness Monitoring Program as the foundation for the development of a plan for the New West and the New East Zones. The plan will outline how we will meet all of DPW encounter requirements. Our 14 year experience in the Southeast and Lehigh/Capital Zones with successful encounter submissions to DPW will aid in this process. We will submit the plan to DPW annually for review and approval.

Data Completeness Monitoring Program

Encounter Completeness Monitoring

Our well-defined and repeatable encounter processes, and related reconciliation and operational quality reviews, provide the framework for data completeness.

1. **Provider Claims Reconciled Upon Receipt -** Claims and encounters received either via electronic data interface (EDI) or by paper claim are edited for compliance. Claim acknowledgements are returned to providers via the clearinghouse or by ACS, our paper claims processing subcontractor. Discrepancies are identified, researched, corrected and resubmitted.
2. **Adjudication of Claims -** AmeriHealth Mercy processes claims through our claims processing system, applying all required payments rules and edits. Claims that do comply with billing requirements and encounter requirements are denied. Remittance Advices (RA) are sent to providers detailing all claims submitted, and their adjudication status. The reasons for adjustment or denial are also provided on the RA.
3. **Claims Reconciled to Encounters -** Paid and denied claims, along with provider and member demographic information, are loaded and reconciled into the data warehouse for reporting purposes. Claim counts and payment amounts are validated between the claims processing system and the Data Warehouse system.

Following encounter processing by DPW, the EDI response files received from DPW will be reconciled to the encounter audit file to determine disposition. Should AmeriHealth Mercy not receive a response file, dispositions will be resolved in collaboration with DPW.

Encounter Data Information Survey

On an annual basis, DPW sends us an Encounter Data Information Survey for completion. The survey is a list a question where we describe, in detail, our processes for submitting encounter data (including those processed by subcontractors) to DPW; reconciling reports and files; documentation for submitting adjustments to encounter data submitted; and assessment of encounter data completeness and timeliness. The survey results provided by DPW are utilized to enhance the process either through adding system controls, edits and enhancements to workflows.

Quality and Independent Audits

Internal Quality audits are performed frequently and discrepancies are investigated promptly. Quality and independent audits are conducted by sampling claims and encounters processed by AmeriHealth Mercy systems (AmeriHealth Mercy processed and Subcontractor processed encounters). Queries are written and pre-approved by an auditor. Specific data elements may be requested (i.e., provider NPI, procedure, diagnosis codes, bill amount, payment amount, etc.) Query results are provided to the auditor to verify the samples against AmeriHealth Mercy internal systems, and will be provided for verification with encounter data residing in DPW's databases.

On-Site Audit

After review of the Encounter Data Information Survey, DPW schedules an on-site audit to observe the processes and procedures outlined in the survey. Our encounter process has been improved based on the outcome of the audits to ensure that we remain compliant with DPW contract requirements.

Policies Procedures and Reports

The table below lists the policies and procedures that we follow, and the types of reports that we produce, to monitor accuracy and compliance. The reports are generated every month for reconciliation purposes and to identify claims that have errors, so that the claims can be corrected or adjusted and the encounters may be resubmitted in a timely fashion.

Table 7: Encounter Accuracy and Compliance Policies and Procedures

Policies and Procedures	Sample Reports
Encounter File BBA Cert File Process Policy	BUILD_RECON_AUG11.xls
Encounter File Submission Schedule Policy	EXT_REJECT_DROPPED_AUG11.xls
Encounter File Transfer Oversight Policy	PROVIDER_ERR_01JUL2010_30SEP2011.xls
Encounter Performance Standard & Error Corrections Policy	RA_CUMULATIVE_ERRORS_AUG11.xls
Encounter Pre-Edit Process Policy	RA_MONTHLY_ERRORS_AUG11.XLS
Encounter Production Job Authorization Forms Policy	RA_STATUS_ANALYSIS_AUG11.xls

Data Completeness Oversight

On a daily basis, our Encounter Data Team manages all aspects of encounter submissions to ensure that all encounters are complete and delivered to DPW on a monthly basis. To achieve this goal, the team:

- Meets daily to collaborate and handle any urgent issues

- Ensures the encounter files have successfully passes all completeness checks
- Review internal compliance reports
- Ensures that the encounter submissions are prepared in advance of the time they are due
- Tracks every file submitted to DPW along with pertinent data (e.g., date, record counts, etc.)
- Distributes reports to management for review of any potential files missed
- Addresses all issues on a timely basis

The Medical Economics Department monitors our Data Warehouse for data anomalies, part of which includes missing or incomplete data from subcontractors. If data anomalies are discovered, Medical Economics communicates potential issues to the Information Systems Department to be sure that the anomalies are not due to any internal processes related to loading the source data. Medical Economics also communicates with Quality Management and Provider Network Management Departments to follow-up with providers and subcontractors, when needed, to obtain complete and correct data and reports.

Our Delegated Oversight Area, managed from the Quality Management Department, in conjunction with Provider Network Management, monitors the submission of reporting from subcontractors on a monthly basis. Inadequacies are followed-up swiftly with the applicable subcontractor and corrective action plans are implemented when appropriate.

QUESTION 9

How will you ensure and verify that providers and subcontractor(s) submit timely, accurate, complete and required encounter data elements to you for subsequent transmission to the Department? How often will you verify the data?

(Limit to three pages)

RESPONSE TO QUESTION 9

AmeriHealth Mercy understands that it is ultimately accountable for the performance of all services performed by subcontractors. As such, we have defined strict management information system requirements and related policies, procedures, and protocols, to ensure all AmeriHealth Mercy subcontractors adhere to DPW and AmeriHealth Mercy compliance provisions, including the submission of timely, accurate, and complete encounter data. Our policies and procedures guide our initial selection of subcontractors and ongoing adherence performance monitoring and oversight.

Ensuring Timeliness

Providers

Providers are required to submit encounters on a standard claim form (HCFA 1500 or UB 04) to AmeriHealth Mercy within 180 calendar days from the date that services were rendered or compensable items were provided. Re-submission of previously denied claims with corrections and requests for adjustments must be made within 365 calendar days from the date that services were rendered or compensable items were provided. Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 days of the date shown on the primary insurer's EOB.

AmeriHealth Mercy's claims processing system is configured with the timely filing rules to ensure that providers submit their encounters in a timely manner. We have the capability to run reports by providers to identify any patterns of late submission of encounters. Often the provider will contact AmeriHealth Mercy via phone or in writing to dispute payment denials for timely filing. The Network Management Department is notified if a pattern of late submission is identified, and a Provider Management Account Executive contacts the provider to reinforce the claims billing guideline.

Subcontractors

AmeriHealth Mercy requires that all of its subcontractors submit encounter data on a standard 837 EDI format weekly, bi-weekly, or monthly depending on State requirements. AmeriHealth Mercy utilizes a file tracking system, which tracks the submission status of encounter files based on a defined schedule. If a file is not submitted on the day it is expected, the system will send an alert to the Encounter Managers who will in turn contact the subcontractor to alert him that his file has not been received. All file transactions are tracked and reviewed monthly to identify any negative trends in the timely submission and quality of the data. If a trend is identified, the issue is escalated to AmeriHealth Mercy's Subcontractor Oversight Manager to seek immediate resolution, including the following: the specific actions that can be taken, a request for a formal corrective action plan, and/or performance penalties assessed for non-compliance with contractual service level standards.

AmeriHealth Mercy's Quality of Service Committee annually conducts a comprehensive review of each subcontractor's ability to submit encounters in compliance with all applicable standards. These reviews are conducted by an independent auditor or by the AmeriHealth Mercy Audit department. If a subcontractor's performance falls below the threshold level stipulated in their contractual agreement with AmeriHealth Mercy or otherwise does not comply with DPW requirements, the subcontractor is required to complete and submit a corrective action plan explaining the specific reasons for underperformance. To support subcontractors' efforts to meet

performance expectations, we provide regular updates of the State's procedure codes, diagnosis codes, and provider data reference files.

Ensuring Accuracy

Providers

Provider encounters are submitted on a claim form and then processed through the claims processing system, which verifies the completeness and accuracy of provider numbers, member ID numbers, diagnosis codes, and procedure codes. The claims processing system rejects claims with missing or inaccurate information; rejected claims are returned to the providers for correction.

The claims processing system utilizes claim clinical editing functions based on valid Current Procedure Terminology, ICD-9 (or ICD-10 when implemented by the State), HCPCS codes, and National Correct Coding Initiative standards. When encounter data are loaded from the claims processing system into the encounter database (from which we prepare encounter data submissions to the State), the data passes through a secondary pre-edit process. This process enables AmeriHealth Mercy to identify, investigate, and correct significant errors before submitting the encounters to the State in the required formats.

Subcontractors

Subcontractors are required to apply claim level edits at the point of adjudication. Subcontractor 837 professional and institutional files must pass HIPAA compliance examination prior to submission to the State. In addition, AmeriHealth Mercy uses an encounter audit tables for data validation, and files are required to pass a second level of the pre edits process. This chart shows our encounter acceptance rate from our subcontractors for Calendar Year 2011.

Ensuring Completeness

Providers

We continually strive to ensure complete encounter submissions from our capitated PCPs. We have several initiatives in place to achieve this goal. We continue to offer a $1.00 incentive payment for every complete and accurate encounter form submitted by our capitated PCPs and our Primary Care Provider Incentive Program provides financial incentives for the submission of accurate and complete health data.

In April 2007, AmeriHealth Mercy implemented an initiative to ensure complete encounter reporting of all diagnosis for chronic illnesses. The PCPs receive enhanced fee-for-service reimbursement for providing outreach and comprehensive evaluation and management services to a defined member population. The target population is identified by comparing current period claim experience to a two-year historical look-back. In all cases where active members have a history of chronic illness, but no current record of claims reporting the same illness, the assigned PCP is notified and requested to validate the continued presence of the condition by providing a comprehensive evaluation and management services and submitting a claim reporting all active diagnoses.

Encounter submission rates for providers are reviewed every six months by the Provider Network Management team. An encounter submission report is generated from the Facets claims payment system that lists every provider and encounter submission rate per month. In addition, a variance field exists that indicates the percentage change from the prior reporting period.

We verify the completeness of PCPs' claims submissions through biannual medical record reviews. During these reviews, we collect data from medical records and compare them to claim encounter submissions. When encounter rates fall below a specified threshold, the provider is contacted to discuss the issue and is required to prepare a corrective action plan. Capitated PCPs who continually under-report encounter data are notified that continued non-compliance may result in the change of their reimbursement from capitation to fee-for-service, or that we may apply sanctions up to and including contract termination. This action has been every effective and we have seen an increase in our submission rates as a result.

Subcontractors

AmeriHealth Mercy monitors the number of service encounters submitted for every service that an enrollee receives. A cross-functional review of the medical record/claims data of the subcontractor is conducted by AmeriHealth Mercy departments with a stakeholder interest, such as Medical Affairs, Informatics, and Claims, to verify that complete data are being submitted.

Data are analyzed and evaluated for over/under/misutilization of medical services based on national benchmarks (such as Medicaid Quality Compass scores, HEDIS, and other nationally-accepted industry standards and measures) and in accordance with the requirements of the RFP. During our medical record review, if we determine that encounters were not submitted, the subcontractor is required to develop and implement a corrective action plan. AmeriHealth Mercy requires all subcontractor files to pass HIPAA compliance examination for all 837 files prior to submission to the State. If any file fails this compliance examination, the subcontractor is required to return a corrected encounter file to us within four business days. This process is used every time that files are received from subcontractors, typically once a month.

Encounter Transmission to the State

All encounter data received from a provider or subcontractor will undergo the same editing for completeness and accuracy required from all encounter records. A more detailed description of the process is provided in Question 7. AmeriHealth Mercy will submit multiple encounter files to the State monthly containing internally processed claims and claims processed by subcontractors. An initial file is submitted once a month; throughout the rest of the month, subsequent adjustments and corrections will be submitted as needed. By separating the file, DPW will be able to conduct any further audit and/or reviews for subcontractor encounter data.

QUESTION 10

How will you manage the non-submission of encounter data by a provider or subcontractor? Will it result in any assessment of penalties? If so, please describe.

(Limit to 2 pages)

RESPONSE TO QUESTION 10

AmeriHealth Mercy has systems and processes in place to verify and ensure that providers and subcontractors provide us with timely, accurate and complete encounter data for transmission to DPW. This combination of activities has enabled, AmeriHealth Mercy to exceed DW encounter acceptance standard.

To encourage encounter submissions by capitated PCPs, AmeriHealth Mercy makes a $1.00 incentive payment for each timely, accurate and complete capitated encounter submitted to the Plan.

Non-Submission of Encounters by Participating Providers

AmeriHealth Mercy reimburses all participating providers, with the exception of some Primary Care Providers, on a fee-for-service basis. Providers who are paid on a fee-for-service basis do not receive payment from AmeriHealth Mercy unless they submit an encounter (claim) form. Our primary focus is on ensuring the submission of encounter data from our capitated Primary Care Providers.

The first step in ensuring encounter submissions occur is appropriate provider education and communication. AmeriHealth Mercy Provider Network Representatives conduct in-service/orientation meetings with participating providers to review policies and procedures, reimbursement, billing requirements, encounter submission requirements, and performance metrics. Providers with low encounter submission rates receive additional, ongoing training and education.

The second step to ensure encounter submissions by primary care providers includes financial rewards. AmeriHealth Mercy offers a financial incentive to PCPs for each timely, accurate and completed capitated encounter submitted.

AmeriHealth Mercy monitors encounter submissions by PCP practices, whether capitated or fee-for-service, on a regular basis. The encounter submission rate is expressed in terms of an average number of encounters per member per year (PMPY). Encounter submission reports are generated from our Facets claims payment system showing the monthly encounter submission rate for every participating primary care provider, along with the percentage change from the prior reporting period. When a capitated provider's Encounter submission rates fall below a pre-determined threshold, we contact the provider to discuss the concern and inform him/her of the need for corrective action. Persistent outliers, particularly low encounter submitters that reimbursed through capitation, are converted to fee-for-service payment arrangements to encourage complete encounter submissions.

Non-Submission of Encounters by Subcontractors

AmeriHealth Mercy's contracts with subcontractors who process claims include performance standards for timely, accurate and complete encounter data submissions. Our subcontract agreements include language providing for the implementation of progressive sanctions for non-compliance, up to and including contract termination.

Encounter data performance standards are incorporated into the subcontract through written service level agreements. Our encounter data analysts monitor subcontractor encounter data submissions, volumes, and accuracy, with every data transmission and on a monthly basis. If service levels are not met, they escalate the non-performance issue to the AmeriHealth Mercy

Subcontract Oversight Manager who in turn escalates the issue to the appointed subcontractor encounter data contact. The issues are discussed jointly with the subcontractor and a corrective targeted corrective action plan is developed, documented and tracked. As discussed above, continued non-compliance will result in the application of progressive sanctions, up to an including penalties and contract termination.

On an annual basis, AmeriHealth Mercy's Quality of Service Committee conducts a comprehensive review of each subcontractor's ability to transmit timely, accurate, and complete encounter submissions in accordance with AmeriHealth Mercy and DPW requirements. This review is conducted by an independent auditor or by the AmeriHealth Mercy Audit department. If a subcontractor's performance falls below the performance threshold stipulated in their contract with AmeriHealth Mercy, or otherwise does not comply with DPW requirements, the subcontractor will be required to submit and complete a corrective action plan targeted at the specific reasons for underperformance. Again, continued non-compliance with encounter submission performance standards will result in the application of penalties, up to and including contract termination, as per AmeriHealth Mercy's subcontractor agreements.

QUESTION 11

Describe in detail your process for utilizing the daily, weekly, and monthly files to manage your membership. Include the process for resolving discrepancies between your membership data and the above files.

(Limit to four pages)

RESPONSE TO QUESTION 11

Maintaining complete and accurate membership data is critical to AmeriHealth Mercy's ability to provide high quality and cost-effective care to all enrollees. Our enrollment processes and technologies provide a solid infrastructure for the management of enrollment information, including clear documentation and tracking to resolve discrepancies. This process has been enhanced in the nearly 30 years we have served Medicaid recipients in Pennsylvania.

Process for Utilizing Daily, Weekly and Monthly Files

AmeriHealth Mercy's enrollment process is built around nationally-accepted, HIPAA-compliant transactions and file layouts that allow us to process and reconcile eligibility information effectively. We have developed and operated processes to utilize the daily, weekly, and monthly files that we receive to enroll new enrollees, disenroll enrollees, re-enroll enrollees, update enrollee demographic data, and assign PCPs in a timely and accurate manner.

AmeriHealth Mercy currently receives daily, weekly, and monthly enrollment files from DPW in an ASC X12N 834 Benefit Enrollment and Maintenance transaction. Each file is automatically processed nightly in our Facets Healthcare Application, our core eligibility and claims processing system, serving as the central repository for all enrollee data. This process loads changes to enrollment data so that the information in Facets can be reconciled with the information from the State. Any online modification of demographic information, alteration in category of assistance, change of medical assistance, eligibility, new enrollment, disenrollment or PCP change automatically updates our enrollee records. In order to effectively manage the accuracy of our enrollment data, we process files in the order in which they are received, and we process records in chronological order for each enrollee.

Weekly Eligibility File Process

AmeriHealth Mercy is required to produce a Weekly Membership Enrollment and Disenrollment Outbound File for DPW, which contains alerts and notifications consisting of newborns, returned mail, pregnancy, death notifications, TPL data and demographic changes. These alerts are a means to communicate changes in membership data to DPW for incorporation into the Pennsylvania State System.

DPW returns the enrollment/disenrollment file weekly with a disposition of each record that was sent to them on the file. Each record returned contains an edit code indicating whether the record was processed, and the type of processing that was completed. AmeriHealth Mercy's Enrollment Department manually reviews all edits codes that require additional research. Our Enrollment Department staff also loads the edit codes for each member into our Facets system for future reference.

Weekly Pending Enrollment File

DPW's Enrollment Broker Contractor generates the Weekly Pending Enrollment File. This file contains new enrollees who were recently submitted to DPW along with the members' PCP selection and special needs information. We run automated queries to compare the Weekly Pending Enrollment File information already in our system. If a match is found, the PCP information is automatically updated into the member's enrollment record. If a match cannot be made, the information is included in an error report (see below). We recycle unprocessed Weekly Pending Enrollment records for 40 days, after which they are purged.

AmeriHealth Mercy's Enrollment Department generates and reconciles the following reports:

- **Recipient Not in Healthcare System and Members with Duplicate ID Numbers** – This report identifies any member who could not be located by recipient number in the Facets system or where duplicate recipient numbers exist.
- **Unprocessed Records Report** – This report identifies members who are not an active member assigned to AmeriHealth Mercy and were never found in the Facets system. These records are purged after 40 days from their original receipt date.
- **PCP Update Error Report** – This report identifies members whose PCP assignment could not be processed automatically due to PCP panel restrictions or PCP's participation status has changed.

Monthly Eligibility File

AmeriHealth Mercy receives a Monthly Eligibility File from DPW that contains the most current record for each recipient who becomes Managed Care eligible within the next month.

Upon receiving this file, AmeriHealth Mercy completes automated comparisons to identify discrepancies with our Facets system. We accumulate this information into categories and report it to the Enrollment Department. The Enrollment Department proactively reviews, researches, and updates discrepancies to reconcile our system with the Pennsylvania State System. We make all changes within 72 hours of receipt of the file from DPW. Once the reconciliation is complete, we continue the processes for generation of PCP panel lists and PCP capitation.

Newborn Database

AmeriHealth Mercy developed a database to track and monitor all claims for newborn members who do not yet have Medicaid eligibility. This database interfaces with our Facets system, which permits daily refreshing of the data, so that all updates from DPW are captured quickly and routinely. In this way, newborn claims can be addressed on an expedited basis.

This process and database also allow our Enrollment Department to track the status of notifications to DPW about the need for newborn eligibility information and ensures that notification is timely and not redundant. This streamlines the process for assignment of Medicaid eligibility in our Facets system, reducing administrative costs for both DPW and AmeriHealth Mercy. It also ensures greater access to necessary services for newborns through timely availability of the latest eligibility information for member and provider inquiries.

Eligibility Information from Other Sources

During our process, eligibility discrepancies are identified through a number of sources: medical records, discharge planning, PCP notification, enrollee self-reports, Explanation of Benefits (EOBs), claims, and returned mail. The most common discrepancies are address changes, name spelling errors, e-mail addresses, changes to third party insurance coverage, and wrong telephone numbers. Our employees enter updates into our Facets system using Streamline, which is a custom-designed, front-end graphical user interface. Demographic changes are communicated to the State via the weekly outbound file process described above.

Resolving Discrepancies

AmeriHealth Mercy compares eligibility transactions to our existing enrollee records on a daily basis, and updates or adds them as necessary. Specifically, the enrollee data on the daily inbound file are loaded into the Facets system within 24 hours of receipt of the file.

If there is a discrepancy identified, the system is configured to default the record to an error report which is resolved by an enrollment specialist within 24 hours (for example, there may be an invalid exemption code on the record of a terminated enrollee). This information is accumulated into categories and researched by the enrollment specialist. The enrollment specialist proactively reviews the reports, researches, and updates any discrepancies to reconcile our system with the State.

Our enrollment specialist will provide the State and/or the enrollment broker with written notification of all discrepancies that are identified during the reconciliation process. We intend to utilize the file layout of the report and reconciliation file we currently produce in our Pennsylvania plans. The table below shows the error code descriptions that we will provide on the reconciliation file:

Table 8: Enrollment Error Code and Description

Frequency	Error No.	Error Description
Daily	3	INVALID EXEMPTION CODE FOR TERM MEMBERS
	4	BLANK FACILITY CODE
	9	PH CODE AND GROUP POLICY MISMATCH
	15	MATCH BETWEEN MEMBER INBOUND EFFECTIVE BEGIN AND END DATES
	18	MEMBER TERMINATED WITH INVALID CURRENT PLAN SEGMENT
	7	VALID EFFECTIVE DATE WITH A VALID MEDICAID TERMINATION DATE [MIN]
	22	ERROR IN PREGNANCY
	25	NEW EFF DATE PRIOR TO FACETS MECD EFF DATE
	26	NEW EFF DATE PRIOR TO FACETS MELC EFF DATE
	27	FACETS EFF DATE PRIOR TO NEW EFF DT FOR NON-TERMED
	28	CUTOFF DATE IS PRIOR TO ELIGIBILITY BEGIN DATE
	17	ERROR IN CURRENT PLAN AND HMO EFFECTIVE DATE SEGMENTS
	24	NEW PLAN IS NULL/BLANK/NOT VALID
	20	MIN OF MEDICAID TERM DATE NOT EQUAL TO OPEN-ENDED DATE
	20	PCP ERROR FOR RE-INSTATED MEMBERS
	45	DUPLICATES EXIST FOR MEDICAID ID

Frequency	Error No.	Error Description
	46	DUPLICATES EXIST FOR SSN
Monthly	0	TERM BY ABSENCE
	1	ELIGIBLE IN INBOUND NOT IN FACETS
	2	TERMED IN INBOUD BUT ACTIVE IN FACETS
	3	TERM DATE MISMATCH
	5	CATEGORY CODE AND PSC MISMATCH
	7	NON EXISTENCE OF CATEGORY CODE IN FACETS
	8	TERMED IN FACETS BUT ACTIVE IN INBOUND
	9	DECEASED IN INBOUND BUT ACTIVE IN FACETS
	9	PH CODE AND GROUP POLICY MISMATCH
	10	INBOUND DECEASED DATE MISMATCH WITH FACETS TERM DATE
	11	PRENANCY DATE MISMATCH
	12	PREGNANCY INDICATOR INBOUD BUT NOT IN FACETS
	13	PREGNANCY DATE MATCH BUT FACETS HEALTH PREFIX IS A
	14	PREGNANCY INDICATOR IN FACETS BUT NOT INBOUND
	45	DUPLICATES EXIST FOR MEDICAID ID

Quality Auditing Process

AmeriHealth Mercy has a very effective Quality Assurance program. The program is geared to identify errors performed by the Enrollment Representative during the reconciliation process and to identify any trends in the quality of the enrollment files sent by DPW and/or the Enrollment Broker. Through this process we have been able to reduce eligibility errors and address data quality issue early so they did not impact a member's ability to access service or a provider reimbursement.

In addition to the automated identification of enrollment discrepancies, 5 percent of the work performed manually by AmeriHealth Mercy's Enrollment Department is audited. The 5 percent is selected through a random sample of the total work completed by the Enrollment Representative during a given time period. Detailed quality reports that document overall accuracy and error trends are provided to the manager on a monthly basis. The reports are utilized for training, trending and performance monitoring purposes.

QUESTION 12

Explain in detail your process for providing membership information to each of your subcontractors (dental, vision, etc.). Include the subcontractor's name, their purpose and how often membership data is submitted.

(Limit to three pages)

RESPONSE TO QUESTION 12

AmeriHealth Mercy has processes and procedures in place to provide our subcontractors with timely and accurate membership information to support all delegated clinical and administrative functions. In addition to the processes we have service level agreements with each of our subcontractor to ensure they receive and load the eligibility file timely so not to prevent members from access services.

Our process for providing membership information to each of our subcontractors begins with our receipt of the daily, weekly and monthly enrollment files from DPW. These files are processed each night in our Facets Healthcare Administration Application. This process automatically applies changes to the membership data and updates information about members so that the information in Facets is synchronized with the information received from the State or Enrollment Broker. Any online modification of demographic information, category of assistance, change of medical assistance, eligibility, new enrollment, disenrollment or PCP change automatically updates our member records. Our Enrollment Department resolves and discrepancies and makes all updates to the members eligibility records on Facets. For a more detail description of the enrollment file reconciliation process, please refer to Question 8 of this section.

Productions and Submissions of Eligibility file to Subcontractors

AmeriHealth Mercy produces a daily change file and monthly full eligibility file for each of the subcontractors. These files are transmitted to the subcontractors using a CISCO Tidal job scheduler to initiate and manage the generation of the outbound files. The outbound file production schedule is configured with the CISCO Tidal Enterprise Scheduler, which allows for alerts to be generated and routed in the event a file is not sent as expected, if the file transfer is not successful, if any processing step fails, and under other exception conditions. AmeriHealth Mercy monitors the data exchange process twenty-four hours a day, seven days a week. In addition, we have the ability to identify which subcontractors are not retrieving their eligibility files timely. If a pattern is identified, the Subcontractor oversight manager will be notified and further action taken as needed.

Data Security

The security of all data files transferred is guaranteed via point-to-point connectivity or secures virtual private networks across the Internet. We utilize a “Lock Step” method executed with each data movement to ensure all received and outbound exchanges are archived and logged for future reference or processing. This enables us to track the status of each file and identify potential errors.

Error Reconciliation

AmeriHealth Mercy has workflows and processes to assist all Subcontracts with the reconciliation of all files. When the subcontractor loads the eligibility file into their system, on occasion they will receive errors which prevent the file or a specific member record to automatically load into their system (Example: If they receive a member with an ID number that has already been assigned to another member). The Subcontractor will contact the Enrollment department to work through the error. The error fix can result in a manual update to their system, AmeriHealth Mercy System or resubmission of a new file. All errors are tracked a logged to assist with trending.

Service Levels

We achieve superior data exchange service levels through our commitment to proven procedures and operational controls. We practice strict adherence to scheduled processing times, routine error handling/reporting and associated processes to address discrepancies through reconciliation of data between parties and audits. The audits include operational quality assurance audits, internal audits, and/or third party audits, including State and Federal regulatory audits.

The following table is the list of our subcontractors and the eligibility files they receive:

Table 9: Subcontractor Eligibility Files

Subcontractor	Purpose/Description of Services Provided	Daily Eligibility File	Monthly Eligibility File
DentaQuest	Dental	X	X
Argus	Pharmacy	X	X
Connections	Member outreach	X	X
Quest Labs	Medical Lab	X	X
Davis	Vision	X	X
ACS Commercial Solutions	Data Processing	X	X
ACS Recovery Services Inc.	Subrogation Recoveries	X	X
Healthcare Management Systems	TPL and COB identification and recovery	X	X
MedSolutions Inc.	Utilization Management for outpatient diagnostic imaging services	X	X
ProgenyHealth	Neonatal intensive care management	X	X
PerformRx LLC	Pharmacy Benefit Management	X	X

QUESTION 13

Explain your process for maintaining your provider file with detailed information on each provider sufficient to support provider payment and also meet the Department's reporting and Encounter Data Requirements. Include how you cross reference your internal provider ID number with the PROMISe provider ID and the provider's NPI number.

(Limit to two pages).

RESPONSE TO QUESTION 13

Maintaining Provider Data

AmeriHealth Mercy recognizes the importance of creating and maintaining current provider demographic information to ensure the accuracy of claims payment, state reporting, encounter data requirements, and provider directories. We coordinate our contracting, credentialing, provider file maintenance and encounter processes to ensure that provider file information is current and accurate.

Initial Provider Enrollment

Each new provider contracted with AmeriHealth Mercy completes a credentialing application and signs an agreement that defines both parties' reimbursement obligation. Provider Network Management is responsible for receipt of a completed application package that includes validation of all required provider identification numbers. This package is then forwarded to the Credentialing Department where a provider profile is created in Visual Cactus. The profile includes all necessary information: name, address, phone, fax, email, ID numbers (PROMISe and NPI), license numbers, board certifications, languages spoken, and site review information (such as handicapped accessibility). Providers are requested to review information obtained during the credentialing verification process, and, if it is substantially different from what they submitted on their application, are given the opportunity to correct erroneous information. Once approved through the credentialing process, the provider data are extracted from Visual Cactus and loaded into the Facets System by the Provider Maintenance Department. Reimbursement information from the executed provider contract is formatted into a Contracting Implementation Template and delivered to our Facets Configuration Team, which creates or updates the agreement details in the Facets System. Since many providers are paid based on the same fee schedule, this usually involves simply associating the new provider to an existing agreement. Facility agreements require specific reimbursement configuration and are routinely tested prior to implementation to ensure reimbursement at the contracted rate for various services.

Each provider record loaded into the Facets System is given a sequentially generated, unique practitioner or facility ID number, but NPI and PROMISe Provider ID (PPID) numbers are also stored on the Facets provider data table. The NPI and PPID are cross-referenced to the practitioner ID and the associated provider Group ID and Payee ID. The Facets provider platform maintains this unique link through the duration of the record's existence on the platform. The integrated NPI crosswalk table within Facets enables AmeriHealth Mercy to link all practitioner-related claims information. AmeriHealth Mercy's Encounter Analysts also monitor encounter rejection reports on a monthly basis. If any provider data errors are identified (e.g., providers with invalid data such as PROMISe ID, invalid NPI number, etc.), encounter data analysts will work with the Provider Network Management Department and Claims Operations to make corrections to provider or claims data. The provider master data are corrected as necessary to ensure that future payments are accurate.

Routine Monitoring

The on-going accuracy of our provider database is monitored through multiple processes:

- Daily audit of the manual updates performed by our Provider Maintenance employees
- Quarterly review by Provider Network Management representatives through a combination of provider office visits, telephonic, electronic media, and facsimile-based confirmation

- During the routine re-credentialing cycle

Updates from provider data can also come from external sources. We perform State and federal file comparisons that reconcile data elements such as name, address, license, DEA, office locations, NPI and State ID numbers. Corrections to provider data are also made on an ad hoc basis whenever reported to us directly by the provider or identified as the result of a claim investigation. As a final monitoring effort, AmeriHealth Mercy performs a complete provider data validation annually. Through this process, all providers are required to validate and edit the data stored in our provider database. This process has proven to be very effective as a means to ensure accuracy of provider directories. Provider Services or Provider Network Management staff submits change requests to Provider Maintenance. All such requests are completed within two business days.

QUESTION 14

Explain your process for ensuring that providers are enrolled in MA and have a valid PROMISe Provider ID number and NPI. Include how you will monitor your subcontractors to ensure their providers are enrolled in MA and have a valid PROMISe provider ID number and NPI.

(Limit to two pages)

RESPONSE TO QUESTION 14

AmeriHealth Mercy Health Plan provider enrollment procedures have been established to maintain compliance with the requirement that prospective and participating providers are enrolled in the Pennsylvania Medical Assistance (Medicaid) Program and have valid PROMISe ID (PPID) and National Provider Identifier (NPI) numbers prior to being added to our provider database.

Participating Provider Enrollment

For those providers who must be credentialed by AmeriHealth Mercy as a condition of participation in our network, we verify enrollment in the Pennsylvania Medical Assistance Program and the existence of a valid PPID number and NPI number during the initial provider credentialing process and during re-credentialing. If we receive an application that does not include the PPID or NPI number, we contact the provider's office to verify that they have submitted an application to receive a PPID and/or an NPI number. Providers who have not submitted an application for a PROMISe ID or NPI number are directed to do so. More often, we find that the request for the PPID or NPI number has been made, but is still pending review by the DPW. In these instances, we proceed with the credentialing process, but pend the final credentialing approval upon receipt of the valid PROMISe ID or NPI number. Upon notification that the provider has been enrolled by DPW and/or has received the NPI number, the credentialing process is completed. AmeriHealth Mercy verifies the validity of the PPID and/or NPI number prior to entering it into the Facets System by checking Pennsylvania PROMISe database. The PPID and NPI numbers are both stored on the Facets provider data tables and cross-referenced to the system-generated Facets ID number.

Subcontracted Provider Enrollment

Our sub-contractor agreements also require that all subcontractor providers are enrolled in the Pennsylvania Medical Assistance Program and have a valid PROMISe Provider ID and NPI number. Our subcontractors follow similar processes to those outlined above to verify that a provider in their network has a valid PPID number.

AmeriHealth Mercy also shares its PVR 415 files with all subcontractors. Additionally, we conduct a secondary review of the PPIDs and NPIs submitted by our subcontractors through the encounter process. Prior to submission to DPW, all encounters are run through a pre-editing process that verifies the existence of a PPID and NPI number.

Non-Participating Providers verification

AmeriHealth Mercy submits a request to add a non-participating provider who do not exist in our Facets database to our Provider Maintenance Department to obtain an internal provider identification number. Providers who do not have a valid PPID and/or NPI may be entered into the Facets System as a non-participating provider only. Each non-participating provider addition is researched on the PROMISe system to validate their participation in the Pennsylvania Medicaid Program, and to obtain or validate the PPID number and NPI number.

Maintenance

We investigate missing and invalid PPIDs and NPIs on a monthly basis via a query comparing the 415 file received from DPW against our Facets database. This report identifies any provider (participating and non-participating) in our Facets database who does not have a valid PPID or NPI. AmeriHealth Mercy investigates missing and invalid PPID and NPI numbers in the

PROMISe database and corrects the information in the Facets database if the valid information is found. If we find a provider without a valid PPID or NPI, AmeriHealth Mercy contacts the provider to educate and assist him/her in obtaining a PPID or NPI number.

If AmeriHealth Mercy receives claims and/or work requests that require changes and updates to provider data for subcontractors, we use the PROMISe system to validate the PPID and NPI number. If the provider is not in the PROMISe system, we do not set up a provider record. Instead, the request is pended and assistance is requested from our Provider Contracting Department. Once the PPID and NPI is obtained and provided, a provider record is set up for the subcontractor in the provider database. If a subcontracted provider is found to be without a valid PPID or NPI number, AmeriHealth Mercy notifies the subcontractor to contact the provider for education and assistance in obtaining a PPID and/or NPI. We re-educate the subcontractor about their responsibility to ensure that all providers in their network have a valid PPID and NPI number. If a pattern of problems is noted through the encounter edit process, the subcontractor would be subject to sanctions.

QUESTION 15

What is your plan to ensure that claims timeliness standards are met and that providers are paid timely?

(Limit to two pages)

RESPONSE TO QUESTION 15

AmeriHealth Mercy has achieved high standards for timely and accurate claims processing and provider payment by using state-of-the-art technology, well-trained staff, and a rigorous quality assurance process. As shown in the table below, we far exceeded DPW payment timeliness standards for time to pay within 30 days of receipt, and our performance at the 45- and 90-day mark materially complies with DPW's requirements over the past year (DPW has a threshold for compliance for 45 and 90 days of 99.5% or greater).

Table 10: AmeriHealth Mercy Health Plan Clean Claim Payment Results

Time to Pay Requirement AmeriHealth Mercy 90% of Clean Claims in 30 days											
Nov-10	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**
99.9%	99.9%	95.6%	99.9%	98.9%	98.0%	94.0%	96.1%	98.1%	97.7%	97.1%	99.5%
Time to Pay Requirement for AmeriHealth Mercy 100% of all Clean Claims in 45 days											
Nov-10	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**
99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	98.5%	99.8%	99.9%
Time to Pay Requirement for AmeriHealth Mercy 100% of all Claims in 90 days											
Nov-10	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**
100.0%	99.9%	99.9%	100.0%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%

Adherence to claims payment standards and requirements is achieved through daily monitoring of the claims inventory by the AmeriHealth Mercy claims management team. Specifically, our 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 processing and payment performance 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.

Facets offers a high degree of automation and data capture, achieving fast, accurate claims processing and high auto-adjudication rates. AmeriHealth Mercy affiliate has achieved a yearly average of an 87 percent claims payment auto-adjudication rate. These high rates have been achieved by utilizing standard provider agreements and pricing methodology (such as percentage of fee schedule and DRGs). 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.

Of the 18 million claims we receive annually across our family of companies, over 89 percent are electronically submitted.

Facets' electronic auto adjudication allows us to process claims faster and more accurately than paper claims. AmeriHealth Mercy employees can adjudicate all medical and hospital claims that are submitted electronically in a batch mode. The batch mode capability allows us to process a large amount of claims at one time automatically. We can also adjudicate pended claims that have been mass-released for re-adjudication as a batch process. 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.

Table 11: AmeriHealth Mercy Health Plan Auto Adjudication Rates

Auto Adjudication Rates for AmeriHealth Mercy											
Nov-10	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**
92.2%	88.9%	85.3%	88.9%	87.4%	90.3%	85.9%	87.3%	80.9%	89.2%	87.1%	88.1%

AmeriHealth Mercy utilizes SunGard EXP Macess imaging-based operations management, workflow management, enterprise content management and customer service solution. EXP Macess 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 claims workflow, helping managers identify bottlenecks and increase efficiency. EXP Macess offers solutions for document management, content management and business process management that help organizations automate workflow and improve productivity. Some of the documents we capture include:

- Incoming correspondence from members or providers
- Claims
- Medical records
- Detail invoices
- Prior authorization records
- Letters of medical necessity (electronic and scanned images)
- Outgoing correspondence to an enrollee or provider (such as letters to request additional information, notice of action, notice of appeal resolution)
- Electronic documents

EXP's Doc Flow module enables records/documents to be processed into work queues for efficient work assignment and management. EXP Macess enables queue-based work distribution. Users can use a graphical design component to create electronic workflow and routing flows to match a predefined workflow process. The system will perform automatic searches for supporting documents, in order to complete tasks in the queue. 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. Together, these integrated systems provide for accurate and prompt claims payment to our providers.

PHARMACY

CONTENTS

QUESTION 1

Describe your approach to control pharmacy costs. Describe programs/initiatives that have been successful at controlling costs.

(Limit to three pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy controls pharmacy costs within the broader context of reducing the overall cost of care for our members. Our pharmacy programs are designed to improve the comprehensive health needs of our members through optimal use of medication therapy. By ensuring that our members receive the right medication, at the right time, at the lowest possible cost, we are able to achieve the highest quality care in the most cost effective manner.

Our programs have successfully controlled costs. The six key drivers of our pharmacy cost containment efforts are:

- Effective use of clinical pharmacy utilization protocols
- Maximizing the use of generic medications through strategic formulary design
- Driving prescribing patterns through targeted member and provider interventions
- Negotiating competitive reimbursement policies
- Effectively managing a robust rebate management program, and specialty drug program; and
- Application of dose optimization criteria to minimize member tablet burden and daily medication costs

Some of these components are described in detail in the following questions, but a brief summary is below.

Pharmacy Utilization Management

AmeriHealth Mercy's pharmacy utilization management program is the foundation of our approach to controlling pharmacy costs. Although the DUR program is explained more in Question 2, and prior authorization is explained more in Question 3, a quick example of the effectiveness of our program involves the drug Synagis.

Peer reviewed clinical literature as well as national guidelines have clearly demonstrated that treatment with Synagis, an extremely high cost medication, is cost effective when administered only to a specific set of newborns with particular risk factors. Accordingly, we developed stringent prior authorization guidelines for Synagis to reduce its inappropriate use and aid providers in determining which members will benefit most from this therapy. When paired with physician and member education, our Synagis management program has achieved a 40% reduction in inappropriate utilization over the past year.

Additionally, the use of step therapy protocols, quantity limits, age limits, and prior authorization criteria drive favorable utilization patterns. Step therapy protocols ensure that all members try at least one of the three mainstays of treatment prior to obtaining newer, more expensive therapies. Similarly, quantity limits restrict the number of doses members can receive without prior authorization to reserve their use for their indication. Lastly, age limits restrict the use of certain medications to only those members who are determined to be age-appropriate users.

Drug Formulary

Through careful consideration of both clinical effectiveness as well as pharmacoeconomic data, AmeriHealth Mercy has been able to design and maintain a formulary that offers our members and providers a wide array of clinically appropriate therapeutic options while driving utilization toward cost effective first-line therapies. This results in a formulary that meets all of the requirements as described in Exhibit BBB (1) of the draft HealthChoices Agreement, and serves as the cornerstone for maintaining pharmacy cost trends. Maximizing the use of generic

medications, which often cost up to 90% less than their brand-name counterparts, is a key factor to our success in "bending" the pharmacy cost trend. Over the past four years our generic dispensing rate has increased 10% to our current average of 80%. To encourage continued growth of generic medications in the future, AmeriHealth Mercy has maintained its zero copay for generic initiative which waives the copay for all generic medications.

In addition, we monitor for upcoming patent expirations to ensure our formulary design will serve us well in the future. For example, the brand-named medication Plavix is anticipated to become generically available in mid-2012. While in the current market, Plavix and its competitors are similar in both price and efficacy, we have maintained Plavix as our sole formulary option so we can achieve the maximum cost savings when the generic product is introduced.

In 2011, we implemented a 90-day program for select generic medications where the dispense fee paid to the pharmacy for months two and three exceed the cost of the medication provided. By providing all of the medication for a single dispensing fee we are able to save these two dispensing fees. This program is especially advantageous for our members with limited means of transportation because it allows them to make fewer trips to the pharmacy for their medication. Since the program began in September 2011, nearly 14,000 claims have been filled for a 90-day supply with an anticipated savings of approximately $57,000 in pharmacy dispensing fees.

Targeted Interventions

Our targeted physician and pharmacist interventions promote medically appropriate and cost effective use of prescription drugs for specific members.

When targeted interventions are required to quickly transition a large number of members to a different medication, we generate and distribute pre-populated prescription templates to the prescribing physicians. These pre-populated prescription templates contain the member and provider information as well as information on the member's current therapy and our recommended cost-effective alternative therapy. By reducing the administrative burden of transitioning members, prescribers are more apt to accept our recommendation resulting in improved cost trends.

Since our members are ultimately taking the medications prescribed for them, providing education to ensure them of the safety and clinical equivalence of a different medication product is an important part of improving member utilization rates.

Competitive Pharmacy Reimbursement

In addition to the rigorous formulary management methods discussed previously, AmeriHealth Mercy also pursues opportunities to achieve unit cost price reductions through pharmacy contract negotiations. We routinely assess our reimbursement for brand name medications against national and regional reimbursement levels to ensure our contracted rates are aggressive, yet equitable. For generic medications, we use a Maximum Allowable Cost (MAC) program which covers approximately 95% of our generic prescription drug claims, and 90% of our generic drug expenditures. Our MAC list is maintained on a monthly basis to accommodate the frequent price fluctuations of generic products.

Specialty Pharmacy Program and Rebate Management Program

AmeriHealth Mercy's in-house specialty pharmacy program fosters appropriate use of self-administered injectables and physician-administered specialty drug products, while controlling the cost of these very high-cost medications. Our program has achieved significant per-member-per-month cost reductions over the past few years, despite rising drug prices and, in some cases, increasing utilization. More information about AmeriHealth Mercy's specialty pharmacy program is provided in our response to Question 5.

Our national pharmacy benefit management program enables us to negotiate our rebate agreements based on approximately 3.2 million members nationwide. We currently have rebate agreements with 55 drug manufacturers covering 630 NDC level products. These rebate-eligible products accounted 62% of all brand prescriptions, filled for AmeriHealth Mercy members.

Dose Optimization

AmeriHealth Mercy's Dose Optimization programs have been successful from both a quality perspective, and a financial perspective. Through point of sale edits and prescriber education, AmeriHealth Mercy has been successful in converting members from multiple daily dosing drug regimens to single daily dosing. For example, some physicians may prescribe Pulmicort 0.25mg Respules twice a day when clinical literature supports the use of Pulmicort 0.5mg once a day with similar outcomes. By consolidating this regimen, medication adherence and satisfaction is increased because therapy can now be completed once a day. In addition, the daily cost of this medication regimen is decreased because only 30 vials are required instead of 60 vials.

QUESTION 2

Describe your policies, procedures or processes for conducting both retrospective and prospective drug utilization review within the MA Program's Drug Utilization Review guidelines. Provide evidence of success. Describe your strategy moving forward to improve performance in this area.

(Limit to four pages)

RESPONSE TO QUESTION 2

AmeriHealth Mercy's pharmacy drug utilization review (DUR) program is designed to monitor medication prescribing and dispensing activities both proactively and retrospectively with the goals of identifying and correcting potentially harmful prescribing patterns, enhancing community-prescribing standards, and detecting patterns of fraud and abuse. Our program and our policies and procedures comply with federal and state statutes and regulations, DPW guidelines, URAC standards, and NCQA guidelines.

Prospective Drug Utilization Review

AmeriHealth Mercy conducts prospective DUR online through a central repository for capturing, storing and updating prospective DUR data. The DUR occurs in real-time at the point-of-sale through the Argus claims adjudication system. Onscreen messages immediately notify pharmacies of potential concurrent or prospective DUR issues for their review and consideration. By generating alerts to the fulfilling pharmacies during the claims adjudication process we are able to minimize the risk of adverse outcomes as a result of improper medication utilization. The system achieves this objective by:

- Reviewing prescription drug claims for therapeutic appropriateness prior to medication dispensing
- Using criteria that include the member's medical history and clinical parameters
- Focusing on those members with conditions that place them at the highest level of risk for potentially harmful outcomes

When a pharmacy submits an online claim for adjudication, the information from the prescription request is automatically compared to the member's drug and medical history in addition to the therapeutic criteria file catalogues containing approximately 228 American Hospital Formulary Service (AHFS) primary classes of drugs and other clinical algorithms. The criteria address disease categories that may predispose patients to inappropriate and potentially harmful drug use situations. When drug therapy problems are identified, the pharmacist receives an on-line alert, and takes additional steps to evaluate the order. Steps may include contacting the prescriber, or discussing the issue with the member. The file also incorporates the following drug therapy problem types:

- Therapeutic duplications
- Therapeutic overlap
- Drug to drug interactions (such as allergy and cross-sensitivity reactions)
- Drug age contraindications
- Early refill (over-utilization)
- Late refill (under-utilization)
- Excessive drug dosage (age-specific)
- Insufficient drug dosage (age-specific)
- Drug pregnancy contraindications
- Excessive quantity dispensed
- Generic product availability

Each problem type is rated using the following severity indicators:

- Cause serious harm to relatively few people (high risk and low incidence)
- Cause relatively minor harm to a large number of people (low risk and high incidence)
- Significantly increase the cost of health care by increasing hospitalizations or the use of other treatment modalities

Pharmacist counseling to our membership regarding appropriate medication use, as well as any of the prospective DUR elements listed above, is part of our contractual agreement with our pharmacy network. Through our pharmacy network, we are able to educate members about the potential risks associated with using two different medications within the same therapeutic class, which is categorized as a therapeutic duplication DUR edit. To resolve a possible therapeutic duplication DUR edit, the pharmacist can collaborate with the prescriber and the member to determine if the member should transition from one agent to another, or take a short-acting medication in the daytime and a long-acting medication in the evening.

Other edits, such as late refill or generic product availability, provide additional opportunities for the pharmacist to educate the member regarding the importance of complying with their prescribed medication regimen or the clinical equivalence of generic medications to their brand-name equivalents.

Similarly, our pharmacy network can use the prospective DUR edits to identify potential cases of fraud and abuse. As an example, a member may be alternating pharmacies in an attempt to obtain duplicate prescriptions for controlled substances. Through our prospective DUR edits, the second pharmacy would be alerted that the member had recently filled a similar controlled substance at different pharmacy, providing the second pharmacist the ability to investigate and determine if the prescription is appropriate to dispense.

Pharmacy claims are subject to post-payment audit and recoupment in the following situations:

- When a claim that has been approved for payment includes DUR messages and written documentation that pertains to the message is not returned with the claim
- When a message is returned saying that the approved claim has a dosage exceeding standards developed by a national database company, and there is no documentation of a discussion between the pharmacist and the prescriber verifying the high dose
- When a duplicate therapy message is returned on an approved claim, and there is no documentation demonstrating that the prescriber spoke with the dispensing pharmacist and approved the concurrent administration of both drugs involved

Retrospective Drug Utilization Review

AmeriHealth Mercy's Retrospective DUR program includes review of member's pharmacy claims data to determine the presence and/or frequency of the following:

- Drug-drug interactions
- Poly-pharmacy
- Over dosing and under dosing
- Aggravation of disease states
- Excessive duration of therapy
- Potential therapeutic failures
- Duplicate therapy
- Fraud and abuse

- Failure to substitute generic drugs
- Over-utilization and under-utilization
- Compliance

Our pharmacy claims processing system electronically captures and stores member prescription data in member profiles, in the NCPDP format. AmeriHealth Mercy has immediate access to the member profiles for a period of 13 months. The data is stored in archives after 13 months and may be retrieved if necessary. AmeriHealth Mercy clinical pharmacists continually review claims history in the member profiles to evaluate drug utilization and prepare retrospective review reports. These reports provide screening and trending of prescription claims data, using therapeutic criteria standards, to identify patterns of inappropriate drug utilization and to evaluate the total cost of care.

The clinical pharmacist analyzes practitioner-prescribing patterns, network pharmacist dispensing patterns, and member utilization to detect episodes of drug-related problems, target therapeutic categories for intervention, and identify inappropriate and/or unnecessary usage patterns.

AmeriHealth Mercy shares the retrospective review reports with our Pharmacy and Therapeutics Committee for review and development of quality improvement programs, such as outcomes research activities, provider education and member education programs. Recent interventions have included targeted provider mailings on patient medication compliance for members with HIV, diabetes, or asthma.

Pharmacy Audits

AmeriHealth Mercy uses a Pennsylvania contractor, ACS, Audit & Compliance Solutions, to conduct audits of participating pharmacies. The objective of our Pharmacy Auditing Program is to educate pharmacy personnel in the proper use of procedures for transmitting claims. AmeriHealth Mercy provides pharmacy paid claims data to ACS monthly. ACS runs the paid claims through its audit criteria to identify unusual or questionable patterns. The results of this analysis are used to identify pharmacies for on-site audits.

Each year, approximately eight percent of AmeriHealth Mercy's participating pharmacies are audited through a combination of desktop audits and on-site audits. Audits are scheduled by either a routine audit of network pharmacies, upon DPW's request, or due to poor compliance to a previous audit. We report the number of audits performed on network pharmacies on a monthly basis and summarize the findings on a quarterly basis after pharmacies have been allowed a period to provide any required documentation.

Evidence of Success

AmeriHealth Mercy has been able to produce sustainable prescribing pattern changes resulting in approximately $100,000 in annual savings through our Therapeutic Interchange program. By evaluating members receiving a brand-name medication and encouraging prescribers to switch these members to its generic equivalent, we were able to transition over seven percent of these members to our preferred product. It is important to note that this transition occurred without implementing any official formulary changes. Instead, we educated our providers regarding the similarities of the two agents and the dramatic cost difference between them.

We have also had success in asthma management through retrospective DUR activities. Through the combination of an educational member mailing, encouraging members to speak with their

physician about whether a controller medication was right for them, and a targeted provider mailing, using pre-populated prescription templates, we were able to increase prescription fill rates of controller medications in this population by 43 percent. Accurate identification of the appropriate member population, reduction of provider administrative burden, and targeted mailings to both providers and members allowed us to achieve this high success rate in a single intervention.

Looking Ahead

AmeriHealth Mercy has many plans for moving forward and improving its existing successful programs. We routinely examine new and existing drug therapies to ensure our drug utilization techniques follow best practices. Our clinical pharmacists, with expertise in clinical drug review, pharmacoeconomics, and outcomes research, review all pertinent evidence-based medical literature related to the particular pharmaceuticals in question. We will continue to monitor member drug utilization, standard of care guidelines, and biopharmaceutical sources to identify opportunities to improve the quality of care and achieve cost savings.

QUESTION 3

Describe your pharmacy prior authorization process, including the following:

- *How are prior authorization criteria developed?*
- *How are requests for prior authorization made?*
- *How do providers (pharmacies and prescribers) and consumers learn about the authorization process and criteria?*

(Limit to four pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy's strategic use of pharmacy prior authorization policies and criteria enables us to ensure that our members receive the care they need, while being good stewards of the limited resources available to the Medical Assistance Program. We use prior authorization processes to ensure that prescribing patterns are supported in the medical literature, that members receive the appropriate medication for their diagnosis, and to promote cost-effective first-line therapies through step therapy protocols. Currently our pharmacy benefit manager has 390 prior authorization and 170 step therapy protocols for oral medications.

Developing Prior Authorization Criteria

AmeriHealth Mercy uses various clinical and biopharmaceutical sources to make recommendations to our Pharmacy and Therapeutics (P&T) Committee regarding prior authorization criteria and treatment algorithms. Upon completion of an exhaustive literature review, drug formulary monographs and medication class summaries including comparative cost data are prepared as appropriate for presentation to the P&T Committee.

AmeriHealth Mercy's P&T committee is comprised of both internal and external pharmacists and physicians with expertise in a variety of disciplines. As required by the P&T Committee our committee consists of, at minimum, one practicing physician and one practicing pharmacist who are experts regarding care of elderly or disabled individuals, one practicing physician specializing in internal medicine, one practicing physician specializing in pediatrics, and one practicing physician specializing in psychiatry. Additional members may be added to the committee to provide expertise in other specialties. After receiving the approval of our P&T Committee, we submit our policies and criteria to DPW for approval. New policies and criteria are implemented only after receiving DPW approval, and providing the required advance notice to members and providers.

Making a Request for Prior Authorization

AmeriHealth Mercy's Pharmacy Department accepts requests for prior authorization from prescribing providers by the web, phone, fax or U.S. Mail. While our Pharmacy Department is staffed 24 hours a day, 365 days a year for questions, prior authorization determinations are only made during business hours.

To ensure our members have adequate access to medication during the submission and review time of prior authorization requests, we use these following temporary supply procedures. In the event that a pharmacy claim rejects at the point-of-sale because a prior authorization is required, and an approval cannot be obtained immediately by calling AmeriHealth Mercy's Pharmacy Department, the pharmacy is directed to dispense a 5-day temporary supply of the medication if the prescription is for a new medication, or a 15-day temporary supply if the prescription is for an ongoing, chronic medication. To facilitate compliance with this requirement, AmeriHealth Mercy has automated the process for participating pharmacies to dispense temporary supplies and receive payment from AmeriHealth Mercy through the online pharmacy claims adjudication system with on-screen messaging for our pharmacy network.

The information that must be supplied by the prescribing provider to obtain prior authorization approval varies based on the drug that is being requested, and whether any other point-of-sale edits were triggered in the process. Most oral medications may be submitted on our "Universal Pharmacy Oral Prior Authorization Form." In addition to the name, strength, and dosing of the

requested medication, the requestor must submit a history of formulary alternatives that the member has tried and failed leading up to the request for the current medication. Specific prior authorization forms have been developed for our most commonly requested injectable and specialty items that require detailed information, such as liver function test values, blood counts, patient's weight, and kidney function test values.

Determinations are made for all prior authorization requests within 24 hours of receipt, excluding weekends and holidays. When the prior authorization request meets medical necessity criteria for approval, authorization is issued for a period of up to 12 months, or for the length of the physician's request, whichever is shorter. We then generate a fax notification to the requesting practitioner and the member's PCP as well as a letter that is mailed to the member informing them of the approval.

If the request does not meet criteria for approval by the reviewing pharmacist, it is forwarded to an AmeriHealth Mercy Medical Director for review. In evaluating the request, the Medical Director relies on information supplied by the prescriber, guidelines published in the Physicians' Desk Reference, accepted clinical practice guidelines, federal and state laws, and DPW requirements. In the event of insufficient information provided by the prescriber, an AmeriHealth Mercy Pharmacist attempts to contact the prescriber to obtain the necessary clinical information for review.

If the Medical Director determines that medical necessity criteria have not been met, a denial is issued within 24 hours of receiving the request, using the denial notice template in Exhibit BBB(3) of the draft HealthChoices Agreement. When requests for a minor (under 21 years old) cannot be approved, an AmeriHealth Mercy clinical pharmacist attempts to contact the prescriber by phone to discuss the case and obtain additional information that may aid the request in meeting medical necessity criteria for an approval. If we are unable to issue a written denial notice within the 24-hour period, we continue to authorize a temporary supply of the requested medication until the member is notified of our decision. The prescribing physician may contact us to request a reconsideration or a peer-to-peer discussion regarding our decision with either an AmeriHealth Mercy Clinical Pharmacist or Medical Director during regular business hours. Prescribers and members may also obtain prior authorization criteria related to a specific denial determination by submitting a written request for the criteria.

In 2012, we will launch the E-Telligent PA system which will provide sophisticated, real-time prior authorization information to our providers. Through this system, providers will not only be able to submit prior authorization requests online but will have the opportunity, for selected medications, to enter clinical information that may yield an automatic approval with an instant authorization entry into Argus for claims payment purposes. For more complex cases, where responses cannot be evaluated automatically, the provider will have the opportunity to attach additional supporting documentation and then submit the request to our clinical pharmacy team for review. Future enhancements will also allow the system to suggest formulary alternatives for the medication the provider is requesting that may alleviate the need to complete the prior authorization entirely.

Member and Provider Education about Prior Authorization Procedures and Criteria

AmeriHealth Mercy educates members and our participating providers and pharmacies about our prior authorization procedures and criteria via the methods described below.

Member Handbook and Provider Manuals

Our Member Handbook and Provider Manuals are mailed to all new members and new providers and are also available on our website. The handbook and manual provide comprehensive information about member pharmacy benefits and currently covers pharmacy topics such as:

- FDA approved medications
- Formulary medications
- No copayment policy for generic medications
- Non-formulary medications that require prior authorization
- Temporary supply procedures
- Examples of covered over-the-counter medications and covered vitamins
- How to request a written copy of the formulary
- How to obtain reimbursement for out-of-pocket payments

Member Websites and Provider Portal

The health education section of our Member Website and the Pharmacy section of the Provider Portal highlight important pharmacy benefit information. Members can view their co-pay schedule and benefits grid, a searchable formulary, and review the Member Handbook. Providers can access a searchable formulary, information on generic medications that require a 90-day supply, and download prior authorization and specialty injectable request forms.

Online Searchable Formulary

Our recently enhanced searchable formulary tool allows members and providers to complete an online formulary search of a particular drug or drug class, prior authorization criteria, and other formulary requirements.

Member Newsletter

All members receive our Member Newsletter by mail at least three times a year. The newsletter is sent as a single document printed in English and Spanish and can be translated into other languages of choice. Formulary updates are provided, as necessary, to inform members when medications are being added or removed from the formulary. The newsletter also contains pharmacy information about benefit changes and other important topics. Past topics have included the safety and efficacy of herbal supplements, how to use an asthma inhaler, and smoking cessation products.

Member Mailings

When new programs only affects a targeted subset of the membership, such as our Dose Optimization Program and our new 90-day generic program, a direct member mailing is sent to the affected members. This is the most efficient way to communicate with members whose regimen may need to be modified as a result of the new program. Members are also educated by their provider and/or pharmacist who receive separate detailed communications on the program.

Provider ScriptNotes Newsletter

Physicians and pharmacies receive a quarterly ScriptNotes newsletter that provides updates on new and deleted prior authorization protocols, formulary additions and deletions, changes from preferred to non-preferred status, therapy guidelines, contraindications, new indications, new products, and safety alerts.

Provider Fax Blasts and Targeted Mailings

Specific formulary materials such as prior authorization criteria, step therapy protocols, and formulary updates are sometimes sent to the entire provider network via a fax blast, or to an individual provider via a targeted mailing or by fax, upon request.

Pharmacy Call Center

Our pharmacy call center currently answers approximately 35,750 calls per month from members and providers about the pharmacy benefit. Our staff is able to answer a multitude of member questions, including questions about covered medications, copays, and the status of prior authorization requests.

QUESTION 4

In regard to pharmacy point of sale, explain:

- *Who adjudicates your pharmacy claims?*
- *How do you ensure adequate oversight and monitoring of the pharmacy claims processor, including fraud and abuse and encounter data?*
- *Are all outpatient medications processed through pharmacy claims? If not, what other method of claims processing is used (e.g., professional claim with HCPCs codes)?*

(Limit to three pages)

RESPONSE TO QUESTION 4

Claims Adjudication

AmeriHealth Mercy contracts with Argus Health Systems to process and adjudicate pharmacy claims. Founded in 1983, Argus is a leading independent prescription claims processor for pharmacy benefit administration. One of the largest providers of independent data processing and related services for the pharmacy benefit administration industry, Argus processed 510 million claims for 26 million recipients throughout the country in 2010. Argus serves a wide variety of customers, including large insurance carriers, managed care organizations, and chain drug stores.

Argus provides a direct point-of-sale interface at AmeriHealth Mercy's participating pharmacies for real-time claims processing and adjudication. This claims processing system facilitates and supports concurrent drug utilization review (DUR) functions that allow for the review and monitoring of the cost-effectiveness, interaction and resulting therapeutic implications of various drugs. By incorporating AmeriHealth Mercy's formulary guidelines and parameters into the Argus system, AmeriHealth Mercy is better able to effectively administer the formulary, and to ensure appropriate pharmaceutical products and services are being provided to our members.

Oversight and Monitoring of the Pharmacy Claims Processing Vendor

AmeriHealth Mercy's oversight and monitoring of Argus begins with the agreement between the parties. Our agreement with Argus describes the scope of services to be performed, performance expectations, reporting responsibilities, and consequences for failure to meet the contract requirements, which include corrective action and/or sanctions, up to and including contract termination. AmeriHealth Mercy conducts an annual review of Argus' policies and procedures and documentation of quality activities, as well as an annual review of Argus' compliance with contractual requirements and policies and procedures. Argus also provides routine monitoring and oversight reports. Weekly and ad hoc meetings are conducted to review and monitor the current state of claims processing and address requested changes or updates to the system.

Encounter Data Oversight

Argus submits monthly encounter files in the NCPDP format by the fifth business day of each month for claims adjudicated in the prior month. Like all subcontractor encounter files, the Argus encounter files must pass the internal pre-edit process prior to our submission of the files to the Department of Public Welfare/EDS. Our pre-edit process validates that header control totals match claim detail counts in the file, and that the file was not previously sent to DPW. In addition, pre-edits validate that all required segments are preset, as well as the Submitter ID, NPI number, and other critical data elements. Any files that fail the validation process are returned to Argus for correction and resubmission within four business days.

Following submission of the encounter files, we forward the NCPDP response file returned by EDS to Argus. Argus documents all encounter rejections and reports this information by error code, rejection counts, and dollar value. AmeriHealth Mercy then works with Argus to discuss a plan of action to correct and resubmit the rejected encounters to DPW.

AmeriHealth Mercy's agreement with Argus includes performance metrics for the timely, accurate and complete submission of encounter data. The agreement also provides for the

submission of corrective action plans, and/or the application of sanctions, up to and including contract termination, if we identify problems with the quality of their encounter submissions. AmeriHealth Mercy has not imposed sanctions on Argus related to encounter data submission at any time during our eight-year contractual relationship. Each month, AmeriHealth Mercy tracks the total claims sent to DPW/EDS, and the total accepted and total rejected, to calculate an acceptance ratio. We monitor this information to verify that the volume of submissions is consistent from month to month, and the acceptance rate does not fall below standards. For 2010, the Argus monthly average acceptance rate was 99%.

We currently have a process to retain and submit PROMISe ICNs for previously submitted encounters that require correction or resubmission. We have been providing reports for PROMISe ICNs pharmacy encounters since 2009.

Fraud and Abuse Oversight

As indicated above, AmeriHealth Mercy conducts an annual review of Argus' policies and procedures and documentation of quality activities, as well as an annual review of Argus' compliance with contractual requirements and policies and procedures. Argus also provides a set of standard monitoring reports that, together with our annual reviews, would help to alert us of possible fraud or abuse.

Additionally, AmeriHealth Mercy has direct 24/7 web-based connectivity to the Argus claims processing system. This allows us to monitor Argus' work remotely and interface with their real-time claim adjudication system. This interface also provides AmeriHealth Mercy with access to the near real-time data in the Argus data warehouse, from which we can perform our own ad hoc claim reviews, run queries and export data to other applications, and generates reports. AmeriHealth Mercy also has the ability to make real-time adjustments or changes in the Argus claims processing system to assist pharmacies in processing point-of-sale transactions.

In addition to our oversight of Argus' performance, AmeriHealth Mercy carefully monitors member prescription patterns, prescribing patterns of physicians, and dispensing practices of network pharmacies, to identify potential circumstances of fraud, waste, or abuse. All potential issues are shared with our Special Investigations Unit for investigation and appropriate follow-up action. Our Fraud, Waste, and Abuse Identification and Prevention program is comprised of the following programs: Drug Utilization Review, Pharmacy Network Auditing, and Recipient Restriction.

- **Retrospective DUR -** Retrospective drug utilization review program provides systematic review of drug utilization and prescribing patterns to ensure member prescriptions are appropriate, medically necessary, and unlikely to result in adverse medical effects.
- **Pharmacy Network Auditing Program** - Our pharmacy claims auditing program is designed to protect against fraud, misuse and abuse at the pharmacy level. Aside from the educating of pharmacy personnel on the proper use and implementation of correct procedures for claims submission, the goal of the process is the identification and verification of aberrant claims and patterns leading to the recovery of funds and the prevention of future Fraud, Waste and Abuse. Pharmacies are selected for auditing by a combination of paid claims data analysis, exchanged or gathered tip information, and our on-site pharmacy audit programs
- **Recipient Restriction Program** - Under this program, identified members must obtain prescriptions from a specific physician or pharmacy to ensure proper prescription

compliance. We offer real-time capability to change a member's physician and/or pharmacy if necessary.

Outpatient Pharmacy Claims Processed Through the Medical Benefit

A small number of outpatient pharmacy claims are billed and adjudicated under the medical benefit using HCPC codes. The types of outpatient pharmacy claims processed through the medical benefit include: oncology infusions, including blood cell stimulator agents, hemophilia treatments, and intravenous agents administered in conjunction with home nursing care such as antibiotics.

Currently, medications billed in this manner by participating providers do not require authorization for payment. However, many of these medications are submitted in conjunction with other medical services, such as home nursing care, that do require authorization. In these instances, our utilization management department reviews the request for the medical service and an approval of the medical service is considered to be a proxy approval of the medication.

QUESTION 5

Describe your specialty pharmacy program. Describe your future plans, including plans to purchase and effectively manage specialty drugs.

(Limit to three pages)

RESPONSE TO QUESTION 5

AmeriHealth Mercy's in-house specialty pharmacy program is designed to foster appropriate utilization of self-administered injectables and physician-administered specialty drug products, while controlling the cost of these high-cost medications. Our program has achieved significant cost reductions on a per-member-per-month basis over the past few years, despite rising drug prices and, in some cases, increasing utilization. These cost reductions have been achieved by implementing the following:

- Competitive drug acquisition price negotiation
- Oversight of office-based injectable prescribing
- Specialty network management
- Dedicated specialty injectable staff
- Effective utilization management programs
- Inventory management at the patient level
- Detailed policies to scrutinize billing

Our specialty pharmacy unit is comprised of individuals trained in specialty medication utilization management techniques. The unit includes pharmacists, nurse case managers and certified pharmacy technicians.

Unlike many specialty pharmacy programs, we do not generate profit or revenue, other than rebates, from the distribution or sale of specialty/biotechnology drugs. Because we manage our specialty pharmacy program in-house, all savings generated from our program result from appropriate utilization, competitive drug acquisition price negotiation, and inventory management.

Our focus is on assertive price negotiation, careful oversight of office-based injectable prescribing, effective network management, and staff dedicated to specialty injectables and effective policies put in place to scrutinize billing.

Evidence of our success in this area is demonstrated through:

- Comprehensive utilization management and checks for patient safety and compliance, plus cost-effectiveness
- Rigorous clinical review based on approved usage protocols
- Measurable waste reduction through stringent Prior Authorization screening
- Expert specialty network management
- Highly capable electronic claims adjudication

In addition, AmeriHealth Mercy has implemented carve-out programs to review high-cost specialty medication use in the hospital and/or physician office setting. One such program monitors the off-label use of the hemophilia agent, NovoSeven. This product is often used off-label for many conditions where there is little or no clinical data to support such use, generating considerable, inappropriate expenditures. Through this program, each claim is reviewed by a medical professional based on criteria that was developed by reviewing the medical literature and practice guidelines, virtually eliminating inappropriate utilization patterns.

The following is an outline of our major action steps that have aided in the creation of a successful specialty pharmacy program and will continue to provide value into the future:

- Re-crafted reimbursement process
  - Mandated claims submission through the pharmacy benefit
  - Required use of J-codes
- Formulated a cost-effective supply chain distribution system
  - Negotiated discounts/rebates
  - Channeled distribution through lowest cost specialty vendor
  - Pre-determined reimbursement or injectable drug replacement program options for physicians
- Implemented rigorous point-of-service 'hard' edits and prior authorization criteria across several products
  - Reduced inappropriate length of therapy and utilization
  - Developed hundreds of evidenced-based and clinically appropriate specialty injectable prior authorization protocols
  - Incorporated evidenced-based clinical studies and guidelines
- Staffing Upgrades and Training
  - Upgraded the specialty pharmacy team which is now comprised of pharmacists, technicians, nurse, and support staff experienced with biopharmaceuticals and injectable products in key therapeutic areas
  - Integrated Pharmacy/Nurse case management oversight
  - Continued education ranging from new biopharmaceuticals to system applications

AmeriHealth Mercy's approach emphasizes the involvement of care management departments, disease management teams, and providers (medical and pharmacy) to engage members in care management. This approach has enabled us to overcome barriers to care such as medication adherence issues, difficulty in locating members, inappropriate use of the emergency room, and cultural differences.

Future Plans - Pay for Performance

We implemented pay for performance programs specifically for specialty management in the Southeast Zone that may be applicable in the new zones. This innovative program incorporates medical and pharmacy resources to provide a seamless management strategy that promotes clinically appropriate and cost effective treatment. Participating providers are encouraged to follow agreed upon treatment pathways that are designed using best practice guidelines. These providers would then be eligible to earn incentives for achieving adherence to the pathways. This program has the potential to generate cost savings while ensuring that members are treated safely and effectively.

QUESTION 6

Describe how your pharmacy claim information is coordinated with medical claim data to provide comprehensive care management.

(Limit to two pages)

RESPONSE TO QUESTION 6

Our integrated care management strategy is data driven and relies on all available data streams including medical, pharmacy, vision, dental, and lab to ensure the best possible member outcomes. This integration is for our care managers and prior authorization staff to access on a case-by-case basis as well as in our backend data reporting systems where we monitor cost and utilization trends as well as generate quality and cost containment initiatives.

Desktop Applications

One of the best examples of this interaction is the AmeriHealth Mercy Desktop Pharmacy Application. This comprehensive resource was built internally to support our care coordination efforts and is refreshed on a weekly basis to ensure access to the latest claims information. Associates are able to use this application to generate a six month medication profiles including the medication possession ratio compliance calculation for either internal use or distribution to a provider. In addition there are direct links to formulary information, prior authorization criteria, third-party patient assistance programs, drug information resources, searchable tables of DME products billable via Argus for hard to find items, and finally pharmacy gaps in care.

Currently, our application identifies eleven pharmacy care gaps that can be accessed in a variety of ways for individual case management or population management through provider and member notifications. Below are some brief details of each of the care gaps. In order to provide broad notification of these pharmacy care gaps to our providers and members, four of the eleven pharmacy care gaps have been integrated with our medical care gaps for provider and Member Services. In 2010, we loaded the ACEI or ARB for diabetics, lipid lowering therapy for members with high cholesterol and the asthma monotherapy measure. In 2011, the test strip measures as well as the acute coronary syndrome measures discussed below were added.

Outreach

In 2009, AmeriHealth Mercy began a member and provider outreach to increase the percentage of our members with recent acute coronary syndrome (ACS) events (heart attack or severe, heart related chest pain) receiving the five medication categories recommended by the ACC/AHA guidelines for secondary prevention. Since the greatest risk for a second event is shortly after the primary event, we identify these members through data captured by our concurrent review nurses rather than waiting for paid claims data. Medication fills for these members are then evaluated for usage of the five recommended medication categories. Members who are missing one or more of these categories receive a letter educating them about the importance of receiving all components of this regimen to decrease the risk of another event and encouraging them to speak with their provider. Simultaneously, the member's provider receives a letter informing them that the member is missing one of the guideline recommended medications as well as a pre-populated prescription template displaying both the most recent fill dates of medications the member is receiving and our covered formulary options for those the member is not.

As a result of this program we have seen the number of members diagnosed with an ACS event receiving none of the recommended therapies decrease from 24% to 11% while the number of members receiving all five medications has increased from zero to 14%.

We have also successfully combined our medical and pharmacy data for our automated telephonic refill reminder program. This program identifies members receiving medications to treat asthma or behavioral health conditions who have a proven history of filling their

medications late. To further identify the members at highest risk of experiencing and adverse outcome due to their non-compliance we then evaluate this list of members for those who have had three or more emergency room visits in the past twelve months. This list of high risk members is then enrolled into a proactive automated telephone outreach program which contacts the member when their prescription is due to be refilled and provides the option to warm transfer them to their pharmacy to place a refill request.

Finally, we are launching a pilot with NaviNet Mobile Connect to display both medical and pharmacy gaps in care directly to the clinician on a hand-held PDA during their office visit with a patient. The NaviNet Mobile Connect gives providers e-prescribing software as well as PDAs to aid them in creating operational efficiencies in their office while being able to access pertinent patient and medical information available through NaviNet. By moving care gap information from the front office staff into the hands of the clinician, we can more effectively convey our care gap information at the most appropriate time during the clinical decision making process.

Looking Ahead

Looking to the future, technology will enable us to make our integrated data "powerful" enough to reduce administrative burden and improve member care. For example, as we make further strides in acquiring and integrating lab data we may be able to streamline the prior authorization process by auto approving requests where a lab value is the main determining criteria (e.g. Hepatitis C viral loads) and is already known in our claims database. In addition, as we explore the development of quality-based pharmacy, provider and facility contracting, where reimbursement is variable based upon the quality of the care provided, pharmacy metrics such as formulary compliance, generic utilization rate, and medication adherence may be key elements in the scoring and ranking system.

QUESTION 7

Describe how you will use the CMS Drug File to ensure access to all drugs covered under the MA Program and compliance with data reporting requirements for the Federal Drug Rebate Program.

(Limit to four pages)

RESPONSE TO QUESTION 7

As a current managed care organization, AmeriHealth Mercy is already in compliance with the Department's requirements regarding the CMS Drug File and the Federal Drug Rebate Program data reporting. On a quarterly basis, we obtain and process the CMS Drug File. In 2011, we began submitting monthly supplemental rebate files to DPW with an encounter acceptance rate that exceeded, and continues to surpass, 96%. Our rebate and encounter data submission team remains committed to meeting all requirements for reporting of Federal Rebate Program data as required by DPW and CMS now and in the future.

CMS Drug File

In order to ensure access to all drugs covered under the MA Program, and compliance with data reporting requirements for the Federal Drug Rebate Program, AmeriHealth Mercy downloads the CMS Drug File quarterly and supplemental rebate reporting file as soon as it is made available. In addition, we receive regular systems notices from DPW regarding updates to the Participating Drug Company List for the Medicaid Drug Rebate Program and MCO Pharmacy Encounter Data NDC Updates. As detailed below, we created a two-stage internal process to expeditiously review and address these changes.

Stage One

AmeriHealth Mercy identifies any medications that are no longer covered by the MA program. Claims history of these medications is analyzed to determine the impact to our existing membership. When the analysis has been completed, a recommendation is made to our clinical team and chief medical officer for their review. Upon acceptance of the recommendation, the proposed formulary changes are prepared and presented at the next Pharmacy and Therapeutics (P&T) Committee for approval. As per our policies and procedures, as well as DPW requirements, affected members are informed via mail of the impending formulary change and provided a 60-day grandfather period before their medication therapy is discontinued. Affected members are encouraged to speak to their provider about alternative medication therapies to use.

Often, a medication is removed from the drug file because the manufacturer no longer participates in the Federal Drug Rebate Program. In this instance, a different manufacturer's medication product of the same ingredient and strength generally remains available on the drug file, allowing members to make a nearly seamless transition.

Stage Two

AmeriHealth Mercy identifies any medications that have been added to the MA Program. These products are immediately available to our members via the prior authorization process. The new medications are reviewed by our clinical pharmacy team and their recommendations to exclude or include the medications from the formulary are presented to our P&T Committee for approval. Once reviewed by the P&T Committee, medications recommended for inclusion on the formulary are made available to members with no prior authorization. Medications that were not recommended for formulary inclusion will continue to be available through the prior authorization process.

Federal Drug Rebate File

AmeriHealth Mercy's pharmacy benefit manager provides rebate contracting services to commercial, Medicaid, and Medicare clients. They are experienced in supporting a wide range of

rebate data, reporting standards and regulations to ensure timely and accurate compliance to all federal and state requirements.

AmeriHealth Mercy's current supplemental rebate encounter files meet all requirements for NCPDP 5.1 standards, including the updates released in the fourth quarter of 2010. We are confident that our staff is able to generate file formats and create production and delivery schedules that will meet all future federal and state rebate reporting requirements. We continually strive to increase automation and generate operational efficiencies, and are working towards streamlining these processes in the future.

PLANNED APPROACH

CONTENTS

QUESTION 1

Describe in detail how you will develop your network and set up operations capable of supporting membership and meeting requirements of the RFP and draft Agreement, no later than three months prior to the anticipated implementation date of 9/1/12 in the NW Zone and/or no later than three months prior to the anticipated implementation date of 3/1/13 in the NE Zone.

Describe your approach for meeting the requirements and include:

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

(Limit to five pages)

RESPONSE TO QUESTION 1

As a longtime Pennsylvania HealthChoices Managed Care Organization, AmeriHealth Mercy Health Plan (AmeriHealth Mercy) has a proven track record for developing provider networks and implementing operations that provide quality service to Pennsylvania Medicaid consumers. We serve as a partner to the provider community and an advocate for our members, and will expand these roles to meet the unique needs of the New West and New East Zones. Using our established provider networks and health plan operations as the foundation for the new zones, we will build on that base to support the membership and meet state requirements prior to June 1, 2012, for the New West Zone, and prior to December 1, 2012, for the New East Zone. This will allow us to quickly expand our existing reach and execute the unique needs of the new zones.

Our project management methodology has proven successful in previous network development and business activation projects and will be described in detail after our network and operations overview. This methodology has most recently been utilized in an expansion opportunity in Louisiana, in which AmeriHealth Mercy successfully completed a readiness review and met 100% of the 906 operational requirements of that state's regulatory agency. In addition, the network development team for that state has built a solid network of over 6700 rural and urban provider locations in only six months.

Network Development Plan

AmeriHealth Mercy's approach to network development is inclusive rather than exclusive. We strive to contract with all available hospitals and physicians who meet our credentialing standards. As part of our mission to build healthy communities, we contract with community-based providers, with particular attention to those who are culturally competent and understand the backgrounds and needs of our members. Our network management staff is working throughout Pennsylvania, meeting, educating and recruiting physicians, hospitals, FQHCs, RHCs and ancillary providers. We are aggressively implementing our provider network development plan and will continue to add providers to the network to ensure the best possible access for our future members.

AmeriHealth Mercy's implementation plan for the development of the network in the New West and New East Zones is included in the response to Question 2 of this section. The plan details our approach to the contracting, education, and ongoing management of a robust provider network prepared to meet the needs of Pennsylvania's Medicaid members, providers and communities, as well as what is required for the Readiness Review. Highlights of the Provider Network Development Plan are identified in Table 1, including the individuals responsible for the activities.

Table 1: Provider Network Development Plan

Actions	Party Responsible	Due Date (NW/NE)
Identify Medicaid Providers	Steve Orndorff	Complete
Obtain LOI's and Provider Contracts	Steve Orndorff	Ongoing
Finalize Provider Manual	Denise Kirkham	In progress
Finalize Policies	Benetta Rapier	In progress
Create Provider Directory	Scott Stroman	July 2012/January 2013
Host Provider Workshops	Benetta Rapier	October 2012/April 2013

In anticipation of being awarded an agreement for both the New West and New East Zones, we formed a cross-functional team with employees from our existing AmeriHealth Mercy Health Plan, located in Harrisburg. Our goal is to assure access to care in rural Pennsylvania and identify opportunities to reduce the administrative burden on our providers during both the recruitment phase and ongoing operations. We were able to launch our provider network recruitment with relative ease because of our strong relationships with providers in our existing 15 county service area.

Operation Set-Up

As an existing HealthChoices managed care organization in the Lehigh/Capital Zone, AmeriHealth Mercy currently has a fully-functional operational model that encompasses all back office services, including but not limited to: call centers, claims processing, auditing, and technology infrastructure, as well as all policies, procedures, processes and staff to perform the full set of HealthChoices requirements. Our focus for the New West and New East Zones will be to expand the capacity of existing operations to serve additional membership and meet any and all unique requirements for these zones. Our existing AmeriHealth Mercy management team will partner with our New Business Activation (NBA) team to identify and implement all necessary work for this expansion. The NBA team is a group of subject matter experts from every discipline within the company that works with the business leaders and the enterprise project management office to ensure the flawless execution of each new business opportunity. Using the project management methodology described below, the team will coordinate all activities necessary for successful implementation of these new Pennsylvania contracts.

Project Management Methodology

AmeriHealth Mercy's project management methodology provides a framework for the project deliverables for the New West and New East Zones, ensuring consistency and completeness. It provides a structure for an efficient, effective, and predictable quality outcome. AmeriHealth Mercy's Enterprise Project Management Office's (EPMO's) methodology is based on industry standards of best practices and an established project management methodology made up of eight individual phases, see Figure 1:

Figure 1: Project Management Methodology

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

Our Project Management Methodology is built on the following principles:

- Consistent utilization of industry standards of best practices in project management methodologies
- A dedicated project management team with more than 250 collective years of project management experience
- A stable and predictable implementation staffing model
- Effective and accurate communications focused on building strong relationships with the Department of Public Welfare's (DPW) personnel
- Management of a comprehensive communication plan (see Attachment 1)
- Execution of a detailed implementation work plan
- Rapid identification, quantification, and resolution of project issues
- Development of comprehensive contingency plans to address project risks

The New West and New East Zone project team, with support from the EPMO, has developed a detailed implementation plan governed by leaders representing key functional areas. The project team and local management are led by:

- **Dr. Jay Feldstein**, who has had a distinguished, two-decade career in health plan administration and clinical leadership and is the Regional President responsible for Pennsylvania health plans
- **Marge Angello**, AMHP's current Executive Director, who is based in the Harrisburg area and has over 25 years of clinical and operational experience serving Pennsylvania residents
- **Joanne McFall**, VP and Chief of Staff for the AmeriHealth Mercy Family of Companies, who has 20 years of experience in project execution, technology application, and implementation of AmeriHealth Mercy's strategic plan.

In addition, our project team and the EPMO have begun executing itemized tasks in our comprehensive work plan (see Question 2), which covers all aspects of the implementation, including preparation for the Readiness Review.

Issue Identification, Assessment, Alternatives and Resolution

Throughout the lifecycle of each implementation project, AmeriHealth Mercy utilizes an issue resolution process that dictates how issues are identified, documented, assigned, and resolved during the course of the implementation. This process defines the level of information that must be captured for each issue in each step of the process. Issues are prioritized based on the level of potential impact and magnitude of the issue as it relates to the schedule, a specific state

requirement, or level of functionality. Throughout the life of the project, issues are identified by various members of the implementation team. These issues are identified and captured in an issue log.

As issues are identified, the Project Management Team performs an impact assessment and analysis of each identified issue to determine its downstream effects and severity on the implementation. All issues that impact the project are addressed in a timely manner using the following guidelines:

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

In the event that the resolution of an issue results in a change to the project scope, schedule, and/or budget, a formal change management process is followed. The change request includes documentation of a detailed reason for the change, associated costs, resources needs, internal and/or external impact to the project or other projects, and any new dependencies or assumptions. The request must be accompanied by a realistic contingency plan. The Governance Team performs a preliminary review of the request and, if approved, forwards the request to the appropriate member of senior management for final approval.

Resource Allocation and Deployment

Our EPMO has a well-defined, enterprise-wide, demand management process that enables us to analyze the complete enterprise portfolio of project work including an assessment of our resources and a deployment of those resources across all of our lines of business. This includes projects already in progress as well as new requests to determine the value and impact across the organization.

As business needs and priorities change, the demand management process provides the framework for comparing new requests against the existing body of work based on strategic value, risk assessment, cost/benefit, net gain, and resource impacts to staff and infrastructure.

Each new project requires a documented business justification and resource analysis. The process ensures that there is an adequate supply of subject matter experts from across our business and operations areas, as well as technical experts available when needed during the course of the implementation.

Reporting of Status and Ensuring Accuracy of Information

AmeriHealth Mercy believes that effective communication is the cornerstone to maintaining and growing our strong collaborative relationship with the Commonwealth of Pennsylvania. If awarded additional contracts, we will utilize our existing relationships with DPW and build new implementation-specific relationships to establish a regular communication and reporting plan. Components of this plan will include twice-weekly conference calls with DPW, written status reports, and other reporting mechanisms as established by the team.

In addition to the conference calls and written status reports recommended above, we suggest other reporting mechanisms such as regularly scheduled and ad-hoc reports as well as live,

interactive meetings and site visits. Examples of such reporting mechanisms include, but are not limited to:

- Detailed Implementation Plan Reporting - The work plan will be used to create a comprehensive management report, detailing project scope, status, staffing, and timelines.
- Risk Management & Issue Reporting - This proactive process will be used to identify critical issues needing to be addressed in an escalated or expedited manner. Using a proprietary, custom-made database, AmeriHealth Mercy will be able to provide real-time updates to both internal and State staff.
- Site Visits and Meetings - The Executive Director and Implementation Project Manager will meet with DPW as necessary to facilitate effective communications.
- Ongoing Operational Reporting – Upon timely completion of the New West and New East implementations, we will continue our regular reporting to DPW based on the reporting structure that is in place for our current contracts.

Assuring Accuracy

Our success in completing accurate reports is due largely to the front-end work of our Statutory Reporting unit and the quality assurance mechanisms it has established. Our Statutory Reporting unit works very closely with other internal departments to develop report specifications that identify supporting systems, data requirements, reporting periods, and appropriate coding documentation needed to meet all reporting requirements. Based on the outcome of that research, a technical solution is developed to extract the required information from the most appropriate data source for the particular report. The Statutory Reporting unit audits each report for accuracy and to ensure that the report is in the exact format specified.

Prior to submission, all reports are subject to review and approval by Statutory Reporting/Finance management and the appropriate internal business owner(s). Once the report generation process is stabilized and verified, detailed report documentation is created and subsequently tested by the Statutory Reporting unit. This documentation serves to ensure consistency and continuity between reporting periods and to support the cross-training of staff. Hard copies of all report submissions and supporting documentation are maintained in central files and copies of all computer files are stored under discrete directories on a network drive that is backed up each evening.

QUESTION 2

Provide a work plan for implementation. At a minimum, the work plan should include:

- *A description of all activities necessary to obtain required contracts for your provider network as specified in the draft Agreement; and*
- *An itemization of activities that you will undertake during the period between notification of selection to proceed to Readiness Review and the implementation date of 9/1/12 in the NW Zone and/or the implementation date of 3/1/13 in the NE Zone. The activities shall have established deadlines and timeframes.*

(Limit to four pages)

RESPONSE TO QUESTION 2

Overview

Detailed project planning and execution are the keys to the successful implementation of a program of this magnitude. AmeriHealth Mercy's comprehensive implementation plan lists all tasks, timelines and resources necessary to meet the State's implementation requirements and timelines for each zone and is included as Attachment 2. In addition, we will work closely with the State and partners throughout the implementation to ensure a smooth transition for all impacted members, providers, and other stakeholders.

AmeriHealth Mercy has a standard work plan and implementation structure, which we have successfully used in other markets. The plan will be tailored to integrate the New West and the New East into our existing operations in the Lehigh/Capital Zone. This plan and structure have been refined after each implementation from our lessons learned and feedback we received from the States. Based on the RFP requirements and timelines, a separate work plan will be created for each zone, although the tasks will be essentially the same for both. Throughout the implementation, AmeriHealth Mercy will also involve consumers, providers, and other stakeholders in this important effort. Our goal is to implement the program in a manner that is sensitive to the local needs and not simply a "cookie-cutter" managed care approach.

The work plan identifies all tasks necessary to meet the RFP requirements, with associated timelines and key personnel. Each task has a specified owner who is accountable for ensuring timely completion of the task, communication with other task owners and project teams, and escalation of issues as needed. The work plan also outlines the specific tasks that will be performed to contract and configure the Provider Network as well as all activities needed to certify readiness.

Network Management Development

As described in Question 1, AmeriHealth Mercy has a robust plan in place for the identification, recruitment, contracting and education of the comprehensive provider network necessary for providing access to all members in the New West and New East Zones. The activities listed in the Provider Network Management section of the Work Plan have already begun, and will continue throughout the implementation.

The provider network development activities began in the fall of 2011 with outreach to key providers known to AmeriHealth Mercy throughout the area and identification of all other providers necessary to form a comprehensive network to support member access to care. The AmeriHealth Mercy contracting team then began contacting providers via letters, telephone outreach and in-person office visits to introduce the organization and begin contracting activities.

See Table 2 for key components of the provider network management section of the work plan:

Table 2: Key Provider Network Management Components

Task	Start Date	NW End Date	NE End Date
Establish team and document network strategy	October 2011	November 2011	November 2011
Develop provider outreach list	November 2011	December 2011	December 2011
Create and distribute provider recruitment materials	December 2011	December 2011	February 2012
Establish data collection and credentialing workflow	December 2011	January 2012	January 2012
Conduct outreach activities and obtain signed contracts	December 2011	August 2012	February 2013
Produce regular Geo Access and status reports to monitor adequacy as network is developed	February 2012	August 2012	February 2013
Finalize New West and New East provider network management policies and procedures, based on existing materials	March 2012	May 2012	May 2012
Finalize Provider Manual, including DPW review component	March 2012	May 2012	May 2012
Configure batch processes, interfaces and workflows that will be used to share data with DPW and the enrollment broker	March 2012	June 2012	December 2012
Conduct provider education sessions	May 2012	October 2012	April 2013
Implement ongoing provider relationship management process	July 2012	August 2012	February 2013

Project Activities through Readiness Review

Each zone has its own implementation plan. The management processes and tasks are similar and each accommodates their respective anticipated timelines. Table 3 provides a brief overview:

Table 3: Implementation Plan Overview

Zone	Estimated Start	Implementation Date	Estimated Duration
New West	3/5/2012	9/1/2012	< 6 months
New East	9/1/2012	3/1/2013	6 months

In order to meet the New West implementation date of September 1, 2012 and to ensure high quality, AmeriHealth Mercy has already begun our pre-planning process as part of this RPF response. We are confident in our ability to meet the aggressive timeline for the New West Zone implementation because of our experience in Pennsylvania and the quality of our proven project management processes and experiences.

AmeriHealth Mercy's detailed work plan was developed utilizing a standard project mythology. The specific phases include: pre-initiate, initiate, planning, design, development, testing, stabilization and monitoring. Table 4 below highlights phases, timelines and major milestones for this implementation:

Table 4: Milestones for Implementation

Phase	Milestone	NW Timeline	NE Timeline
Pre Initiate	Initiate network development activities (including subcontractors) Implement project management structure and develop Work Plan Submit RFP response	10/1/11 – 3/5/12	10/1/11 – 3/5/12
Initiate	Receive RFP award Activate Project Team Receive State approval of Work Plan Schedule ongoing State meetings (Core Team, enrollment broker, financial intermediary, etc.) Begin employee recruitment	3/5/12 – 4/2/12	3/512 – 4/2/12
Planning	Finalize business and system functional requirements Initiate marketing and member outreach campaign	3/15/12 – 4/15/12	3/15/12 – 8/15/12
Design	Complete network development activities Finalize system design (Architecture) Complete policy, procedure and workflow design	4/15/12 – 5/15/12	8/15/12 – 9/17/12
Development	Complete all system configuration	5/15/12 – 6/1/12	9/17/12 – 12/1/12
Testing	Finalize all system integration and user acceptance testing Complete testing with subcontractors and State agencies Complete State readiness review (system and operational)	6/1/12 – 9/1/12	12/3/12 – 3/1/13
Stabilization	**Go Live**	9/1/12 – 10/31/12	3/1/13 – 4/30/13

Phase	Milestone	NW Timeline	NE Timeline
	Repair all defects and address any open issues Begin member mailings, welcome calls, outreach efforts and transition planning		
Monitoring	Review all key performance indicators	11/1/12 – 12/31/12	5/1/13 – 6/30/13

Operational and System Readiness Review

AmeriHealth Mercy has a strong, stable and proven Readiness Review process that encompasses all organizational functions, as seen in Attachment 3. This process includes the review of the following components and artifacts to ensure they meet state requirements and federal regulations:

- Operational policies, procedures and workflows
- Network adequacy reports and provider listing, as well as periodic network status reports
- Member materials (handbook, marketing materials, disease management materials, phone scripts, and sample ID card) and outreach processes
- Provider materials and communication strategies, including the Provider Handbook
- Marketing strategy
- Staffing models and proposed staffing levels
- Member, provider and staff training approach and materials
- Medical management protocols, policies and procedures
- System applications to support key functions and associated testing plans
- System security and control processes , as well as results of recent audits
- Disaster recovery and business continuity plans, as well as results of recent tests

In the spring of 2011 AmeriHealth Mercy was awarded the statewide physical health MCO contract for the State of Louisiana. Readiness review activities began 30-days post contract award and we recently received notification that we have completed 100% of the readiness review requirements ahead of schedule. Of over 900 requirements, 99% were certified complete at the initial submission.

As a result of our current experience in the Pennsylvania HealthChoices program, a majority of the required materials have already been developed and will only need to be modified to meet the specific needs of the New West and New East Zones.

Our process includes the following steps: document development, internal review and editing, document revisions and formatting, functional leader approval, submission to DPW, edits and revisions per DPW comments and resubmission for approval. In addition, we will enhance our standard system and functional presentation and system demonstrations for an onsite review. Although our process is simple, the keys to our success are the direct results of having the appropriate version control process in place, proven processes and procedures, appropriate management oversight at the right level, adequate resources and ability to respond to any defects quickly.

Provider Network Composition and Network Management

Contents

QUESTION 1

Explain your plan to ensure that your provider network meets the network and access requirements in the draft Agreement. Specifically include:

- *The method you plan to use on an ongoing basis to assess and ensure that network standards outlined in the draft Agreement are maintained for all provider types.*
- *Describe your process for continuous improvement in your network over and above contract compliance.*
- *Describe how you will ensure that appointment access standards are met when members cannot access care within your provider network and must go to an out-of-network provider?*
- *Describe how you will collect and record language needs for those consumers with limited English proficiency and how you will ensure all written notices are language appropriate.*
- *Describe how you will educate and coordinate interpreter services with your network providers.*

(Limit to six pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy's experience with serving Medicaid enrollees in Pennsylvania for nearly 30 years makes it uniquely qualified to build an expansive provider network and to ensure that its provider network meets all of the State's network and access requirements. We have developed a proven process to ensure we can quickly implement a comprehensive provider network that not only meets – but exceeds – DPW's requirements. Our plan for the New West and New East network was established based on the following critical elements:

- The anticipated Medicaid enrollment and expected utilization of services, considering the characteristics and health care needs of particular Medicaid populations
- The numbers and types of providers required to supply the contracted Medicaid services
- The numbers of network providers who are not accepting new Medicaid patients
- The geographic location of providers and members, considering distance, travel time, and commonly used means of transportation, and provisions for physical access for members with special health care needs

Assessment of Network Adequacy

AmeriHealth Mercy monitors network adequacy against the State's access to care standards on a frequent basis in the months prior to and after program implementation. Minimum network adequacy is determined by utilizing Geo Access mapping. Geo Access mapping is used to define our statewide comprehensive networks for: hospitals, including children's, tertiary care and critical access hospitals, PCPs, specialists, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as well as other providers as necessary to meet Exhibit AAA(1) requirements for Network Composition/Service Access.

After the network has been stabilized, PCP networks are monitored on a monthly basis. Specialty networks and other provider networks are monitored at least quarterly thereafter, using Geo Access mapping. In addition to the regularly scheduled assessments, we also prepare Geo Access reports any time there is a significant change in the provider network that could negatively impact access to care. Should a gap be found or predicted based on expected provider changes or membership growth, an outreach plan is created that includes targeted provider recruitment, or as appropriate, outreach to currently contracted providers to ask them to accept more members.

Continuous Improvement of Our Network

Continuous improvement in the New West and New East provider networks will be critical to assuring adequate access in rural areas. We have several initiatives we are considering as strategies to drive continuous improvements of our network if necessary.

Provider Incentive Programs

These programs will be tailored to incent the providers to improve access and/or improve specific health outcomes. As part of the incentive programs, we give information to the providers, in individualized reports, regarding how they compare to their peers on a variety of measures. For example, the report may compare how the physician compares to other physicians with regard to prescribing generic medications, or on specific HEDIS measures.

Mobile Services

AmeriHealth Mercy will continue our practice of going into the community where our members reside, to offer mobile services. For example, we have an existing contract with a mobile

mammography company, Lackawanna Mobile Diagnostic Services. We have already reserved dates to offer mammograms to our members in the New West and New East.

Telehealth Programs

Telehealth programs are necessary to expand access. For example, we have a telehealth program for members with heart failure. Participating members monitor their daily weight fluctuations - a key indicator of heart failure - and blood pressure using a digital weight scale and a blood pressure monitor. The wireless telemedicine device easily and automatically stores and sends health information to designated medical professionals, enabling them to make timely decisions that can prevent unnecessary hospital stays. Home Agency staff utilizes these opportunities as "teachable moments" with our members, especially when symptoms are most acute.

Health Navigators

We will also use Health Navigators in the rural counties. Nurses, specially trained outreach coordinators and other professionals serve as Health Navigators and act as a liaison between the member, provider and health plan. Our Health Navigators are poised to conduct health education sessions at locations in each county. In the rural communities of Luzerne, Lackawanna, Monroe, Carbon and Pike counties that we currently serve, AmeriHealth Mercy conducts this type of educational programs at a variety of community locations such as Friends of the Poor, Salvation Army and the Community Intervention Center.

Meeting Appointment Access Standards

Providers are contractually required to meet standards for timely access to care and services, taking into account the urgency of the need for the services. In a practitioner's absence, the patient must be instructed, via an answering service or a telephone answering machine, on how to reach their PCP or an approved practitioner providing 24-hour coverage. In addition to the standards being communicated in a provider's contract, access and appointment availability standards are routinely communicated via the provider manual (also available on line), provider website, on-site orientation of new providers, ongoing training and the provider newsletter.

Once the accessibility standards have been communicated to providers, follow-up contact with the providers ensures that the member's experience is consistent with these standards. Compliance with the accessibility standards is monitored through a number of tracking and reporting vehicles. We track calls from members related to dissatisfaction with appointment and wait times. Individual complaints are forwarded to the Provider Contracting Representative assigned to the provider for investigation and resolution. In addition, aggregate complaint data related to dissatisfaction with appointments and wait times is trended to identify physician offices with repeated problems.

We also conduct assessments via "Secret Shopper" surveys, as well as provider audits. "Secret Shopper" calls allow us to directly experience the response from the physician's office that our members receive. For this assessment, we call physician offices after normal business hours to verify whether members who call at this time are able to reach a physician, if necessary. We also audit provider scheduling records to determine the availability of the next appointment for preventive, routine, and urgent care. During on-site visits, we monitor office wait times.

Providers who are non-compliant with any of the accessibility standards are notified of our findings by their Provider Contracting Representative and re-instructed regarding the standards. The assigned Provider Contracting Representative schedules another monitoring event, either an

on-site visit to monitor office wait times, a "Secret Shopper" call to check appointment availability, or an after-hours call to verify the availability of the practitioner.

Offices that are non-compliant during repeated monitoring attempts are required to prepare and implement a corrective action plan. The Provider Contracting Representative monitors the implementation of any correction action and reports the results to the Quality Service Committee. Non-compliant offices are also automatically included in the provider list for the next monitoring session.

Our Provider Contracting Representatives work with provider offices to assist them in implementing creative solutions and adjusting their processes to become more compliant. For example, one of our providers in central Pennsylvania implemented walk-in hours from 7:00 a.m. to 9:00 a.m. on Monday through Thursday, providing the practice with greater flexibility in meeting standards for urgent appointments.

Appointments by Non-Participating Providers

If services cannot be provided by participating providers within the required mileage radius, AmeriHealth Mercy allows members to seek care from a non-participating provider. An authorization will be entered into our medical management system authorizing the services to be rendered by the non-participating provider as long as a participating provider is unavailable to provide such services.

Our Provider Contracting Representatives will assist all authorized, non-participating providers in obtaining the necessary information to assure their claims are paid timely. We will also discuss the possibility of the non-participating provider's participation in our network in the future.

In some areas of rural Pennsylvania, the specific type of provider may not be located within the required mileage radius. In such cases, we will identify the nearest provider available to expedite the delivery of care.

Capturing Our Members Language Needs

AmeriHealth Mercy is a national leader in recognizing the diversity in our member population and the need to understand the various cultures, ethnicities, languages and races in our communities. We design our programs to incorporate the cultural and language needs of our members. In addition to the key topics covered in our standard orientation, AmeriHealth Mercy offers educational programs to providers on numerous topics, some of which are CME-accredited, including:

- Cultural Competency Training
- Patient Centered Medical Homes
- Health Literacy

Within the AmeriHealth Mercy affiliated plans, three of our companies have been awarded the Distinguished Multicultural Health Care Distinction award from the National Committee for Quality Assurance (NCQA).

Our approach incorporates the collection of race, ethnicity, and language data provided by state agencies using the Federal Office of Management and Budget (OMB) guidelines. We recently enhanced our information systems and customer service processes to further expand the information we received from the state to improve the race and ethnicity data about our

members. We are able, without over-writing the state data, to capture up to five additional categories of race and ethnicity, and preferred written and spoken language. We are able to retain over 300 distinct levels of racial, ethnic, and language groups, and have the capacity to roll up to the OMB standard categories.

Our Member Services representatives and Care Managers actively collect data on race, ethnicity and language from members. As we collect this information, we enter it into our information system. This information serves as a powerful driver to assure that we send language appropriate written materials, and also helps drive future initiatives to reduce health care disparities. We analyze our health outcome data to identify health issues among specific populations and design programs to address those issues. We also leverage race, ethnicity and language data to ensure that the cultures prevalent in our membership are reflected to the extent possible in our provider network, and provide translation services to assist members to bridge language barriers. We also provide member's spoken language to our PCPs via their patient rosters. In the future, we will add this information to the provider portal and it will be available when providers verify eligibility.

To promote understanding of written materials, we maintain information on the enrollee's preferred language as part of our enrollee demographic data set (if the information is provided). All written materials are routinely printed in English and Spanish. We advise members that materials can be translated in other languages through a tagline in English, Russian, Cambodian, Vietnamese, Spanish, Chinese and any other language as required by DPW. For enrollees where a language other than English or Spanish is identified as the preferred language, written notices and materials will be translated into the enrollee's preferred language prior to mailing. AmeriHealth Mercy will use currently contracted translation vendors to serve individuals in the New West and New East Zones. Through these translators, we are able to translate materials in over 170 languages and into large print, braille and audio-tape formats.

Examples of written materials that can be translated include our new enrollee welcome packages, member handbook, member newsletter, educational materials supporting our care management programs, and our health education and outreach materials. We also translate all materials related to appeals and grievances. For example, for appeals and grievances, a system flag will alert the appeal coordinator that translation or an alternative medium is needed. Based on the flag, the system automatically creates a workflow record requesting the translation and setting a reminder for the coordinator to verify that translation was received and sent.

We also request our providers submit information regarding race, ethnicity and language of the provider, office staff, and language services available at the practice site into the Provider Validation Process. By asking all participating providers to check the information in our system on an annual basis, we have the most current race, ethnicity, and language data on our provider network. This information is used to monitor that we have enough providers available to service our members in their preferred language. We also provide this information to members as part of the provider directory, allowing them to choose providers who match their language preferences.

Interpreter Services

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. AmeriHealth Mercy is accustomed to 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.

We assist callers who require other language assistance through the services of Language Services Associates (LSA). LSA offers Interpreting by Telephone (IBT), Instant Communication, Total Understanding as well as Face-to-Face Interpreting when there is a need for an interpreter to be physically present. These services enable us to communicate with members in more than 170 languages. The Member Service representative can facilitate a three-way call between the members and LSA. This service is available at no charge to our members. LSA employees understand the specific needs of the Medicaid population which helps to facilitate the call to meet the members' needs.

Additionally, Member Services has the technology to respond to Deaf/Teletypewriter (TTY/TDD) calls. A desktop application is loaded on the representative's desktop, where the representative logs into a TTY/TDD serve, "sharing" central TTY modems over a network. When a call is received an alert will appear on the desktop notifying them of a call waiting. This optimizes call-handling procedures because the representative is equipped to handle an incoming TTY/TDD call without the need for additional equipment.

Under the Americans with Disability Act (ADA), health care providers have an independent obligation to provide reasonable accommodations to care for members with sensory impairments and to provide translation services when necessary. We recognize that many providers participating in the Medicaid program are not equipped to provide oral interpretation services for their patients; therefore, AmeriHealth Mercy provides a toll-free service which providers can utilize in order to provide the necessary access to members who require interpretation services and to reduce their administrative costs.

QUESTION 2

How will you use Geo Access mapping to ensure network adequacy?

(Limit to two pages)

RESPONSE TO QUESTION 2

AmeriHealth Mercy seeks to maximize access to care for our members and therefore we take an inclusive approach to provider contracting using Geo Access mapping to ensure network adequacy. We strive to contract with all available providers who meet our credentialing standards and will refine the network over time, as needed, to ensure we retain providers who meet our network requirements. While establishing and maintaining the AmeriHealth Mercy network, we considered several aspects of access including, but not limited to, the following:

- Our anticipated enrollment and the expected utilization of services, considering the characteristics and health care needs of the Medicaid populations
- The numbers and types of providers required to supply the contracted Medicaid services;
- The numbers of network providers who are not accepting new Medicaid patients
- The geographic location of providers and members, considering distance, travel time, commonly used means of transportation, and provisions for physical access for members with disabilities

Geo Access mapping will be used to define our statewide comprehensive networks for: Hospitals, PCPs, Specialists, Urgent Care Centers, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Our ability to partner effectively with providers enables us to meet the required Geo Access standards. We will make certain we meet the following State-mandated Geographic Access-Standards:

- Two (2) PCPs within 30 miles of members in urban counties and 60 miles in rural counties;
- Two (2) high-volume specialists within 30 miles of members in urban counties and 60 miles in rural counties for the following specialties: General Surgery, Cardiology, Obstetrics & Gynecology, Pharmacy and General Dentistry, Oncology, Orthopedic Surgery, Physical Therapy, Radiology
- At least one (1) hospital within 30 minutes in urban counties and 60 minutes in rural counties and a second choice within the Managed Care service area

AmeriHealth Mercy monitors network adequacy against the State's access to care standards on a frequent basis in the months prior to and after program implementation and at least quarterly thereafter, using Geo Access mapping. In addition to quarterly assessments, we also prepare Geo Access reports any time there is a significant change in the provider network that could negatively impact access to care.

The following information is included in the quarterly Geo Access reports:

- Geographic Overview Maps that display the provider locations in the geographical area requested
- Provider and Member Location Maps showing an overlay of the provider network against the enrollee base
- Potential Member Accessibility Summary that provides an overview of the entire analysis displayed in the report showing number and percentages of potential enrollees with or without access
- Accessibility Detail Data Sheet that provides an in-depth summary of the information contained on the Accessibility Summary Page

Should a gap be found or predicted based on expected provider changes or membership growth, an outreach plan is created that includes targeted provider recruitment, or as appropriate, outreach to currently contracted providers to ask them to accept more members.

As our provider network grows daily during the recruitment process, we continue to evaluate access to care and to develop a robust network of high quality providers.

While the Geo Access reports are a tool to determine availability of providers for our members, we utilize other tools and resources to ensure access to care for our members. Demonstrating coverage on a map is the beginning of the evaluation process, but we conduct additional analyses to ensure that providers are accepting new patients and scheduling timely appointments. We also monitor customer complaints about access and understand that a dot on the map does not translate into care for our members, so we are always attuned to member, advocate, and community input. Ensuring that health care services are available requires special relationships with hospitals, primary care physicians, specialists and others.

QUESTION 3

Explain the policy and procedure utilized to insure your provider directories are accurate and up to date. Please describe how policies are applied to both hard-copy and on-line or electronic versions.

(Limit to three pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy recognizes the importance of creating and maintaining current provider demographic information to ensure the accuracy of provider directories, claims payment, encounter data and statutory reporting to DPW. Over the years, AmeriHealth Mercy has developed a detailed process with control points to ensure the provider data is reviewed, validated and updated regularly.

We coordinate our contracting, credentialing and provider setup processes to ensure that provider file information is accurate, current and audited. Detailed provider data is routinely integrated into our Facets system, and is therefore directly tied to provider directories, claims payment, and encounter data submission.

Audits

We ensure that our provider directories are accurate and updated by regularly reviewing and auditing the provider information on file. The Provider Directory is pulled directly from Facets, our claims processing system, which serves as the official source for all provider data. The accuracy of our provider database is regularly monitored through a quality auditing process that evaluates transactional activity associated with updating and maintaining it. We conduct a daily audit of the manual updates performed by our Provider Maintenance Management staff 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. Provider Contracting Representatives validate provider demographic data, at least quarterly, to ensure the accuracy of that information. Validation will occur through a combination of personal visits, telephonic outreach, electronic media and faxed confirmation.

Additionally, we run monthly reports which identify any possible discrepancies in the system that would result in directory errors. Queries search for basic information, such as:

- Phone numbers, for the correct number of digits
- Invalid/duplicate office hours
- Practitioner/group address/phone number disconnect
- Missing county on service site
- Missing or invalid phone number
- CRNPs listed as having board certification
- Missing or invalid gender code
- Directory print conflict within group
- Invalid panel restrictions
- Missing hospital affiliations

Discrepancy reports are distributed to Provider Contracting Representatives for investigation and correction, if necessary. All changes are submitted to the Quality Auditing Department for audit selection.

Quarterly Provider Profile Validation for Health Systems

On a quarterly basis, AmeriHealth Mercy generates a provider data profile report for large health systems that is sent to the health system's contact for review and validation. This profile contains a snapshot of the health system providers' demographic information contained in the Facets system. The health system contact is asked to carefully review the information, update as necessary and return the report to the Provider Contracting Representative. Once approved by the

Provider Contracting Representative, the changes are sent to the Provider Maintenance Management team to update the Facets system. This process is well received by the large health system providers.

Data Validation

Annually, AmeriHealth Mercy performs a full network provider data 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 very effective as a means to ensure accuracy of provider directories. Additional validations are as follows:

- State and federal file comparisons that reconcile data elements such as name, address, license, DEA, office locations, NPI, and Pennsylvania PROMISe Provider ID
- Provider office visits at least once a year (and in some cases quarterly) by the Provider Contracting Representative to verify demographic data
- Receipt of claims and/or demographic change requests that require changes and updates to provider data
- Provider self-reporting to update to update any information
- Provider Contracting Representative inquiries about provider changes, such as new providers, anticipated changes and other demographic modifications on a recurring basis during provider visits

Accuracy of Provider Directories

AmeriHealth Mercy maintains a searchable online provider directory that queries the Facets system for participating network providers. The online provider directory is refreshed daily, incorporating all manual updates that are performed by the Provider Maintenance Management team. This daily update ensures that the online provider directory displays the most up to date information available about participating network providers. Members are encouraged to utilize the online provider directory to obtain the most accurate information about AmeriHealth Mercy network providers.

AmeriHealth Mercy produces two types of paper provider directories yearly. The Provider Directory includes primary care physicians, specialists, hospitals, nursing facilities, ancillary providers and diagnostic laboratory drawing stations. The Dental/Vision and Pharmacy Provider Directory lists participating dental and vision providers and pharmacies. The data used to create the provider directories is pulled from the Facets system, extensively reviewed and subsequently validated by the Provider Network Management team, and is accurate at the time of printing. The paper provider directories are mailed to members and providers upon request, though we always recommend that the requestor consult the online provider directory or Member Services for the most up to date information.

QUESTION 4

Explain your plan to manage contracted skilled nursing and home health providers to meet members' growing needs for access to home and community based services for medically complex cases.

(Limit to two pages)

RESPONSE TO QUESTION 4

There is a growing need for skilled nurses and home health providers in the Pennsylvania market. This demand is further exacerbated in rural counties where there are fewer skilled employees and the expansive geography limits the number of visits possible per day. AmeriHealth Mercy has been successful in managing these challenges by working collaboratively with contracted skilled nursing and home health providers to both increase the bandwidth of each provider and by increasing the number of providers. The following strategies are reviewed in greater detailed below:

1. Ensuring provider shift adherence
2. Incentives for remote locations
3. Supporting the hiring effort
4. Enabling telehealth functionality
5. Supporting back-up staffing models
6. Ensuring other member safeguards

Ensuring Provider Shift Adherence

To ensure that Providers meet their scheduled requirements, all missed shifts are reviewed on a monthly basis via the Missed Shift Report. The report contains a list of all members who were scheduled for a skilled nursing or home health visit that was not completed due to a provider missed shift. The report is submitted monthly by AmeriHealth Mercy to the Department and reviewed via conference call.

Incentives for Remote Locations

In working within Pennsylvania, AmeriHealth Mercy knows that it is harder to secure skilled nursing and home health aide visits for members located in more remote locations, as providers are not always fairly compensated for the additional travel expenses. AmeriHealth Mercy believes that to keep members healthy they need access to the right type of care at the right time; this includes skilled nursing and home health aides. To that end, AmeriHealth Mercy works with their contracted providers to offer travel incentives to increase the range that providers are willing to travel to provide care to our members.

We also work with contracted agencies to negotiate special rates for to care for multiple members living in the same household and on occasion for cases that are difficult to staff.

Supporting the Hiring Effort

AmeriHealth Mercy has learned that recruiting and hiring top talent can be a challenge, especially for smaller organizations who have limited resources to invest. This is of even greater challenge in areas with a smaller talent pools to draw from. As a result, AmeriHealth Mercy partners with their contracted skilled nursing and home health providers to help them hire. More specifically, AmeriHealth Mercy sponsors their contracted providers' participation in on campus recruiting events and actively refers local, known candidates to these organizations. These strategies have placed a significant number of employees - just this year - with contracted skilled nursing and home health providers.

Telehealth Functionality

To enhance access, AmeriHealth Mercy partners with home health providers to offer telehealth programs to members with heart disease, diabetes and members who are categorized as being a

high-risk pregnancy. These programs allow members to be remotely monitored for things like blood pressure levels, weight gain or loss and daily blood glucose levels. High-risk pregnant members, who participate with the program, have their contractions monitored remotely by a tocometer. Wireless telemedicine devices easily stores and sends health information to designated medical professionals, enabling them to make timely decisions that can prevent unnecessary hospital stays. This also allows home health aides and skilled nursing providers to triage which members need immediate care and when.

Back-up Staffing Model

AmeriHealth Mercy strives to work collaboratively with home health and skilled nursing providers. AmeriHealth Mercy wants these providers to see AmeriHealth Mercy as an ally. As such, AmeriHealth Mercy's home health agencies are requested to contact us if they are not able to complete a home visit for any reason. With prior notification, there is no retribution to these home health and skilled nursing providers for requesting support from AmeriHealth Mercy.

Upon such notification, AmeriHealth Mercy immediately locates another agency to provide coverage and will orchestrate communication between the relevant parties to ensure clear communication and documentation of care. In some cases this means that AmeriHealth Mercy will authorize home nursing services to be delivered by non-participating providers.

Additional Safeguards

As mentioned above, AmeriHealth Mercy's goal is to ensure that members stay healthy. We believe this requires members to have access to the right care at the right time. Even with the strategies noted above, AmeriHealth Mercy is sensitive to the scenarios when home health care or skilled nursing care is not available. In these rare instances, AmeriHealth Mercy is willing to offer a number of contingency plans including moving a member to a skilled nursing facility or rehabilitation facility until the appropriate level of home healthcare can be offered. In some instances, AmeriHealth Mercy has authorized services to be provided in a Medical Day Care Program setting, when that level of care was medically appropriate.

Our Discharge Planners and Care Managers work directly with hospitals to ensure that the correct step-down care is always identified and in place to support the member upon discharge.

QUESTION 5

What risk adjustment strategies and/or provider incentives do you employ in PCP contracting to ensure members with complex medical needs have adequate access to primary care and care coordination services? How do you measure and assure that these members have adequate access to care?

(Limit to two pages)

RESPONSE TO QUESTION 5

Access is one of the primary needs of Medicaid recipients in Pennsylvania, and AmeriHealth Mercy will enhance its payment structure to Primary Care Providers to increase access for members with complex medical needs and coordinated care services utilizing two strategies: provider incentives and monitoring and enforcing adherence to access standards.

Provider Incentives

Quality Enhancement Program

The Quality Enhancement Program (QEP) rewards PCPs for high-quality and cost-effective care. The program provides additional reimbursement to providers who care for members with complex medical needs. In the most recent cycle of the QEP program, a total of 1,165 unique PCPs qualified to receive incentives based on their performance caring for over 104,000 members.

The Quality Enhancement Program contains four performance metrics: quality, illness severity, cost efficiency, and non-emergent emergency room utilization. Focusing on our members with complex medical needs, the severity of illness metric rewards practices (on a risk-adjusted basis) for treating higher risk panels relative to their peers.

Practice performance is evaluated every six months (based on a rolling 12 months of encounter data). The measure and ranking are combined in an overall report card which is shared with the practice. Provider Contracting Representatives use the data to support and encourage high performing practices. In the case of poor performing practices, Provider Contracting Representatives work with these groups to collaboratively develop performance action plans.

PCP groups contracted to receive capitation reimbursement may be moved to a fee-for-service reimbursement method if claim submission volume remains low or coding accuracy has not improved after education and re-evaluation.

Intensive Case Management Reimbursement Program

The Intensive Case Management (ICM) Reimbursement Program provides PCP practices additional reimbursement for delivering care to chronically ill patients. Over a recent span of 12 months, the ICM Reimbursement Program has identified over 38,000 members with chronic and/or complex illnesses being evaluated and managed by almost 700 providers.

Program goals are as follows:

1. Assist practices by identifying members with chronic and/or complex medical needs
2. Assure chronically ill members are routinely accessing primary care services
3. Improve appointment compliance through member outreach
4. Report complete and accurate diagnosis and disease acuity information to the Department of Public Welfare

The ICM Reimbursement Program is continuously monitored to assure PCPs are submitting claims for evaluation and management services that include the chronic and associated episodic diagnoses of their identified members. Provider Contracting Representatives receive monthly reports enumerating the volume of ICM Reimbursement Program members by PCP group and the number of claims with chronic diagnoses that have been received from the PCP group within the previous six months. The Provider Contracting Representative will visit low performing PCPs to educate them about the goals of the ICM Reimbursement Program and offer additional

assistance with member outreach, appointment scheduling and/or medical record review by AmeriHealth Mercy Certified Professional Coders to determine if the practice is correctly coding diagnosis data.

All ICM Reimbursement Program data is available to PCPs via the NaviNet.

Integrated Care Management

All AmeriHealth Mercy members are considered for our Complex Integrated Care Management (ICM) program, discussed in greater detail in the Coordination of Care section. The ICM program provides member with a single point-of-contact for all of their healthcare needs. Members are selected for ICM through our data stratification process – which electronically analyses every single member's need - or though provider referrals. Members may also self-refer for ICM.

Appointment Access

AmeriHealth Mercy network providers are required to meet and treat members according to the standards for timely access – appointment and wait times – established by the Department.

Monitoring of Standards

Once the accessibility standards have been communicated to providers, follow-up contact with the providers ensures that the member's experience is consistent with these standards, and is a critical component of assessing access to care.

Review and Analysis of Findings

Providers who are non-compliant with any of the accessibility standards receive written notification of our findings and are re-instructed regarding the standards. The assigned provider network management representative schedules another monitoring event, either an on-site visit to monitor office wait times, a "Secret Shopper" call to check appointment availability, or an after-hours call to verify the availability of the practitioner.

QUESTION 6

How do you monitor and evaluate PCP compliance with availability and scheduling requirements outlined in the draft Agreement? What is your plan to ensure PCP-to-member ratio requirements are maintained throughout the term of the Agreement?

(Limit to two pages)

RESPONSE TO QUESTION 6

PCP Availability

AmeriHealth Mercy provides geographic access to two PCPs within 30 minutes travel time in urban/suburban areas and 60 minutes travel time in rural areas. Contracted Federally Qualified Health Center Facilities (FQHCs) are considered PCP sites and are available for member selection in the provider directory. On an annual and/or an "as needed" basis, AmeriHealth Mercy monitors the geographic availability of its participating providers to ensure that members have timely access to health care services, as well as to comply with the Availability Standards outlined by DPW.

Appointment Scheduling Access

AmeriHealth Mercy network providers, including PCPs, are required by contract to meet standards for timely access to care and services, taking into account the urgency of the need for the services. Appointment scheduling standards have been established and are communicated to PCPs and Specialists in the Provider Manual and discussed in orientation meetings. After normal business hours, AmeriHealth Mercy PCPs are required to instruct members on how to reach their PCP or an approved practitioner providing 24-hour coverage.

Monitoring and Evaluating Compliance

AmeriHealth Mercy has implemented the following procedures to monitor its PCP network to evaluate compliance with availability and appointment scheduling standards.

Geographic Distribution and Provider Availability – Annual Assessment

Annually, Provider Network Management utilizes the GeoNetworks® software program to generate number and geographic distribution of provider sites in relation to membership to assure that the established standard is met. The goal is to have a 98% compliance rate or better. If gaps are identified, AmeriHealth Mercy implements interventions and other corrective measures, such as recruitment of necessary service providers, in order to ensure compliance. Results are reported annually to the Quality Service Committee, which monitors compliance and issues recommendations for improvement. The Quality Service Committee compares the following year's annual assessment of the geographic distribution of providers and number of providers to members to determine whether the previous year's interventions had the desired effect.

Education and Communication of Standards

AmeriHealth Mercy uses all available methods to educate and communicate provider appointment scheduling standards with the aim of ensuring providers have a clear understanding of expectations. Appointment scheduling standards will be routinely communicated via on-site orientation of new providers, ongoing training, the provider manual (available online), provider website, and the provider newsletter.

Evaluating Compliance

Follow-up contact with the providers ensures that the member's experience is consistent with these standards. Compliance is monitored through a number of tracking and reporting vehicles, including tracking calls from members related to dissatisfaction with appointment and wait times. Complaints are forwarded to a Provider Contracting Representative for investigation and resolution. Aggregate complaint data is trended to identify physician offices with repeated problems.

AmeriHealth Mercy also conducts assessments via "Secret Shopper" surveys, and provider audits. "Secret Shopper" calls allow us to directly experience the response from the physician's office that our members receive. We call physician offices after normal business hours to verify access. We also audit provider scheduling records to determine appointment availability and monitor wait times during on-site visits.

Non-compliant providers are notified of findings by their Provider Contracting Representative and re-instructed regarding the standards. The Provider Contracting Representative then schedules another monitoring event to check appointment availability.

Corrective Measures

Offices that are non-compliant during repeated monitoring attempts are required to prepare and implement a corrective action plan. The Provider Contracting Representative monitors implementation and reports the results to a Quality Service Committee. Non-compliant offices are also automatically included in the provider list for the next monitoring session to make certain the providers have corrected their procedures and are now meeting AmeriHealth Mercy standards.

Results of our monitoring activities are combined with select Consumer Assessment of Healthcare Providers and Systems (CAHPS) responses and AmeriHealth Mercy Health Plan phone access performance evaluations to create a global picture of Appointment Scheduling Access and Geographic Availability. The findings are reported to the Quality Service Committee where, as appropriate, corrective action plans are recommended and monitored to make certain the providers are meeting Plan standards.

PCP to Member Ratio

All member and provider data are stored in the Facets system. Facets functionality supports setting a maximum panel count value on each practitioner record. We set a maximum value that preserves the 1000 recipient per full time equivalent PCP ratio and prevents additional assignment of members when the value will be exceeded. Daily panel count reports are delivered to both Member Services and Provider Network Management to monitor "open panel" status. Through use of this functionality, daily reports and on-going evaluation of Geo Access data, PCP to member ratios are consistently monitored and used to define provider recruitment needs.

QUESTION 7

How do you ensure that members have access to medical care for needs that arise after hours and for urgent, non-emergency situations? How do you monitor providers to ensure that follow-up is done with the member and the member's PCP to facilitate transfer of information from the after-hours provider? Describe any incentive programs you have in place to improve access to care by rewarding providers who provide extended and/or after hours care.

(Limit to two pages)

RESPONSE TO QUESTION 7

AmeriHealth Mercy has several complementary strategies to improve access to after-hours care and urgent care. We have long been aware of the problem, as well as its consequences in terms of discontinuity of care, member and provider inconvenience, and misuse of healthcare dollars. AmeriHealth Mercy recognizes the importance of good communication with both providers and members, especially when related to follow-up of the diagnosis or treatment of a condition, including emergency care, post-stabilization care, or acute or chronic condition management.

AmeriHealth Mercy offers enhanced compensation to PCPs for extended office hours on weekdays and on weekends. Additionally, we offer additional compensation to providers for opening their offices outside of their normal business hours to address an urgent patient need. AmeriHealth Mercy is working to improve access to after-hours care and urgent care through contracts with urgent care centers and by encouraging area health systems to offer increased urgent care centers and "walk-in" clinics for routine care. We provide a 24/7 Nurse Call Line for members to call if they need advice related to an urgent medical need. In a practitioner's absence, the patient must be instructed, via an answering service or a telephone answering machine, on how to reach their PCP or an approved practitioner providing 24-hour coverage.

Care managers work to proactively facilitate PCP appointments for members as appropriate following after-hours and emergency care or post-stabilization care, as well as for enrollees who are in need of such assistance due to an acute or chronic condition. Our Care Management team ensures that all key/current providers, including specialists and behavioral health clinicians, who are involved with the enrollee's care are kept informed of relevant medical events and treatments to identify areas for care coordination and participation in the development of the plan of care. The frequency and extent of communication following the diagnosis and treatment of a condition, emergency care, or post-stabilization care will be provided in accordance with the guidelines of our Intensive Care Management (ICM) program.

If the member is admitted to the hospital following the ER visit, our Medical Director or utilization management staff notifies the PCP and works with them to assure continuity of care. In addition, the PCP has access to the full history of health care delivered to the member through the Clinical Patient Summary via the NaviNet system. This data includes care rendered in the ER or after hours care provided by another practitioner. Accessing this data allows the PCP to be aware of all healthcare services provided to his/her patients.

Follow-up contact by the providers ensures that the member's experience is consistent, and is a critical component of assessing access to care.

Providers who are non-compliant with any of the accessibility standards are notified of our findings by their Provider Contracting Representative and re-instructed regarding the standards.

Offices that are non-compliant during repeated monitoring attempts are required to prepare and implement a corrective action plan. The Provider Contracting Representative monitors the implementation of any corrective action and reports the results to the Quality Service Committee. Non-compliant offices are also automatically included in the provider list for the next monitoring session.

Our Provider Contracting Representatives work with provider offices to assist them in implementing creative solutions and adjusting their processes to become compliant.

In 2010, AmeriHealth Mercy ER utilization rates increased from the previous year. Since then, our provider incentive programs have become effective in reducing our members' non-emergent ER usage. As mentioned in question 5, one of the performance metrics for AmeriHealth Mercy's primary care provider incentive program (Quality Enhancement Program) rewards PCPs for improving the management of members who frequently use the ER. In the most recent cycle of the program, a total of 1,165 PCPs qualified to receive incentives based on their performance in caring for 104,000 members. Additionally, we offer enhanced compensation to PCPs for extended office hours and compensation to providers for opening their offices outside of their normal business hours to address an urgent patient need.

QUESTION 8

Describe the policies and procedures followed in response to the network termination or loss of a large-scale provider group or health system. Please develop the response taking the following areas into consideration:

- *System utilized for identification and notification of members affected by the provider loss;*
- *The automated systems and membership supports utilized in assisting affected members with provider transitions;*
- *Systems and policies utilized for continuity of care of members experiencing provider transition; and*
- *Outcomes experienced in coverage of the membership with existing network resources following the terminations.*

(Limit to five pages)

RESPONSE TO QUESTION 8

Overview

AmeriHealth Mercy's processes require us to take all necessary steps to work with a provider to address any concerns, and take necessary steps to prevent the termination of providers from our network. In instances when we have to terminate a provider from our network, such as if a provider no longer meets our credentialing standards, AmeriHealth Mercy has an effective process in place for minimizing the impact to and communicating with the member.

When faced with a possible termination of a provider, particularly one whose loss would adversely impact care to a significant number of members, we will first and foremost take all reasonable measures to prevent such a termination. If the termination is being initiated by the provider, we will immediately contact the provider to ascertain the reasons for the termination notice. Regardless of the reason the provider initiated the termination notice, we will explore whether there are administrative modifications we can make to improve provider satisfaction to prevent the loss of the provider to our network.

While we will exhaust all reasonable options to retain the provider**,** AmeriHealth Mercy also has detailed contingency plans to ensure a network provider termination is managed effectively and efficiently and to assure that the continuity of care for our members is not compromised.

Whenever a provider's contract is terminated, all affected members will be notified in writing by AmeriHealth Mercy. In the case of a member who received his or her primary care from, or was seen on a regular basis by the terminated provider, we will make a good faith effort to give written notice of termination of a contracted primary care provider at least 30 days before the termination effective date, to each such member.

In the case of terminated primary care physicians, "affected members" are defined as those who have designated the terminating provider as their primary care practitioner. In the case of terminating specialty physicians, utilization data will be used to identify those members who had seen the terminating specialist for specialty services during the preceding 12 months. In the case of a terminating hospital, utilization data will be used to identify members who had been treated at the terminating hospital for services during the preceding 12 months.

Critical to a smooth provider termination is proper identification and notification of the members and providers affected by the termination as well as proper and timely notification to DPW and related agencies. The contingency planning process includes the following activities when a large-scale provider group or health system is terminating.

Identification of Members and Providers

- Identify all providers owned (employees of the provider group or health system) by the provider group or health system
- Determine community providers (not employed by the provider group or health system) with admitting privileges only at terminating facilities
- List community providers (not employed by the provider group or health system) with admitting privileges at terminating facilities and who also can admit to other hospitals in the network
- Identify members who within the past 12 months received health care services from a terminating facility or provider or whose primary care practitioner (PCP) is terminating

- Identify those members with special needs or who will have continuity of care issues for immediate outreach – especially pregnant women, members in care management programs, members with HIV/AIDS, children in foster care or in children and youth custody

Analysis of Network Adequacy

- Analyze member health care access issues caused by facility and practitioner termination through a Geo Access Survey
- Develop strategies to mitigate access to care issues, e.g., recruitment of additional providers and practitioners to fill gaps in care

Timely DPW/Related Agency Notification

- Inform the state and benefits counselor and other relevant parties of the potential for a termination
- Provide DPW written notice of any material change to the provider network at least 60 days prior to the effective date of the termination. Notice will include the reason(s) for the proposed action
- Draft and obtain DPW's approval of member and provider notification letters, scripts for associates who will outreach to and receive calls from affected members, and related materials
- Submit to DPW a termination work plan and supporting documentation within 10 days of notification to DPW of the termination

Continuing Care/Transition to Alternative Providers

- Manage all open authorizations at a terminating provider so continuity of care arrangements can start for members in an active course of treatment
- Create a member strategy and identify and outreach to physicians to whom members will be transitioned

Notification to affected members will include information regarding assistance in choosing another contracted practitioner and referral to the AmeriHealth Mercy website for a list of network providers in the member's area. The member may also call Member Services for assistance in selecting a new PCP, specialist or hospital provider.

Once the termination notification has been mailed, members with terminating PCPs are given at least 10 days from the letter's date to choose a new PCP. Once the time period ends, the members are automatically assigned to a new PCP through a process algorithm, which places the member with a geographically accessible PCP. Members will also receive information on how to change the assigned PCP if they are not happy with the assignment.

A strong communication plan details steps taken to ensure that AmeriHealth Mercy is not only complying with DPW requirements, but also ensuring that we are assisting all affected members in transitioning to new providers. Communication plans will include updates to the provider directories as required by Section V.F.16 of the agreement with DPW.

Automated Systems and Membership Supports

AmeriHealth Mercy employs various types of additional notification strategies which are used as needed to supplement the written notification and to ensure that members receive timely information. These strategies are implemented if we are unsuccessful in reaching members or for any reason the traditional methods are not successful. These strategies include phone calls, "on hold" messages, and automated and interactive phone calls. Special effort is made to contact

members with special needs so that the health care services they receive continue without interruption. Members with special needs receive repeated phone calls and/or home visits arranged by our Rapid Response staff until our Case Managers have successfully transitioned or arranged for continuation of their care.

Geo Access maps are prepared to determine network composition and access with, and without, the provider in question. This allows the development of a recruitment plan to replace the needed provider specialty, if possible. Additionally, we take steps to ensure early identification of members with special needs. Early outreach to all affected members enables the arrangement of appropriate, quality alternative health care services and mitigates disruption to both members and the provider network. If alternative providers and practitioners cannot be located, early outreach allows AmeriHealth Mercy to arrange continuation of care with the terminating provider for as long as medically necessary, without disrupting care for the member.

Continuity of Care Policies

AmeriHealth Mercy allows members to continue ongoing treatment with a health care provider whose contract terminates, except when the provider's contract is terminated "for cause" reasons. "For cause" includes quality of care issues, the provider is not a Medical Assistance provider, or the provider did not comply with regulations or contract requirements. AmeriHealth Mercy can approve requests for ongoing treatment or services when the request is made by the provider or by the member. Continuing care requests are reviewed on a case-by-case basis. AmeriHealth Mercy considers treatment "ongoing" if the member was treated during the past 12 months for a condition that requires follow up care or additional treatment. Services are also considered "ongoing" if they have been prior authorized. Once AmeriHealth Mercy has received the request for continuing care with a terminating provider, the case is reviewed. AmeriHealth Mercy notifies the member and provider by telephone if the request is approved. If the request is not approved, AmeriHealth Mercy will call the provider and the member and will also send a letter explaining the decision and describing the member's appeal rights.

When continuing care is approved, members may continue to see the terminated provider for 90 days beyond the date the member was initially notified. If the member is pregnant, continuing care will be approved with that obstetrician or midwife and hospital provider through the end of the postpartum care period.

Outcomes experienced in coverage of the membership with existing network resources following the terminations

AmeriHealth Mercy has an excellent record in transitioning members to other network providers when a provider termination necessitates initiation of contingency plans. An example of this occurred in April 2010, when AmeriHealth Mercy terminated its relationship with Milton S. Hershey Medical Center and the University Physicians Group. AmeriHealth Mercy successfully transitioned all PCP panel members to other PCPs near the members' homes. AmeriHealth Mercy entered into a contract with an alternative health care provider (Pinnacle Health System) and has not had enduring network access issues due to the loss of the Hershey providers.

Provider Network Composition and Network Management

Contents

QUESTION 1

Explain your plan to ensure that your provider network meets the network and access requirements in the draft Agreement. Specifically include:

- *The method you plan to use on an ongoing basis to assess and ensure that network standards outlined in the draft Agreement are maintained for all provider types.*
- *Describe your process for continuous improvement in your network over and above contract compliance.*
- *Describe how you will ensure that appointment access standards are met when members cannot access care within your provider network and must go to an out-of-network provider?*
- *Describe how you will collect and record language needs for those consumers with limited English proficiency and how you will ensure all written notices are language appropriate.*
- *Describe how you will educate and coordinate interpreter services with your network providers.*

(Limit to six pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy's experience with serving Medicaid enrollees in Pennsylvania for nearly 30 years makes it uniquely qualified to build an expansive provider network and to ensure that its provider network meets all of the State's network and access requirements. We have developed a proven process to ensure we can quickly implement a comprehensive provider network that not only meets – but exceeds – DPW's requirements. Our plan for the New West and New East network was established based on the following critical elements:

- The anticipated Medicaid enrollment and expected utilization of services, considering the characteristics and health care needs of particular Medicaid populations
- The numbers and types of providers required to supply the contracted Medicaid services
- The numbers of network providers who are not accepting new Medicaid patients
- The geographic location of providers and members, considering distance, travel time, and commonly used means of transportation, and provisions for physical access for members with special health care needs

Assessment of Network Adequacy

AmeriHealth Mercy monitors network adequacy against the State's access to care standards on a frequent basis in the months prior to and after program implementation. Minimum network adequacy is determined by utilizing Geo Access mapping. Geo Access mapping is used to define our statewide comprehensive networks for: hospitals, including children's, tertiary care and critical access hospitals, PCPs, specialists, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as well as other providers as necessary to meet Exhibit AAA(1) requirements for Network Composition/Service Access.

After the network has been stabilized, PCP networks are monitored on a monthly basis. Specialty networks and other provider networks are monitored at least quarterly thereafter, using Geo Access mapping. In addition to the regularly scheduled assessments, we also prepare Geo Access reports any time there is a significant change in the provider network that could negatively impact access to care. Should a gap be found or predicted based on expected provider changes or membership growth, an outreach plan is created that includes targeted provider recruitment, or as appropriate, outreach to currently contracted providers to ask them to accept more members.

Continuous Improvement of Our Network

Continuous improvement in the New West and New East provider networks will be critical to assuring adequate access in rural areas. We have several initiatives we are considering as strategies to drive continuous improvements of our network if necessary.

Provider Incentive Programs

These programs will be tailored to incent the providers to improve access and/or improve specific health outcomes. As part of the incentive programs, we give information to the providers, in individualized reports, regarding how they compare to their peers on a variety of measures. For example, the report may compare how the physician compares to other physicians with regard to prescribing generic medications, or on specific HEDIS measures.

Mobile Services

AmeriHealth Mercy will continue our practice of going into the community where our members reside, to offer mobile services. For example, we have an existing contract with a mobile

mammography company, Lackawanna Mobile Diagnostic Services. We have already reserved dates to offer mammograms to our members in the New West and New East.

Telehealth Programs

Telehealth programs are necessary to expand access. For example, we have a telehealth program for members with heart failure. Participating members monitor their daily weight fluctuations - a key indicator of heart failure - and blood pressure using a digital weight scale and a blood pressure monitor. The wireless telemedicine device easily and automatically stores and sends health information to designated medical professionals, enabling them to make timely decisions that can prevent unnecessary hospital stays. Home Agency staff utilizes these opportunities as "teachable moments" with our members, especially when symptoms are most acute.

Health Navigators

We will also use Health Navigators in the rural counties. Nurses, specially trained outreach coordinators and other professionals serve as Health Navigators and act as a liaison between the member, provider and health plan. Our Health Navigators are poised to conduct health education sessions at locations in each county. In the rural communities of Luzerne, Lackawanna, Monroe, Carbon and Pike counties that we currently serve, AmeriHealth Mercy conducts this type of educational programs at a variety of community locations such as Friends of the Poor, Salvation Army and the Community Intervention Center.

Meeting Appointment Access Standards

Providers are contractually required to meet standards for timely access to care and services, taking into account the urgency of the need for the services. In a practitioner's absence, the patient must be instructed, via an answering service or a telephone answering machine, on how to reach their PCP or an approved practitioner providing 24-hour coverage. In addition to the standards being communicated in a provider's contract, access and appointment availability standards are routinely communicated via the provider manual (also available on line), provider website, on-site orientation of new providers, ongoing training and the provider newsletter.

Once the accessibility standards have been communicated to providers, follow-up contact with the providers ensures that the member's experience is consistent with these standards. Compliance with the accessibility standards is monitored through a number of tracking and reporting vehicles. We track calls from members related to dissatisfaction with appointment and wait times. Individual complaints are forwarded to the Provider Contracting Representative assigned to the provider for investigation and resolution. In addition, aggregate complaint data related to dissatisfaction with appointments and wait times is trended to identify physician offices with repeated problems.

We also conduct assessments via "Secret Shopper" surveys, as well as provider audits. "Secret Shopper" calls allow us to directly experience the response from the physician's office that our members receive. For this assessment, we call physician offices after normal business hours to verify whether members who call at this time are able to reach a physician, if necessary. We also audit provider scheduling records to determine the availability of the next appointment for preventive, routine, and urgent care. During on-site visits, we monitor office wait times.

Providers who are non-compliant with any of the accessibility standards are notified of our findings by their Provider Contracting Representative and re-instructed regarding the standards. The assigned Provider Contracting Representative schedules another monitoring event, either an

on-site visit to monitor office wait times, a "Secret Shopper" call to check appointment availability, or an after-hours call to verify the availability of the practitioner.

Offices that are non-compliant during repeated monitoring attempts are required to prepare and implement a corrective action plan. The Provider Contracting Representative monitors the implementation of any correction action and reports the results to the Quality Service Committee. Non-compliant offices are also automatically included in the provider list for the next monitoring session.

Our Provider Contracting Representatives work with provider offices to assist them in implementing creative solutions and adjusting their processes to become more compliant. For example, one of our providers in central Pennsylvania implemented walk-in hours from 7:00 a.m. to 9:00 a.m. on Monday through Thursday, providing the practice with greater flexibility in meeting standards for urgent appointments.

Appointments by Non-Participating Providers

If services cannot be provided by participating providers within the required mileage radius, AmeriHealth Mercy allows members to seek care from a non-participating provider. An authorization will be entered into our medical management system authorizing the services to be rendered by the non-participating provider as long as a participating provider is unavailable to provide such services.

Our Provider Contracting Representatives will assist all authorized, non-participating providers in obtaining the necessary information to assure their claims are paid timely. We will also discuss the possibility of the non-participating provider's participation in our network in the future.

In some areas of rural Pennsylvania, the specific type of provider may not be located within the required mileage radius. In such cases, we will identify the nearest provider available to expedite the delivery of care.

Capturing Our Members Language Needs

AmeriHealth Mercy is a national leader in recognizing the diversity in our member population and the need to understand the various cultures, ethnicities, languages and races in our communities. We design our programs to incorporate the cultural and language needs of our members. In addition to the key topics covered in our standard orientation, AmeriHealth Mercy offers educational programs to providers on numerous topics, some of which are CME-accredited, including:

- Cultural Competency Training
- Patient Centered Medical Homes
- Health Literacy

Within the AmeriHealth Mercy affiliated plans, three of our companies have been awarded the Distinguished Multicultural Health Care Distinction award from the National Committee for Quality Assurance (NCQA).

Our approach incorporates the collection of race, ethnicity, and language data provided by state agencies using the Federal Office of Management and Budget (OMB) guidelines. We recently enhanced our information systems and customer service processes to further expand the information we received from the state to improve the race and ethnicity data about our

members. We are able, without over-writing the state data, to capture up to five additional categories of race and ethnicity, and preferred written and spoken language. We are able to retain over 300 distinct levels of racial, ethnic, and language groups, and have the capacity to roll up to the OMB standard categories.

Our Member Services representatives and Care Managers actively collect data on race, ethnicity and language from members. As we collect this information, we enter it into our information system. This information serves as a powerful driver to assure that we send language appropriate written materials, and also helps drive future initiatives to reduce health care disparities. We analyze our health outcome data to identify health issues among specific populations and design programs to address those issues. We also leverage race, ethnicity and language data to ensure that the cultures prevalent in our membership are reflected to the extent possible in our provider network, and provide translation services to assist members to bridge language barriers. We also provide member's spoken language to our PCPs via their patient rosters. In the future, we will add this information to the provider portal and it will be available when providers verify eligibility.

To promote understanding of written materials, we maintain information on the enrollee's preferred language as part of our enrollee demographic data set (if the information is provided). All written materials are routinely printed in English and Spanish. We advise members that materials can be translated in other languages through a tagline in English, Russian, Cambodian, Vietnamese, Spanish, Chinese and any other language as required by DPW. For enrollees where a language other than English or Spanish is identified as the preferred language, written notices and materials will be translated into the enrollee's preferred language prior to mailing. AmeriHealth Mercy will use currently contracted translation vendors to serve individuals in the New West and New East Zones. Through these translators, we are able to translate materials in over 170 languages and into large print, braille and audio-tape formats.

Examples of written materials that can be translated include our new enrollee welcome packages, member handbook, member newsletter, educational materials supporting our care management programs, and our health education and outreach materials. We also translate all materials related to appeals and grievances. For example, for appeals and grievances, a system flag will alert the appeal coordinator that translation or an alternative medium is needed. Based on the flag, the system automatically creates a workflow record requesting the translation and setting a reminder for the coordinator to verify that translation was received and sent.

We also request our providers submit information regarding race, ethnicity and language of the provider, office staff, and language services available at the practice site into the Provider Validation Process. By asking all participating providers to check the information in our system on an annual basis, we have the most current race, ethnicity, and language data on our provider network. This information is used to monitor that we have enough providers available to service our members in their preferred language. We also provide this information to members as part of the provider directory, allowing them to choose providers who match their language preferences.

Interpreter Services

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. AmeriHealth Mercy is accustomed to 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.

We assist callers who require other language assistance through the services of Language Services Associates (LSA). LSA offers Interpreting by Telephone (IBT), Instant Communication, Total Understanding as well as Face-to-Face Interpreting when there is a need for an interpreter to be physically present. These services enable us to communicate with members in more than 170 languages. The Member Service representative can facilitate a three-way call between the members and LSA. This service is available at no charge to our members. LSA employees understand the specific needs of the Medicaid population which helps to facilitate the call to meet the members' needs.

Additionally, Member Services has the technology to respond to Deaf/Teletypewriter (TTY/TDD) calls. A desktop application is loaded on the representative's desktop, where the representative logs into a TTY/TDD serve, "sharing" central TTY modems over a network. When a call is received an alert will appear on the desktop notifying them of a call waiting. This optimizes call-handling procedures because the representative is equipped to handle an incoming TTY/TDD call without the need for additional equipment.

Under the Americans with Disability Act (ADA), health care providers have an independent obligation to provide reasonable accommodations to care for members with sensory impairments and to provide translation services when necessary. We recognize that many providers participating in the Medicaid program are not equipped to provide oral interpretation services for their patients; therefore, AmeriHealth Mercy provides a toll-free service which providers can utilize in order to provide the necessary access to members who require interpretation services and to reduce their administrative costs.

QUESTION 2

How will you use Geo Access mapping to ensure network adequacy?

(Limit to two pages)

RESPONSE TO QUESTION 2

AmeriHealth Mercy seeks to maximize access to care for our members and therefore we take an inclusive approach to provider contracting using Geo Access mapping to ensure network adequacy. We strive to contract with all available providers who meet our credentialing standards and will refine the network over time, as needed, to ensure we retain providers who meet our network requirements. While establishing and maintaining the AmeriHealth Mercy network, we considered several aspects of access including, but not limited to, the following:

- Our anticipated enrollment and the expected utilization of services, considering the characteristics and health care needs of the Medicaid populations
- The numbers and types of providers required to supply the contracted Medicaid services;
- The numbers of network providers who are not accepting new Medicaid patients
- The geographic location of providers and members, considering distance, travel time, commonly used means of transportation, and provisions for physical access for members with disabilities

Geo Access mapping will be used to define our statewide comprehensive networks for: Hospitals, PCPs, Specialists, Urgent Care Centers, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Our ability to partner effectively with providers enables us to meet the required Geo Access standards. We will make certain we meet the following State-mandated Geographic Access-Standards:

- Two (2) PCPs within 30 miles of members in urban counties and 60 miles in rural counties;
- Two (2) high-volume specialists within 30 miles of members in urban counties and 60 miles in rural counties for the following specialties: General Surgery, Cardiology, Obstetrics & Gynecology, Pharmacy and General Dentistry, Oncology, Orthopedic Surgery, Physical Therapy, Radiology
- At least one (1) hospital within 30 minutes in urban counties and 60 minutes in rural counties and a second choice within the Managed Care service area

AmeriHealth Mercy monitors network adequacy against the State's access to care standards on a frequent basis in the months prior to and after program implementation and at least quarterly thereafter, using Geo Access mapping. In addition to quarterly assessments, we also prepare Geo Access reports any time there is a significant change in the provider network that could negatively impact access to care.

The following information is included in the quarterly Geo Access reports:

- Geographic Overview Maps that display the provider locations in the geographical area requested
- Provider and Member Location Maps showing an overlay of the provider network against the enrollee base
- Potential Member Accessibility Summary that provides an overview of the entire analysis displayed in the report showing number and percentages of potential enrollees with or without access
- Accessibility Detail Data Sheet that provides an in-depth summary of the information contained on the Accessibility Summary Page

Should a gap be found or predicted based on expected provider changes or membership growth, an outreach plan is created that includes targeted provider recruitment, or as appropriate, outreach to currently contracted providers to ask them to accept more members.

As our provider network grows daily during the recruitment process, we continue to evaluate access to care and to develop a robust network of high quality providers.

While the Geo Access reports are a tool to determine availability of providers for our members, we utilize other tools and resources to ensure access to care for our members. Demonstrating coverage on a map is the beginning of the evaluation process, but we conduct additional analyses to ensure that providers are accepting new patients and scheduling timely appointments. We also monitor customer complaints about access and understand that a dot on the map does not translate into care for our members, so we are always attuned to member, advocate, and community input. Ensuring that health care services are available requires special relationships with hospitals, primary care physicians, specialists and others.

QUESTION 3

Explain the policy and procedure utilized to insure your provider directories are accurate and up to date. Please describe how policies are applied to both hard-copy and on-line or electronic versions.

(Limit to three pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy recognizes the importance of creating and maintaining current provider demographic information to ensure the accuracy of provider directories, claims payment, encounter data and statutory reporting to DPW. Over the years, AmeriHealth Mercy has developed a detailed process with control points to ensure the provider data is reviewed, validated and updated regularly.

We coordinate our contracting, credentialing and provider setup processes to ensure that provider file information is accurate, current and audited. Detailed provider data is routinely integrated into our Facets system, and is therefore directly tied to provider directories, claims payment, and encounter data submission.

Audits

We ensure that our provider directories are accurate and updated by regularly reviewing and auditing the provider information on file. The Provider Directory is pulled directly from Facets, our claims processing system, which serves as the official source for all provider data. The accuracy of our provider database is regularly monitored through a quality auditing process that evaluates transactional activity associated with updating and maintaining it. We conduct a daily audit of the manual updates performed by our Provider Maintenance Management staff 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. Provider Contracting Representatives validate provider demographic data, at least quarterly, to ensure the accuracy of that information. Validation will occur through a combination of personal visits, telephonic outreach, electronic media and faxed confirmation.

Additionally, we run monthly reports which identify any possible discrepancies in the system that would result in directory errors. Queries search for basic information, such as:

- Phone numbers, for the correct number of digits
- Invalid/duplicate office hours
- Practitioner/group address/phone number disconnect
- Missing county on service site
- Missing or invalid phone number
- CRNPs listed as having board certification
- Missing or invalid gender code
- Directory print conflict within group
- Invalid panel restrictions
- Missing hospital affiliations

Discrepancy reports are distributed to Provider Contracting Representatives for investigation and correction, if necessary. All changes are submitted to the Quality Auditing Department for audit selection.

Quarterly Provider Profile Validation for Health Systems

On a quarterly basis, AmeriHealth Mercy generates a provider data profile report for large health systems that is sent to the health system's contact for review and validation. This profile contains a snapshot of the health system providers' demographic information contained in the Facets system. The health system contact is asked to carefully review the information, update as necessary and return the report to the Provider Contracting Representative. Once approved by the

Provider Contracting Representative, the changes are sent to the Provider Maintenance Management team to update the Facets system. This process is well received by the large health system providers.

Data Validation

Annually, AmeriHealth Mercy performs a full network provider data 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 very effective as a means to ensure accuracy of provider directories. Additional validations are as follows:

- State and federal file comparisons that reconcile data elements such as name, address, license, DEA, office locations, NPI, and Pennsylvania PROMISe Provider ID
- Provider office visits at least once a year (and in some cases quarterly) by the Provider Contracting Representative to verify demographic data
- Receipt of claims and/or demographic change requests that require changes and updates to provider data
- Provider self-reporting to update to update any information
- Provider Contracting Representative inquiries about provider changes, such as new providers, anticipated changes and other demographic modifications on a recurring basis during provider visits

Accuracy of Provider Directories

AmeriHealth Mercy maintains a searchable online provider directory that queries the Facets system for participating network providers. The online provider directory is refreshed daily, incorporating all manual updates that are performed by the Provider Maintenance Management team. This daily update ensures that the online provider directory displays the most up to date information available about participating network providers. Members are encouraged to utilize the online provider directory to obtain the most accurate information about AmeriHealth Mercy network providers.

AmeriHealth Mercy produces two types of paper provider directories yearly. The Provider Directory includes primary care physicians, specialists, hospitals, nursing facilities, ancillary providers and diagnostic laboratory drawing stations. The Dental/Vision and Pharmacy Provider Directory lists participating dental and vision providers and pharmacies. The data used to create the provider directories is pulled from the Facets system, extensively reviewed and subsequently validated by the Provider Network Management team, and is accurate at the time of printing. The paper provider directories are mailed to members and providers upon request, though we always recommend that the requestor consult the online provider directory or Member Services for the most up to date information.

QUESTION 4

Explain your plan to manage contracted skilled nursing and home health providers to meet members' growing needs for access to home and community based services for medically complex cases.

(Limit to two pages)

RESPONSE TO QUESTION 4

There is a growing need for skilled nurses and home health providers in the Pennsylvania market. This demand is further exacerbated in rural counties where there are fewer skilled employees and the expansive geography limits the number of visits possible per day. AmeriHealth Mercy has been successful in managing these challenges by working collaboratively with contracted skilled nursing and home health providers to both increase the bandwidth of each provider and by increasing the number of providers. The following strategies are reviewed in greater detailed below:

1. Ensuring provider shift adherence
2. Incentives for remote locations
3. Supporting the hiring effort
4. Enabling telehealth functionality
5. Supporting back-up staffing models
6. Ensuring other member safeguards

Ensuring Provider Shift Adherence

To ensure that Providers meet their scheduled requirements, all missed shifts are reviewed on a monthly basis via the Missed Shift Report. The report contains a list of all members who were scheduled for a skilled nursing or home health visit that was not completed due to a provider missed shift. The report is submitted monthly by AmeriHealth Mercy to the Department and reviewed via conference call.

Incentives for Remote Locations

In working within Pennsylvania, AmeriHealth Mercy knows that it is harder to secure skilled nursing and home health aide visits for members located in more remote locations, as providers are not always fairly compensated for the additional travel expenses. AmeriHealth Mercy believes that to keep members healthy they need access to the right type of care at the right time; this includes skilled nursing and home health aides. To that end, AmeriHealth Mercy works with their contracted providers to offer travel incentives to increase the range that providers are willing to travel to provide care to our members.

We also work with contracted agencies to negotiate special rates for to care for multiple members living in the same household and on occasion for cases that are difficult to staff.

Supporting the Hiring Effort

AmeriHealth Mercy has learned that recruiting and hiring top talent can be a challenge, especially for smaller organizations who have limited resources to invest. This is of even greater challenge in areas with a smaller talent pools to draw from. As a result, AmeriHealth Mercy partners with their contracted skilled nursing and home health providers to help them hire. More specifically, AmeriHealth Mercy sponsors their contracted providers' participation in on campus recruiting events and actively refers local, known candidates to these organizations. These strategies have placed a significant number of employees - just this year - with contracted skilled nursing and home health providers.

Telehealth Functionality

To enhance access, AmeriHealth Mercy partners with home health providers to offer telehealth programs to members with heart disease, diabetes and members who are categorized as being a

high-risk pregnancy. These programs allow members to be remotely monitored for things like blood pressure levels, weight gain or loss and daily blood glucose levels. High-risk pregnant members, who participate with the program, have their contractions monitored remotely by a tocometer. Wireless telemedicine devices easily stores and sends health information to designated medical professionals, enabling them to make timely decisions that can prevent unnecessary hospital stays. This also allows home health aides and skilled nursing providers to triage which members need immediate care and when.

Back-up Staffing Model

AmeriHealth Mercy strives to work collaboratively with home health and skilled nursing providers. AmeriHealth Mercy wants these providers to see AmeriHealth Mercy as an ally. As such, AmeriHealth Mercy's home health agencies are requested to contact us if they are not able to complete a home visit for any reason. With prior notification, there is no retribution to these home health and skilled nursing providers for requesting support from AmeriHealth Mercy.

Upon such notification, AmeriHealth Mercy immediately locates another agency to provide coverage and will orchestrate communication between the relevant parties to ensure clear communication and documentation of care. In some cases this means that AmeriHealth Mercy will authorize home nursing services to be delivered by non-participating providers.

Additional Safeguards

As mentioned above, AmeriHealth Mercy's goal is to ensure that members stay healthy. We believe this requires members to have access to the right care at the right time. Even with the strategies noted above, AmeriHealth Mercy is sensitive to the scenarios when home health care or skilled nursing care is not available. In these rare instances, AmeriHealth Mercy is willing to offer a number of contingency plans including moving a member to a skilled nursing facility or rehabilitation facility until the appropriate level of home healthcare can be offered. In some instances, AmeriHealth Mercy has authorized services to be provided in a Medical Day Care Program setting, when that level of care was medically appropriate.

Our Discharge Planners and Care Managers work directly with hospitals to ensure that the correct step-down care is always identified and in place to support the member upon discharge.

QUESTION 5

What risk adjustment strategies and/or provider incentives do you employ in PCP contracting to ensure members with complex medical needs have adequate access to primary care and care coordination services? How do you measure and assure that these members have adequate access to care?

(Limit to two pages)

RESPONSE TO QUESTION 5

Access is one of the primary needs of Medicaid recipients in Pennsylvania, and AmeriHealth Mercy will enhance its payment structure to Primary Care Providers to increase access for members with complex medical needs and coordinated care services utilizing two strategies: provider incentives and monitoring and enforcing adherence to access standards.

Provider Incentives

Quality Enhancement Program

The Quality Enhancement Program (QEP) rewards PCPs for high-quality and cost-effective care. The program provides additional reimbursement to providers who care for members with complex medical needs. In the most recent cycle of the QEP program, a total of 1,165 unique PCPs qualified to receive incentives based on their performance caring for over 104,000 members.

The Quality Enhancement Program contains four performance metrics: quality, illness severity, cost efficiency, and non-emergent emergency room utilization. Focusing on our members with complex medical needs, the severity of illness metric rewards practices (on a risk-adjusted basis) for treating higher risk panels relative to their peers.

Practice performance is evaluated every six months (based on a rolling 12 months of encounter data). The measure and ranking are combined in an overall report card which is shared with the practice. Provider Contracting Representatives use the data to support and encourage high performing practices. In the case of poor performing practices, Provider Contracting Representatives work with these groups to collaboratively develop performance action plans.

PCP groups contracted to receive capitation reimbursement may be moved to a fee-for-service reimbursement method if claim submission volume remains low or coding accuracy has not improved after education and re-evaluation.

Intensive Case Management Reimbursement Program

The Intensive Case Management (ICM) Reimbursement Program provides PCP practices additional reimbursement for delivering care to chronically ill patients. Over a recent span of 12 months, the ICM Reimbursement Program has identified over 38,000 members with chronic and/or complex illnesses being evaluated and managed by almost 700 providers.

Program goals are as follows:

1. Assist practices by identifying members with chronic and/or complex medical needs
2. Assure chronically ill members are routinely accessing primary care services
3. Improve appointment compliance through member outreach
4. Report complete and accurate diagnosis and disease acuity information to the Department of Public Welfare

The ICM Reimbursement Program is continuously monitored to assure PCPs are submitting claims for evaluation and management services that include the chronic and associated episodic diagnoses of their identified members. Provider Contracting Representatives receive monthly reports enumerating the volume of ICM Reimbursement Program members by PCP group and the number of claims with chronic diagnoses that have been received from the PCP group within the previous six months. The Provider Contracting Representative will visit low performing PCPs to educate them about the goals of the ICM Reimbursement Program and offer additional

assistance with member outreach, appointment scheduling and/or medical record review by AmeriHealth Mercy Certified Professional Coders to determine if the practice is correctly coding diagnosis data.

All ICM Reimbursement Program data is available to PCPs via the NaviNet.

Integrated Care Management

All AmeriHealth Mercy members are considered for our Complex Integrated Care Management (ICM) program, discussed in greater detail in the Coordination of Care section. The ICM program provides member with a single point-of-contact for all of their healthcare needs. Members are selected for ICM through our data stratification process – which electronically analyses every single member's need - or though provider referrals. Members may also self-refer for ICM.

Appointment Access

AmeriHealth Mercy network providers are required to meet and treat members according to the standards for timely access – appointment and wait times – established by the Department.

Monitoring of Standards

Once the accessibility standards have been communicated to providers, follow-up contact with the providers ensures that the member's experience is consistent with these standards, and is a critical component of assessing access to care.

Review and Analysis of Findings

Providers who are non-compliant with any of the accessibility standards receive written notification of our findings and are re-instructed regarding the standards. The assigned provider network management representative schedules another monitoring event, either an on-site visit to monitor office wait times, a "Secret Shopper" call to check appointment availability, or an after-hours call to verify the availability of the practitioner.

QUESTION 6

How do you monitor and evaluate PCP compliance with availability and scheduling requirements outlined in the draft Agreement? What is your plan to ensure PCP-to-member ratio requirements are maintained throughout the term of the Agreement?

(Limit to two pages)

RESPONSE TO QUESTION 6

PCP Availability

AmeriHealth Mercy provides geographic access to two PCPs within 30 minutes travel time in urban/suburban areas and 60 minutes travel time in rural areas. Contracted Federally Qualified Health Center Facilities (FQHCs) are considered PCP sites and are available for member selection in the provider directory. On an annual and/or an "as needed" basis, AmeriHealth Mercy monitors the geographic availability of its participating providers to ensure that members have timely access to health care services, as well as to comply with the Availability Standards outlined by DPW.

Appointment Scheduling Access

AmeriHealth Mercy network providers, including PCPs, are required by contract to meet standards for timely access to care and services, taking into account the urgency of the need for the services. Appointment scheduling standards have been established and are communicated to PCPs and Specialists in the Provider Manual and discussed in orientation meetings. After normal business hours, AmeriHealth Mercy PCPs are required to instruct members on how to reach their PCP or an approved practitioner providing 24-hour coverage.

Monitoring and Evaluating Compliance

AmeriHealth Mercy has implemented the following procedures to monitor its PCP network to evaluate compliance with availability and appointment scheduling standards.

Geographic Distribution and Provider Availability – Annual Assessment

Annually, Provider Network Management utilizes the GeoNetworks® software program to generate number and geographic distribution of provider sites in relation to membership to assure that the established standard is met. The goal is to have a 98% compliance rate or better. If gaps are identified, AmeriHealth Mercy implements interventions and other corrective measures, such as recruitment of necessary service providers, in order to ensure compliance. Results are reported annually to the Quality Service Committee, which monitors compliance and issues recommendations for improvement. The Quality Service Committee compares the following year's annual assessment of the geographic distribution of providers and number of providers to members to determine whether the previous year's interventions had the desired effect.

Education and Communication of Standards

AmeriHealth Mercy uses all available methods to educate and communicate provider appointment scheduling standards with the aim of ensuring providers have a clear understanding of expectations. Appointment scheduling standards will be routinely communicated via on-site orientation of new providers, ongoing training, the provider manual (available online), provider website, and the provider newsletter.

Evaluating Compliance

Follow-up contact with the providers ensures that the member's experience is consistent with these standards. Compliance is monitored through a number of tracking and reporting vehicles, including tracking calls from members related to dissatisfaction with appointment and wait times. Complaints are forwarded to a Provider Contracting Representative for investigation and resolution. Aggregate complaint data is trended to identify physician offices with repeated problems.

AmeriHealth Mercy also conducts assessments via "Secret Shopper" surveys, and provider audits. "Secret Shopper" calls allow us to directly experience the response from the physician's office that our members receive. We call physician offices after normal business hours to verify access. We also audit provider scheduling records to determine appointment availability and monitor wait times during on-site visits.

Non-compliant providers are notified of findings by their Provider Contracting Representative and re-instructed regarding the standards. The Provider Contracting Representative then schedules another monitoring event to check appointment availability.

Corrective Measures

Offices that are non-compliant during repeated monitoring attempts are required to prepare and implement a corrective action plan. The Provider Contracting Representative monitors implementation and reports the results to a Quality Service Committee. Non-compliant offices are also automatically included in the provider list for the next monitoring session to make certain the providers have corrected their procedures and are now meeting AmeriHealth Mercy standards.

Results of our monitoring activities are combined with select Consumer Assessment of Healthcare Providers and Systems (CAHPS) responses and AmeriHealth Mercy Health Plan phone access performance evaluations to create a global picture of Appointment Scheduling Access and Geographic Availability. The findings are reported to the Quality Service Committee where, as appropriate, corrective action plans are recommended and monitored to make certain the providers are meeting Plan standards.

PCP to Member Ratio

All member and provider data are stored in the Facets system. Facets functionality supports setting a maximum panel count value on each practitioner record. We set a maximum value that preserves the 1000 recipient per full time equivalent PCP ratio and prevents additional assignment of members when the value will be exceeded. Daily panel count reports are delivered to both Member Services and Provider Network Management to monitor "open panel" status. Through use of this functionality, daily reports and on-going evaluation of Geo Access data, PCP to member ratios are consistently monitored and used to define provider recruitment needs.

QUESTION 7

How do you ensure that members have access to medical care for needs that arise after hours and for urgent, non-emergency situations? How do you monitor providers to ensure that follow-up is done with the member and the member's PCP to facilitate transfer of information from the after-hours provider? Describe any incentive programs you have in place to improve access to care by rewarding providers who provide extended and/or after hours care.

(Limit to two pages)

RESPONSE TO QUESTION 7

AmeriHealth Mercy has several complementary strategies to improve access to after-hours care and urgent care. We have long been aware of the problem, as well as its consequences in terms of discontinuity of care, member and provider inconvenience, and misuse of healthcare dollars. AmeriHealth Mercy recognizes the importance of good communication with both providers and members, especially when related to follow-up of the diagnosis or treatment of a condition, including emergency care, post-stabilization care, or acute or chronic condition management.

AmeriHealth Mercy offers enhanced compensation to PCPs for extended office hours on weekdays and on weekends. Additionally, we offer additional compensation to providers for opening their offices outside of their normal business hours to address an urgent patient need. AmeriHealth Mercy is working to improve access to after-hours care and urgent care through contracts with urgent care centers and by encouraging area health systems to offer increased urgent care centers and "walk-in" clinics for routine care. We provide a 24/7 Nurse Call Line for members to call if they need advice related to an urgent medical need. In a practitioner's absence, the patient must be instructed, via an answering service or a telephone answering machine, on how to reach their PCP or an approved practitioner providing 24-hour coverage.

Care managers work to proactively facilitate PCP appointments for members as appropriate following after-hours and emergency care or post-stabilization care, as well as for enrollees who are in need of such assistance due to an acute or chronic condition. Our Care Management team ensures that all key/current providers, including specialists and behavioral health clinicians, who are involved with the enrollee's care are kept informed of relevant medical events and treatments to identify areas for care coordination and participation in the development of the plan of care. The frequency and extent of communication following the diagnosis and treatment of a condition, emergency care, or post-stabilization care will be provided in accordance with the guidelines of our Intensive Care Management (ICM) program.

If the member is admitted to the hospital following the ER visit, our Medical Director or utilization management staff notifies the PCP and works with them to assure continuity of care. In addition, the PCP has access to the full history of health care delivered to the member through the Clinical Patient Summary via the NaviNet system. This data includes care rendered in the ER or after hours care provided by another practitioner. Accessing this data allows the PCP to be aware of all healthcare services provided to his/her patients.

Follow-up contact by the providers ensures that the member's experience is consistent, and is a critical component of assessing access to care.

Providers who are non-compliant with any of the accessibility standards are notified of our findings by their Provider Contracting Representative and re-instructed regarding the standards.

Offices that are non-compliant during repeated monitoring attempts are required to prepare and implement a corrective action plan. The Provider Contracting Representative monitors the implementation of any corrective action and reports the results to the Quality Service Committee. Non-compliant offices are also automatically included in the provider list for the next monitoring session.

Our Provider Contracting Representatives work with provider offices to assist them in implementing creative solutions and adjusting their processes to become compliant.

In 2010, AmeriHealth Mercy ER utilization rates increased from the previous year. Since then, our provider incentive programs have become effective in reducing our members' non-emergent ER usage. As mentioned in question 5, one of the performance metrics for AmeriHealth Mercy's primary care provider incentive program (Quality Enhancement Program) rewards PCPs for improving the management of members who frequently use the ER. In the most recent cycle of the program, a total of 1,165 PCPs qualified to receive incentives based on their performance in caring for 104,000 members. Additionally, we offer enhanced compensation to PCPs for extended office hours and compensation to providers for opening their offices outside of their normal business hours to address an urgent patient need.

QUESTION 8

Describe the policies and procedures followed in response to the network termination or loss of a large-scale provider group or health system. Please develop the response taking the following areas into consideration:

- *System utilized for identification and notification of members affected by the provider loss;*
- *The automated systems and membership supports utilized in assisting affected members with provider transitions;*
- *Systems and policies utilized for continuity of care of members experiencing provider transition; and*
- *Outcomes experienced in coverage of the membership with existing network resources following the terminations.*

(Limit to five pages)

RESPONSE TO QUESTION 8

Overview

AmeriHealth Mercy's processes require us to take all necessary steps to work with a provider to address any concerns, and take necessary steps to prevent the termination of providers from our network. In instances when we have to terminate a provider from our network, such as if a provider no longer meets our credentialing standards, AmeriHealth Mercy has an effective process in place for minimizing the impact to and communicating with the member.

When faced with a possible termination of a provider, particularly one whose loss would adversely impact care to a significant number of members, we will first and foremost take all reasonable measures to prevent such a termination. If the termination is being initiated by the provider, we will immediately contact the provider to ascertain the reasons for the termination notice. Regardless of the reason the provider initiated the termination notice, we will explore whether there are administrative modifications we can make to improve provider satisfaction to prevent the loss of the provider to our network.

While we will exhaust all reasonable options to retain the provider**,** AmeriHealth Mercy also has detailed contingency plans to ensure a network provider termination is managed effectively and efficiently and to assure that the continuity of care for our members is not compromised.

Whenever a provider's contract is terminated, all affected members will be notified in writing by AmeriHealth Mercy. In the case of a member who received his or her primary care from, or was seen on a regular basis by the terminated provider, we will make a good faith effort to give written notice of termination of a contracted primary care provider at least 30 days before the termination effective date, to each such member.

In the case of terminated primary care physicians, "affected members" are defined as those who have designated the terminating provider as their primary care practitioner. In the case of terminating specialty physicians, utilization data will be used to identify those members who had seen the terminating specialist for specialty services during the preceding 12 months. In the case of a terminating hospital, utilization data will be used to identify members who had been treated at the terminating hospital for services during the preceding 12 months.

Critical to a smooth provider termination is proper identification and notification of the members and providers affected by the termination as well as proper and timely notification to DPW and related agencies. The contingency planning process includes the following activities when a large-scale provider group or health system is terminating.

Identification of Members and Providers

- Identify all providers owned (employees of the provider group or health system) by the provider group or health system
- Determine community providers (not employed by the provider group or health system) with admitting privileges only at terminating facilities
- List community providers (not employed by the provider group or health system) with admitting privileges at terminating facilities and who also can admit to other hospitals in the network
- Identify members who within the past 12 months received health care services from a terminating facility or provider or whose primary care practitioner (PCP) is terminating

- Identify those members with special needs or who will have continuity of care issues for immediate outreach – especially pregnant women, members in care management programs, members with HIV/AIDS, children in foster care or in children and youth custody

Analysis of Network Adequacy

- Analyze member health care access issues caused by facility and practitioner termination through a Geo Access Survey
- Develop strategies to mitigate access to care issues, e.g., recruitment of additional providers and practitioners to fill gaps in care

Timely DPW/Related Agency Notification

- Inform the state and benefits counselor and other relevant parties of the potential for a termination
- Provide DPW written notice of any material change to the provider network at least 60 days prior to the effective date of the termination. Notice will include the reason(s) for the proposed action
- Draft and obtain DPW's approval of member and provider notification letters, scripts for associates who will outreach to and receive calls from affected members, and related materials
- Submit to DPW a termination work plan and supporting documentation within 10 days of notification to DPW of the termination

Continuing Care/Transition to Alternative Providers

- Manage all open authorizations at a terminating provider so continuity of care arrangements can start for members in an active course of treatment
- Create a member strategy and identify and outreach to physicians to whom members will be transitioned

Notification to affected members will include information regarding assistance in choosing another contracted practitioner and referral to the AmeriHealth Mercy website for a list of network providers in the member's area. The member may also call Member Services for assistance in selecting a new PCP, specialist or hospital provider.

Once the termination notification has been mailed, members with terminating PCPs are given at least 10 days from the letter's date to choose a new PCP. Once the time period ends, the members are automatically assigned to a new PCP through a process algorithm, which places the member with a geographically accessible PCP. Members will also receive information on how to change the assigned PCP if they are not happy with the assignment.

A strong communication plan details steps taken to ensure that AmeriHealth Mercy is not only complying with DPW requirements, but also ensuring that we are assisting all affected members in transitioning to new providers. Communication plans will include updates to the provider directories as required by Section V.F.16 of the agreement with DPW.

Automated Systems and Membership Supports

AmeriHealth Mercy employs various types of additional notification strategies which are used as needed to supplement the written notification and to ensure that members receive timely information. These strategies are implemented if we are unsuccessful in reaching members or for any reason the traditional methods are not successful. These strategies include phone calls, "on hold" messages, and automated and interactive phone calls. Special effort is made to contact

members with special needs so that the health care services they receive continue without interruption. Members with special needs receive repeated phone calls and/or home visits arranged by our Rapid Response staff until our Case Managers have successfully transitioned or arranged for continuation of their care.

Geo Access maps are prepared to determine network composition and access with, and without, the provider in question. This allows the development of a recruitment plan to replace the needed provider specialty, if possible. Additionally, we take steps to ensure early identification of members with special needs. Early outreach to all affected members enables the arrangement of appropriate, quality alternative health care services and mitigates disruption to both members and the provider network. If alternative providers and practitioners cannot be located, early outreach allows AmeriHealth Mercy to arrange continuation of care with the terminating provider for as long as medically necessary, without disrupting care for the member.

Continuity of Care Policies

AmeriHealth Mercy allows members to continue ongoing treatment with a health care provider whose contract terminates, except when the provider's contract is terminated "for cause" reasons. "For cause" includes quality of care issues, the provider is not a Medical Assistance provider, or the provider did not comply with regulations or contract requirements. AmeriHealth Mercy can approve requests for ongoing treatment or services when the request is made by the provider or by the member. Continuing care requests are reviewed on a case-by-case basis. AmeriHealth Mercy considers treatment "ongoing" if the member was treated during the past 12 months for a condition that requires follow up care or additional treatment. Services are also considered "ongoing" if they have been prior authorized. Once AmeriHealth Mercy has received the request for continuing care with a terminating provider, the case is reviewed. AmeriHealth Mercy notifies the member and provider by telephone if the request is approved. If the request is not approved, AmeriHealth Mercy will call the provider and the member and will also send a letter explaining the decision and describing the member's appeal rights.

When continuing care is approved, members may continue to see the terminated provider for 90 days beyond the date the member was initially notified. If the member is pregnant, continuing care will be approved with that obstetrician or midwife and hospital provider through the end of the postpartum care period.

Outcomes experienced in coverage of the membership with existing network resources following the terminations

AmeriHealth Mercy has an excellent record in transitioning members to other network providers when a provider termination necessitates initiation of contingency plans. An example of this occurred in April 2010, when AmeriHealth Mercy terminated its relationship with Milton S. Hershey Medical Center and the University Physicians Group. AmeriHealth Mercy successfully transitioned all PCP panel members to other PCPs near the members' homes. AmeriHealth Mercy entered into a contract with an alternative health care provider (Pinnacle Health System) and has not had enduring network access issues due to the loss of the Hershey providers.

TRANSPARENCY

CONTENTS

QUESTION 1

Describe how you currently use or how you would in the future create and use a tool that includes a graphical interface that allows users to track costs for specific medical procedures across the network of providers. Describe how this tool has been or could be adapted for shared use by Department staff, and whether this tool currently does or will in the future allow the Department to determine the population of providers who will accept a certain payment rate and the associated savings if the Department paid no more than a set payment rate which becomes a defined benefit maximum payment?

(Limit to two pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy has a long history of using actionable data and benchmarks to assess the quality of our provider networks. We believe that providing actionable data to members and providers, along with compelling incentives, can drive behavioral changes, thereby creating a more efficient and higher quality network.

This section will briefly outline our current PerformPLUS provider profiling system and how we believe this system can be expanded to track costs for specific medical procedures, store provider current and potential contract rates and be diverse, secure and flexible enough for ad hoc reports to be run and analyzed by both AmeriHealth Mercy and the Department.

PerformPLUS

Developed by AmeriHealth Mercy, PerformPLUS is a data repository and analytics tool that supports our methodology for profiling and reporting provider performance. PerformPLUS currently allows us to provide network providers with actionable and benchmark data by compiling all sources of data, such as claims, encounter, membership, provider contract rates, and utilization data, into a single data repository. Reports are then prepared from this database and shared with providers monthly, quarterly, and annually so that providers may review key information on their performance relative to their peers.

Our PerformPLUS tool tracks HEDIS measures, member Care Gaps and key cost metrics for hospitals and specialists. Physician incentives are aligned with key metrics to promote the efficient use of resources. Please see Attachment 1 for a sample PCP and Hospital Profile.

AmeriHealth Mercy PCPs receive bonuses based on the quality of care they deliver. Top-tier providers are segmented within each respective category and supplemental bonus opportunities are available for statistically significant achievement relative to the baseline.

Current performance metrics include:

- Inpatient admissions
- Quality reporting measures*
- Average Length of Stay (by DRG)**
- Ambulatory care sensitive conditions*
- Emergency room utilization
- Potentially preventable readmission rates*
- Average cost per admission (by DRG)**

** Relative to the practitioner's specialty*

***Hospital specific metric*

Future State

AmeriHealth Mercy's partner in the New East Zone, Blue Cross of Northeastern Pennsylvania (BCNEPA), currently allows its members to review and compare a variety of costs for specific hospital and outpatient services using BCNEPA's secure member portal. This tool would enable members to identify providers willing to accept a certain payment rate. The associated savings to the Department of Public Welfare, if it paid no more than a set payment rate, could be calculated if the member receives services beyond the defined benefit maximum. AmeriHealth Mercy and BCNEPA will collaborate on efforts to enable AmeriHealth Mercy to leverage the existing BCNEPA tools and infrastructure to support AmeriHealth Mercy's Medicaid program.

As needed, AmeriHealth Mercy would potentially secure its own contract with a "front-end" graphical interface vendor. Today, a leading vendor is this market space is SAP and their *Crystal Reports*. A tool such as *Crystal Reports* would allow a user to 'slice-and-dice' the data held by PerformPLUS by any predefined metric. For example, a very simple report could be prepared

that would show inpatient rates categorized by provider, region, or primary diagnosis. Additional examples include reviewing the average length of stay by diagnosis-related group (DRG) by hospital, and the average cost of DRGs by specialist. All variances, trends, and benchmarks could be assessed with the support of a front-end analytics tool. The analysis available to a user would be unlimited.

For data to be actionable, it also must be timely. As such, we will work towards refreshing the available data as close to real-time as possible. As claims are submitted and adjudicated regularly, PerformPLUS could be updated in tandem.

Department Access

AmeriHealth Mercy also understands the importance that this data and analytics ability would have to the Department. As such, AmeriHealth Mercy would ensure that the Department would have their own secure log-in to the graphical interface. As the data would only flow from PerformPLUS to the interface — and not the other way around — there would be no risk to the integrity of the underlying data source. We would also ensure that the Department's log-in was supported by all modern security to ensure protection of members' private health information. All State and Federal regulations around data safety would be followed at all times.

Timeline

There are currently two limiting factors to going live with this process. The first is the implementation of a front-end analytics tool such as *Crystal Reports*. Again, should we seek support from SAP, the generally proposed timeline for implementation for this process is six months to one year. This includes an allowance for end-user training. This model would be scalable to be applied to additional populations and geographic regions.

An additional limiting factor would be the collection of data that does not currently exist within PerformPLUS. For example, we do not currently store data concerning which providers are willing to accept a certain payment rate. However, if our Provider Contracting Representatives were to collect this information during their monthly meetings with providers, we could surely create a field for such data in PerformPLUS, which would then be available in our graphical interface for an end-user to run analytics. AmeriHealth Mercy would welcome a dialogue with the Department on additional metrics that they would like to be made available in the PerformPLUS database.

QUESTION 2

Describe how you currently or would in the future provide cost transparency information to Medicaid consumers through a call center and over the Internet using a secure web portal. Describe whether and how this call center and/or web portal currently allows or would in the future allow the consumers to shop for required medical services by selecting the most cost-effective healthcare settings, locations and providers, while continuing to ensure appropriate access to high quality, medically necessary healthcare services and procedures.

(Limit to two pages)

RESPONSE TO QUESTION 2

As discussed in Question 1 above, AmeriHealth Mercy believes that providing actionable data to members and providers, along with compelling incentives, can drive behavioral changes that create a more efficient and higher quality network. As such, AmeriHealth Mercy has invested heavily in providing data to Members through telephonic outreach, mail campaigns, health education materials, community outreach programs, and many more avenues. However, our Member Portal provides the most efficient way to deliver valuable data.

This section will briefly discuss the current state of our Member Portal; its interface with our Member Services team; and how we believe that cost transparency data can be added to support members in the selection of cost-effective and high quality healthcare settings and providers.

Member Portal

The objective of the Member Portal is to provide members with efficient and secure interactive tools to help them develop a clear picture of their medical care. By giving members access to such information, clinical outcomes improve through better medication adherence and a reduction in Care Gaps.

The Portal allows members and guardians to establish a user ID and password for secure access. To date, the following options available to members via this secure environment:

- PCP Information
- Medication List
- Care Gap Report
- Member Clinical Summary
- EPSDT Clinical Summary
- Request an ID Card
- Request a Handbook
- Send secure email
- Health and Wellness Library
- Complete a Health Risk Assessment

Once a member is connected to the Portal, the Portal supports good member decision-making by emailing the member reminders for office visits and for upcoming Care Gaps and/or EPSDT needs. These reminders are also supported by health education materials available via the Health Library.

Call Center Support

Make Every Member Contact Count

Care Gaps are integrated with all internal information systems. This integration provides an alert to any AmeriHealth Mercy employee who enters the member's ID number into the system. These alerts enable staff to address gaps in services during every member encounter. As such, should a member call our call center for any reason, the Member Services Representative is informed of the member's Care Gaps and reminds the member of the gap as part of their standard script. Additionally, the Member Services Representative offers to assist the member in scheduling an appointment, should that be required, and will also connect the member to our Rapid Response team, should additional barriers to care be identified.

Future State

As discussed above, AmeriHealth Mercy has a strong infrastructure in place to direct valuable information to members to improve their health outcomes. Looking towards the future, we will collaborate with our partner in this proposal, Blue Cross of Northeastern Pennsylvania (BCNEPA), on efforts to enable AmeriHealth Mercy to leverage the existing BCNEPA tools and infrastructure to support AmeriHealth Mercy's Medicaid program. As discussed in our response

to Question 1, BCNEPA members can view and compare specific procedure costs at hospitals and outpatient facilities using BCNEPA's secure member portal. Physician cost and quality transparency data will be available through this same member portal beginning in the first quarter of 2012.

As discussed in Question 1, AmeriHealth Mercy also has a strong, supportive data foundation. With the addition of stronger data analytics, such information could also be directed to members through the Member Portal. Such analytics could be similar to the web page that the member now views when selecting a primary care provider (PCP). When a member completes this process, they first enter their zip code, and the system filters the data by location. The member is also able to enter a number of selections including physician gender, language, and specialty. The system then filters the data by these selections and provides the member with the respective matches.

In this future state, when a member is selecting a PCP, they could also be prompted to select a high-efficiency provider, as defined by average cost of procedure or visit and quality performance. The member could also be prompted to select a provider with the highest Healthcare Effectiveness Data and Information Set (HEDIS) adherence rates. Furthermore, when a member is prompted to follow-up on a Care Gap or EPSDT screening for a child, they could also be prompted to use a number of cost- and quality-related filters. For example, should a member need a procedure, they could search for the providers and locations with the highest quality, as measured by health outcomes.

Should a member call into our Contact Center, the Member Services Representative could guide the member through this selection process verbally. As discussed above, the Member Services Representative would be alerted to the potential need for services by the member's ID and simply direct the member through the analytic process to aid in his/her selection of the appropriate care location and provider.

Cost transparency data will also be made available to the member in the explanation of benefits (EOB) statement and the member's landing page on the Member Portal. The EOB explains what medical treatments and services were reimbursed on the member's behalf, describing: the service performed (including the date and description of the service, as well as the name and location of the service provider); the provider's fee and the MCO's contribution; and the amount for which the patient is responsible, if any, and directions for filing an appeal. The member's landing page on the Member Portal will contain the same information in an electronic format.

Timeline

The greatest limiting factor in providing members access to such cost transparency data is defining the data definitions. AmeriHealth Mercy would look to partner with the Department on setting these definitions, so that when communicating to a member that a certain PCP is a high-quality provider, all parties are in agreement as to the precise definition. As noted in Question 1, the analytics should be up and running 6–12 months after vendor selection. AmeriHealth Mercy estimates that an additional year of research and discussions will be required to roll out the additional analytics to members. The Member Portal build-out and education of Member Services staff could be completed in-house and in parallel to the definition finalization. This model would be scalable to additional populations and geographic regions.

QUESTION 3

Describe any methods and strategies you currently or would in the future employ to encourage Medicaid consumers to utilize the most cost-effective healthcare settings, locations and providers, while continuing to ensure appropriate access to high quality, medically necessary healthcare services and procedures. In particular, describe how you currently or would in the future reward or incent Medicaid consumers who utilize a cost-effective location identified by shopping through the call center or member web portal described above.

(Limit to two pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy believes that providing actionable data to members and providers, along with compelling incentives, can drive behavioral changes, thereby creating a more efficient and higher quality network.

This section will briefly outline our current education and incentive programs and how we believe that these programs can be expanded to encourage members to utilize cost effective health care locations and providers.

Member Incentives

AmeriHealth Mercy has a history of successfully leveraging actionable information with member incentives to change behavior. For example, our affiliated South Carolina plan was faced with poor adherence to Prenatal Care guidelines and was subsequently experiencing poor birth outcomes. AmeriHealth Mercy set out, and achieved, the NCQA 90th percentile on these measures.

To achieve this goal, AmeriHealth Mercy pursued a number of interventions including:

- Better identification of at-risk members
- Better education of at-risk members, leveraging technology for reminding and tracking purposes, literature, and community outreach
- Better incentives for mothers who achieved certain care goals, via our Baby Shower program through a partnership with March of Dimes

For a complete review of this Case Study, including a review of the results, please see Attachment 2. We also have a similar program in our Pennsylvania market, where moms receive gift cards after reaching certain milestones with their pre- and postnatal care:

- First prenatal visit during the first trimester or within 42 days of joining the plan
- Completion of over 80% of expected prenatal visits (calculated by using a combination of data from eligibility date, delivery date, and gestational age)
- Upon completion of a postpartum visit within 45 days of the delivery

Information concerning these benefits is communicated through the Member Handbook, Member Portal, as well as through pregnancy-related educational materials and prenatal care improvement initiatives coordinated by AmeriHealth Mercy's WeeCare (Maternity) program. The WeeCare staff educate and reinforce the benefits during their interactions with pregnant members. Additionally, AmeriHealth Mercy conducts targeted communication campaigns (electronic, text, telephone, mail) to the pregnant population to inform them of the benefit.

AmeriHealth Mercy believes that the incentive program, described above is the best-in-class and the structure — member identification, education and incentives — can be used to direct members to leverage the provider cost and quality shopping tool in the Member Portal.

Future State

AmeriHealth Mercy believes that it already possesses a strong base of usable data and an excellent methodology for sharing relevant information with members. Our software, either internally or externally developed as discussed in greater detail in Question 4, will allow us to know the lowest cost provider or site of service for certain procedures that maintain quality standards. As also discussed above, we will then direct members via the Member Portal, or

through telephonic interactions with our Member Services Representatives to those providers and locations.

With the addition of a member incentive to the other elements of the program, AmeriHealth Mercy feels that it would be successful in driving utilization towards this resource. Members will receive financial incentives and support services, such as transportation, to ensure that barriers to cost effective and high quality care are removed.

To that end, AmeriHealth Mercy recommends a similar incentive for members who seek care in the more cost effective health settings and locations. Of course, all member incentives would also be in accordance with all local, State, and Federal laws and with the approval of the Department. Potential incented behaviors could be:

- First selection of a provider or care location from the Member Portal selection tool or via a telephonic interaction with a Member Services Representative verbally guiding them through the process
- Completion of over 80% of care interactions with high-quality providers, as defined by AmeriHealth Mercy
- Upon completion of a procedure at a high quality and preferred location, as defined by AmeriHealth Mercy

The definitions of these settings and their correlation to quality would need to be well-defined and supported. The priority is always in directing members to the most efficient and highest quality care resources available.

Once an incentive is clearly defined, member education would be provided through the Member Handbook, Member Portal, and related educational materials, as well as through more targeted outreach efforts initiated from our Integrated Care Management team. Additionally, we would conduct targeted communication campaigns (electronic, text, telephone, mail) to the population known to be high utilizers or more likely to seek a medical procedure in the near future.

Also as discussed in Question 2 above, our Member Services Representatives would be instructed on the details of this program, and would remind a member of the rewards while aiding them in scheduling appointments.

Timeline

The metrics to be incented would be defined and refined through collaboration between AmeriHealth Mercy and the Department. We commit to partnering with the Department in the preparation of any waivers to CMS in order to gain approval for these programs for their successful future implementation. We believe that such incentive programs will be beneficial for both members and taxpayers. These conversations could occur in parallel to the implementation and build-out, and would be operational at the time that the Member Portal is able to go live. This model would be scalable to additional populations and geographic regions as needed.

QUESTION 4

Describe how you currently (or would in the future) perform detailed analysis of claims and/or encounter data, including Medicaid claims data provided by the Department, to generate total average costs for specific medical procedures or tests at various provider locations across the provider network. Describe how you would present and incorporate the results of such analysis both within the shopping tool and as part of the defined benefit maximum tool for use by the Department.

(Limit to two pages)

RESPONSE TO QUESTION 4

AmeriHealth Mercy has much experience in analyzing data to extract actionable information for members and providers. As discussed in Question 1, we have sifted through these numbers for many years to provide direction to providers via our Provider Profiles.

This section will briefly outline our current analysis of claims and encounter data and how we would look to leverage that data to refine the statistics on average costs per procedure or test to share that information with members and the Department.

PerformPLUS

As discussed in Question 1, AmeriHealth Mercy designed PerformPLUS as a data repository tool that supports our methodology for profiling and reporting provider performance. PerformPLUS currently allows us to offer network providers actionable and benchmark data by compiling all sources of data, such as claims, encounter, membership, provider contract rates, and utilization data, into a single data repository.

With the addition of stronger data analytics, also discussed as part of Question 1 above, such information could be available via a graphical interface and 'sliced-and-diced' in numerous ways. Given the aforementioned functionality, AmeriHealth Mercy would be required to review average costs of procedures or tests via a consistent data field. The fields that are in use today are DRG codes, current procedural terminology (CPT) codes, and average length of stay. As such, we are able to assess the cost of a DRG by admission, and then further dissect the data by location, provider, or even by a specific time period. AmeriHealth Mercy does not currently have a grouper beyond such building blocks.

Future

The greatest value of the current PerformPLUS tool is the extensive data that it stores and with which it is updated at regular intervals. Looking towards the future, we will collaborate with our partner in this proposal, Blue Cross of Northeastern Pennsylvania (BCNEPA), to leverage BCNEPA's existing tools and infrastructure used to group medical and pharmacy claims and encounters into episodes of care for use with AmeriHealth Mercy's Medicaid Program.

BCNEPA calculates an average cost per episode by service categories within specific medical conditions. The results are presented for a provider or for various facilities. Similar results are generated for hospitals and outpatient facilities, so that BCNEPA members can select the most cost-efficient provider. These results are currently presented for hospitals and outpatient facilities through BCNEPA's secure member portal, and cost and quality results will be available for physicians beginning in the first quarter of 2012.

As needed, AmeriHealth Mercy would potentially secure a contract with a vendor that has been developing a grouper agent that examines Episodes of Care. Today, two leading vendors in this market space are Cave Consulting Group and Compass Healthcare Advisers. Both vendors provide tools offering existing, internally validated groupers that create Episodes of Care and correlations to health outcomes. The Compass shopping tool (Compass Choice Rewards) can incorporate additional information alongside cost rankings, for example, combining both cost and quality measures into an amalgamated provider ranking model that is provided to members.

Member Portal

Once the aforementioned grouper information is secured, a member selecting a PCP could also be prompted to select a provider with the highest quality outcomes, as defined by a quality grouper. Furthermore, when a member is prompted to follow-up on a Care Gap or EPSDT screening for a child, he/she could also be prompted with a number of cost- and quality-based filters. For example, should a member need a procedure, they could search for the providers and locations with the highest quality, as measured by health outcomes.

Should a member call into our Contact Center, the Member Services Representative could also guide the member through this selection process verbally. As discussed above, the Member Services representative would be alerted to the care need by the member's ID and simply directs the member through the analytic process to aid in their selection of the appropriate care location and provider.

Department Access

AmeriHealth Mercy also understands the importance that this data and analytics ability would have for the Department. As such, AmeriHealth Mercy would ensure that the Department would have its own secure log-in to the graphical interface, including this grouping data. As the data would only flow from PerformPLUS to the interface — and not the other way around — there would be no risk to the integrity of the underlying data source. We would also ensure that the Department's log-in was supported by all modern security measures to ensure protection of members' private health information. All State and Federal regulations concerning data safety would be followed at all times.

Timeline

Cave Group Consulting and Compass Healthcare Advisers usually propose a 6 month to 1 year implementation period, including end-user training. This could be done in parallel with the installation of *Crystal Reports* analytics software. This model would be scalable to additional populations and geographic regions as needed.

QUESTION 5

Describe how your current systems provides and how you use, or how you would in the future create and use, (and how you are or will be able to share the Department) the following:

- *Reports that capture consumer program activity/utilization for both the shopping service and defined benefit maximum service, including consumer interactions, incentives delivered and corresponding claim savings attributable to consumers selecting cost-effective locations.*
- *Geographic reports that capture total cost by medical procedure, allowing users to understand cost variation across the network and to analyze the impact of maximum allowed reimbursement rates on cost savings?*
- *Listings of all in-network providers within specific geographic areas that provide specific medical procedures and the cost for those procedures (or denoting high cost users from low cost users).*

(Limit to two pages)

RESPONSE TO QUESTION 5

AmeriHealth Mercy has a long history of using data and benchmarks to assess the quality of our provider networks. Additionally, AmeriHealth Mercy has a strong history of directing relevant information to members. We believe that providing actionable data to members and providers, along with compelling incentives, can drive behavioral changes, thereby creating a more efficient and higher quality network.

This section will briefly outline our current data sharing protocols and how we believe that they can be expanded in the future to better track member activity/utilization of relevant tools, and to educate members on cost variation across the network as well as the impact that it has on the overall cost of healthcare.

Tracking Consumer Program Activity/Utilization

As discussed in greater detail in Question 2, AmeriHealth Mercy is very proud of its Member Portal and its integrated care system that allows our staff to see a member's current condition, simply by entering the member's ID into the system.

As the shopping service and defined benefit maximum services do not currently exist, there is no current reporting. However, as the Member Portal requires a user to create a username and password, it would be simple for us to track member activity and utilization of the tools. For nonmembers or members who choose to not create a password, we would simply track the number of 'hits' on the website. These data are of limited value due to their lack of detail, but would still be a usable statistic that could directionally express the tools' popularity.

Furthermore, should we implement a member incentive, we would store the member's utilization history within the Portal, and also make this information available to the Department through its associated site, as discussed in Question 3. The availability of this information would allow the member to see their incentive history and provider choice. It would also graphically display the cost savings associated with the member's provider and his/her care location selection. Member cost savings and utilization would require an annual review at minimum to assess the impact of the member incentive, and to modify it, as appropriate.

Geographic and Provider Cost Reporting

As discussed in Question 2, AmeriHealth Mercy has a strong infrastructure and supportive data foundation in place to direct valuable information to members to improve their health outcomes. With the addition of stronger data analytics, also discussed as part of Question1 above, such information could also be pushed to members as part of the member portal.

Such analytics could be similar to the web page that the member now views when selecting a PCP. When a member completes this process, they first enter their zip code, and the system filters the data by location. The member is also able to enter a number of selections including physician gender, language, and specialty. The system then filters the data by these selections and provides the member with the respective matches.

In this future state, when a member is selecting a provider, he/she could also be prompted to select a high-efficiency provider. This could be associated with a graphic demonstrating the overall cost to the Medicaid program if the member were to select one provider over another. This information would also be made available to the Department for further analysis.

WASTE, FRAUD, AND ABUSE

CONTENTS

QUESTION 1

Describe the internal controls you will implement to detect potential waste, fraud and abuse within your own organization.

(Limit to two pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy has a comprehensive system of internal controls for detecting potential fraud, waste and abuse (FWA). These controls exist in the various systems and processes of the organization including a Corporate Compliance Program, Fraud Hot Line, and internal detection strategies.

Corporate Compliance Program

AmeriHealth Mercy has implemented and continually enforces policies and procedures to detect and prevent FWA and to provide protections for those who suspect and report wrongdoing through our Corporate Compliance Program. The Compliance Program serves as the universal platform for how we internally control the detection of FWA, and includes a written plan that contains the elements required by CMS and found at www.cms.hhs.gov/states/fraud.

AmeriHealth Mercy educates its employees, contractors and agents about:

1) Its policies and procedures for detecting and preventing FWA
2) Its Associate Guidebook and Code of Ethics and Conduct, including compliance with of the Federal and State False Claims Acts
3) The right of employees to be protected as whistleblowers
4) Compliance with the False Claims Act

Well publicized disciplinary procedures apply to all employees. AmeriHealth Mercy has, and will continue to communicate to employees, its zero tolerance of employees violating any law, including failing to report violations, such as FWA.

Fraud Hot Line and Tip Form

AmeriHealth Mercy has a confidential, toll-free telephone line for all members, providers, employees, contractors, and consultants to report suspected FWA activity. The Fraud Hotline number is promoted to vendors, provider, employees and members through newsletters, handbooks, websites, and contracts. Employees, contractors, consultants, members or providers will not be subject to retaliation or reprisal for reporting, in good faith, actions that they feel violate our Standards of Conduct.

AmeriHealth Mercy also has a “Fraud Investigation Tip Form” and a Corporate Compliance intake form on our intranet that permits employees to submit concerns related to FWA.

Internal Detection Strategies

Departments across the organization support FWA prevention and detection through a system of internal controls, including the following:

- **Claims Clinical Editing -** Upcoding, unbundling, and correct coding is identified through the prospective claims clinical editing. For example, rules are used to define what constitutes a definite or possible duplicate claim. We contract with a vendor, iHealth Technologies, to enhance the clinical editing capabilities of our Facets claims processing system to assist in the detection of FWA.
- **Prior Authorization Review -** We use InterQual guidelines to evaluate medical necessity and appropriate level of care for high cost services and services that are known to be over-utilized. We routinely administer inter-rater reliability testing to ensure consistent application of utilization criteria across all reviewers.

- **High-Dollar Claim Pre-Payment Review -** Security edits in our claims system are set at the individual employee level. This prevents claims processors from releasing payment above established dollar amounts without management approval. Payment for high dollar claims cannot be released without senior management approval. For example, an inter-disciplinary group routinely reviews all high-dollar claims above established thresholds to ensure claims are billed accurately and paid correctly.
- **Medical Record Review -** We conduct medical record chart reviews to ensure that the medical record is consistent with billed services.
- **Credentialing and Re-credentialing -** During the initial credentialing and re-credentialing process, we ensure that providers seeking to become or remain part of our network are in good standing and are not precluded from participation in state and federal programs.
- **Accounts Payable Controls -** We use industry-standard software to manage all accounts payable activity outside of our claims processing system. Security is set at the individual employee level so that employees cannot process payments without appropriate management approval.
- **Information System Controls -** We have comprehensive internal security controls governing access to our information systems. Security is set at the individual employee level to prevent access into systems that are not related to the employee's individual job responsibilities. We prohibit our employees from sharing passwords and require each employee to change his/her password every 45 days. Each employee knows that the company retains the right to monitor, inspect, or search any information system with or without the consent of the employee.

Looking Ahead

In keeping with our dedication to continuous improvement of our FWA detection abilities, AmeriHealth Mercy recently expanded its contract with Health Management Systems (HMS) to augment our FWA activities. A national leader in cost containment solutions for government-funded programs, HMS has a strong track record of FWA identification and intervention.

Our extended partnership with HMS will include retrospective data mining services and forensic editing post adjudication, as well as pre-payment fraud, waste and abuse support.

HMS's subsidiary, IntegriGuard, recently won the Investigation of the Year Award from the National Health Care Anti-Fraud Association for its work in the following case:

Dr. Stephen Schneider and his wife Linda were operating a pain management clinic in Kansas. They were found guilty of healthcare fraud resulting in death, conspiracy, money laundering and illegally prescribing narcotics. Each was sentenced to 30 years in prison. Over an eight year period, investigators found the Schneider's had dispensed potent and addictive medications to hundreds of patients. Many of these patients were later determined to be addicts, who had not exhibited symptoms of pain, and who received little monitoring or follow up. The pill mill resulted in over 100 drug overdoses and 68 deaths.

This case was brought to closure by a collection of agencies working in collaboration for the benefit of the Medicaid and Medicare programs. Together, they detected patterns of fraud and abuse, conducted medical reviews, and pooled their resources to ensure the investigation was airtight.

QUESTION 2

Describe the types of fraud detection methods you will use to detect potential waste, fraud and abuse.

(Limit to two pages)

RESPONSE TO QUESTION 2

AmeriHealth Mercy has implemented various methods to detect fraud, waste, and abuse (FWA) by providers, members, and employees, while providing protection for those who suspect and report wrongdoing. These include confidential reporting, data analytics, periodic sampling and internal audits, and follow-up of suspicious activity. Clinical editing during claims processing and the use of prepayment correct coding edits (which can lead to claims cost avoidance) supports our data analytics method.

Confidential Reporting

AmeriHealth Mercy maintains a toll-free Fraud Hotline for internal and external use. The hotline is solely for the purpose of receiving reports of suspected improper/illegal activities or misconduct on a confidential basis. All incoming referrals are recorded in the case tracking tool. The Corporate and Financial Investigations (CFI) department investigates each potential FWA activity.

Data Analytics

The CFI department utilizes automated applications to assist in detecting and preventing potential fraud, as well as access to public records and industry-wide databases. These efforts are supported by industry-leading clinical editing during prepayment claim processing. Our prepayment correct-coding edits have led to claim cost avoidance that supports reduction of FWA for a savings of more than two percent of payments. For post-payment efforts, the anti-fraud software package provides analytics, case tracking, data manipulation and visualization tools, as well as ad hoc and scheduled analyses. The department also uses an internal data warehouse to identify patterns that may be indicative of FWA. When combined, these tools are used to identify potential cases of member FWA, including, but not limited to:

- Overutilization
- Up-coding
- High-dollar claims
- Unusual patterns by subscribers, providers or facilities
- Unusual dates of service
- Excessive time units for time-based codes
- Unusual claims volume by providers or subscribers
- Unbundling services
- Incorrect reimbursement to providers, subscribers, facilities and/or pharmacies
- Incongruous procedure code, prescription, and diagnostic code combinations

The CFI utilizes the following tools:

- ***ViPS STAR Sentinel™*** - This data analysis system is used for the purposes of healthcare fraud detection, investigation, documentation, and case coordination. Using this tool, the CFI department is able to identify patterns of behavior and potential impact.
- ***Facets Claims System Edit*** - The NCCI edits are applied in a pre-payment manner to all medical claims that are processed through the Facets claims system.

Periodic Sampling and Internal Audits

Detection of FWA is facilitated through the use of data analysis from many areas of the organization, including Informatics, Claims Cost Management, and other departments that routinely perform data analysis.

The CFI department proactively identifies potential incidents of FWA as part of its program for ongoing monitoring and auditing. The procedures that CFI has in place to safeguard AmeriHealth Mercy against provider or member fraud and abuse includes the following:

- Periodic evaluation of claims data to detect apparent abnormalities in provider billing or member utilization patterns
- Periodic sampling of bills/claims to determine propriety of payments
- Sampling of services through member contact to ascertain that billed services were rendered for provider cases
- Contractual provisions for providers and subcontractors requiring compliance with FWA program standards as a condition of contracting
- Dissemination of information to members and providers concerning FWA

For example, in reviewing one of our reports, we noted a participating orthopedic group had billed an X-ray procedure with nearly every office visit. After review of the information with the group, the level of x-ray testing decreased noticeably.

The CFI Department conducts audits/investigations in response to referrals suggesting that claims are being paid inappropriately. Referrals are received from a variety of internal and external sources that are critical in monitoring and detecting potential cases of FWA.

QUESTION 3

Describe the activities you will undertake to safeguard against potential member fraud.

(Limit to two pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy's Corporate Compliance Program includes a comprehensive program to prevent, detect, and investigate potential member fraud.

Training and Education

Effective training is an integral part of the compliance plan. We routinely educate members on awareness and prevention of fraud and abuse through member newsletters, the Member Handbook, and the member website.

Coordination for fraud, waste and abuse (FWA) complaints received by AmeriHealth Mercy will be handled in accordance with State requirements. This includes complaints about a member's eligibility, a member's utilization of benefits, and health care provider's or contractor's conduct in the network. An investigator obtains necessary data for making a determination as to whether to investigate the case. Corporate and Financial Investigations (CFI) 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.

Confidential Reporting

Confidential reporting is available to all of our members. Several independent paths for reporting FWA are available. Confidential reporting may occur either through the Compliance Hotline, a telephone line to be used solely for the purpose of receiving reports of suspected improper/illegal activities or misconduct on a confidential basis or the Fraud Hotline. The Fraud Hotline is intended to be dedicated to fraud tips, concentrating on member and provider fraud; however, both Hotlines may be used to report infractions of AmeriHealth Mercy's Code of Ethics and Conduct or FWA concerns.

Data Analytics

The CFI department proactively identifies potential incidents of FWA as part of its program for ongoing monitoring and auditing. For example, CFI conducts periodic evaluation of claims data to detect apparent abnormalities in member utilization patterns. The CFI efforts are supported by industry-leading, anti-fraud technology. The anti-fraud software package provides analytics, case tracking, data manipulation and visualization tools, as well as ad hoc and scheduled analyses. The department also uses an internal data warehouse to identify patterns that may be indicative of FWA. When combined, these tools are used to identify potential cases of member FWA, such as:

- Overutilization
- Unusual patterns by subscribers, providers or facilities
- Excessive time units for time-based codes
- Unusual claims volume by providers or subscribers

Follow-up of Suspicious Activity

Upon suspicion of FWA activity, the CFI Manager will request a suspension of payment for all claims processed for the provider and/or member under investigation, and all claims payments for the provider and/or member will accordingly be suspended or withheld. Relevant departments — including, but not limited to, Operations, Provider Contracting, Medical Management and Finance — are notified of the suspension. The suspension is released upon completion of the investigation.

AmeriHealth Mercy reports substantiated instances of member fraud to appropriate regulatory, governmental oversight, and/or law enforcement agencies within the required time frame as defined by DPW. When the determination has been made that an external referral is warranted, CFI consults with Corporate Compliance and Legal Affairs to review case-specific information and complete the referral. Corrective action will be implemented if appropriate.

Pharmacy Detection

Our pharmacy network utilizes its prospective Drug Utilization Review (DUR) edits to identify potential cases of fraud and abuse. For example, a member may be alternating pharmacies in an attempt to obtain duplicate prescriptions for controlled substances. Through our prospective DUR edits, the pharmacies would be alerted that the member had recently filled a similar controlled substance at different pharmacy, providing the pharmacist the ability to investigate and determine if the prescription is appropriate to dispense.

Recipient Restriction

AmeriHealth Mercy's Recipient Restriction Committee evaluates members at risk for fraud, waste and abuse of their health benefits.Referrals for restriction are received from internal and external sources. We review six months of pharmacy claims and one year of medical claims to identify members for restriction to a specific pharmacy or medical provider. We also identify any instances of suspected fraudulent prescriptions.

Candidates for restriction are presented monthly at the Recipient Restriction Committee and recommendations for restriction are then sent to DPW for review and approval.

Upon approval from DPW, members are restricted to a combination of a PCP, a pharmacy or a facility (hospital). In accordance with DPW requirements, members are not restricted in their selection of an ER.

QUESTION 4

Describe how you use consumer verification techniques regarding the cost of inpatient and outpatient services to detect provider waste, fraud and abuse.

(Limit to two pages)

RESPONSE TO QUESTION 4

Minimum Sampling Criteria

In an effort to enhance our fraud, waste and abuse activities, AmeriHealth Mercy will provide individual notices to a sample group of the enrollees who received services, and who will be selected based on a statistically valid sample size. The enrollees will be asked to review the information provided and if they do not believe the service listed was provided, they will be instructed to contact our Member Services department. The required notice will include:

- The service furnished
- The name of the provider furnishing the service
- The date on which the service was furnished
- The exact amount of the payment made for the service

The number of enrollees to contact will be determined based on a statistically valid sample size and the enrollees will be randomly selected based on claims paid.

APPENDIX L
DOMESTIC WORKFORCE UTILIZATION CERTIFICATION (07/24/09)

To the extent permitted by the laws and treaties of the United States, each proposal will be scored for its commitment to use the domestic workforce in the fulfillment of the contract. Maximum consideration will be given to those offerors who will perform the contracted direct labor exclusively within the geographical boundaries of the United States or within the geographical boundaries of a country that is a party to the World Trade Organization Government Procurement Agreement. Those who propose to perform a portion of the direct labor outside of the United States and not within the geographical boundaries of a party to the World Trade Organization Government Procurement Agreement will receive a correspondingly smaller score for this criterion. In order to be eligible for any consideration for this criterion, offerors must complete and sign the following certification. This certification will be included as a contractual obligation when the contract is executed. Failure to complete and sign this certification will result in no consideration being given to the offeror for this criterion.

I, Jay Feldstein, D.O., Northeast Regional President **[title]** of AmeriHealth Mercy Health Plan **[name of contractor]** a Pennsylvania **[place of incorporation]** corporation or other legal entity, ("Contractor") located at 200 Stevens Drive, Philadelphia, PA 19113 **[address],** having a Social Security or Federal Identification Number of 23-2859523, do hereby certify and represent to the Commonwealth of Pennsylvania ("Commonwealth") (Check **one** of the boxes below):

☒ All of the direct labor performed within the scope of services under the contract will be performed exclusively within the geographical boundaries of the United States or one of the following countries that is a party to the World Trade Organization Government Procurement Agreement: Aruba, Austria, Belgium, Bulgaria, Canada, Chinese Taipei, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hong Kong, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Liechtenstein, Lithuania, Luxemburg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Singapore, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and the United Kingdom

OR

☐ percent (%)of the direct labor performed within the scope of services under the contract will be performed within the geographical boundaries of the United States or within the geographical boundaries of one of the countries listed above that is a party to the World Trade Organization Government Procurement Agreement. Please identify the direct labor performed under the contract that will be performed outside the United States and not within the geographical boundaries of a party to the World Trade Organization Government Procurement Agreement and identify the country where the direct labor will be performed:

_____

[Use additional sheets if necessary]

The Department of General Services **[or other purchasing agency]** shall treat any misstatement as fraudulent concealment of the true facts punishable under Section 4904 of the *Pennsylvania Crimes Code*, Title 18, of Pa. Consolidated Statutes.

Attest or Witness:

Robert H. Gilman 1/4/12
Signature/Date

Robert H. Gilman, Secretary
Printed Name/Title

AmeriHealth Mercy Health Plan
Corporate or Legal Entity's Name

Jay Feldstein DO 1/4/12
Signature/Date

JAY FELDSTEIN, Northeast Regional President
Printed Name/Title

II-2. Prior Experience – New West Zone

Contents

INTRODUCTION

Vista Health Plan, Inc. (the Offeror) and AmeriHealth Mercy Health Plan (the prime subcontractor to Vista), together with our corporate parents and affiliates, bring unparalleled experience to the development and operation of Medicaid managed care systems. Together, we have been providing managed care services to Medicaid recipients in Pennsylvania and throughout the country for nearly 30 years.

With premier operational and health care capabilities, AmeriHealth Mercy Health Plan ("AmeriHealth Mercy") and its affiliated companies is one of the country's largest Medicaid organizations, serving almost 800,000 members in Medicaid managed care plans in three states, including 106,000 enrollees in the HealthChoices Lehigh/Capital and voluntary managed care programs, and 317,803 enrollees in the HealthChoices Southeast program through our Keystone Mercy Health Plan affiliate. AmeriHealth Mercy also offers other services such as pharmacy benefits management, behavioral health care, and management of medical care to an additional 3.2 million Medicaid, Medicare, and CHIP beneficiaries in 12 states. In addition, we provide expertise in customer service, informatics, information systems, claims management, enrollment, and 24/7 nurse triage support.

AmeriHealth Mercy provides members with access to quality health care through our network providers and through our own health management programs. Our experience serving adults and children in urban and rural areas, and in ethnically diverse communities, provides us with a first-hand opportunity to identify and build upon best practices throughout the country. Our mission of caring for underserved, at-risk populations gives us the advantage of being able to customize our systems and processes to best serve their needs. We have been awarded an Excellent accreditation status from the National Committee for Quality Assurance (NCQA) and we are ranked the #22 Medicaid Health Plan NCQA. Additionally, AmeriHealth Mercy and two of our affiliated health plans are among only six companies nationwide to become early adopters of the Multicultural Health Care (MHC) Distinction program from NCQA.

CORPORATE BACKGROUND

In addition to relevant prior work done by your company, experience shown should include relevant work done by specific individuals who will be assigned to the New West and/or the New East Zones.

a. Corporate Background. *The Offeror must describe the corporate history and relevant experience of the Offeror and any subcontractors. This section must detail information on the ownership of the company (names and percent of ownership), the date the company was established, the date the company began operations, the physical location of the company, and the current size of the company. The Offeror must provide a corporate organizational chart as part of this section. The Offeror must submit, as an appendix, its organization's Articles of Incorporation. If its Articles of Incorporation does not include all the information in Appendix J. Ownership Structure and Related Information, this information must also be provided.*

Offerors must identify any current contracting or subcontracting relationship(s) that may result in a conflict of interest with the requirements of this RFP. Offerors must also abide by the Department's conflict of interest standards identified in ***Appendix E,*** *Standard Terms and Conditions for Services and* ***Appendix F****, Department of Public Welfare Addendum to Standard Terms and Conditions.*

RESPONSE TO CORPORATE BACKGROUND

Vista Health Plan ("Vista") is the Offeror under this proposal. Vista is a licensed Pennsylvania HMO, and an indirect, wholly-owned subsidiary of Independence Blue Cross, the leading health insurer in southeastern Pennsylvania, providing coverage to nearly 3.1 million people. Vista is a current HealthChoices Physical Health contractor in the HealthChoices Lehigh/Capital and Southeast Zones, and in the voluntary managed care program. Vista provides coverage in the Lehigh/Capital Zone through AmeriHealth Mercy Health Plan, and through Keystone Mercy Health Plan in the HealthChoices Southeast Zone.

Through an integrated delivery system agreement, Vista Health Plan will delegate to AmeriHealth Mercy Health Plan all responsibilities under RFP #20-11, except for family planning services and member complaints and grievances.

AmeriHealth Mercy Health Plan ("AmeriHealth Mercy") is a Pennsylvania general partnership wholly owned through subsidiaries by BMH LLC. BMH LLC, a recently formed company, is owned 61.26% by Independence Blue Cross, through its subsidiaries and affiliates, and 38.74% by Blue Cross Blue Shield of Michigan.

AmeriHealth Mercy traces its roots to Mercy Health Plan, which was established in 1982 to serve Medicaid recipients in West Philadelphia. Between 1982 and 1992, Mercy Health Plan expanded to serve Medicaid recipients throughout Philadelphia County and into Berks, Bucks, Chester, Delaware, Lancaster, Lehigh, and Montgomery counties. AmeriHealth Mercy assumed responsibility for the existing operations of Mercy Health Plan in Berks, Lancaster and Lehigh counties in 1997. Today, AmeriHealth Mercy serves more than 106,000 members in the HealthChoices Lehigh/Capital Zone and in five counties in the Voluntary Managed Care Program.

Please see Tables 1 and 2 below for the following information on Vista and AmeriHealth Mercy:

- Ownership (names and %)
- Date established
- Date operations began
- Physical location
- Current size

Table 1: Ownership of the Offeror

Offeror	Vista Health Plan, Inc.
Ownership	Indirect, wholly-owned subsidiary of Independence Blue Cross
Date Company Established	Vista was incorporated on December 18, 1985 and was acquired by Independence Blue Cross on September 21, 1990
Date Company Began Operations	July 1, 2004
Physical Location	Philadelphia, PA
Current Size	423,470 members

Table 2: Ownership of the Prime Subcontractor

Prime Subcontractor	AmeriHealth Mercy Health Plan
Ownership	Partnership of Independence Blue Cross (IBC) and Blue Cross Blue Shield of Michigan (BCBSM). IBC, through its subsidiaries and affiliates, holds a 61.26% ownership interest in BMH LLC, which is the entity that owns AmeriHealth Mercy. BCBSM holds a 38.74% share in BMH LLC.
Date Company Established	1996
Date Company Began Operations	1997
Physical Location	Corporate Headquarters in Philadelphia, PA Regional Office in Harrisburg, PA
Current Size	106,470 members

Please see Attachment 1 for our corporate organizational charts depicting the ownership structure of Vista Health Plan and of AmeriHealth Mercy Health Plan.

The Vista Health Plan Articles of Incorporation are provided in Attachment 2.

The information required in Appendix J, Ownership, Structure and Related Information is provided at the end of this section.

Vista Health Plan and AmeriHealth Mercy Health Plan do not have any current contracting or subcontracting relationships that may result in a conflict of interest with the requirements of RFP #20-11. As a current HealthChoices contractor, we currently comply, and will continue to comply, with DPW's conflict of interest standards identified in Appendix E, Standard Terms and Conditions for Services and Appendix F, Department of Public Welfare Addendum to Standard Terms and Conditions.

CORPORATE EXPERIENCE

b. Corporate Experience. *The Offeror must describe its experience providing similar services, including the name, address, and telephone number of the responsible*

official of the customer, company, or agency who may be contacted. This section of the proposal must include a description of the Offeror's:

i. Qualifications and experience with Medicaid managed care systems;
ii. Qualifications and experience operating any managed care medical program; and
iii. Experience with other Commonwealth agencies.

The Offeror must also submit ***Appendix G****, Offeror's Managed Care Experience. If the Offeror has no prior experience as referenced above, explain what qualification or past experiences may serve as a substitute.*

RESPONSE TO CORPORATE EXPERIENCE

Qualifications and Experience with Medicaid Managed Care Systems

AmeriHealth Mercy, together with our corporate parents and affiliates, brings unparalleled experience to the development and operation of Medicaid managed care systems. Together, we have been providing managed care services to Medicaid recipients in Pennsylvania and throughout the country for nearly 30 years.

AmeriHealth Mercy's experience with Medicaid managed care systems is described immediately below, followed by a summary of the Medicaid managed care experience of AmeriHealth Mercy's affiliates in Table 4. The information requested in Appendix G, Offeror's Managed Care Experience, is provided in Attachment 3.

AmeriHealth Mercy Health Plan

AmeriHealth Mercy first began serving Pennsylvania's Medicaid population in 1982 through our predecessor, Mercy Health Plan. From our beginnings in Lancaster, Berks and Lehigh counties, we have expanded to serve 106,000 Medicaid consumers in the HealthChoices Lehigh/Capital Zone and five voluntary managed care counties in northeastern Pennsylvania (Carbon, Lackawanna, Luzerne, Monroe, and Pike).

As a testament to the strength of the services and programs we offer to our members and providers in the HealthChoices Lehigh/Capital Zone, our membership has more than tripled since 2001 and our provider network has grown dramatically to keep pace with our increased membership. Currently, AmeriHealth Mercy enrolls 33 percent of the total HealthChoices eligible population in the Lehigh/Capital Zone. Our HealthChoices Lehigh/Capital and voluntary managed care members benefit from our comprehensive provider network comprised of 28 area hospitals and 73 participating hospitals in total; nearly 1,300 primary care providers; 9,800 specialists (including out-of-area specialists not available in the service area); and more than 900 ancillary providers. Our network relationships with children's hospitals and major tertiary facilities are particularly important in caring for our most medically complex members.

AmeriHealth Mercy serves many of the most medically fragile members in the HealthChoices program. We currently provide home and community-based shift nursing services to more than 231 children in the HealthChoices Lehigh/Capital and voluntary managed care programs. More than 1,700 AmeriHealth Mercy members are enrolled in our Care Coordination program through which they receive guidance and support in managing the following conditions: Asthma; Diabetes; Cardiovascular Disease (Health Failure/Heart Risk); HIV/AIDS; Sickle Cell; Hemophilia; and Pregnancy with co-morbid conditions. Members with multiple chronic illnesses are enrolled in our Intensive Case Management Program where they receive intensive interventions through an interdisciplinary team consisting of our Care Managers, Medical Director, pharmacists, and practicing physicians. External agencies involved in the members' care also participate on the care team as needed.

AmeriHealth Mercy uses state-of-the-art technology to identify members at-risk for future adverse health events and engage them in our Care Coordination Program. Looking even deeper, we use technology proactively to identify care gaps that if not addressed, could result in an otherwise avoidable ER admission or hospitalization. We have taken these efforts outside our own organization with our deployment of the Member Clinical Summary (MCS) to participating

hospital ERs. The MCS is a web-based electronic medical record that integrates claims data, pharmacy data, and care gap data, and presents the information in a usable format to the treating physician or provider. We also make this electronic medical record available to our participating ERs, so that the treating ER physician is better able to care for our members, minimizing the likelihood of a repeat ER visit.

AmeriHealth Mercy is fully integrated in the communities we serve. Recognizing that healthcare is local, we have maintained our centrally located office in Harrisburg since 2001. We perform all medical management, provider network management, and health education and outreach functions from this location. We staff this office with associates who live in communities throughout the counties we serve, and by virtue of living and working in the region, are familiar with regional differences in healthcare delivery and the needs of the community. Our Provider Contracting and Community Outreach Representatives spend the majority of their time in the field, meeting with our members and providers. Our Medical Management team members also spend considerable time in the community, meeting with participating providers and working directly with our members, completing home visits and even accompanying members to medical appointments. If awarded new contracts to serve the New West and New East Zones, we will supplement our existing staff with provider contracting representatives and outreach representatives who live and work in these additional counties.

From January to December 2011, AmeriHealth Mercy provided more than 170 community-based health education workshops in the HealthChoices Lehigh/Capital Zone. These self-empowerment educational workshops cover chronic conditions that are part of the DPW's MCO Pay-for-Performance program, and our Provider Pay-for-Performance program, including asthma, diabetes, heart health, women's health, maternity education, and poison prevention (including lead poisoning), and childhood obesity, medication safety, teen health and youth sports safety.

We understand the unique cultural and linguistic landscape of the regions we serve, and have implemented health education and outreach programs to promote health equity. For example, our Healthy Hoops program uses basketball as a platform to educate young asthmatics and their families in African-American communities about asthma management. This innovative program received the 2006 NCQA CLAS award for Recognizing Innovation in Multi-Cultural Healthcare. Likewise, we offer our Women's Wellness program and our Healthy You, Healthy Me childhood obesity program through partnerships with community organizations, community health centers, and school-based clinics primarily serving African-American and Hispanic members.

AmeriHealth Mercy's experience as a current contractor under the HealthChoices Lehigh/Capital Program also provides us with the practical experience necessary to meet all DPW contract requirements and DPW's expectations, from day-one of the new Agreement period. We have an excellent record of meeting DPW's requirements and expectations in the following areas:

- Claims processing timeliness
- Encounter data reporting
- Provider network access standards
- Member services hotline (average speed of answer and abandonment rate)
- Member enrollment procedures
- Timeliness of utilization review decisions
- Timely processing of member complaints and grievances
- Compliance with state reporting requirements

Finally, we make every effort to establish and maintain a collaborative working relationship with DPW. We strive to provide high quality customer service by offering timely, accurate and complete responses to all inquiries and information requests, and by keeping DPW apprised of important developments.

AmeriHealth Mercy's expansion into the New West and New East Zones will be led by a highly experienced team of Medicaid managed care professionals who currently manage our HealthChoices Lehigh/Capital and voluntary managed care programs. Perhaps most importantly, our Executive Director for AmeriHealth Mercy, and our Chief Medical Officer, have extensive managed care experience.

Marge Angello, RN, is the Executive Director of AmeriHealth Mercy and will lead our expansion into the New West and New East Zones. Ms. Angello led utilization management and patient care management departments at AmeriHealth Mercy and Keystone Mercy, our southeast Pennsylvania affiliate, for more than ten years. Ms. Angello has nearly 30 years of managed care experience working for health plans.

Eric Berman, DO, is the Chief Medical Officer for AmeriHealth Mercy. Dr. Berman has served in this role since 2009. Dr. Berman has more than 11 years' experience serving as a Medical Director in a variety of health plan settings.

Please see Section II-3. Personnel for more information about the highly experienced team that will lead AmeriHealth Mercy's expansion into the New West and New East Zones.

Agency Official to Contact for further information on AmeriHealth Mercy:
Gary Alexander
Secretary, Pennsylvania Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17120
(717) 787-2600

Medicaid Managed Care Experience of AmeriHealth Mercy Affiliates

The following table summarizes the qualifications and experience of other AmeriHealth Mercy affiliates related to Medicaid managed care programs.

Table 4: Qualifications and Experience of AmeriHealth Mercy Affiliates

AmeriHealth Mercy Health Plan Affiliate	Agency/Customer to Contact
Keystone Mercy Health Plan Keystone Mercy Health Plan, through its predecessor Mercy Health Plan, has served Medicaid recipients in what is now the Southeast Zone since 1983. Keystone Mercy currently serves more than 317,000 Medicaid recipients in Pennsylvania through the HealthChoices Southeast Program. Keystone Mercy has an Excellent accreditation status from NCQA and is rated the #25 Medicaid Health Plan in America.	Gary Alexander Secretary, Pennsylvania Department of Public Welfare P.O. Box 2675 Harrisburg, PA 17120 (717) 787-2600
PerformRx, LLC PerformRx provides comprehensive pharmacy benefit management services for more than 3.2 million covered lives	Patricia Tanquary, MPH, PhD Chief Executive Officer 595 Center Avenue, Suite 100

AmeriHealth Mercy Health Plan Affiliate	Agency/Customer to Contact
nationwide, with unique expertise in Medicaid and Medicare Part D. PerformRx programs include network management, audit service, utilization management, formulary design, rebate management, prior authorization, call center, mail pharmacy, and specialty pharmacy. PerformRx is among the first companies to have received accreditation under URAC's Pharmacy Benefit Management Standards.	Martinez, CA 94553 (925) 313-6004
Community Behavioral Health Network of Pennsylvania (CBHNP) CBHNP is a full-service behavioral health managed care company that supports over 1 million members nationwide through specialized behavioral health and human service programs in the public and private sector. CBHNP currently serves approximately 200,000 Medicaid recipients in 12 counties in Pennsylvania through the HealthChoices Behavioral Health Program. CBHNP has been awarded full accreditation by the National Committee for Quality Assurance (NCQA), which is the highest level of NCQA accreditation.	Scott Suhring CEO, Capital Area Behavioral Health Collaborative 2300 Vartan Way, Suite 206 Harrisburg, PA 17110 (717) 671-7289
Passport Health Plan AmeriHealth Mercy has provided administrative services for Passport Health Plan, the Medicaid HMO of University Health Care in 16 counties in the Louisville region of Kentucky, since November 1, 1997. Passport manages the delivery of health care services for 140,000 TANF, TANF-related and SSI members through Kentucky's mandatory Medicaid managed care program. In addition, Passport provides services to CHIP members and sponsored a Dual Eligible Special Needs Plan through December 31, 2011. NCQA has awarded Passport an Excellent accreditation status and has rated it the #13 Medicaid health plan in America. PerformRx also provides pharmacy benefit management services for Passport.	Mark Carter Chief Executive Officer Passport Health Plan 5100 Commerce Crossings Drive Louisville, KY 40229 (502) 585-8580
Select Health of South Carolina Select Health, a wholly owned subsidiary of AmeriHealth Mercy Health Plan, provides Medicaid managed care services to 225,000 TANF, SSI and CHIP members in South Carolina. Select Health has earned an Excellent Accreditation status from NCQA and is one of the first six plans in the nation to be awarded NCQA's Multicultural Healthcare Distinction.	Anthony Keck Director, Dept. of Health and Human Services P.O. Box 8206 Columbia, SC 29202 (803) 898-3929
MDwise Hoosier Alliance	Charlotte MacBeth,

AmeriHealth Mercy Health Plan Affiliate	Agency/Customer to Contact
MDwise Hoosier Alliance provides managed care services for 140,000 Indiana Medicaid members in partnership with MDwise, Inc.	President, MDwise, Inc. 1200 Madison Avenue Suite 400 Indianapolis, IN 46225 (317) 822-7116

Qualifications and Experience Operating any Managed Care Medical Program

Together with our owners and affiliates, AmeriHealth Mercy has extensive experience managing CHIP programs in and outside of Pennsylvania, as well as programs for the uninsured in Pennsylvania (adultBasic) and Indiana. Our affiliated health plans also have managed Medicare Advantage D-SNP programs, and our Pharmacy Benefit Management company, PerformRx, manages Medicare Part D pharmacy programs. Table 4 above includes a description of our affiliated health plans' experience serving CHIP, and Medicare Advantage D-SNP members, and also describes the managed care experience of our Pharmacy Benefit Management company, PerformRx. The managed care experience of Vista and its corporate parents and affiliates, and the experience of BCNEPA and its affiliates, is also described above in the Introduction and Corporate Background sections of our response.

Experience with Other Commonwealth Agencies

Through our participation in the Pennsylvania Medicaid Program, AmeriHealth Mercy has developed strong, effective partnerships with Commonwealth agencies that share our mission of helping people get care, stay well, and build healthy communities. These include other offices within DPW, such as the Office of Income Maintenance and the County Assistance Offices, the Office of Children, Youth and Families, and the Office for Developmental Programs. We also work with the Department of Education through the school districts to coordinate care for children with special needs and to offer programs on asthma and childhood obesity. We work with the Department of Aging to coordinate PDA Waiver Services and with the Department of Health and local health departments on a variety of health promotion activities.

- **Office of Children, Youth and Families (OCYF) -** AmeriHealth Mercy works closely with the OCYF within our region to coordinate care for our members. Our Special Needs Unit affords OCYF a single point of contact to make it easy for them to communicate with us. The Special Needs Unit also maintains regular contact, provides trainings upon request, and works with County Children and Youth Agencies as needed for member-specific coordination of care. In addition to coordinating screenings and immunizations, our staff coordinate dental, behavioral health, shift nursing, maternity care, infant wellness, and other health needs. Our staff also frequently assists OCYF staff and foster parents with obtaining out-of-area care for members who have been placed outside of the Lehigh/Capital Zone, but who have not yet been disenrolled from AmeriHealth Mercy. In addition, we help educate OCYF staff and foster parents about covered benefits and how to use Medicaid managed care services.
- **Office of Developmental Programs (ODP) -** We work with the ODP to facilitate waiver services for eligible members. These waiver programs provide the opportunity for members to receive additional benefits, resources, and community supports to remain in the

community and in their home. We make a particular effort to make appropriate transitions for members who will be "aging out" of the EPSDT program, since shift nursing services are not covered for members age 21 and older under the Medicaid Program. We communicate with caregivers and providers, arrange for an assessment to make sure the member can still stay in a community setting safely, and arrange services so that members have a smooth transition into waiver programs.

- **Department of Health -** We work with the state Department of Health and local health departments to share information on blood lead screening, and we collaborate with local health departments on a variety of priority health issues, including but not limited to diabetes, childhood obesity, dental screening, and more.
- **Department of Aging -** We work with the Area Agencies on Aging to coordinate Options Assessments for members who may qualify for the PDA Waiver Program, allowing them to receive services in their homes instead of in nursing facilities.
- **Department of Education -** AmeriHealth Mercy works with individual school districts to coordinate care for children with special needs, especially those who require shift nursing during school hours. We also have partnered with schools to offer asthma education and training for school nurses, and to develop and implement programs to combat childhood obesity. Additionally, we frequently partner with Head Start Agencies to provide health education programs for our members and their parents.

"This partnership with AmeriHealth Mercy is going to change the health for our students and generation to come. The team has been kind, professional, and a blessing to our school."
*- **Ms. Anne Clark**, Title One parent advisory council member for Pennsylvania Department of Education.*

- **Office of Income Maintenance/County Assistance Offices (CAOs) -** AmeriHealth Mercy works closely with the CAOs in the Lehigh/Capital Zone to help guide members through the eligibility re-determination process. Our collaboration in this area is led by our Member Retention Unit, which is staffed by former cash assistance recipients. In speaking with our members and the CAOs, we learned that many members lose Medicaid eligibility temporarily only because they do not complete their Medicaid re-determination packages on time. Also, we learned that the re-determination documents can be daunting, especially for members with limited English proficiency. Our Member Retention Unit works with our members and the CAOs to facilitate the timely completion of this process, which will eliminate eligibility gaps that result in gaps in care.

REFERENCES

c. References. *The Offeror must provide a list of at least three (3) relevant contracts within the past three (3) years to serve as corporate references. This list shall include the following for each reference:*

i. *Name of contractor*
ii. *Type of contract*
iii. *Contract description, including type of service provided*
iv. *Total contract value*
v. *Contracting officer's name and telephone number*
vi. *Role of subcontractor(s) (if any)*
vii. *Time period in which service was provided*

The Offeror must submit ***Appendix H,*** *Corporate Reference Questionnaire****,*** *directly to the contacts listed. The references should return completed questionnaires in sealed envelopes to the Offeror. The reference individual should sign their name over the seal.*

The Offeror must include these sealed references with its proposal.

RESPONSE TO REFERENCES

AmeriHealth Mercy Health Plan has solicited corporate references from the individuals listed in Attachment 4. Copies of the completed Appendix H, Corporate Reference Questionnaires are provided in Attachment 5. Please also see Attachment 6 for copies of letters of support for AmeriHealth Mercy from participating providers and community agencies.

RFP ATTACHMENT J – OWNERSHIP STRUCTURE AND RELATED INFORMATION

The Offeror must include, at a minimum, the following:

1. **Narrative explanation of its ownership structure**
   Vista Health Plan, Inc. ("Vista"), as the licensed managed care company, is the Offeror under this proposal. Vista is a for-profit, licensed managed care company writing business and domiciled in the Commonwealth of Pennsylvania. All outstanding shares of Vista are owned by AmeriHealth HMO, Inc., which is a wholly-owned subsidiary of AmeriHealth Integrated Benefits, Inc., which is a wholly owned subsidiary of AmeriHealth, Inc. Vista's ultimate parent is Independence Blue Cross.

   Vista will delegate all responsibilities under this proposal, with the exception of member complaints and grievances and family planning services, to AmeriHealth Mercy Health Plan.

   AmeriHealth Mercy Health Plan ("AmeriHealth Mercy") is a Pennsylvania general partnership wholly owned through subsidiaries by BMH LLC. BMH LLC, a recently formed company, is owned 61.26% by Independence Blue Cross, through its subsidiaries and affiliates, and 38.74% by Blue Cross Blue Shield of Michigan.

   Organizational charts depicting the ownership structure of Vista and AmeriHealth Mercy and are provided in Attachment 1.

2. **A description of any anticipated merger and the impact on ownership structure.**

   There are no anticipated mergers.

3. **A copy of any executed merger agreement.**

   Not applicable.

4. **A copy of the Articles of Incorporation.**

   A copy of the Vista Articles of Incorporation is provided in Attachment 2.

5. **All related organizational documents.**

   A copy of Vista's bylaws in provided in Attachment 7.

6. **A copy of any guaranty agreement.**

   A copy of Independence Blue Cross' Parental Financial Guarantee of certain portions of Vista business is provided in Attachment 8.

7. **Copy of contractual or other arrangements with any affiliate (including Parent, and other affiliates) to which Offeror is bound and/or which imposes fees on Offeror to affiliate.**

   Copies of contractual or other arrangements with Vista affiliates to which Vista is bound and/or which imposes fees on Vista to an affiliate are provided in Attachment 9. Please also see our response to Question 17 below.

8. Breakdown of financial statement amounts due to and from Offeror's affiliates.

The following is a breakdown of financial statement amounts due to and from Vista's affiliates:

As of September 30, 2011, the amount due from parents, subsidiaries, and affiliates was $131. This amount represents the receivable for support services provided by QCC Insurance Company.

As of September 30, 2011 the amounts due to affiliates was $222,626,982. This primarily represents funds due from the Department of Public Welfare for capitation and the Health Quality Care assessment program, net of the gross receipts tax that is due to Keystone Mercy Health Plan and AmeriHealth Mercy Health Plan upon receipt. This balance also includes money owed to Keystone Health Plan East, an affiliate of Vista, and represents family planning claims paid by Keystone Health Plan East, charged to Vista, and then billed back to AmeriHealth Mercy Health Plan and Keystone Mercy Health Plan. The smaller amounts owed to Independence Blue Cross and AmeriHealth HMO are for some of the supporting services that are performed for AmeriHealth Mercy Health Plan and Keystone Mercy Health Plan.

9. Copies and explanations of any payments made to Offeror's affiliates.

The amounts referenced in our response to Question 8 are short term balances incurred in the normal course of operations and are settled on a monthly or quarterly basis. There are no other payments or long term debt obligations reflected in these balances.

10. Narrative of any trust arrangement.

There is no trust arrangement.

11. Disclosure of prior suspensions or debarment by state or federal or any other government involving the proposer of any affiliate.

Neither Vista and its affiliates, nor AmeriHealth Mercy and its affiliates, have ever been suspended or debarred by any state or federal or any other government entity.

12. Narrative on any pending lawsuits or investigations involving the Offeror or any affiliate.

Below is a narrative of each material pending lawsuit that could affect Vista or the Medical Assistance program and any investigation that could affect Vista or its affiliates. Any other pending lawsuits are not material and arise in the ordinary course of business.

Avrum Baum vs. Keystone Mercy Health Plan and AmeriHealth Mercy Health Plan, Philadelphia Court of Common Pleas, January Term 2011, No. 003876. Putative Class Action alleging negligence and breach of Pennsylvania unfair trade practice/consumer protection law for alleged disclosure of personal health information (PHI). Case was recently removed to Federal Court (U.S.D.C., E.D. Pa, Case Number 2:11-CV-01261-AB) and a Motion to Dismiss the Complaint was filed on March 2, 2011. (In-house reserves established.) Complaint seeks statutory damages (based upon Pennsylvania Law) as well as compensatory damages in excess of Fifty Thousand Dollars ($50,000).

Teresa Sims v. Passport Health Plan, Jefferson Circuit Court, Kentucky. Plaintiff is a former AmeriHealth Mercy Health Plan employee hired to support Passport Health Plan, a Kentucky

Medicaid health plan for which AmeriHealth Mercy Health Plan provides certain administrative and management services pursuant to an administrator agreement. Plaintiff is claiming she was unlawfully terminated due to her disability and that AmeriHealth Mercy Health Plan failed to accommodate her disability under Kentucky law. She is seeking compensatory damages along with front and back pay and benefits. (In-house reserves established.)

PharmMD v. Denise Kehoe and PerformRx, LLC, Davidson County, Tennessee, No. 11-331-IV. This Complaint was filed in Tennessee State Court (it was subsequently removed to Federal Court - Middle District of Tennessee) by the former employer of Denise Kehoe who was an employee of PerformRx at the time the suit was filed. The suit seeks to enforce an employment agreement Ms. Kehoe signed with PharmMD which contained non-disclosure, non-solicitation and non-competition covenants. The Complaint seeks equitable remedies and unspecified damages. (In-house reserves established.)

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

13. Information which identifies any parent corporation ownerships and relationship status (direct or indirect).

Please see our response to Question 1. An organization chart depicting the ownership structure is provided in Attachment 1.

14. Amounts on first quarter filing with Department of Labor.

We understand this question requests filings with the United States Department of Labor. Vista does not make any such filings. On a monthly basis, AmeriHealth Mercy Health Plan reports to the Bureau of Labor and Statistics the number of AmeriHealth Mercy Health Plan employees as of the 12th day of that month. The most recent filing by AmeriHealth Mercy Health Plan, indicates that there were 94 AmeriHealth Mercy Health Plan employees in the Lehigh/Capital Zone.

15. Information on intermediary subsidiary which holds Offeror's stock (indirect only).

All outstanding shares of Vista are owned by AmeriHealth HMO, Inc., which is a wholly-owned subsidiary of AmeriHealth Integrated Benefits, Inc., which is a wholly-owned subsidiary of AmeriHealth, Inc. Vista's ultimate parent is Independence Blue Cross. For additional information regarding Vista's ownership structure, please refer to Questions 1 and 13 above.

16. Statement on whether any affiliates will be a subcontrator.

Vista will delegate all responsibilities under this proposal, with the exception of member complaints and grievances and family planning services, to AmeriHealth Mercy Health Plan. Responses to Questions 1 and 13 above describe the affiliated relationship between Vista and AmeriHealth Mercy Health Plan.

AmeriHealth Mercy will subcontract pharmacy benefit management services to its wholly-owned subsidiary PerformRx, LLC.

17. Identification of the affiliate(s) receiving management fees and copies of any such contractual arrangements.

In addition to the arrangements described in our responses to Questions 7, 8 and 9 above, Vista remits payments to AmeriHealth Mercy Health Plan for the administration of all responsibilities under the HealthChoices New West Program, with the exception of member complaints and grievances and family planning services, which are not delegated by Vista. Vista retains a portion of the payments it receives from the Department of Public Welfare for the administration of the member complaints and grievances process and for the provision of family planning services.

A copy of the Integrated Delivery Systems Agreement between Vista and AmeriHealth Mercy is provided in Attachment 10.

II-3. PERSONNEL

CONTENTS

INTRODUCTION

AmeriHealth Mercy understands that success in managing the delivery of health care services is contingent upon the implementation of a strong, effective organizational structure made up of experienced, talented professionals. A broad set of technical and managerial skills is required to deliver an effective, high-quality Medicaid managed care program. In addition, key personnel must truly understand the unique requirements of the Medicaid Program and the people it serves.

AmeriHealth Mercy has a strong, experienced executive management team and key administrative personnel in place to manage our existing HealthChoices Lehigh/Capital and contract and our proposed expansion in the New West and New East Zones.

EXECUTIVE MANAGEMENT

a. Executive Management (Section V.M of the draft Agreement)

Full time positions for executive management as described in V.M. of the draft Agreement mean full time positions dedicated to the Medicaid Managed Care Program in Pennsylvania.

For the Chief Executive Officer, Chief Operations Officer, Chief Financial Officer, Chief Medical Officer, Pharmacy Director, HealthChoices Program Manager and the Chief Information Officer, please provide the following information for each position:

1. *Describe the executive's role in the organization.*
2. *During the most recent 36 months, how many months was this position not filled by an employee permanently assigned to the position? During the most recent 36 months, how many different people filled this position?*
3. *Describe the level of effort he/she provides related to each of the major program areas of contract management, financial management, quality management, utilization management, data management, consumer services and provider utilization.*

For all management positions specifically identified in your proposal, including the executive management positions listed above, provide:

- *Résumés of the management personnel already employed by the organization as an appendix to your proposal.*
- *A job description for each management position for the proposed organizational structure for the HealthChoices NW and/or NE programs.*
- *Specify where management personnel will be physically located during the time they are engaged to work.*

RESPONSE TO EXECUTIVE MANAGEMENT

Table 1 provides the names of the persons holding the Executive Management positions outlined in Section V.M of the draft Agreement, as well as the information requested in Section II-3.a of the RFP. Resumes and job descriptions for these individuals are provided in Attachment 1.

Please note in our responses below that AmeriHealth Mercy combines the Chief Executive Officer/Administrator and the Chief Operating Officer/HealthChoices Program Manager as one position, under the leadership of Marge Angello, RN, Executive Director of AmeriHealth Mercy Health Plan.

Table 1: Executive Management

Chief Executive Officer/Administrator	Marge Angello, RN
Role	Ms. Angello is responsible for planning, oversight, and operational management of AmeriHealth Mercy's Pennsylvania HealthChoices and voluntary managed care contracts. Ms. Angello is charged with the oversight and management of hospital, physician and ancillary contracting; community relations and public affairs; utilization management, care coordination, and quality management.
Past 36 months	Ms. Angello has held this position on a full-time basis since April 2010.
Level of effort related to each major program area	100% of Ms. Angello's time is focused exclusively on our Pennsylvania Medical Assistance lines of business.
Location	Harrisburg, PA

Note: AmeriHealth Mercy does not have a separate Chief Operating Officer/HealthChoices Program Manager position. These roles are combined under the CEO/Administrator role held by Marge Angello, RN, Executive Director of AmeriHealth Mercy Health Plan.

Chief Financial Officer	Open
Role	The Chief Financial Officer (CFO) is responsible for managing all of the financial aspects of our Pennsylvania Medical Assistance contracts, including contract and rate negotiations with the Department of Public Welfare. The CFO also ensures that all written financial policies are updated as needed and monitors budget compliance to assure that operational performance results are achieved. The CFO coordinates all financial information with the Regional President of the Corporate finance department.
Past 36 months	The CFO position was held on a full-time basis by Russell. Gianforcaro from December 2006 – July 2010. Mr. Gianforcaro assumed the Chief Accounting Officer position in our corporate office in July 17, 2010, but has maintained his responsibility as the acting CFO for our Pennsylvania Medical Assistance contracts while we conduct a national search to identify his successor, who will be 100% dedicated to our Pennsylvania Medical Assistance lines of business.
Level of effort related to each major program area	100% of the CFO's time is dedicated to our Pennsylvania managed care contracts. As noted above, we are engaged in a national search to identify a successor to Mr. Gianforcaro to fill this position on a full-time basis, exclusively dedicated to our Pennsylvania Medical Assistance lines of business.
Location	Philadelphia, PA

Chief Medical Officer	Eric Berman, D.O.
Role	Dr. Berman is directly responsible for the Medical Management division of our Pennsylvania Medical Assistance business, including medical management initiatives such as utilization, quality, care management, and disease management.
Past 36 months	Dr. Berman has held this position on a full-time basis since February 2009. Prior to Dr. Berman's tenure, this position was filled with one other individual, Dr. Jay Feldstein, in the past 36 months. Dr. Feldstein has since accepted the position of Regional President, Northern Division, for AmeriHealth Mercy.
Level of effort related to each major program area	100% of Dr. Berman's time is focused exclusively on our Pennsylvania Medical Assistance lines of business.
Location	Philadelphia, PA

Pharmacy Director	Jeffrey Kreitman, Pharm. D.
Role	Dr. Kreitman oversees and monitors all aspects of AmeriHealth Mercy's Pharmacy operations, including the agreement with PerformRx to perform Pharmacy Benefit Management Services. He collaborates with medical affairs to conceive, design, and implement quality improvement and cost containment pharmacy initiatives to more effectively manage overall member care. He monitors drug utilization trends and supports pharmacy prior authorization activities for complex members. Dr. Kreitman also plans and implements provider and member education initiatives.
Past 36 months	Mr. Kreitman has held this position with AmeriHealth Mercy since July 2006.
Level of effort related to each major program area	100% of Mr. Kreitman's time is focused exclusively on our Pennsylvania Medical Assistance lines of business.
Location	Harrisburg, PA

Information Systems Coordinator	Gail Gatto
Role	Gail Gatto is responsible for enterprise wide planning, operations, and delivery of information technology services for AmeriHealth Mercy's Pennsylvania plans. She leads technology efforts to support administrative and medical management initiatives; efforts to improve efficiency, effectiveness and collaboration through technology; and coordinates with all corporate applications, data center, solution development, architecture, help desk, electronic commerce, telecommunications, data warehouse, and information reporting.
Past 36 months	Ms. Gatto has occupied this position since April of 2011. Prior to that time, oversight for the PA plans was the responsibility of the corporate Chief Information Officer, Michael O. Willis, in conjunction with the management team of the corporate Information Solutions department. In April of 2011, the department was reorganized and a new Business Engagement area was created. It is through this team that the PA plans are now receiving full-time support through a dedicated coordinator.
Level of effort related to each major program area	100% of Ms. Gatto's time is focused exclusively on our Pennsylvania Medical Assistance lines of business.
Location	Philadelphia, PA

KEY ADMINISTRATIVE POSITIONS

b. Key Administrative Positions (Section V.N of the draft Agreement)

In this section, the Offeror must identify the name and position of the person authorized to finalize an Agreement with the Department, and the name and position of the person who will have ultimate responsibility and accountability for the Agreement should one be entered into.

In addition, for each of the key administrative positions/functions listed below, provide the following information:

1. *Attach a job description that includes minimum education for each staff position identified in the offeror's proposal for the proposed organizational structure for the HealthChoices NW and/or NE program.*
2. *Specify where these personnel will be physically located during the time they are engaged to work.*

Key Administrative Positions/Functions

- *Quality Management Coordinator*
- *Utilization Management Coordinator*
- *Full-Time (FT) Special Needs Coordinator*
- *FT Government Liaison*
- *Maternal Health/EPSDT Coordinator*
- *Member Services Manager*
- *Provider Services Manager*
- *Complaint, Grievance and Department Fair Hearing Coordinator*
- *Claims Administrator*
- *Contract Compliance Officer*
- *Other key personnel identified by Offeror*

For ease of reference, Offerors may use the chart in Appendix I, Executive Staff and Key Administrative Personnel Checklist, to ensure that their response provides all the documents and information pertaining to the Executive Management and Key Administrative positions and functions discussed in this section.

Board Members

The Offeror must describe the role of board members in governance and policy making and specify the manner in which MA consumers are to be represented in an advisory and/or decision making capacity for the HealthChoices NW and/or NE Zones. In accordance with Pennsylvania Department of Health regulations, one-third of the board's membership must be "subscribers" of the MCO.

RESPONSE TO KEY ADMINISTRATIVE POSITIONS

Steven Udvarhelyi, MD, President and Chief Executive Officer of Vista Health Plan, is authorized to finalize an Agreement with the Department and has ultimate responsibility and accountability for an Agreement, should one be entered into.

Table 2 provides the names and work locations of the persons holding the key administrative positions outlined in RFP #20-11. Resumes and job descriptions for these individuals are provided in Attachment 2.

Table 2: Key Administrative Positions

Key Administrative Position	Person Holding Position	Physical Location
Quality Management Coordinator	Lori McNew, RN, MHA, MBA	Harrisburg, PA
Utilization Management Coordinator	Jessica Yasher, RN, BSN	Harrisburg, PA
Full Time Special Needs Unit Coordinator	Danielle Thompson, MSW	Harrisburg, PA
Full Time Government Liaison	Ellan Baumgartner	Philadelphia, PA
Maternal Health/EPSDT Coordinator	Sharon Griffiths, RN, BC, CCN	Harrisburg, PA
Member Services Manager	Sandra Duffy	Philadelphia, PA
Provider Services Manager	Steve Orndorff	Harrisburg, PA
Complaint, Grievance and Department Fair Hearing Coordinator	Stephanie Curtis, RN	Philadelphia, PA
Claims Administrator	Sandra Duffy	Philadelphia, PA
Contract Compliance Officer	Laura Herzog	Philadelphia, PA

Board Members

AmeriHealth Mercy is governed by a Partnership Board whose members are appointed by AmeriHealth Mercy's partners. The Partnership Board's exclusive commitment is to the Medical Assistance members enrolled in AmeriHealth Mercy. It is responsible for ensuring that the AmeriHealth Mercy management team operates in accordance with the missions of our founding organizations. The President and Chief Executive Officer of AmeriHealth Mercy Health Plan reports to the Partnership Board on all areas of AmeriHealth Mercy's performance, including the provision of medical services, operational support functions, quality management, financial management, and regulatory compliance.

Medicaid consumers are represented in an advisory capacity to AmeriHealth Mercy and the Partnership Board through our Health Education Advisory Committee (HEAC). The HEAC is a

diverse panel of community leaders, health care providers and Pennsylvania Medicaid consumers. The HEAC meets quarterly to help ensure promotion of the mission of AmeriHealth Mercy, The findings and recommendations of the HEAC are reported to the Partnership Board.

As required by Department of Health regulations, one-third of the Vista Health Plan Board will be members.

ORGANIZATION

The Offeror must submit a current or proposed org chart so that a determination can be made as to whether the overall organizational structure reflects usual and customary business practices consistent with other managed care programs operating in the Commonwealth. Offerors need not duplicate but may cross-reference org charts provided elsewhere in the proposal.

RESPONSE TO ORGANIZATION

Operational Structure

AmeriHealth Mercy's organizational structure has been developed in alignment with the strategic direction that guides all of our affiliate plans, and in conjunction with the specific requirements of the DPW contract. This organizational structure is illustrated below. This structure highlights the functions that will be performed at the local, regional, and corporate levels. AmeriHealth Mercy's proven business processes, technology platform, and operational policies and procedures will be crucial to the success of the new Pennsylvania Zones. In addition to our strong existing team in the Harrisburg market, our regional and corporate resources, as part of our dedicated implementation team, will provide training and support to ensure a smooth implementation.

Local Office

In keeping with our strategy of an "enterprise reach with a local touch," AmeriHealth Mercy's core member-and-provider-facing functions are performed at the local level in each of our markets. For the New West and New East HealthChoices Zones, we will continue to build on our existing operational presence in Harrisburg. Figure 1 below shows the existing AmeriHealth Mercy Health Plan organizational chart that will be expanded with the addition of new members from the New West and New East Zones. Following Figure 1 in Table 3 is a full listing of all of the functions that are and will continue to be performed at the local office.

AmeriHealth Mercy Health Plan
Organizational Chart

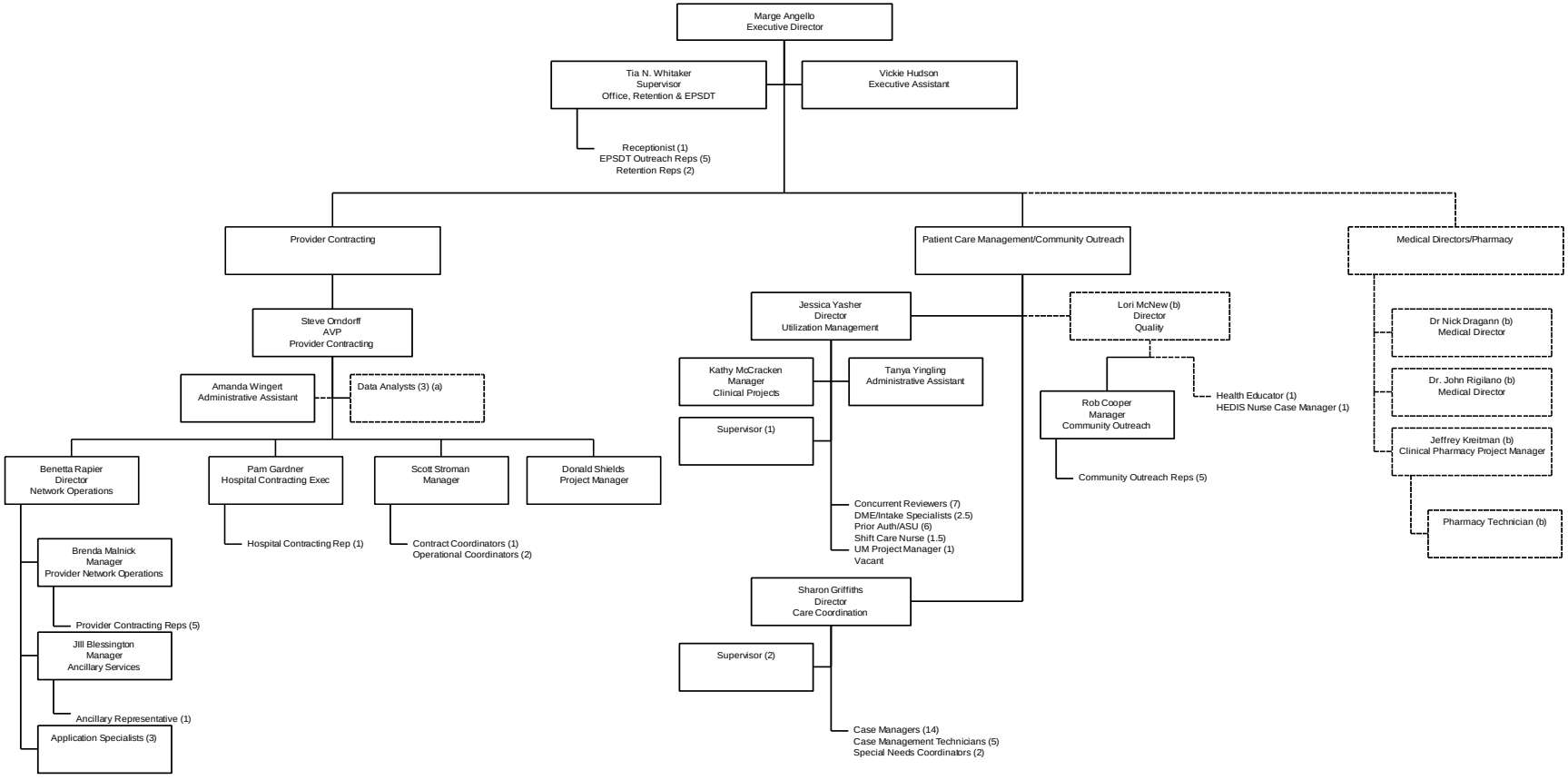

Figure 1: Organizational Structure – Local Office

Table 3: Functions to be performed at the Harrisburg Office

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

Regional Office

AmeriHealth Mercy's regional office structure offers a second level of support for the Pennsylvania plans based on the concept of shared functions for those areas that require less direct contact with members, providers, and other external parties. Functions managed at the regional level will include credentialing, utilization management, and our unique Rapid Response team that serves as an immediate contact point for enrollees with medical, transportation, or other social needs. This Rapid Response team also serves as a connector point for enrollees with providers, social agencies, and other community resources. Additional regional functions include Finance, Government Affairs, and Human Resources. The organizational chart in Figure 2 below depicts the assignment of resources at the regional level for these functions, and Table 4 contains a detailed list of the functions to be performed at the Regional level.

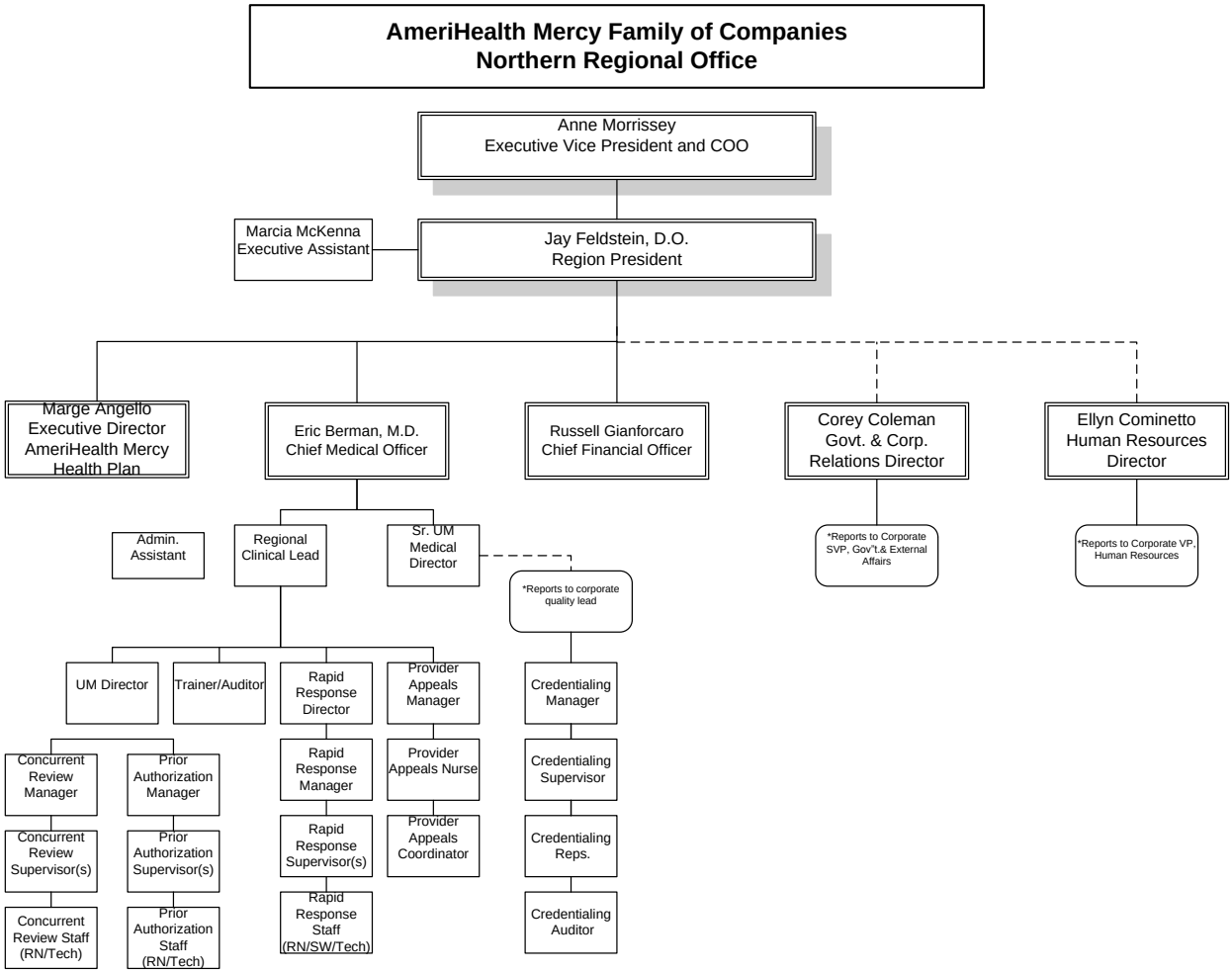

Figure 2: Organizational Structure – Regional Office

Table 4: Functions to be performed at the Northern Regional Office

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

Corporate Office

AmeriHealth Mercy's service delivery model includes a direct connection to a robust set of corporate functional areas that provide support to affiliated plans in all markets nationwide. This structure ensures that the local plans reap the benefits of efficiently managed back office functions such as the Member Contact Center, provider support, enrollment, claims processing, and information technology. In addition, AmeriHealth Mercy provides enterprise oversight and strategic direction for our Provider Network Management, Medical Management, Finance, Mission and Values, Human Resources, Government Relations, and Legal/Compliance functions that operate at the local and regional levels. The organizational charts in Figures 3 - 5 below highlight this corporate-level support, with corporate functions listed in Table 5.

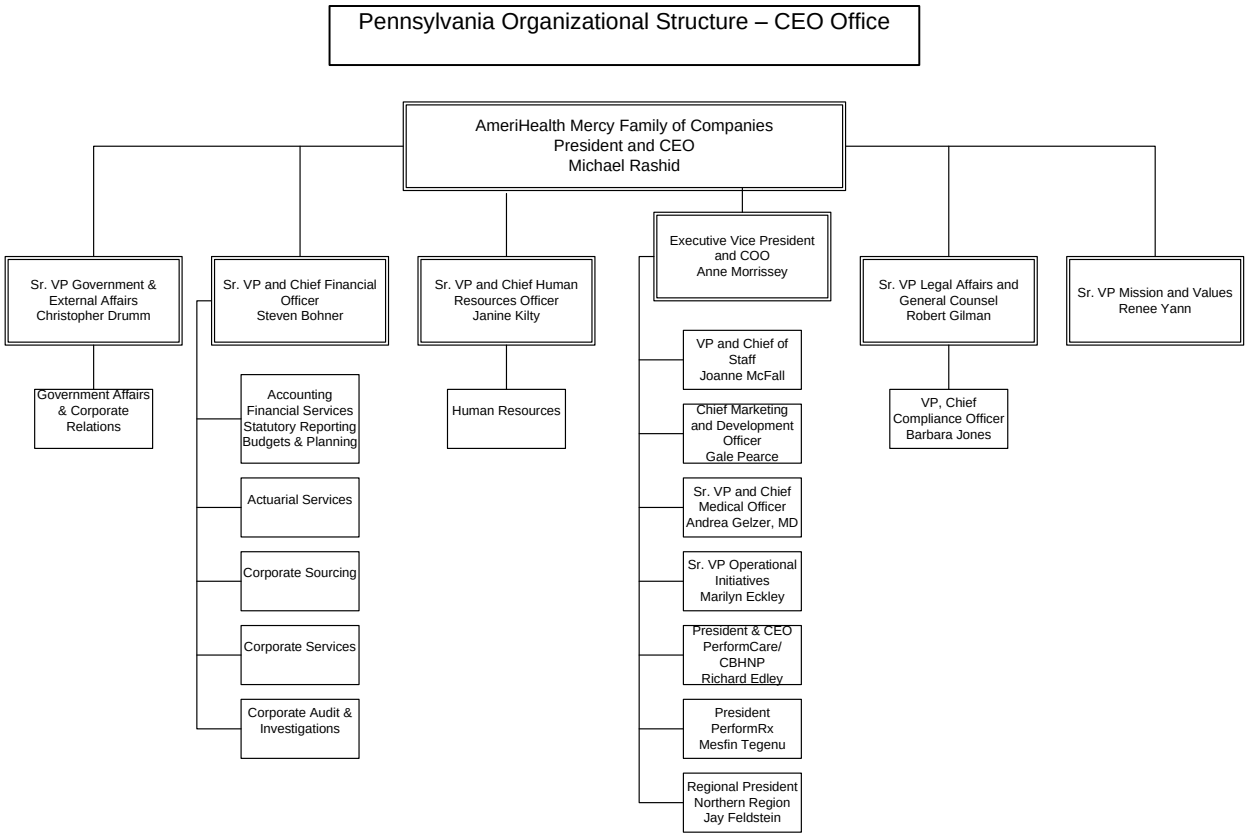

Figure 3: Organizational Structure – Corporate CEO Office

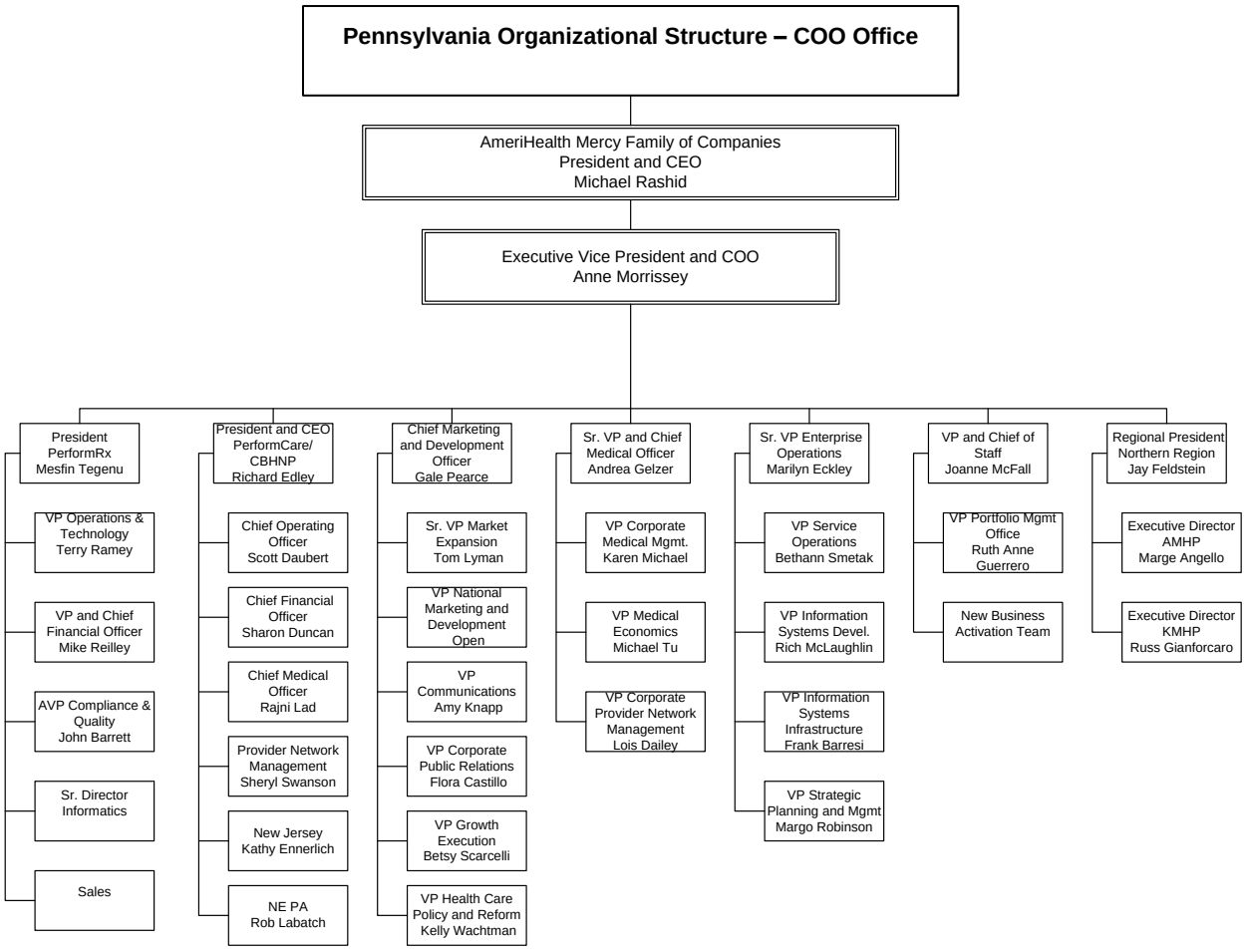

Figure 4: Organizational Structure – Corporate COO Office

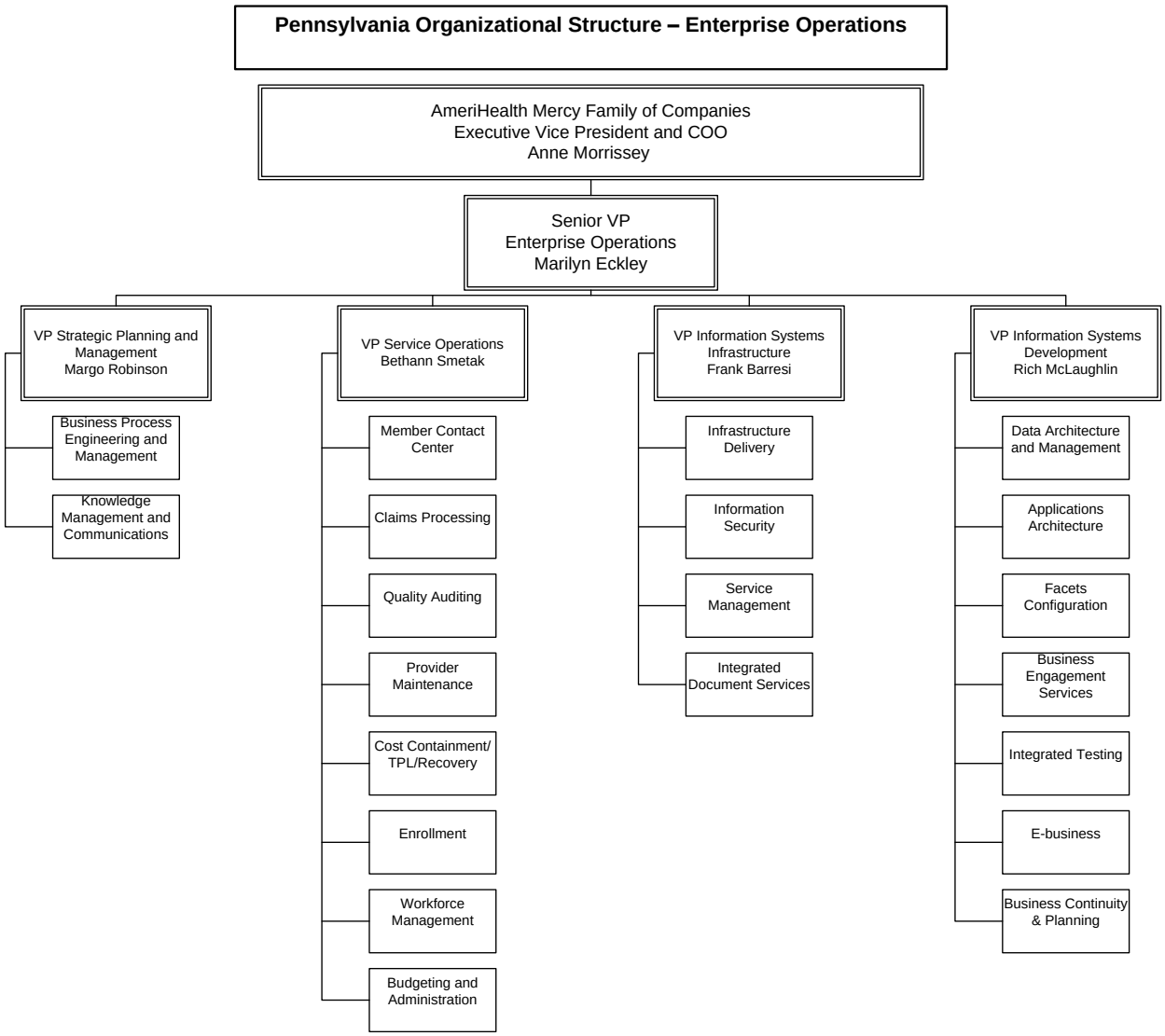

Figure 5: Organizational Structure – Enterprise Operations

Table 5: Functions to be performed at the AmeriHealth Mercy Corporate Office

Administration	Human Resources
▪ Corporate oversight and management ▪ Corporate P&L responsibility ▪ Government relations – state and federal ▪ Mission and values ▪ Strategy implementation ▪ Operational oversight and risk management ▪ Portfolio Management (PMO) ▪ New business activation	▪ HR strategy ▪ HR policies and procedures ▪ Compensation and benefits ▪ HR systems ▪ Talent management – recruiting, hiring, staff development ▪ Associate relations and business support ▪ Learning and organizational effectiveness
Finance	**Integrated Care Management**
▪ Accounting ▪ Financial services and systems ▪ Statutory reporting ▪ Budgets and planning ▪ Actuarial services ▪ Corporate sourcing ▪ Corporate services ▪ Corporate Audit and Investigations - fraud, waste and abuse program	▪ Integrated care management strategy development ▪ Clinical quality oversight ▪ Medical policy development and oversight ▪ Utilization management strategy and oversight ▪ Medical loss review ▪ Care management systems
Legal & Compliance	**Mission and Values**
▪ Corporate legal oversight ▪ Corporate compliance program	▪ Integration of the AmeriHealth Mercy mission and values into all aspects of the business
Provider Network Management	**Data Management**
▪ Provider Network Management strategy and systems ▪ Payment policy development and oversight ▪ Network management policies and procedures ▪ National contracting ▪ Provider incentive program strategy	▪ Production reporting ▪ Data management and governance ▪ Strategic business intelligence ▪ Quality and medical analytics ▪ Network and ancillary analytics ▪ Data management systems
Service Operations/IS	**Government Affairs**
▪ Service level oversight, reporting and monitoring ▪ Member and provider services – contact center ▪ Claims processing, research and analysis ▪ Enrollment and eligibility ▪ Operations support ▪ Facets configuration and testing ▪ Cost containment, TPL and recovery ▪ Quality auditing	▪ Liaison to federal and state legislators and regulators for legislative affairs, policy development, and regulatory affairs

▪ Provider data maintenance ▪ Business continuity and planning ▪ Vendor management ▪ Information systems ▪ Business engagement ▪ Security ▪ Infrastructure delivery ▪ Data architecture and management, e-business ▪ Encounter data management ▪ Applications development ▪ Service management	
Marketing and Development	
▪ Market expansion ▪ Product development ▪ Health care reform/regulatory oversight ▪ Marketing and communications ▪ Strategic planning	

STAFFING PLANS

The Offeror must include a comprehensive statement of its proposed staffing plan demonstrating how it will provide adequate staffing to address all requirements found in the RFP and the draft Agreement. Include comprehensive org charts that detail the number of staff and positions for each existing or proposed department within the MCO.

RESPONSE TO STAFFING PLANS

As a current HealthChoices contractor, AmeriHealth Mercy already has the organizational and management structure needed to support the requirements of RFP #20-11. We have staffing models for all positions directly supporting our Pennsylvania Medicaid business, and we will use these tested models to augment our staff based on our anticipated membership in the New West and New East Zones to meet and exceed the performance standards set forth in the draft Agreement.

AmeriHealth Mercy believes that maintaining a consistent presence in the communities we serve is essential to understanding and addressing the needs of our members and our network providers. To this end, we recruit and hire provider network representatives and community outreach representatives who live in the counties we serve and spend nearly all of their time working directly in the community as our "feet on the street." In 2011, this team completed more than 5,800 visits and since 2010 have connected with more than 34,000 people in the communities. They have been to provider offices to supply the staff with health education materials and training on available health education programs, community agencies and support organizations. They collaborate with faith-based settings, provide general member/community education and attend health fairs in the communities we serve. They have presented more than 170 workshops to educate and empower the community to take care of their health. These health education programs include asthma, diabetes, heart health, childhood obesity, poison prevention, medication safety, teen health, women's health, maternity education and youth sports safety.

Staffing for these positions is dictated by the geographic and demographic characteristics of the region, rather than specific staffing models. The effectiveness of this consumer-centric and provider-centric approach is evidenced by the excellent relationships we enjoy with our enrollees, community agencies, and participating providers. Our community agencies are equally enthusiastic about our services. Please see Attachment 3 for letters of support we have received from community agencies and participating providers for AmeriHealth Mercy's proposed expansion to the New West and New East Zones.

As part of our service delivery model described in the Organizational Structure section above, key functional areas at the Local, Regional and Corporate level will require enhanced staffing to meet the expanded membership from the New West and New East Zones. These areas represent those most directly connected to our hands-on approach to member and provider relationship management and are described in Table 6 below.

Table 6: AmeriHealth Mercy Staffing Projections for New West and New East HealthChoices Zones

Local Harrisburg Office	
New West – Projected Membership 40,000	*New East – Projected Membership 70,000*
Community Outreach Representatives – 3	Community Outreach Representatives - 2
Manager, Community Outreach - 1	Manager, Community Outreach – N/A
Provider Representatives – 2	Provider Representatives – 4
Hospital Representative – 1	Hospital Representative – 1
Hospital Account Executive – 1	Hospital Account Executive – N/A
DME Representative - 1	DME Representative – N/A
Manager, Provider Contracting - 1	Manager, Provider Contracting – N/A
CPP Program (EPSDT/Retention) - 4	CPP Program (EPSDT/Retention) - 2
Application Specialist - 1	Application Specialist – N/A
Case Management Nurses – 4	Case Management Nurses – 7
Total Positions - 19	Total Positions - 16
Regional Office	
New West – Projected Membership 40,000	*New East – Projected Membership 70,000*
UM Nurses – 4	UM Nurses – 7
Rapid Response Team - 2	Rapid Response Team - 3
Appeals Team - 1	Appeals Team - 2
Concurrent Review Team - 4	Concurrent Review Team - 7
Total Positions - 11	Total Positions - 19
Corporate Office	
New West – Projected Membership 40,000	*New East – Projected Membership 70,000*
Member Services/Provider Services – 4.3	Member Services/Provider Services – 10.3
Provider Claims Services – 1.2	Provider Claims Services – 3.3
Claims Processing – 3	Claims Processing – 5.5
Research and Analysis – 2.2	Research and Analysis – 4.3
Team Lead – 1	Team Lead – N/A
Supervisors – 2	Supervisors – N/A
Enrollment Rep - 1	Enrollment Rep – N/A
Claims Payment Research – 0.75	Claims Payment Research – 2
Data Analysis/System Enhancement – 0.25	Data Analysis/System Enhancement – 0.5

Facets Configuration – 0.5	Facets Configuration – 0.5
Provider Maintenance & Reporting – 0.25	Provider Maintenance & Reporting – 0.75
Quality Auditing – N/A	Quality Auditing – 2
Recovery/TPL – 0.5	Recovery/TPL – 1
Total Positions – 16.95	Total Positions – 30.15

Note: At the Corporate level, other areas including, but not limited to, Legal, Finance, Information Solutions, and Administration will be able to absorb the expanded membership without adding staff. This also applies to the Credentialing function performed at the Regional level.

SUBCONTRACTS

Provide a description of each subcontractor with responsibilities related to the provision of services to consumers, including but not limited to the provision of medical services, consumer services, and administrative support including but not limited to claims processing along with an organizational synopsis of services to be provided by each of these subcontrators. Provide a separate response for each subcontract (limit to 2 pages for each subcontract). Note that if the subcontract provides for financial risk, the HealthChoices MCO will be required to comply with the subcontracting requirements set forth in Section XIII of the draft Agreement.

RESPONSE TO SUBCONTRACTS

AmeriHealth Mercy utilizes subcontractors to manage the following:

- Vision services – Davis Vision
- Dental services – DentaQuest, LLC (formerly Doral Dental USA, LLC)
- 24/7 Nurse Call Line– Connextions Health
- Neonatal intensive case management services – ProgenyHealth Inc.
- Management of Medical Imaging Services – MedSolutions, Inc.
- Document scanning, data entry and imaging – ACS Commercial Solutions, Inc.
- Subrogration – ACS Recovery Services Inc.
- TPL/COB program support - Health Management Systems
- Pharmacy claims processing – Argus Health Systems
- Pharmacy benefit management - PerformRx

Information on these subcontractors, including a description of the responsibilities delegated to each, is provided below.

Davis Vision

Davis Vision is AmeriHealth Mercy's subcontractor for vision care services. Founded in 1964, this Plainview, New York-based company is one of the country's leading managed care vision and eyewear providers, serving more than 19 million people throughout the country through a national network of 11,000 vision care professionals. In addition to serving managed care organizations like AmeriHealth Mercy, Davis also serves municipalities, union trust funds, insurance companies, and corporations. Davis is known for the quality of its management, which is run under Total Quality Management (TQM) principles.

Under our contract with Davis Vision, Davis is responsible for arranging for the provision of vision care services to AmeriHealth Mercy members, as defined by AmeriHealth Mercy's vision benefit. Davis serves all AmeriHealth Mercy members. AmeriHealth Mercy has delegated provider credentialing and re-credentialing, utilization management, quality management, claims management, financial services, and informal member dispute responsibilities to Davis. AmeriHealth Mercy has retained the member services function, although Davis is actively involved in the investigation and resolution of member concerns relating to vision services.

DentaQuest, LLC

DentaQuest (formerly Doral Dental) is AmeriHealth Mercy's dental benefits management subcontractor. Founded in 1993, the Wisconsin-based company is the largest multi-state Medicaid dental administrator in the country, serving four million Medicaid members. In addition to providing these services to numerous managed care organizations in twenty states, DentaQuest also administers the Medicaid dental program for the state of Illinois. Supporting DentaQuest's network of 8,000 dental provider sites is proprietary software installed in provider offices that features advanced reporting capabilities that foster nearly error-free data reporting and reduced overhead costs.

Under our contract with DentaQuest, DentaQuest is responsible for arranging for the provision of dental services to AmeriHealth Mercy members, as defined by AmeriHealth Mercy's dental benefit. DentaQuest serves all AmeriHealth Mercy members eligible for the dental benefit. AmeriHealth Mercy delegates the following responsibilities to DentaQuest: provider credentialing and re-credentialing, claims management, utilization management, quality

management, financial services, and informal member disputes. AmeriHealth Mercy has retained the member services function, although DentaQuest is actively involved in the investigation and resolution of member concerns relating to dental services.

Our dental providers are paid on a fee-for-service basis; AmeriHealth Mercy reimburses DentaQuest for claims paid by DentaQuest. In addition, DentaQuest receives an administrative fee from AmeriHealth Mercy.

Connextions Health

Under the contract with AmeriHealth Mercy, Connextions conducts 24/7 nurse triage services (AmeriHealth Mercy's Nurse Call Line). Using member and provider files supplied by AmeriHealth Mercy, Connextions responds to calls from AmeriHealth Mercy members, using AmeriHealth Mercy-approved algorithms. The Nurse Call Line is staffed by registered nurses. The services are provided to assist members in identifying the appropriate level and source of care based on symptoms reported and/or health care questions asked during the call. Members also have access to the Connextions Audio Health Library through the Nurse Call Line. Additional elements of this service include the ability to conduct "warm transfers" (the Connextions agent stays on the line with the caller until the call is accepted by an AmeriHealth Mercy agent) to AmeriHealth Mercy's Member Services Department; reporting Nurse Call Line contacts to the member's PCP; and the reporting of all Nurse Call Line encounters to AmeriHealth Mercy. Services (including the Audio Health Library) are offered in English and Spanish, and they can also be provided in other languages via the AT&T Language Line, and via TTY for hearing-impaired members.

ProgenyHealth Inc.

AmeriHealth Mercy contracts with ProgenyHealth for the provision of neonatology management services pursuant to ProgenyHealth's evidence-based clinical management guidelines, which have been reviewed and approved by AmeriHealth Mercy. AmeriHealth Mercy contracts with ProgenyHealth to achieve a number of goals, including: management of the delivery of neonatology services consistent with national standards of quality and utilization; assurance of appropriate member outcomes and improved health status; and provision of access by AmeriHealth Mercy to neonatology clinical expertise. ProgenyHealth is accredited by URAC in Health Utilization Management.

ProgenyHealth's service model is primarily care management and facilitation with an emphasis on a strong case management program. ProgenyHealth begins working with AmeriHealth Mercy members the moment they are notified that an infant has been admitted to the intensive care nursery following birth. ProgenyHealth's team of neonatologists, pediatricians, and NICU-experienced/pediatric nurses begin by collaborating with the hospital professional staff to coordinate the health care needs of the neonate. ProgenyHealth's model stresses comprehensive care management to meet the health care needs of the infant. For those infants requiring a higher level of intervention, ProgenyHealth has an intensive case management program dedicated to supporting and enhancing the Medical Home throughout the first year of life.

Specific neonatal medical management services that ProgenyHealth provides include: concurrent review approvals and denial recommendations of NICU admissions through discharge; discharge planning; ongoing case management services; family education; and medical necessity reviews of specialized pharmaceuticals for newborns. AmeriHealth Mercy has not delegated utilization review denial determinations to ProgenyHealth, and ProgenyHealth is

further required to obtain AmeriHealth Mercy's authorization before approving certain high-cost services. ProgenyHealth surveys member families and providers who have respectively received and provided services covered under our contract, to assess satisfaction with ProgenyHealth's services.

MedSolutions, Inc.

AmeriHealth Mercy contracts with MedSolutions, Inc. for utilization management services for certain outpatient diagnostic imaging services. MedSolutions, Inc. provides a physician-supportive, patient-centric approach to achieve enhanced patient care. MedSolutions, Inc. applies clinical algorithms to improve the quality and efficiency of radiology modality choices by ordering physicians, while providing AmeriHealth Mercy and our participating physicians with information on overall radiology ordering practices.

Under this contract, AmeriHealth Mercy has formally delegated to MedSolutions, Inc. the implementation and management of a utilization review/management program for specified outpatient diagnostic imaging procedures. MedSolutions, Inc. maintains a call center in order to accept telephonic requests for prior authorization from AmeriHealth Mercy's participating providers. MedSolutions, Inc. also offers password-protected near-real-time Internet access, through its proprietary software application, which providers can use to obtain updated information on authorization status. In addition, MedSolutions, Inc. is responsible for conducting provider education programs relating to its utilization management services, and for surveying provider satisfaction. AmeriHealth Mercy and MedSolutions, Inc. work closely together in the context of a local advisory committee to ensure consistency between our policies and procedures and MedSolutions, Inc.'s utilization management program. MedSolutions, Inc.'s nationwide reach allows it access to comprehensive data against which to measure utilization and assist AmeriHealth Mercy in establishing appropriate benchmarks for performance improvement.

ACS Commercial Solutions

AmeriHealth Mercy contracts with ACS Commercial Solutions, Inc. (ACS), through the contract of its affiliate Keystone Mercy Health Plan, for data processing and related services. This Dallas-based company offers innovative outsourcing solutions around the world. ACS' capabilities and expertise include business process outsourcing, information technology outsourcing, systems and integration and e-solutions. ACS was formerly known as ACS Shared Services, Inc.

ACS provides support to AmeriHealth Mercy for a number of functions where ACS is better suited to leverage its resources. Specifically, ACS provides mailroom and data entry services for health claim forms. This process involves the conversion of paper claims into an electronic format that AmeriHealth Mercy can then import to its claims system for more efficient electronic adjudication and payment. ACS provides similar scanning and electronic conversion functions for paper referral forms; data captured from referral forms is entered directly to AmeriHealth Mercy's claims processing system.

ACS has a rigorous quality control process in place to monitor the timeliness and accuracy of its services under this contract; AmeriHealth Mercy receives frequent reports from ACS so that we can detect and correct performance deficiencies before they become significant problems. Performance expectations are high, in accordance with the vital nature of the services being performed.

ACS Recovery Services Inc.

ACS Recovery Services (ACSRS) is AmeriHealth Mercy's recovery vendor of choice to support Subrogation-related overpayment recoveries. With AmeriHealth Mercy oversight, ACSRS performs the primary function of Worker's Compensation case identification, communication, recovery and reporting. To accomplish this, AmeriHealth Mercy sends monthly paid Claims data to ACSRS, along with Eligibility, Provider and Third Party Liability data. ACSRS analyzes this data in an effort to identify those claims for which AmeriHealth Mercy has paid as primary, but that may be for a work-related injury. When this analysis identifies potential Worker's Compensation cases, ACSRS sends a survey to the identified Members in order to ascertain whether or not their claims are related to injuries that may be the responsibility of a Worker's Compensation carrier. Since surveys are helpful but often are not returned or are returned, but with gaps, ACSRS utilizes a variety of methods, tools, and techniques to obtain the necessary information, such as outgoing telephone calls, court docket searches, Internet searches for contact information, ISO ClaimSearch lookups, or requests for emergency services and/or police records.

With this research, cases confirmed to be Worker's Compensation-related and with recovery potential, are followed-through by ACSRS. Communication with Attorneys is typical in this process, especially with respect to liens, and this is also handled by ACSRS. ACSRS monitors progress of all open cases and provides reports to keep AmeriHealth Mercy informed on progress and results to-date. As cases are closed, recoveries obtained are provided to AmeriHealth Mercy and compensation for services is remitted to ACSRS upon invoice.

Healthcare Management Systems

AmeriHealth Mercy contracts with Health Management Systems (HMS), through the contract of its affiliate Keystone Mercy Health Plan, to support our third party liability (TPL) and Coordination of Benefits identification and recovery efforts. HMS leads the nation in cost-containment, coordination of benefits and program integrity services for government healthcare programs. Using information technology and data mining techniques, HMS identifies other insurance coverage, coordinates benefits and recovers overpayments.

For more than 20 years, HMS has worked throughout the U.S. with Medicaid programs specifically. HMS helps its clients recover more than one billion dollars annually, and helps them save comparable amounts through cost avoidance. HMS helps AmeriHealth Mercy meet the mandate that Medical Assistance be the payer of last resort. HMS provides AmeriHealth Mercy with files twice monthly that identify TPL and COB resources for our members. AmeriHealth Mercy's operating system extracts information from these files where a TPL or COB resource has been identified for a member but where our file does not contain that resource. The responsible insurance carrier is thus identified for these members.

Argus Health Systems

AmeriHealth Mercy contracts with Argus Health Systems to process and adjudicate pharmacy claims. Founded in 1983, Argus is a leading independent prescription claims processor for pharmacy benefit administration. One of the largest providers of independent data processing and related services for the pharmacy benefit administration industry, Argus processed 510 million claims for 26 million recipients throughout the country in 2010. Argus serves a wide variety of customers, including large insurance carriers, managed care organizations, and chain drug stores.

Argus provides a direct point-of-sale interface at AmeriHealth Mercy's participating pharmacies for real-time claims processing and adjudication. This claims processing system facilitates and supports concurrent drug utilization review (DUR) functions that allow for the review and monitoring of the cost-effectiveness, interaction and resulting therapeutic implications of various drugs. By incorporating AmeriHealth Mercy's formulary guidelines and parameters into the Argus system, AmeriHealth Mercy is better able to effectively administer the formulary, and to ensure appropriate pharmaceutical products and services are being provided to our members.

Through remote connectivity to the Argus system, AmeriHealth Mercy is able to conduct its own ad hoc claim review and other data analysis. AmeriHealth Mercy is able to query the Argus system and export data to other applications so that the data can be analyzed as necessary in response to individual business needs. This is in addition to the standard set of reports that Argus produces on a routine basis.

Argus also supports AmeriHealth Mercy's manufacturer rebate reporting. AmeriHealth Mercy is further able to access Argus' "wrap-around" pharmacy network as needed to meet access requirements, and to access Argus' pharmacy call center as a back-up to our own internal pharmacy provider call center in emergency situations to maintain business continuity.

PerformRx, LLC

PerformRx was originally formed in 1999 as a business unit of AmeriHealth Mercy, as a way to deal directly with the complex administrative, operational and regulatory challenges inherent in providing Medicaid pharmacy benefits. PerformRx has met this challenge in providing the "next generation" of PBM services in the Medicaid marketplace; this same philosophy has driven PerformRx's expansion into the Medicare Part D and commercial marketplaces. PerformRx, LLC (a Pennsylvania limited liability company) is a member of the AmeriHealth Mercy Family of Companies (AmeriHealth Mercy). PerformRx, LLC has been operating as a wholly-owned subsidiary of AmeriHealth Mercy Health Plan since January 1, 2010; prior to that date, PerformRx operated as a business unit of AmeriHealth Mercy.

As a pharmacist-led organization, PerformRx understands the importance of maintaining a clinically focused staff with specific experience in managed care. In fact, more than 60 percent of PerformRx's staff is credentialed either as pharmacists or as certified pharmacy technicians – which means that we have the clinical experience and knowledge to effectively manage your pharmacy program.

We explore issues from multiple angles, looking for every possible way –conventional and unconventional – to identify clinical intervention opportunities. Our proven and time-tested clinical solutions were born from our experience serving millions of managed care members since 1999.

PerformRx's uniqueness lies in its focus on providing PBM services for the managed health care sector. We specialize in providing pharmacy benefits management services for members of Medicaid managed care organizations, state Medicaid plans, and Medicare Part D plans.

PerformRx is a transparent organization and has no ownership ties to drug manufacturers. This enables us to create innovative clinical solutions for our customers and their members without the conflicts of interest that impact other PBMs.

The PerformRx business model does not allow us to benefit from any undisclosed rebates, discounts or spread advantage. Not only do we offer our clients a commitment to transparency, we are also willing to fully comply with an independent third-party audit process.

II-6. Objections and Additions to Standard Contract Terms and Conditions

Contents

OBJECTIONS AND ADDITIONS TO STANDARD CONTRACT TERMS AND CONDITIONS

The Offeror will identify which, if any, of the terms and conditions (contained in **Appendices A, E and F**) it would like to negotiate and what additional terms and conditions the Offeror would like to add to the agreement. The Offeror's failure to make a submission under this paragraph will result in its waiving its right to do so later, but the Department may consider late objections and requests for additions if to do so, in the Department's discretion, would be in the best interest of the Commonwealth. The Department may, in its sole discretion, accept or reject any requested changes to the standard contract terms and conditions. The Offeror shall not request changes to the other provisions of the RFP, nor shall the Offeror request to completely substitute its own terms and conditions for **Appendices A, E and F**. All terms and conditions must appear in one integrated Agreement. The Department will not accept references to the Offeror's, or any other, online guides or online terms and conditions contained in any proposal.

Regardless of any objections set out in its proposal, the Offeror must submit its proposal on the basis of the terms and conditions set out in **Appendices A, E and F**. The Department will reject any proposal that is conditioned on the negotiation of the terms and conditions.

Inasmuch as the terms and conditions set out in **Appendices A, E and F** of the RFP are substantially the same as the terms and conditions that govern Vista Health Plan's existing relationship with the Department of Public Welfare under current HealthChoices contracts, Vista agrees to these terms and conditions. We look forward to working with the Department of Public Welfare to address and resolve inconsistencies between the terms and conditions in the RFP and those in our current contracts.

RESPONSE TO OBJECTIONS AND ADDITIONS

Inasmuch as the terms and conditions set out in Appendices A, E and F of the RFP are substantially the same as the terms and conditions that govern Vista Health Plan's existing relationship with the Department of Public Welfare under current HealthChoices contracts, Vista agrees to these terms and conditions. We look forward to working with the Department of Public Welfare to address and resolve inconsistencies between the terms and conditions in the RFP and those in our current contracts.

MEMBER MANAGEMENT

CONTENTS

QUESTION 1

Describe what innovative approaches your MCO will take to promote personal responsibility among MA consumers by involving them in managing their own healthcare benefits and providing incentives that encourage wellness and healthy lifestyles.

(Limit to 2 pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy shares DPW's goal of encouraging independence and personal responsibility to promote positive health outcomes and control program costs. Our strategy focuses on empowerment through engagement and education, and is interwoven in all components of our clinical programs. This is coupled with innovative and award-winning community-based wellness programs and member incentives to engage members in taking control of their health. Our prominent programs and incentives are described below.

Integrated Care Management

AmeriHealth Mercy's Integrated Care Management model actively engages members in care planning to empower them to take responsibility for their care. Our engagement strategy begins with asking the member to identify personal goals rather than "health care" goals. By focusing on the member's concerns, like wanting to walk a child to school or climb stairs, the Care Manager can address items such as dietary changes required for healing a diabetic member's foot wound or proper use of asthma medication. Once plans are in motion to address the member's personal goals, the Care Manager works toward addressing additional issues revealed in health assessment findings and utilization data. For each intervention, the Care Manager focuses the discussion on how the particular intervention will benefit the member.

Members who are able to actively participate in the care plan are assigned 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 help members maintain an open, active dialogue that leads to improved care.

Member Web Portal

To help members manage their healthcare, the Member Web Portal gives members the ability to view their Care Gaps. Care Gaps are services that are recommended by nationally-accepted clinical guidelines for which there is no claim evidence that the member received the service. Members are also able to see detailed information about medications they received within the past six months and their recent visits to the doctor, hospital and emergency room. This information is available as a printable Member Clinical Summary that members can take to their physician appointments. AmeriHealth Mercy will print and mail the Member Clinical Summary to members who do not have access to a computer or printer.

Our Member Web Portal also provides state-of- the-art interactive tools to perform self-service for specific activities and includes a robust Health and Wellness section, with information on preventive care, wellness strategies and management tips for living with a chronic condition.

Member Wellness Programs and Incentives

AmeriHealth Mercy effectively engages members in their own health by partnering with them, and with community leaders, faith-based organizations and agencies already trusted in the community. By establishing a relationship of mutual trust, we help the member become an active participant in their care. A key component to all of our programs is a specific and clear call to action, defining a path for the member to use in addressing the target behavior or care need. Several of our programs are described below and in more detail in the Member Management Attachments.

- **Healthy Hoops® -** Our NCQA award-winning program uses basketball to educate pediatric members with asthma and their families about asthma management and obesity prevention.
- **Lose-to-Win -** Our URAC award-winning program uses a contest format loosely mirrored on TV's "Biggest Loser" to educate and engage members with type-2 diabetes and obesity on nutrition and exercise.
- **Women's Health Ministry 40-Day Journey -** This NCQA-recognized program focuses on improving the health of African-American women and their families through a multi-week educational series emphasizing nutrition, exercise, medication compliance and water intake.
- **Know Your Numbers -** This program stresses the importance of knowing key health numbers, including blood pressure, cholesterol level and blood sugar level.
- **Prepare For Your Visit** -This personal responsibility program provides an easy-to-use guide to help a member ask the right questions during their doctor's visit.
- **4 Your Kid's Care -** Our newest program, 4 Your Kid's Care provides young mothers with hands-on training and education on how to care for a sick child at home. Focused on reducing inappropriate emergency room utilization, this program offers educational sessions in local community venues and train-the-trainer sessions for community-based organizations.
- **Smoking Cessation and Nutritional Support** - All AmeriHealth Mercy members are eligible for 70 tobacco cessation counseling sessions per calendar year without referral or prior authorization. Members who are eligible for pharmacy services can get tobacco cessation drug medicines like bupropion and the generic nicotine patch. We also provide our members with access to registered dieticians and nutritional counselors.

AmeriHealth Mercy uses health incentives to increase members' motivation and willingness to change and maintain healthy lifestyles. We adjust our member incentive programs over time based on our retrospective evaluation of the effectiveness of each incentive, and ensure that incentives target those areas most in need of improved outcomes. Some of the member incentives we use today or have used in the past are listed below.

- Gift cards for completed mammograms, pap tests, and prenatal care visits
- Movie Tickets for adolescents who complete an Adolescent Well Care visit
- Baby "onesie" for new mothers who complete a timely post-partum visit

Looking Ahead

AmeriHealth Mercy is ready to seek DPW approval to launch new member incentive programs to encourage members to engage in specific health related activities. For example,

- **Reward Points** - Members earn points for joining the online portal, completing a health risk assessment and for obtaining preventive care services, such as mammogram, annual physical exam (adult and child), prenatal visits, post-partum visit and LDL/HgbA1c tests (diabetics). Points can be redeemed for gift cards to a selection of vendors.
- **Over-the-Counter Products** – Members receive over-the counter products for completing wellness and chronic condition monitoring care related to pregnancy (prenatal and post-partum care), hypertension (controlled blood pressure) and diabetes (HgbA1c and LDL measurement; dilated retinal exam).

As another way to engage members in their own care, AmeriHealth Mercy will begin sending an Explanation of Benefits to members to communicate the actual cost of the care they receive to promote a more aware and educated consumer.

QUESTION 2

Describe any experience your MCO has in using state of the art technology to provide your members with resources for managing their own healthcare benefits (including the use of incentives or "smart accounts.")

(Limit to two pages)

RESPONSE TO QUESTION 2

AmeriHealth Mercy uses several technology strategies to provide members with resources for managing their own healthcare benefits, including our Member Web Portal, technology programs and participation in smart accounts. Some of the incentive programs we have used are described in Question 1 of this section.

Member Web Portal

Our Member Web Portal provides members with state of the art interactive tools to perform self-service for specific activities. For example, the portal gives members the ability to view demographic information about their doctor, including languages spoken, or find a new PCP using a link to the online Provider Directory. The portal also contains a robust Health and Wellness section, with information on preventive care, wellness strategies and management tips for living with a chronic condition. To help members manage their healthcare, the Member Web Portal gives members the ability to view their Care Gaps. Care Gaps are services that are recommended by nationally-accepted clinical guidelines for which there is no claim evidence that the member received the service. Members are also able to see detailed information about medications they received within the past six months including the date prescribed, medication name, dosage and prescribing physician. Members also are able to view their recent visits to the doctor, hospital and emergency room. Each of these sections can be printed individually, or together as a Member Clinical Summary (MCS) document. We encourage members to take a copy of the MCS to their physician appointments as a tool to discuss their healthcare needs with their physician.

Our Member Web Portal uses best practice designs based on the US Government's Web Guidelines on usability to ensure that members can easily find information and services that AmeriHealth Mercy provides. All the features and offerings on the website meet or exceed the Section 508 of the Americans with Disabilities Act Requirements 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.

Other Technology Programs

AmeriHealth Mercy uses other technological programs to enhance members' ability to manage their health conditions. Examples are summarized below.

- **moms2b -** We engage pregnant members in prenatal healthy behaviors through our moms2b social media program. The moms2b Club utilizes a social media and a mobile technology platform to promote prenatal and post-partum care. Through a partnership with a mobile phone service provider, OB/GYN providers, community partners and our WeeCare maternity program, moms2b engages high-risk pregnant members to keep them connected to our WeeCare Care Managers and their available services.
- **Cell phones for pregnant women** - Free phones with 250 free monthly voice minutes are offered to pregnant members for a 12 month period. In addition to the free voice minutes, members receive free text messages containing healthy reminders and other pregnancy-related messages, as well as phone calls from AmeriHealth Mercy.

- **Home Monitoring - Heart Failure and Diabetes -** High risk members receive remote patient monitoring (RPM) equipment to monitor and report blood pressure, blood sugar and weight.
- **Cell phone-connected glucometers** – Our southeastern Pennsylvania affiliate, Keystone Mercy Health Plan, provided 93 high risk members belonging to one of three practices in an underserved area of Philadelphia with cell phone-connected glucometers. Participants saw a decrease of 8.6 percent in HgbA1c and a decrease of 13.5 percent in emergency room visits.

Smart Accounts

Through our Indiana affiliate, we participate in the state's Healthy Indiana Plan (HIP), which provides healthcare benefits to uninsured individuals who do not qualify for Medicaid. HIP members have a POWER account that is jointly funded by the state and the member (on an income-based sliding scale) for use in covering the cost of healthcare services the member receives. If the member receives the required preventive care services and POWER account dollars remain at the end of the year, the remaining dollars rollover to the next year and can be used to decrease the member's payment into the POWER account for the next year. AmeriHealth Mercy welcomes the opportunity to discuss this innovative approach with DPW.

Looking Ahead

We will actively work with DPW to identify and implement technology-supported services to provide members with resources and incentives to manage their own healthcare. For the New West and New East Zones, we will provide our interactive Member Web Portal, and a free cell phone program for pregnant women.

To better serve members in the rural areas of the New West and New East Zones, AmeriHealth Mercy has begun discussions with Logistics Management Consultants Inc. (LMC) on a Telemedicine Preventative Health Care Program to provide direct care to the member at their various locations in the community. LMC's interactive health kiosks can be provided at fixed locations throughout underserved communities or made available through mobile trailers. With doctor and nurse connectivity, the system is able to monitor blood pressure, weight, oximetery, temperature, and blood glucose and cholesterol. Data is shared with member's Primary Care Provider (PCP) and prescriptions can be printed at the kiosk.

This program, which is Electronic Medical Record-compatible, has the ability to service 150 members within eight hours and complies with all HIPAA fraud prevention standards. Especially helpful in the most remote areas of the Commonwealth, the system is not affected by poor cell phone reception or internet connectivity.

QUESTION 3

Describe the management techniques, policies, procedures or initiatives you have implemented to promote health care equity for your members. Please provide evidence of success. Describe your strategy moving forward to improve performance in this area.

(Limit to six pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy is a national leader in the design and implementation of programs and initiatives to promote healthcare equality for the members we serve. Our award-winning programs are based on our understanding of the cultural norms of our members. AmeriHealth Mercy and two of our affiliated health plans are among only six companies nationwide to become early adopters of the Multicultural Health Care Distinction Program from the National Committee for Quality Assurance (NCQA). All three health plans scored 100% to earn this Distinction.

Embedded in all of our efforts is a culturally and linguistically appropriate approach to the delivery of health care services. We foster cultural awareness both in our staff and in our provider community. Additionally, we leverage race, ethnicity, and language data to ensure that the cultures prevalent in our membership are reflected to the greatest extent possible in our provider network. We routinely examine Access to Care Standards for both the general population and the population who speak a primary language other than English. In addition, every edition of the provider newsletter includes a pertinent article on addressing cultural or language issues.

Every six months, we analyze member demographic trends, and we review our HEDIS and CAHPS data annually to compare results across the population by available race, ethnicity, and language categories. These data allow us to identify the subpopulations within our membership whose health outcomes are not as favorable as the general population. Results of this analysis are used to guide our Performance Improvement Projects and Integrated Care Management initiatives.

Our 2011 Disparity Analysis of health outcomes for our HealthChoices Lehigh/Capital members found no evidence of health disparities between our African American and Caucasian members on the following measures:

- Frequency of Ongoing Prenatal Care: >81 % of the Expected Number of Prenatal Care Visits
- Child-Adolescent Access to Care (Ages 12-19 years)
- Cervical Cancer Screening (Ages 24 to 64 years)
- Breast Cancer Screening (Ages 42-69 years)
- Annual Dental Visits (Ages 7-10 years and ages 15-18 years)

Our analysis of outcomes for Hispanic/Latino and non-Hispanic/Latino members found that members of Hispanic/Latino ethnicity have consistently better outcomes on HEDIS measures than there non-Hispanic/Latino counterparts.

Central Pennsylvania Healthcare Disparity Initiatives

Because AmeriHealth Mercy's Lehigh/Capital Zone population is largely African American and Hispanic, we have made a concerted effort to address the disease states that affect these populations disproportionately.

- **Type 2 Diabetes Program for Latinos -** In partnership with Edgardo G. Maldonado MD, Medical Director, Centro de Salud and Community Health and Wellness Center in Allentown, AmeriHealth Mercy implemented a Type 2 Diabetes program among Latinos, providing health education, implementation of preventive practices, and increased access to

health care services. Program interventions included Spanish-language educational materials, a Promotora program to train community members as healthy diabetes advocates/lay educators and distribution of a Platillos Latinos ¡Sabrosos y Saludables! (Delicious Heart-Healthy Latino Recipes) cookbook. AmeriHealth Mercy Care Managers work directly with diabetic members in the area to enroll them in the program. Program results showed improved diabetic testing scores and significantly lowered HbA1C levels, a key clinical indicator in diabetes control. Detailed analysis showed a significant improvement for both LDL and HbA1C management measures for the Latino population in Allentown region.

- **Go Red for Women Heart Health Program for Latinas -** Similarly, AmeriHealth Mercy has worked with the American Heart Association to sponsor an annual *Go Red for Women* Latina Community Luncheon. This event is both social and educational, designed to encourage women in the Latina community to become champions of their own health. The program is held at a popular restaurant and includes Spanish-speaking lecturers, health screenings with bi-lingual health professionals, cooking demonstrations that teach women how to reduce fat and salt in their favorite recipes, and salsa dancing to promote the importance of exercise. The event is attended by over 150 women each year and is open to the public.
- **African American Women's Wellness Empowerment Program -** AmeriHealth Mercy partners with African American faith-based community leaders, like those at The Bright Side Baptist Church in Lancaster, to address health disparities in the African American community. AmeriHealth Mercy has held four Women's Wellness Empowerment Fairs in partnership with faith-based organizations in the Lehigh/Capital Zone.
- **Healthy You, Healthy Me Childhood Obesity Program -** Our Healthy You, Healthy Me Program, modeled after the CATCH (Coordinated Approach to Child Health) Kids Curriculum, helps children and their parents and caregivers combat and prevent obesity. This curriculum provides activities and programs that encourage improved nutritional choices and increased physical activity in children ages 5 to 13. The six-week Healthy You, Healthy Me program is implemented in partnership with summer or after-school programs to bring health information to underserved youth in our service area, primarily in African American communities.

Healthcare Disparity Initiatives in other Markets

In our Southeastern Pennsylvania affiliate, two of our programs to improve healthcare disparities were recognized by NCQA. AmeriHealth Mercy intends to bring these award-winning programs to the New West and New East Zones, and to our HealthChoices Lehigh/Capital members.

- **Healthy Hoops® -** Our NCQA award–winning program uses basketball as a mechanism to engage pediatric members with asthma and their families in education on asthma management and obesity prevention.
- **Women's Health Ministry 40-Day Journey -** This NCQA-recognized program focuses on improving the health of African-American women and their families through a multi-week educational series emphasizing nutrition, exercise, medication compliance, and water intake.
- **Community Baby Shower Program -** This program received the 2011 Outreach Award by the Medicaid Health Plans of America (MPHA) for its impact on reaching into racial/ethnic minority communities. Through this program, we partner with community agencies and invite pregnant members and their families to attend festive community baby showers. Care Management nurses and social workers are present to complete clinical assessments on the

pregnant women (many of whom are teens), identify possible high-risk conditions, and offer health care guidance throughout the duration of the women's pregnancy for a healthy delivery. The community baby showers have also included mobile dental vans to provide the pregnant women with routine dental exams, stressing the importance of dental hygiene during pregnancy in relation to the infants' development. The community baby showers also include fun activities, nutritious food, and baby shower gifts donated by our employees. The goal of the community baby showers is to increase pregnant women's awareness of the importance of prenatal care and how to access those health care services.

Culturally Competent Approach

Another key to AmeriHealth Mercy's ability to address health care disparities among our membership is our focus on cultural competency for our staff and within our provider community. We begin with a diverse workforce, hiring staff from the communities that we serve, including those hired through our Contractor Partnership Program. Our outreach phone unit is staffed by Welfare-to-Work participants who live in the same neighborhoods as our members and have unparalleled insight into our members' challenges and perspectives.

AmeriHealth Mercy employees take part in training on diversity and Culturally and Linguistically Appropriate Services (CLAS) principles, and we educate our providers on the same. CLAS principles are reinforced during semi-annual Provider Symposiums and are included in all quarterly provider education packets. A provider attending our CLAS presentation at a Provider Symposium recently invited us to present to the entire provider office staff.

In addition, we routinely sponsor conferences to assist providers in becoming more aware of cultural differences and how they impact patient care.

"Your seminar was unique and combined together two very important aspects of our lives: culture and health care. Given that we live in such a multicultural society, it is crucial that we as health care providers understand the culture from which each of our patients comes from, and how this culture affects their oral health. Only by gaining cultural competency can we establish a trusting relationship with our patients, and provide them with excellent dental care as well as with proper preventive measures. "
– Dr. Albert Aloian

Looking Ahead

Using Census Bureau data and information from the Center for Rural Pennsylvania, we have identified that African Americans and Hispanics comprise the prominent racial and ethnic minorities in the New West and New East Zones, which is consistent with our experience in the Lehigh/Capital Zone and in the five voluntary managed care counties where we currently operate. We are confident that the programs and initiatives we have established to serve our current African American and Hispanic members will provide a strong platform for addressing healthcare disparities in the new zones, and we look forward to adjusting our existing approaches as needed to address the more rural communities in the New West and New East Zones. To assist in our efforts, we have identified several opportunities to partner with local agencies in the new zones to improve health equity for Medicaid consumers. Some of these are described below.

Pennsylvania Area Health Education Centers (AHECs)

AHECs are known nationally for linking community services in rural and urban settings with teaching hospitals and health centers. They have a special focus on recruiting and retaining PCPs and allied health professionals, particularly individuals from minority and underserved communities and populations, to provide care in underserved areas. They also develop effective

community-based health promotion programs. A solid relationship with the Pennsylvania AHEC holds the potential for strong, locally-focused initiatives in health equity, smoking cessation, and domestic violence.

AmeriHealth Mercy staff has experience working within the AHEC framework. Currently, AmeriHealth Mercy hosts medical students participating in the New Jersey AHEC for two week rotations every year, and a staff member with our southeastern Pennsylvania affiliate, Keystone Mercy Health Plan, previously served as the director of the regional AEHC for Northeast Florida.

Building Local Partnerships to Address Health Disparities

In preparing for expansion into the New West and New East Zones, we have been working with local community agencies and leaders to identify health care needs unique to this region. We have identified a particularly promising opportunity for addressing health disparities through our conversation with Andy Glass, Director of the Erie County Department of Health. Mr. Glass shared information about PartnerSHIP for a Healthy Community, the local affiliate "State Health Improvement Plan" partner for the Pennsylvania Department of Health. The key objectives of the initiative are to reduce and ultimately eliminate health care disparities, to increase access to care, and to improve the health status of everyone. Mr. Glass also informed us of a partnership that the Erie Department of Health has established with the Erie County Medical Society to address health literacy. We are very enthusiastic about the opportunity to work with Mr. Glass and the PartnerSHIP for a Healthy Community, and the Erie County Medical Society to address health disparities in Erie County, and to extend the successes here to other New West Zone counties.

The increased prevalence of diabetes is a common area of concern expressed by nearly everyone we have met in the New West and New East Zones. This was echoed in our conversations with Amy Woods, Executive Director of the United Way of Crawford County and Jim Minksy, Executive Director of the United Way of Mercer County. It is evident from these conversations that AmeriHealth Mercy's Lose to Win and Healthy You, Healthy Me programs would be welcomed opportunities for collaboration with their respective organizations and the local YMCAs. In the New East Zone, Sojourner Truth Ministries (Williamsport) is also particularly interested in AmeriHealth Mercy's diabetes education programs and our preventive care programs.

One other theme from our conversations with local agencies and community groups is that access to care, especially primary care, is problematic in these regions for Medicaid recipients generally, and perhaps more acutely for minority populations. AmeriHealth Mercy has a strong record of improving access to care for our members in the Lehigh/Capital Zone and in the voluntary managed care program, especially in Hispanic communities. We offer enhanced compensation to encourage PCPs to open their practices to new patients, and we offer enhanced compensation for extended office hours. Additionally, our efforts to educate members about keeping their appointments and our assistance in coordinating transportation for members has positively impacted no-show rates, which providers tell us is a key reason they do not accept Medicaid patients.

One of our important community partners in the Lehigh/Capital region, Ngozi Inc., will be opening three new wellness centers in Northumberland County. Our strong ties to this organization, which primarily serves the African American population, will be instrumental in improving access to care for members in this area.

QUESTION 4

Describe the management techniques, policies, procedures or initiatives you have in place to effectively and appropriately control avoidable hospital admissions. Describe your strategy moving forward to improve performance in this area.

(Limit to two pages)

RESPONSE TO QUESTION 4

Effectively managing avoidable hospital admissions requires moving from a reactive, episodic healthcare system to a proactive model that promotes care coordination and evidence-based medicine through information sharing. This is the cornerstone of AmeriHealth Mercy's approach to managing our members' care, as described below, and it has contributed to our continued 4.3percent decrease in inpatient utilization over the past two years. Our success in this area is one of our many contributions to improving health outcomes for our members and lowering taxpayer costs for the Medicaid program.

- **Utilization Management (Prior Authorization, Concurrent Review, and Discharge Planning) -** Our Utilization Management (UM) program is designed to ensure that members receive the right care, at the right time, in the appropriate setting. We require prior authorization for all elective admissions to maximize the delivery of care in the most cost-effective setting. Our concurrent review nurses assess every admission for conformance to evidence-based medicine protocols, and our discharge planners work with every hospitalized member to coordinate home services and referrals to Care Coordination to avoid future admissions or re-admissions.

Integrated Care Management

Our Integrated Care Management model blends traditional Disease Management with complex case management. We offer programs for the following chronic health conditions that if left unmanaged, result in poor health outcomes and high rates of hospitalization: diabetes, asthma, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure, HIV, sickle cell disease, and hemophilia. We also offer our WeeCare Maternity Case Management Program to manage high-risk pregnant members, and a Pediatric Preventive Care Program that targets children ages 0 -2 to ensure compliance with EPSDT services.

Members are identified for enrollment in our Integrated Care Management program through predictive modeling and through referrals from internal AmeriHealth Mercy staff, members or providers. We use Verisk Health's Diagnostic Cost Groups and predictive modeling system ("DxCG") to identify members at highest risk for future admissions, based on the Prospective Risk Score (indication of future risk for avoidable care) and the Likelihood of Hospitalization Score (predictor of future inpatient hospital care), and we focus our most intensive care management efforts on this group.

- **Member Clinical Summaries and Care Gap Identification** - AmeriHealth Mercy facilitates improved care coordination with providers by sharing a Member Clinical Summary, which is a claim-based medical history including pharmacy and medical data, and identified Care Gaps, through our secure Provider Web Portal. Sharing of Care Gap data is especially helpful in identifying issues that if not addressed, could lead to deteriorations in health status resulting in avoidable hospitalization. For example, Care Gap data identifies diabetic members who are overdue for HbA1c testing and members with heart failure who are not on the guideline-recommended "triple-therapy" medications.
- **Pharmacy Coordination -** AmeriHealth Mercy focuses on pharmacy compliance and appropriateness to help our members stay well and avoid deteriorations in health status that can lead to hospitalization. Our care managers have desktop access to the medication profiles of all members enrolled in our Integrated Care Management Program, allowing them to make

timely reminders and assist members in understanding how to take their medications as directed. Our Regional Clinical Pharmacist conducts daily rounds with our Care Managers.

- **Member Health Education and Wellness Programs -** AmeriHealth Mercy is known both locally and nationally for our comprehensive health education programs. We held over 400 programs in the Lehigh/Capital Zone last year. Our programs empower members to take control of their own health and seek to increase member compliance with their care plans. Our Know Your Numbers Program helps members recognize problems, such as blood pressure, cholesterol, or high glucose, early and seek care promptly. Please see our response to Member Management Question 1 for more information about our health education and wellness programs.
- **Telemedicine -** AmeriHealth Mercy is partnering with home care agencies and other vendors to deploy telemedicine technology, especially in rural communities. We are prepared to coordinate remote blood pressure monitoring using a digital blood pressure monitor within the member's home, and remote glucose monitoring using cell phone-connected glucometers. The remote monitors transmit results to the PCP and the AmeriHealth Mercy care manager, alerting both to fluctuations that may require immediate intervention.

Looking Ahead

- **Provider Shared Savings Contracts -** AmeriHealth Mercy has a strong provider Pay for Performance model that aligns provider compensation with desired health outcomes. Moving forward, an analysis of encounter and claims data will identify targets for proactive partnerships, including the possible implementation of our hospital shared savings program. This program enables hospitals to share in savings derived from a reduction in hospital readmissions and ER utilization, and we will seek to include reductions in avoidable readmissions as well. Our southeastern Pennsylvania affiliate, Keystone Mercy Health Plan, has successfully introduced shared savings contracts in that region, and we are confident that we can build upon that success in the New West and New East Zones, and in our existing Lehigh/Capital service area.
- **Embedded Care Management -** Our southeastern Pennsylvania affiliate, Keystone Mercy Health Plan, piloted a program placing Care Managers in provider offices, working with the staff and interacting with plan members during their visits. The embedded Care Manager shared information on filled prescriptions, Care Gaps, emergency room visits and inpatient admissions with the office staff to prepare for the member's office visit. The Care Manager also addressed the members' social concerns such as transportation and child care, and provided coaching on self-care issues such as medication adherence and preventive care measures. In addition, the Care Manager assessed each member for ongoing needs and coordinated care management services for the member in between visits.

  The Care Manager also facilitated proactive outreach to members of the practice who had not had a visit in the last year or who were missing key recommended services (Care Gaps). Among other improvements, the program resulted in a 10 percentdecrease in hospital admissions.

  AmeriHealth Mercy will work to partner with providers in the New West and New East program to bring this successful program to these regions.

QUESTION 5

Describe the management techniques, policies, procedures or initiatives you have in place to effectively and appropriately manage the Transition of Care (TOC) for members being discharged and control hospital readmissions. Describe your strategy moving forward to improve performance in this area.

(Limit to two pages)

RESPONSE TO QUESTION 5

Inpatient care is the largest component of any Medicaid Managed Care Organization's budget. Implementing sound transition of care policies and procedures to control preventable readmissions are paramount to managing members' health outcomes and overall program costs. AmeriHealth Mercy's approach to transition of care management for hospital discharges, and for controlling hospital readmissions, includes the following components:

- A best-in-class integrated data platform to inform care planning
- A collaborative transition of care team and on-site acute care transition managers in high-volume hospitals
- Post-discharge follow-up and Rapid Response team support
- Robust data analytics using the 3M Health Information Systems algorithms
- Shared savings models with hospitals

Our comprehensive approach to managing transitions of care resulted in a decrease in potentially preventable readmissions at AmeriHealth Mercy and all of our affiliated health plans between 2009 and 2010. Our results have been using algorithms developed by 3M Health Information Systems.

AmeriHealth Mercy's Integrated Care Management platform provides a complete member profile showing diagnostic information, medical and pharmacy utilization history, and social data such as family and support system availability. The data included in this system provide the foundation for transition of care planning and all efforts to control avoidable readmissions.

When a member is hospitalized, our care managers use the information contained in our Integrated Care Management system develop a successful, person-centered discharge plan. A plan is developed in collaboration with the member and/or caregiver, treating physicians, and hospital social worker, to align all parties with the transition goals. As discharge approaches, the AmeriHealth Mercy care managers coordinate home health services, specialty care and DME services to ensure a seamless transition and prevent any gaps in ongoing treatment that could result in negative health outcomes and costly readmissions.

AmeriHealth Mercy places acute care transition managers on site at certain high-volume hospitals, to help coordinate care for hospitalized members. The transition managers visit hospitalized members, assessing their discharge needs, coordinating post-discharge physician appointments, and arranging needed equipment and supplies. The transition manager also alerts the Integrated Care Management Team when a member is nearing discharge and will arrange for ongoing support from the team. The transition manager serves as a liaison for the facility and activates resources and services provided by the health plan to support the member.

Post-discharge, our transition of care team follows up with discharged members at regular intervals based on the individual plan of care and the member's ongoing needs. The team assists members with self-management techniques and helps eliminate barriers to achieving better health, like overcoming health literacy issues that impede a member's understanding of the plan of care and contribute substantially to member non-compliance resulting in readmission.

Staff can address questions concerning how to obtain medications, supplies or medical equipment, offer assistance in finding a specialist, and how to get help with making physician appointments. Ongoing medication monitoring assures the member is meeting their responsibility of remaining up-to-date with prescriptions, while those found to be noncompliant

are given a call to action and guidance on obtaining all needed medications. It is not unusual for AmeriHealth Mercy to arrange for home delivery of medication for those members rendered homebound after a hospital stay.

AmeriHealth Mercy continuously monitors the following key measures for all acute care hospital discharges:

- Physician visits within seven and 30 days of discharge
- Readmissions within 30 days of discharge
- Potentially Preventable Readmissions (Using 3M Health Information Systems' methodology)

Results of our evaluation drive improvement and performance goals, both internally and for under-performing facilities. For example, members who do not complete a follow up physician visit post discharge receive targeted outreach from AmeriHealth Mercy, including an offer of assistance in scheduling a follow up appointment.

Avoiding Re-Admission

C is a 60 year-old with female with a history of heart failure, COPD, diabetes, hypertension, gastro esophageal reflux, coronary artery disease, gait imbalance, and two cardiac stents, who was discharged from the hospital after being admitted with chest pain. We contacted C the next day to review her discharge instructions, verify that she had her medications and a follow-up PCP appointment and identify any barriers to following her plan of care.

C identified that she did not have her glucometer anymore. We arranged for delivery of a new glucometer and marked C's case for a follow-up. During the follow-up call, the Care Connector verified that the glucometer arrived. However, in discussing her follow-up PCP appointment, C identified a need for transportation assistance. We initiated the process to connect C to the county transportation service, making multiple phone calls to the PCP office, C and the transportation provider to complete the necessary paperwork so she could use the Medical Assistance Transportation Program to get to her appointment.

Looking Ahead

As we expand the scope of our HealthChoices participation, our transition of care strategy has been shaped by both past experience and research of the New West and New East Zones. In addition to carrying on the aforementioned protocols, we look forward to partnering with DPW to identify facilities with the highest readmission rates in these counties. An analysis of encounter and claims data will identify targets for proactive partnerships, including the possible implementation of our hospital shared savings program, which enables hospitals to share in savings derived from a reduction in hospital readmissions and ER utilization.

In addition, we will seek to engage local agencies in our ongoing efforts to address health literacy issues. We look forward to partnering with people like Andy Glass, Director of the Erie County Department of Health, and providers in the new zones, on health education and literacy programs to help empower our members to take control of their health.

QUESTION 6

Describe how you encourage provider usage of electronic medical records.

(Limit to four pages)

RESPONSE TO QUESTION 6

Electronic Medical Records (EMR) is a required standard for 2015. More importantly, it provides a vehicle to improve patient care, saves time, reduces fraud and helps control costs. AmeriHealth Mercy's ongoing multi-faceted EMR plan encourages our partners and providers to more quickly implement and better utilize EMR along with Pennsylvania's Health Information Exchange (HIE).

Introduction

AmeriHealth Mercy has encouraged implementation of Electronic Medical Records (EMR) in coordination with Pennsylvania's HIE to:

- Improve our members' overall healthcare experience
- Improve member care by allowing providers instant access to members' medical history, so providers can act faster and more efficiently
- Reduce admissions time allowing for faster medical attention
- Reduce medical errors
- Reduce fraud, waste and abuse
- Enhance reporting capabilities and patient tracking to facilitate better member care
- Reduce duplication of tests and delays in treatment
- Improve accuracy of medical records
- Reduce office space, paper filing, storage and other costs due to hard copy files
- Reduce 'lost' charts where files are misplaced or not available to provider at the time of service
- Improve synergies between providers
- Improve disaster relief efforts since records are no longer 'lost' when catastrophic events occur

These improvements in care are mutually beneficial to members, who benefit from improved care coordination leading to better health outcomes, and to the Commonwealth its taxpayers, who benefit from medical and administrative cost reductions resulting from increased efficiencies and better coordinated care. For these reasons, AmeriHealth Mercy is a strong proponent of the use of EMR within our provider network.

Data Integration with Provider EMRs

AmeriHealth Mercy makes an individual Member Clinical Summary available to participating providers for print or download into the provider's electronic medical record via our secure Provider Portal. The Member Clinical Summary is a claim-based medical history including pharmacy and medical management data sets, and any Care Gaps. The Member Clinical Summary is a valuable tool to ensuring appropriate coordination of care.

Provider Education

AmeriHealth Mercy routinely informs providers of funding from various entities for EMR acquisition and implementation through our provider website, our provider newsletter, and our provider education packets (distributed three times a year).

For example, our provider website currently has a notice about the federal incentives and state subsidized assistance available to providers for implementing and using electronic medical

records through the Pennsylvania Regional Extension and Assistance Center for HIT (REACH). We inform providers that the federal incentive program is open to all Pennsylvania providers.

Participation in State and Regional Initiatives

AmeriHealth Mercy is actively involved in Pennsylvania's Health Information Exchange (HIE) projects. We have participated with the Pennsylvania E-Health Collaborative (PaeHC) in the development of their strategic plan for HIE through active involvement on the Business Operations and Finance committees. We have also been involved at the local level in supporting the Southeast PA Health Information Organization (HIO), a collaborative effort with the Delaware Valley Healthcare Council, which represents area hospitals, and the Health Care Improvement Foundation. We also bring HIE experience working with other states, namely the Kentucky HIE, where we are delivering a Continuity of Care Document of health plan information (medications, admissions, office visits, etc.) to providers through the HIE.

Looking Ahead

AmeriHealth Mercy understands that providers may be reluctant to invest in expensive, time consuming and complex EMR technologies. Providers may not have the money, time or expertise to select, implement, and covert current systems and train their staff. Change itself is also a barrier since any process change can disrupt operations.

In response to these concerns, AmeriHealth Mercy is introducing incentives to providers for improving quality performance and utilizing EMR software. This incentive will become part of our existing Provider Incentive Program.

QUESTION 7

Describe your plan's approach to utilization management, including:

- *Lines of accountability for utilization policies and procedures and for individual medical necessity determinations;*
- *Data sources and processes to determine which services require prior authorization and how often these requirements will be re-evaluated;*
- *Process and resources to develop utilization review criteria;*
- *Prior authorization processes for Members requiring services from non-participating providers or for members who require expedited prior authorization review and determination due to conditions that threaten the Member's life or health; and*
- *Processes to ensure consistent application of criteria by individual clinical reviewers.*

(Limit to six pages)

RESPONSE TO QUESTION 7

The most effective approach to controlling healthcare costs and managing utilization is providing the right care, at the right time, delivered by the right provider. Medicaid members are disproportionately impacted by chronic disease, and while we have systems in place that emphasize care for the chronically ill, our approach to utilization management is designed to assist all members - not just those in our case and disease management programs - in getting and staying healthy. Our Utilization Management (UM) program marries technology and decision support systems with a quality focus to promote member responsibility and self-management and minimize the administrative burden for providers.

Our UM program is a comprehensive, systematic, and ongoing effort that is based on nearly 30 years of experience coordinating care for our diverse membership. The UM program employs nationally recognized guidelines, regular and ongoing evaluations, and a thorough employee training program to ensure that members receive high quality, medically necessary care. We will use this proven UM program as a foundation to ensure that our members receive the most sound, efficient, and effective care available.

AmeriHealth Mercy will not structure compensation to individuals or entities that conduct utilization management activities in such a way as to provide incentives for the individual, AmeriHealth Mercy employees or subcontractors to deny, limit or discontinue medically necessary services to any members.

Lines of Accountability for Utilization Policies and Procedures

Our Board of Directors provides strategic direction for the UM Program and retains ultimate responsibility for ensuring that the UM Program is managed, monitored, and evaluated in accordance with accrediting bodies, State, and CMS regulations. Operational responsibility for the development, implementation, monitoring, and evaluation of the UM Program is delegated by the Board of Directors through the Regional President, the Health Plan Executive Director, and our Quality Assessment and Performance Improvement committee (QAPI). The Medical Director reports to the Executive Director and Regional Chief Medical Officer and facilitates communication between regional and local leadership and the Board.

The Medical Director is responsible for the development, implementation, and oversight of all aspects of the UM program. The Utilization Management Director works in concert with the Medical Director and is responsible for oversight of all operational aspects of the UM program. The UM Director, Manager and Supervisor have responsibility for the managerial oversight of the UM program and for ensuring that the basic components of utilization management are established and effectively operating.

A complete set of policies and procedures outline the processes and decisions-support guidelines for the UM Program. UM policies, procedures and medical necessity guidelines are reviewed and approved by the QAPI committee, which includes participating practitioners as voting members.

Staff Roles and Responsibilities

The role of each staff member is clearly defined, documented, and implemented to ensure that all aspects of the UM process fully support care coordination efforts. All care coordination efforts are designed and implemented to support quality administration of health care benefits, in

accordance with all State requirements, state and federal laws and regulations, and accreditation guidelines.

Requests for benefit coverage or Medical Necessity determinations are made through staff, supervised by a Registered Nurse. Decisions to approve coverage for care may be made by UM staff when falling within written guidelines applicable to this program.

Licensed physicians support the staff within the UM Department. Together they provide clinical review of medical information and/or peer-to-peer contacts with attending/treating physicians and/or other healthcare practitioners when there is conflicting medical information or there are questions about appropriate application of Medical Necessity guidelines. Any decision to deny, alter or approve coverage for an admission, service, procedure or extension of stay in an amount, duration, or scope that is less than requested is made by the Medical Director.

Data sources and processes to determine which services require prior authorization

AmeriHealth Mercy uses well-defined and tested algorithms to assess the utility of an authorization process for selected outpatient, medical equipment, supplies, and inpatient services, including monthly review of prior authorization requests. Our written policies and procedures for processing requests for initial and continuing authorization of services meet DPW and NCQA standards. In all cases, we will follow DPW requirements as to which services require prior authorization.

In addition to volume and cost, we look at frequency of denial, potential for abuse, and local market characteristics as indicators for review. For example, one of our affiliated health plans experienced a chronically high level of tonsillectomies in comparison to the Medicaid mean. Although tonsillectomies do not require authorization for most of our health plans, our affiliated health plan nonetheless performs clinical review of these requests in order to better understand and manage utilization.

The Prior Authorization Governance team, consisting of representatives from our Medical Management, Operations and Provider Network Management departments, meets monthly to review data on service utilization and requests for changes to the list of services that require prior authorization. Data on the relative volume of requests (requests per member), the cost of the service, the potential for safety issues or adverse outcomes and the percentage of requests found to be outside of medical necessity guidelines are reviewed. The Governance team can decide to add or remove services from the prior authorization list. In order to have an authorization for services added to the grid, the proposed action must be supported by a rationale (such as a State mandate or an unexplained increase in utilization) and an anticipated return on investment. Additions and deletions are reviewed and approved by the QAPI and DPW.

Process and Resources to develop Utilization Review Criteria

AmeriHealth Mercy uses the nationally-recognized InterQual guidelines for its UM program. We review and update our criteria for at least annually – or more often if needed – during our Quality Assessment and Performance Improvement committee (QAPI) meeting, which includes external physicians as members with voting privileges. The criteria currently in use include:

- InterQual Adult ISD (Intensity of Service, Severity of Illness & Discharge Screens) Criteria
- InterQual Pediatric ISD (Intensity of Service, Severity of Illness & Discharge Screens) Criteria

- InterQual Outpatient Therapy Criteria
- InterQual Home Care Criteria
- InterQual Outpatient Procedures Criteria
- InterQual DME Criteria

As needed, AmeriHealth Mercy develops internal criteria to supplement InterQual. We use the following information sources during the development process:

- Results of the Hayes Incorporated technology assessment report
- Information from appropriate government regulatory bodies, such as the Food and Drug Administration or the DPW Technology Assessment Group
- Published scientific evidence
- Publicly available reference information (including web/online resources)
- Information from a board-certified consultant(s) familiar with the specialty or technology area under review

The final criteria are reviewed and approved by the QAPI committee which will be responsible for the annual review and approval as part of our Quality Assessment and Performance Improvement Program. Practitioners that serve on this committee will provide input in the development and revision of these criteria.

Any request that is not addressed by, or does not meet, the guidelines set forth in the above criteria is referred to a Physician Reviewer for a decision. Medical Necessity decisions are based on DPW's definition of Medical Necessity, in conjunction with the member's benefits, the reviewer's medical expertise, applicable criteria, and/or published peer-review literature. At the discretion of the Physician Reviewer, input to the decision may be obtained from participating board-certified physicians from an appropriate specialty. The Physician Reviewer makes the final decision subject to applicable appeal and grievance procedures.

Prior Authorization for Non-Participating Providers and Expedited Prior Authorization

We have well-defined policies and procedures to follow when a member needs to access care from a non-participating provider or needs an expedited prior authorization determination. Our UM criteria, and the process used for criteria development, are used for both participating providers and non-participating providers. AmeriHealth Mercy also has mechanisms in place to ensure consistent application of review criteria for authorization decisions, and procedures for consultation with the requesting provider when appropriate.

Process for Non-Participating Providers

Although we will make every effort to provide a comprehensive network of providers, there will be occasions when a member needs services from a non-participating provider. We will consider the use of a non-participating provider to be medically necessary in the following situations:

Continuity of Care

Members who are engaged in an ongoing course of treatment with an out-of-network provider can continue to receive services from that provider in the following situations:

- **Newly enrolled Members** may continue an ongoing course of treatment with a nonparticipating Practitioner or Provider for up to sixty (60) days from the date of enrollment with the Plan.

- **Newly enrolled Members who are pregnant** on the effective date of enrollment may continue to receive ongoing treatment from a non-participating Obstetrician or Midwife through delivery and the completion of post-partum care related to the delivery.
- **Current Members** may continue an ongoing course of treatment with a Practitioner whose contract is terminated with the Plan (either by the Plan or by the Practitioner) for up to ninety (90) days from the date that the Member is notified by the Plan of the termination or pending termination.
- **Current Members** may continue an ongoing course of treatment with a Provider whose contract is terminated by the Plan for up to sixty (60) days from the date that the Member is notified by the Plan of the termination or pending termination.
- **Current Members who are pregnant** on the date that the Member is notified by the Plan of their provider's termination or pending termination may continue an ongoing course of treatment with a non-participating Obstetrician or Midwife through the completion of post-partum care related to the delivery.

Services are Unavailable from Participating Specialist/Provider

Prior authorization will be granted for medically necessary out-of-network services if the requested services are not available within the AmeriHealth Mercy network or if participating specialists/providers do not have the necessary expertise/training to provide the services.

Expedited UM Determinations

AmeriHealth Mercy has a process in place to handle expedited or urgent medical requests, separately from non-urgent requests that comply with DPW requirements. The determination is based on what will drive the best outcome for the member.

Members and/or their practitioner or provider can request an expedited review of an authorization request via phone or fax. Expedited requests are flagged as "Urgent" in our Medical Management Information system, alerting the UM staff to the need to follow expedited processing rules and timeframes. The urgent flag also allows UM leadership to monitor and report timeliness of expedited determinations.

Expedited determinations are made and verbal or electronic notification is provided as expeditiously as the Member's health condition requires, at least orally, within 24 hours of receipt of the request unless additional information is needed. If additional information is requested by AmeriHealth Mercy to make a determination, the decision is made and verbal or electronic notification is provided within 24 hours of receipt of the additional information or the date when the additional information was to have been received, whichever is sooner. Both the Member and the Health Care Provider receive verbal or electronic notification of all determinations. Written notification of denial determinations is made within 24 hours of the verbal notification of the decision.

Consistent Application of Criteria

Our training and ongoing education programs for our UM team are based on our proven programs. The programs are designed to help the UM employees understand the delivery of health-related services to our members, as well as to ensure the consistent application of medical necessity criteria. Our multi-layered approach ensures that the goals of the HealthChoices program around stabilizing Medical Assistance spending while sustaining quality health outcomes and appropriate benefit levels are met.

Certified Trainers

We maintain a team who are certified as instructors for InterQual Medical Necessity criteria. Annually, this team goes through training and instructor update certification. Our instructors deliver training on changes and updates to the criteria to our UM staff. We have four (4) RN staff members who are being certified as InterQual Instructors. Initial training on proper application of our criteria is provided during new employee training.

New Employee Training

New employees are educated and trained on job duties by the department manager and program trainer. For a UM nurse, this training includes use of applicable medical necessity criteria and guidelines. Utilization review skills are taught using scenarios that mimic the coverage needs of the Medicaid population and focus on commonly encountered requests. Basic system navigation and documentation of criteria use is taught in the classroom.

Inter-rater Reliability

In addition, UM staff members involved in the application of medical necessity criteria participate in an Inter-Rater Reliability (IRR) process twice per year. This process involves reviewing blind 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 (or disapproval) if criteria appear to have not been met. Physician reviewers also participate in an IRR process twice per year. The IRR process helps to identify if clarification or recommendations for modifying criteria are needed, or if additional individual or group training is indicated. Action plans are developed to address identified variances. Performance results and action plan results are communicated to staff via individual sessions, team meetings and department communications and reported to the QAPI committee.

Individual Coaching

UM cases, including information collection, criteria application, documentation, timeliness and notification, are audited on an ongoing basis. Monthly, a supervisor reviews the results with the individual employee responsible for the case and evaluates 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 care management issues, and also serves as an educational forum to share information, resources and example-based education.

MANAGEMENT TO CONTROL COSTS

CONTENTS

QUESTION 1

Demonstrate how you monitor the performance of your subcontractors to ensure all Agreement responsibilities are met. Provide sample reports showing any actions taken to improve performance and ensure positive results. Describe any sanctions or penalties that apply if the subcontractor fails to perform up to the expectations of your organization. Attach sample performance monitoring reports.

(Limit to two pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy will only delegate activities to organizations meeting the requirements defined in 42 CFR Part 438. We evaluate the prospective subcontractor's ability to perform the delegated activities. After the potential subcontractor demonstrates acceptable capability, a written agreement specifying the delegated activities, required performance standards, reporting responsibilities and contractual remedies related to performance issues, is executed. AmeriHealth Mercy contractually retains the right to investigate and audit a subcontractor at any time; to require corrective action plans; and to implement increased monitoring to meet standards. Subcontractor requirements are based on AmeriHealth Mercy's requirements, the requirements of the RFP, Federal or State regulatory authorities, and applicable accrediting agencies. Oversight of subcontractors includes validating all required certificate(s) of insurance prior to contract implementation and that all such standards are maintained throughout the term of the agreement.

We monitor the performance of our subcontractors through a formal contract-based quality oversight program performed by staff dedicated to this function. Performance measures are monitored through monthly reports submitted by the subcontractor. In addition, annual onsite audits are conducted during which regulatory compliance and performance is reviewed and documented. Monthly subcontractor performance reports and the results of annual on-site audits are reviewed by an AmeriHealth Mercy quality review committee, which meets monthly. Recommendations for any necessary corrective action plan, along with the target completion date(s), are presented to the committee. Based on the committee's decision, the subcontractor is approved or disapproved for continued operation. If a corrective action plan is imposed, the results of the corrective action and subsequent monitoring are brought back to the committee.

Table 1: Sample Performance Monitoring Report - December 2011

Metric	Contractual or RFP Requirement	Actual Performance
Clean Claim (Electronic) Paid in 21 days	98%	100%
Clean Claim (Paper) Paid in 30 days	98%	100%

Sample Report for Performance Improvement

This is a sample of a subcontractor that was not performing consistently with the contract. In this instance, the subcontractor was required to pay clean claims within established time frames 98 percent of the time. The standards were measured in four categories:

- Paper UB-04: 98% of clean claims must be paid within 30 days of receipt
- Paper CMS 1500: 98% of clean claims must be paid within 30 days of receipt
- Electronic UB-04: 98% of clean claims must be paid within 21 days of receipt
- Electronic CMS 1500: 98% of clean claims must be paid within 21 days of receipt

Issue

Subcontractor missed the goal in January 2011 for Paper UB-04 claims due to several issues, and was projected to miss the goal for the first quarter of 2011 for Paper UB-04 claims because of the low rate in January and the fact that this category historically has a low level of claims submitted.

Root Cause Analysis

Several issues were quickly discovered and the Subcontractor Claims and IT Departments continued their root cause analysis to identify all the causes. The overall root cause was attributed to Subcontractor processes not containing a measure of validation that all claims to pay were completely adjudicated and processed.

Table 2: Planned Corrective Actions

Intervention	Date/Status	Comments
Complete root cause analysis to determine issues	01.27.2011: ongoing	
Fix eCura defect	01.27.2011: pending with eCura vendor, InfoMC	Is on high priority status
Implement manual workaround	01.27.2011: manual workaround implemented	Claims staff are manually running a report after every check run to ensure that all claims completed the entire process

QUESTION 2

Describe your method and process for capturing third party resource and payment information from your claims system for use in reporting cost-avoided dollars and provider-reported savings to the Department. Explain how you will use such information. Describe the process you use for retrospective post-payment recoveries of health-related insurance as well as your process for adjudicating a claim involving an auto accident.

(Limit to four pages)

RESPONSE TO QUESTION 2

AmeriHealth Mercy has nearly 30 years of experience in cost avoidance and collection of third party resources (TPR). For calendar year 2010, the AmeriHealth Mercy avoided inappropriate payment of *$67.7 million* across all its affiliated Medicaid risk plans. The capture of TPR is critical to ensuring that Medicaid remains available to those who need it most and that Medicaid is the payer of last resort. Our system has virtually unlimited capacity to capture TPR data from other carriers, agencies and relevant sources.

Method and Process for Capturing Third Party Resources and Payment Information

AmeriHealth Mercy captures TPR information regularly received from many sources, including Explanation of Benefits (EOB) forms sent with provider claims, enrollment files, third-party liability (TPL) files received from the state and through telephone calls from providers and members who self-identify TPR coverage.

AmeriHealth Mercy's dedicated Recovery department identifies and obtains third party payer information, including Medicare, commercial insurance and/or accident-related coverage, and administers the collection and adjudication of TPL information, while meeting all federal and state requirements. The three units of the Recovery department are:

- **Cost-Containment** – Execution of a cost containment strategy, which identifies recovery-related projects (over- and under-payments) ranging in scope from small to large
- **Third Party Liability (TPL)** – Responsible for maintaining and identifying our members' additional insurance carrier information. This includes identifying and flagging records for dual eligible (Medicaid/Medicare) and commercial carriers
- **Subrogation** - Responsible for identifying, tracking and monitoring casualty-related claims for potential recovery

We exercise all applicable full assignment rights and make every reasonable effort to determine third parties to pay for services rendered to members and cost avoid and/or recover any such liability for the third party.

Reporting Cost Avoided Dollars and Provider Reported Savings

AmeriHealth Mercy complies with the State requirement to treat funds recovered from third parties as offsets to claims payments. In addition, we report all cost avoidance values to DPW in accordance with applicable federal guidelines and include the collections and claims information in encounter data submitted to DPW (including any retrospective findings via encounter adjustments). We also report third party collection in the aggregate as required by DPW, and post all third party payments to claim level detail by member. AmeriHealth Mercy will cooperate with DPW and its recovery vendor(s) in any manner as may be requested by DPW. At a minimum, we will report TPR information identified to DPW within two weeks of its receipt. The information will be made available in the appropriate format and media determined by DPW.

We understand that we may retain amounts recovered by third parties, but that these amounts must be reported monthly to DPW. In addition, we understand and acknowledge that DPW is solely responsible for estate recovery activities and will retain any and all funds recovered through these activities. We work with DPW to establish appropriate TPR-related systems and

processes for members who are made retroactively eligible for Medicare and pursue TPR with respect to such members until waiver of enrollment occurs.

As evidence of the successful application of the protocols described in this section, AmeriHealth Mercy reported over $5 million in cost avoided dollars and $3.7 million in Coordination of Benefits (COB) savings to DPW as a result of TPR/COB coordination efforts during the 2010 contract year.

How We Use the Information

AmeriHealth Mercy uses the TPR data to coordinate benefits using the methods of cost avoidance and post-payment recoveries. We utilize cost avoidance methodology whenever there is a verified third party resource.

After the TPR data are loaded, it is immediately available to all Facets (eligibility and claim system) users, including claim examiners, customer service representatives, provider service representatives, enrollment employees, medical management employees, and recovery employees. This information supports specific reporting requirements and enables the Claim department to process COB claims appropriately by using "flags" established within the Facets system. The flags assure that TPR information is considered prior to finalizing claim adjudication.

Our claims processing system automatically routes all claims containing EOBs from other insurance carriers to claim examiners for further examination. A claim examiner reviews the EOB and claim image information captured during claim submission. The COB module in Facets captures and displays line-level data of AmeriHealth Mercy and the alternate insurer(s) allowed amounts. This information is fully available for use in reporting cost-avoided dollars and provider-reported savings to DPW.

In the event the TPR information on the EOB does not match the TPR information documented in the system, the claim is routed via an automated workflow process to the Recovery department. The Recovery department verifies TPR 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 and payment.

Process for Retrospective Post Payment Recoveries of Health-Related Insurance

AmeriHealth Mercy is well-positioned to perform post payment recoveries. We have the capability to perform TPL-related overpayment recoveries directly from liable third party payers through Health Management Systems (HMS). HMS supports our retrospective post payment recoveries of health-related insurance as well as the identification and validation of additional TPR data. HMS maintains a proprietary national database containing TPR information for many of the major commercial carriers, as well as government program information.

We send eligibility information to HMS on a monthly basis, which is compared to HMS's national data sources to determine if other insurance exists for the member. Any information previously unknown to us is routed back for evaluation and appropriate action. This additional TPR information is automatically compared to existing data and, as appropriate, is loaded into our claims processing system via an automated file load process. Any updated information is included in the information sent to the State.

HMS also identifies TPR-related overpayments and is able to generate and transmit secure billing files to responsible third party payers. These payers process the billing files and submit payments to a plan-specific lockbox, which HMS reconciles. Lockbox deposits are routinely monitored by our Finance department. HMS also provides detailed billing and posting files to ensure we are informed of all claims for which a recovery was attempted and for which a recovery was realized.

Claim and line level claim denials are sent to the provider on the EOB. Our claim processing system has the capability to provide the TPR data to the provider so they can submit the claim to the appropriate carrier for payment, and will provide all such information as required by DPW.

AmeriHealth Mercy understands and complies with the State requirement that, notwithstanding any specific measures taken with respect to TPR identification and collection, if the probable existence of a TPR cannot be established the MCO must adjudicate the claim and thereafter utilize its post-payment recovery process. Upon the award of the contract, AmeriHealth Mercy will meet with the State and its vendor to define a processing and reporting protocol to conduct the post-payment reviews; if DPW wants a different process than we currently perform.

Process for Adjudicating an Auto Accident Claim

AmeriHealth Mercy manages all subrogation-related activities including identification of diagnosis for trauma, through ACS. ACS is one of the nation's largest subrogation vendors. Through years of subrogating claims, it has designed criteria and developed queries and algorithms to successfully mine paid claim data and identify potential recoveries. Claim data are processed to identify recovery potential using an algorithm which takes into account a number of detection variables including diagnosis codes, procedure codes and external cause codes found in claims information. ACS's data mining criteria include:

- An automated analysis of claim data based on review of ICD-9-CM diagnosis codes as well as the cost of treatment, demographics associated with an individual, and any related claim matters.
- Review of claim information to determine potential overpayment as it relates to accidents, slip and fall, or other worker's compensation.
- Review of membership eligibility information using a variety of tools and logic such as mandatory Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) Section 111 reports, and the use of real-time commercial eligibility information to prevent the improper payment of claims.
- Identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) and any other applicable trauma codes, including but not limited to E Codes, in accordance with 42 CFR 433.138(e).

AmeriHealth Mercy forwards a claim file each month to ACS containing information related to paid claims and enrollment data. ACS utilizes sophisticated data mining tools to identify potential accident-related claims. The analysis focuses on TPR, automobile medically related coverage, and no fault workers' compensation.

Once a potential subrogation case is identified, ACS will mail a letter and questionnaire to the member to determine whether the incident which generated the claim was accident-related. Three attempts are made to contact the member. If the member does not respond to the mail inquiries, ACS reviews additional resources using ISO ClaimSearch, official court records (court dockets) and other online research sources to further investigate whether a subrogation claim

exists. ISO ClaimSearch is the only comprehensive all-claims database and system for claims processing and fraud detection — serving property/casualty insurers, self-insured organizations, third party administrators, and many state workers compensation insurance funds. Additionally, cases may be opened manually by an ACS investigator when a member, provider, or attorney provides the incident information required to open and investigate a case.

When a case is verified and opened, ACS communicates with members on an "as needed" basis, communicates regularly with attorneys, coordinates with AmeriHealth Mercy on litigation options and settlement negotiations, and follows the case through to closure. We receive regular status reports on open and closed cases.

All cases will be pursued regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by AmeriHealth Mercy outside of the claims processing system will be treated as offsets to medical expenses for the purposes of reporting.

QUESTION 3

Describe any other cost-saving programs/initiatives you have implemented in the last 36 months and provide information on cost-savings realized related to these programs/initiatives. Please identify cost-savings plans you have planned, but not implemented.

(Limit to four pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy has integrated cost savings initiatives and program improvements into our daily approach. We are committed to continuous improvement in quality and in operational and cost efficiency in our local health plan and throughout our corporate enterprise. Over the past 36 months, AmeriHealth Mercy and our affiliated health plans have implemented several initiatives aimed at reducing unnecessary utilization, reducing provider unit costs, administrative cost reductions through operational efficiencies, and activities to deter fraud, waste and abuse. These initiatives are described below.

AmeriHealth Mercy Health Plan Initiatives

Single Source Specialized DME Supplier

AmeriHealth Mercy recently entered into a single-source contract with J&B Medical Supplies to offer full service, drop-ship incontinence supplies. Full implementation will be complete February 28, 2012. We expect to achieve savings of $1 million annually.

Claims Clinical Editing

AmeriHealth Mercy claim payment policies are based on guidelines from established industry sources such as the National Correct Coding Initiative, Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies and medical specialty professional societies. In making claim payment determinations, AmeriHealth Mercy 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 and the International Statistical Classification of Diseases and Related Health Problems (ICD) manual. Our application of iHealth Technology edits to professional and outpatient facility claims has saved more than $7 million since 2009.

Emergency Room Initiatives

AmeriHealth Mercy has a PCP incentive program that rewards PCPs for cost-effecting, high-quality care. Practices are rewarded for achieving lower than average non-emergent ER utilization. We also offer PCP incentives for expanded office hours. In calendar year 2010, we achieved a six percent reduction in ER utilization, which generated savings of appropriately $1 million.

90-Day Program

In 2011, we implemented a 90-day prescription program for select generic medications where the dispensing fee paid to the pharmacy for months two and three exceed the cost of the medication provided.

By providing all of the medication for a single dispensing fee, we are able to save the two additional dispensing fees. This program is especially advantageous for our members with limited means of transportation because it allows them to make fewer trips to the pharmacy for their medication. Since the program began, nearly 14,000 claims have been filled for a 90-day prescription resulting in savings of approximately $200,000. These savings will continue increase as more members are transitioned into the program.

Fraud and Abuse

AmeriHealth Mercy currently utilizes HMS for TPL identification and recovery. We submit full membership files to HMS, which in turn identifies additional sources of TPL information. The

additional information is transmitted back to AmeriHealth Mercy and is automatically loaded into our healthcare system. HMS also recovers claims paid where the member had TPL via billing of the primary carrier(s). Claims paid due to retroactive TPL and/or those that fall under regulatory "pay and chase" requirements are referred to HMS for pursuit from the primary carrier. Through identification, recovery, and cost avoidance activities, AmeriHealth Mercy has saved more than $7.3 million since 2009.

AmeriHealth Mercy has extended its partnership with HMS to include retrospective data mining services and forensic editing post adjudication, and pre-pay prospective fraud, waste and abuse. We expect that this additional support from HMS will result in savings of $11.2 million annually.

AmeriHealth Mercy Family of Companies Corporate Initiatives

Contact Center Initiatives

Enterprise-wide, the AmeriHealth Mercy Family of Companies realized $2.5 million in savings in 2011 through more efficient configuration of call center technologies, workflows and staffing models. Specifically, AmeriHealth Mercy Health Plan has realized a portion of these savings through a reduction in back office fees.

Claims Process Improvements

In addition to call center savings, the AmeriHealth Mercy Family of Companies also realized $1.4 million in savings in 2011 due to claims processing workflow improvements. A portion of these savings are also passed through to AmeriHealth Mercy Health Plan via back office fee reductions.

Looking Ahead

Dental Insourcing

AmeriHealth Mercy Health Plan currently subcontracts dental services to DentaQuest (formerly Doral Dental). Our southeast Pennsylvania affiliate, Keystone Mercy Health Plan, recently in-sourced dental benefit management in an effort to improve quality and utilization and reduce the cost of dental care. Keystone Mercy expects to save $1 million in 2011 as a result. AmeriHealth Mercy anticipates saving approximately $300,000 annually, based on the relative size of our membership.

MANAGEMENT INFORMATION SYSTEMS

CONTENTS

QUESTION 1

Provide a general systems description, including:

- *A systems diagram that describes each component of the management information system and all other systems that interface with or support it;*
- *How each component will support the major functional areas of HealthChoices (In-Plan Services; Coordination of Care; Member Services; Maternity Care Payments; Complaint, Grievance and Fair Hearings; Pharmacy; Special Needs; Provider Network; Provider Services; Service Access; Quality Management/Utilization Management (QM/UM); Claims Payment and Processing, and; Encounter Data Reporting System).*

(Limit to ten pages, including the diagram)

RESPONSE TO QUESTION 1

System Diagram

The diagram below describes each component of the management information system (MIS) and all other systems that interface with or support the functional areas of HealthChoices. The core functional areas supported by AmeriHealth Mercy's healthcare management systems include:

Medical Management

In plan services, care coordination, special needs, utilization management (UM), quality management (QM)

Network Management

Provider Network development (provider contracting, credentialing), provider services (performance management and oversight, education), service access (provider access)

Facets Claims Processing & Eligibility System (Claims Adjudication)

Claims payment and processing, maternity care payments, pharmacy claims processing

Member Contact Center

Member services (eligibility and enrollment) and complaint, grievance and appeal

Encounter Processing and Reporting

Encounter submission, subcontractor encounter submissions and Reporting

Figure 1: Health Care Management Systems

The following matrix provides a cross-reference between PA HealthChoices functional areas and the supporting AmeriHealth Mercy system domains:

Table 1: PA HealthChoices Functional Area – AmeriHealth Mercy System Domain

PA HealthChoices Functional Area	AmeriHealth Mercy System Domain
Medical Management	
In-Plan Services	ZeOmega Jiva
Coordination of Care	ZeOmega Jiva, Verisk DxCG, E-Health Clinical Alerts
Special Needs	ZeOmega Jiva
Quality Management/Utilization Management (QM/UM)	ZeOmega Jiva, McKesson CERME/InterQual®, Treo Solutions

PA HealthChoices Functional Area	AmeriHealth Mercy System Domain
Provider Network Management	
Provider Network	Portico, Visual Cactus, Networx Pricer, Networx Modeler
Provider Services	NaviNet Provider Portal
Service Access	GeoAccess GeoCoder, by Ingenix Suite®, DirectoryExpert®, by Ingenix Suite
Claims Adjudication	
Claims Payment and Processing	TriZetto Facets, EXP MACESS™/Workflow and Imaging, iHealth Technology (iHT)
Maternity Care Payments	TriZetto Facets
Pharmacy	Argus
Member Contact Center	
Member Services	EXP MACESS/Call Documentation/Workflow, Streamline, Member Portal
Complaint, Grievance and Fair Hearings	EXP MACESS/Call Documentation/Workflow
Encounter Processing & Reporting	
Encounter Data Reporting	Data Exchange Services
Reporting	Data Warehouse, Catalyst Technologies – Quality Spectrum®

Medical Management

AmeriHealth Mercy maintains fully integrated Medical Management and e-Health solutions that help manage the delivery of valuable clinical services and information.

ZeOmega Jiva Care Management

The ZeOmega Jiva (Jiva) Care Management application is a collaborative health care management platform for case and disease management, service coordination, preventive health (EPSDT) and utilization management. Jiva's extensive capabilities, coupled with our robust analytic and data mining capabilities, form a comprehensive Care Management Information System for all members, including those with special needs. Highlights of Jiva's system capabilities include:

Utilization Management

- Defined business rules that automatically evaluate care requests to determine whether the request should be approved or pended for further review
- Clinical rules, based on evidence-based medicine, reference materials, industry-standard best practices and physician expertise, for clinical consistency in care management processes
- Provider portal interface allowing providers to create, update and view information on medical necessity authorizations and determinations

Disease and Case Management

- Identification and stratification of target patients and populations to set appropriate levels of intervention and improvements for a member's care
- Integrated access to medical, pharmacy, lab, and behavioral health data to provide a 360 degree view of the member
- Clinically validated Care Gaps and electronic health records derived from claims and care management data
- A series of care management clinical pathways that enable the efficient implementation of our holistic approach to the management of chronic conditions, pregnancy, pediatric preventive care and quality management initiatives that reduce costs and improve the health outcomes
- Comprehensive outreach pathways that incorporate current member needs, health reminders and missed service strategies
- Robust reporting templates and the ability to create ad hoc reports for care management data

Preventive Health/EPSDT

- Support for health risk assessment
- Integrated access to medical, pharmacy, lab, and behavioral health data to provide a 360 degree view of the member

Verisk Sightlines DxCG Risk Solutions

DxCG Risk Solutions offers risk adjustment and prediction engines, used to analyze and quantify both financial and clinical risk. Built using powerful, validated medical and pharmacy classification systems, as well as proven predictive modeling methodologies. Features, capabilities and benefits of Sightlines are:

- Validated, predictive modeling technology
- Advanced analytics to manage risk, improve health outcomes, and contain costs
- Designed to integrate with third party systems, including home-grown financial and actuarial methodologies
- Assess the illness burden of individuals, groups and populations
- Identify cost drivers and allocate healthcare resource budgets
- Develop risk-based provider payment structures
- Measure and demonstrate the impact of care management programs
- Use predicted costs to set underwriting rates
- Develop risk-based provider payment systems

E-Health Solutions

Our e-Health Suite leverages technology to connect providers and the health plan. This e-Health suite enables better care coordination, improves population health, increases access to care, improves quality outcomes, and helps control costs. The e-Health Suite is successfully utilized by our affiliate Pennsylvania health plans and can be customized to meet New West and New East Zone's needs, and includes the following services:

Clinical Alert Services

This solution delivers the right information, on the right member, at the right time to the provider. Instead of waiting for a provider to "pull" relevant information on the member, this solution "pushes" information to the provider. The clinical alert service delivers information on care gaps to providers when they check eligibility online through the Provider Portal. The alert

capability can be customized to deliver other types of clinical information and can be triggered by any transaction in the secure section of the portal.

Mobile Device Integration

AmeriHealth Mercy is piloting the integration of our Clinical Alert Service with handheld devices used by physicians for e-prescribing, in the Lehigh/Capital HealthChoices Zone. In partnership with NaviNet, we placed integrated hand-held devices with 43 primary care providers in 23 practice sites, covering 3300 of our enrollees. When the provider accesses the enrollee's information during an office visit, any missing or overdue recommended services (Care Gaps) for the enrollee will display. The PCP is asked to enter a response indicating that the care gap was addressed and specify the type of action taken. In the initial three months of the pilot, 112 care gaps were viewed and 62 percent were addressed during the visit.

Panel Reports

A comprehensive reporting engine allows PCPs to create panel-level reports for their assigned enrollees. The panel-level reports can be filtered to include specific conditions or preventive health measures. In addition, the PCP can specify whether the report should display as a print-ready PDF file or as a comma-separated values (CSV) file for use in creating mail merge documents or uploading into a practice management system.

Member Clinical Summary

Our Member Clinical Summary (MCS) is available to provider offices, emergency rooms and enrollees through the secure areas of our Member and Provider Web Portals. The MCS is a claim-based medical history for an individual member. Each MCS offers the user a broad view of the care the member has received across the continuum of providers. It includes a medication list, recent encounters, diagnoses, and Care Gaps. It is particularly useful when the member visits an emergency room, and is referred to a provider that has no prior information on the member or if the member requires out-of-network care. The MCS is available as a print-ready report or a Continuity of Care Document (CCD) for downloading into an electronic medical record.

EPSDT Clinical Summary

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 EPSDT Clinical Summary can be printed or downloaded as a Continuity of Care Document (CCD) for electronic integration into an electronic medical record.

Providers can also pull reports on the EPSDT status of their entire panel – and print or download the information in a MS Excel or CSV file format.

Health Information Exchange

Key elements of our e-Health Suite are available in the Continuity of Care Document (CCD) format. The CCD can be integrated with any Health Information Exchange (HIE) that follows current standards. It can also be delivered for direct download to a provider's Electronic Medical Record (EMR)/Electronic Health Record (EHR) through our Provider Portal.

Providers can request e-Health Suite Training through the Contact Center or speak to their Provider Network Management Account Executive. The Provider Network Management

Account Executives work closely with our vendor NaviNet and our e-business solutions team to provide training to our providers.

McKesson Interqual/CERM(e)

McKesson has paired InterQual Criteria with browser-based technology to provide a user-friendly care management application: CareEnhance® Review Manager (CERM (e)). AmeriHealth Mercy uses CERM (e) to automate the review process. Benefits of CERM (e) are:

- Offers easy access to InterQual criteria as well as extensive medical references, glossaries, discussions of patient management and safety warnings
- Provides a common language and foundation for understanding decision points. This leads to improved quality of care and facilitates communications among staff and between health plans and providers
- Integrates into ZeOmega Jiva application
- Streamlines workflows and enhances consistency with nested decision trees for increased productivity and greater defensibility of care management decisions
- Allows customization of content with the optional Custom Criteria Utility, to reflect our policies and integrate our content alongside InterQual criteria for a unified, comprehensive set of guidelines
- Includes integrated, flexible reports that support compliance with HIPAA privacy regulations and other quality initiatives

Treo Solutions

Treo is a Web-based suite of applications which incorporates the 3M methodology for identifying Potentially Preventable Readmissions (PPRs). Using sophisticated algorithms chains of admission and readmission, events are linked to generate rates of PPR for any hospital or group of hospitals versus the network or any segment of it. Treo also can identify Potentially Preventable Initial Admissions (PPIAs) and Potentially Preventable ER visits. Since the member is the basis for this data, we can also report the data by PCP, in order to identify PCPs with the most PPRs and PPIAs so that improvement opportunities can be explored with primary care providers. In addition TREO is used for analytics related to healthcare cost and quality outcomes at the provider level. The insights gained from the analytics are used to develop provider performance management strategies and hospital provider profiles.

Provider Network Management

The core applications of the Provider Network Management systems assist AmeriHealth Mercy in providing services in the following areas: Provider Contracting, Provider Credentialing, Contract Pricing, Contract Modeling, Provider Data Management, Network Adequacy, and Provider Directory.

Portico

Foundational to managing our provider network is Portico's integrated provider management system, through which we are transforming how we manage provider information with the objective to minimize errors, lower costs, and improve provider performance and health outcomes. Portico consists of three components:

- **Contract Manager** - is a single content source for provider contracting and provides the information transparency and process automation necessary for our affiliates to effectively manage the end-to-end provider contracting process. It automates the way our contracts are created, negotiated, amended, viewed, analyzed, managed, distributed, and audited. Utilizing

its components, we are able to streamline negotiations, manage provider demographics, and provide system-wide visibility into provider network information. Allowing us to track report and update contracts that are expiring, have built in term changes or are undergoing renegotiation.

- **Courier** - enables our employees to securely send contracts and amendments electronically. Providers utilize an easy download process that has the functionality to allow them to sign contracts electronically via an internal eSignature process. The electronic signature capability improves provider relations and reduces the cost of contract distribution. Courier is a web-based application that allows providers to access contracts from any internet connection, with no installation of software or a browser plug-in.
- **Negotiator** - provides our affiliates with the ability to have secure online contract negotiations between the affiliate and providers. The Negotiation Center walks all parties through the entire process and highlights comments from actual negotiation requests. Negotiator logs a complete history of the original and edited versions of the contract, resulting in end-to-end lifecycle tracking of the negotiation process. We track all negotiation requests, capture contract change intent, generate negotiation summary reports, and integrate negotiation requests with contract version control.

Visual Cactus

Visual Cactus (CACTUS) is a Windows-based, desktop application, which maintains provider credentialing and re-credentialing information using electronic interfaces with web-based data repositories and primary verification sources, like Council for Affordable Quality Healthcare (CAQH). The repository maintains a history of all provider attestations downloaded and an intuitive viewer provides a side-by-side comparison of select CAQH and CACTUS data. Data currently imported includes: Provider demographics, Provider IDs, Institutions, Licenses, Affiliations, Insurance, Education, Specialties, Boards, Languages, Groups, and Addresses. The import program will also create a credentialing instance for the provider if they are due for credentialing and an instance does not already exist. The electronic interfaces with web-based data repositories and primary verification sources are:

- **Custom Delegate Importer** - takes the data submitted from multiple delegates from a delimited text file containing the required data elements and populates them into CACTUS. The Office of Inspector General (OIG) Manager sweeps the OIG and Medicaid sanction history against the practitioners in the CACTUS database and flags newly found matches.
- **CACTUS ABMS Direct Connect Select -** receives primary source verified data directly from the American Board of Medical Specialties (ABMS) database which contains board certification information, including effective and expiration dates, as well as historical board certification information.
- **License Expiration Monitoring Module (LEMM)** - monitors updates to providers' medical licensing information on the state and/or DEA level. This module incorporates officially published changes in the provider's licensing information into the CACTUS license record for the provider and posts each status change for us to review.

NetworX Pricer

NetworX Pricer is a java-based application that integrates with our claims system and supports greater contract sophistication, specificity, and processing speed, while eliminating inconsistencies and errors in pricing of providers' claims. Combined with NetworX Modeler,

these capabilities position us to model the financial implications of changes during provider negotiations and those driven by regulatory changes, such as the ICD-10 implementation.

NetworX Modeler

NetworX Modeler helps to forecasts results, negotiate optimized terms, and improve the financial outcome of contracts. It helps to target costly or imprecise contractual provisions before agreements are signed, contributing to improved MLR's. It integrates with NetworX Pricer to move contracts electronically between the two so they can be modeled and moved without needing to rebuild the contract.

Provider Portal (NaviNet)

AmeriHealth Mercy uses NaviNet as its Provider Portal. NaviNet's multi-payer design allows the provider to log in once to access information from multiple payers. AmeriHealth Mercy offers access to all the standard transactions through NaviNet including eligibility and benefits, claim status and referral submission and inquiry, as well as links to provider manuals, forms and other important administrative information. Special features offered though NaviNet include a report query tool that allows providers to access reports that can vary by client and an encounters correction tool that can be accessed by providers to improve encounter submissions.

The Provider Portal also delivers valuable features including eligibility, benefits, claim status, searchable provider directory and others. Additionally, clients benefit from a best practice feature set including:

- Clinical information delivery including member clinical summaries and alerts for overdue health screens
- Provider report center that offers administrative and clinical reports in print and downloadable formats
- Eligibility/Benefit Inquiry
- Care Gap Alerts
- Claim Status Inquiry
- Claim Correction
- Referral Creation and/or Inquiry
- Authorization Creation, Update or Inquiry
- Clinical Reports and Clinical Alert Reports
- Member Clinical Summary/EPSDT Summary
- Continuity of Care Document
- Searchable Provider DirectoryGeoAccess GeoCoder, by Ingenix Suite

GeoAccess GeoCoder, by Ingenix Suite, is a desktop software application that provides the precise analysis and mapping of member access to network providers. GeoAccess is used to assist in the auto-assignment process for PCPs and to monitor network access standards. GeoAccess is also used to understand network disruption in the event of a provider termination.

DirectoryExpert, by Ingenix Suite

DirectoryExpert, by Ingenix Suite, is a Microsoft® Windows-based application for database publishing. DirectoryExpert is used to produce comprehensive, customized provider directories that are made available online through the Member Portal, NaviNet Provider Portal and the health plan's website. The directories offer a variety of search features including detail and proximity zip code searches and return detailed data including information on languages spoken, panel status and accreditation or board-certification status.

Claims Adjudication

AmeriHealth Mercy utilizes the following applications to support medical and pharmacy claim processing functions and maternity care payments.

TriZetto Facets Application

AmeriHealth Mercy uses Facets as our core eligibility and claims administration solution. Facets offers a high degree of automation and data capture, achieving fast, accurate claims processing and high auto-adjudication rates. Facets electronic commerce capabilities are designed to accept external claims submitted electronically from trading partners in the HIPAA compliant 837 transaction set standard format. Facets™ can also send remittance information to trading partners in the HIPAA compliant 835 transaction set standard format.

During the various stages of the adjudication process, Facets interacts with membership eligibility, product benefit parameters (in plan services), provider pricing agreements, medical management requirements and clinical editing information to provide accurate and highly automated adjudication of claim and/or encounter submissions. The Facets system allows for generation of checks to individual providers or the combining of payments into one check at the group or IPA level. The Facets system also captures and reports 1099 tax information.

The claims processing applications within Facets are organized for efficiency and ease-of-use by claims processors, while conforming to CMS 1500 and UB-04 formats which are the industry standards. Numerous edits alert our employees to any inconsistencies during entry, and predefined system warning messages facilitate increased accuracy and productivity.

EXP MACESS/Workflow and Imaging

EXP MACESS tracks and manages the flow of data, documents, and business processes including claim processing throughout our corporate offices and affiliates. EXP's tools for capturing, centralizing, and archiving data and documents help ensure that all of our organization's operations are standardized and integrated. Reporting tools monitor workflow, helping managers identify bottlenecks and increase efficiency.

Claim Edits/iHealth Technologies (iHT)

AmeriHealth Mercy utilizes iHT's system for enhanced clinical and business rule editing for claims. iHT's system applies 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, each affiliate has its own library of customized Medicaid-specific medical policies.

Argus

Argus helps AmeriHealth Mercy realize the greatest net benefit with a comprehensive snapshot of drug spend across all our plans. Pharmacy Claim data from Argus is integrated into our Data Warehouse to allow for complete data reporting to support coordination of care, quality and utilization management, and other data analysis as required by the State. Argus allows a broad range of customized benefit processing and analytical reporting and addresses our compliance concerns by maintaining technological and physical standards for HIPAA regulations. Argus provides a reliable and secure data storage environment. Argus has been supporting NCPDP D.0 standards since December 2010 and supports AmeriHealth Mercy-specific eligibility files and custom outbound file layouts.

Member Services

AmeriHealth Mercy uses the following applications to support contact center activities including Member Services and our complaint Grievance and Fair Hearing processes.

EXP MACESS/Call Documentation/Workflow

The SunGard EXP MACESS is utilized by our Member Services and Care Management staff to support automation of internal processes including image storage, documenting 100 percent of all telephonic contacts that come in from a member or provider, and routing requests for information between departments. Our EXP System also utilizes common indexes that facilitate high performance search functions associated with a common event, or transaction such as a complaint, grievance or fair hearing request across all records pertaining to members and providers. EXP MACESS call documentation is used in our Quality Auditing process to ensure that we provide the correct level of service to our members and providers.

Streamline

We implemented Streamline, a custom-designed front-end graphical user interface that allows our employees to enter member demographic updates into our Facets system, request member ID cards, and request member materials, and change their PCP. The Streamline interface simplifies the data entry process and eliminates the need for an end user to access multiple pages in Facets. Updates to Streamline are transmitted to Facets in real time.

Member Portal

Our online Member Portal is designed to meet the unique needs of the Medicaid population. The Member Portal features secure and convenient self-service applications enabling members to quickly reset passwords and unlock their own account. The Member Portal delivers valuable health care features including information on:

- Clinical information delivery such as member clinical summaries and alerts for overdue health screens
- Member health resources and information tailored to the specific needs and comprehension levels of the our membership
- PCP Information
- Medication List
- Care Gap Report
- Member Clinical Summary
- EPSDT Clinical Summary
- Request an ID Card
- Request a Handbook
- Send secure email
- Health Risk Assessment

Public Website

AmeriHealth Mercy has its own public website that delivers up-to-date information to members and providers through the use of web pages, PDFs, applications and videos. This includes an NCQA-compliant searchable provider directory, provider and member handbooks, health and wellness resources, and a wealth of other information about our services and procedures. Our websites are optimized for easy access from Google and other external search engines as well as fully searchable from within the site. Information contained on the public web site also includes:

- Provider newsletters, handbooks and other communications
- Information on health management programs
- Health education materials (members) and Clinical Practice Guidelines (providers)

Encounter Data Processing and Reporting

Data Exchange

AmeriHealth Mercy has implemented standards-based data interfaces to facilitate the exchange of information about enrollments, eligibility, encounters, claims and payments with our customer and provider organizations. The data exchange solution includes:

- The ability to transmit, receive, process, update and send replies in HIPAA-compliant and/or proprietary formats;
- The ability to exchange data through secure file transfer protocol (FTP) over a secure virtual private network (VPN);
- The ability to exchange data for a point in time (e.g., daily, weekly, monthly) or for a real-time transaction; and
- The logging and archiving of all data exchanges for future reference, if needed.

Data Warehouse

DataStage®, by IBM-Ascential Software Inc. ™, provides an extract, transform, and load (ETL) function to populate business intelligence data into our Data Warehouse. Data are extracted from our business systems databases (such as Facets) and loaded to our Oracle Data Warehouse. This data is then utilized by our reporting programs to support our Enrollment, Eligibility, Encounters, and Claim Payment processes.

Catalyst Technologies – Quality Spectrum

Quality Spectrum Insight (QSI) is a NCQA-certified HEDIS reporting software by Catalyst Information Technologies, Inc., a standalone tool that derives performance measure results which adhere to the annually updated NCQA HEDIS guidelines.

QSI calculates HEDIS results from internal and external data for reporting to NCQA, state Medicaid agencies, or for supporting internal quality improvement studies, including encounters. Ready-to-run HEDIS measures are included with each yearly updated version. Source files are loaded monthly into a dedicated data repository used for HEDIS reporting, provider profiling and the generation of "care gap" intelligence. Catalyst is NCQA-certified for HEDIS reporting. Benefits include:

- Full HEDIS reporting capability to easily produce the NCQA Data Submission Tool import template, CMS patient-level detail file, and CAHPS survey sample frame files
- Drill-down analysis tools to investigate quickly why a member did, or did not, meet the measure criteria in response to an auditor inquiry
- Eliminates the need for code review during the HEDIS compliance audit
- Integrates with the Medstat Advantage Suite® to simplify data extract and load

QUESTION 2

Describe any modifications or updates to your Management Information System (MIS) within the next year that will be necessary to meet the requirements of this Agreement, and your plan for their completion

(Limit to four pages)

RESPONSE TO QUESTION 2

As a current HealthChoices contractor, AmeriHealth Mercy's systems are fully compliant with existing HealthChoices contract requirements, and are capable of supporting our proposed expansion into the HealthChoices New West and New East Zones. This same platform has supported our successful implementation of Medicaid managed care programs in multiple states, including Pennsylvania, and we are fully confident that we will meet all Department of Public Welfare (DPW) health information system requirements for the expansion region from day one of implementation.

AmeriHealth Mercy routinely reinvests capital for improvement of our technology and data sharing infrastructure to continuously advance the quality of care and services for our members. We are constantly working toward the goal of providing a fully integrated technology solution through which members, providers, and other partners will have access to a full range of information and tools necessary for accessing and sharing the information needed to proactively manage positive health outcomes.

Below, we describe minor updates to configuration and core business systems, and other system enhancements necessary to support AmeriHealth Mercy's proposed expansion.

Updates to Configuration

Having reviewed the draft agreement included with the RFP, we do not foresee the need to perform any major system configuration changes to support expansion. The table below describes the modest configuration changes that we will undertake.

Table 2: Configuration Update

Function	System Configuration Change
Provider Data Management	We will need to load all newly contracted providers into our Provider Data System and configure their provider contracts to facilitate accurate claim payment.
Eligibility/Enrollment	Our systems are configured so that enrollments for members with a county code outside of our service area will error out of our automated eligibility load process for manual evaluation. We will need to configure our automated eligibility and enrollment processing to accept members with county codes for the New West and New East Zones.
Claims Processing	We will need to program new claims processing rules and guidelines based on negotiated provider agreements in the New West and New East Zones

Updates to Core Business Systems

The table below describes core system update that AmeriHealth Mercy will implement in the next 12 to 24 months to adhere to federal and state requirements.

Table 3: Core Business System Updates

Core Business System	Function Performed by System	Reason for Enhancement
Trizetto Facets	Facets is AmeriHealth Mercy's core claims processing Engine	Upgrading to a new HIPPA 5010 compliant version

As part of our routine system upgrade process, we have scheduled an upgrade of our claims processing system for the third quarter of 2012. The upgraded version of Facets will be HIPPA 5010 compliant. We have a detailed upgrade strategy and patch management process to ensure all of the systems remain in compliance with federal and state regulations, as well as resolve any system bugs. AmeriHealth Mercy will notify DPW of any major system upgrades in the future and provide a high-level summary outlining the reason for the upgrade and project timeline. All upgrades follow our normal change management process.

Plan for System Enhancements

AmeriHealth Mercy's change management process facilitates implementation of both planned and unplanned changes across application and infrastructure environments through the management of changes and version and production control activities. This process minimizes the business impact and risk of system-wide changes in an efficient and cost effective manner.

Systems Change Management Process

Ensuring effective change management practices for all AmeriHealth Mercy environments is critical to maintaining stability and high-quality processing. Adherence to these practices by using change management principles from the Information Technology Infrastructure Library (ITIL) enables us to maintain SAS 70 compliance, as well as low occurrences of production turnover defects.

Our Change Management Board (CMB) is comprised of representatives from each IS discipline who meet weekly to review and evaluate submitted changes. The board evaluates each proposed change in the context of other changes requested to ensure proper sequencing and prioritization. Approved changes are managed through version control and scheduled for release to production through our Production Control team. The change activity lifecycle is maintained and tracked through an automated system, called TeamTrack, which provides a single system of record for changes across the organization.

Key components of the AmeriHealth Mercy Change Management program include:

- **Accurate Documentation and Testing** – Ensuring that relevant information for each change is submitted and reviewed (including quality testing outcomes, a critical factor for error free implementations)
- **Continuous Oversight** – Using a disciplined process of evaluating changes to balance the demands of change while evaluating and managing risk to the production environments
- **Formal, Defined Approval Process** – Following an established, multi-level approval process to ensure that all changes are completed as expeditiously as possible, while ensuring complex, high impact changes receive the oversight necessary to guarantee success

There are three types of change management requests: standard, expedited, and emergency. Each request follows the defined change management process; however, non-standard changes require accelerated and elevated review and additional approvals. Our change management discipline enables us to maintain a stable environment. Continuous improvement is a key part of our discipline. We update processes and procedures to improve our success rate using the lessons learned from prior implementations.

Version Control

Version control is a series of processes and corresponding tools that ensures uniformity and accuracy of the components in an implementation package. An implementation package consists of source code, object code, deployment plans, operations execution instructions, and back out procedures. Through our version control tool, all of these components can be centrally accessed and managed. These processes and tools provide us with the ability to retain each version of an implementation package, allowing us to access any previous version of the package, as required. AmeriHealth Mercy utilizes Microsoft Visual SourceSafe (VSS) as its version control tool.

Production Control Operations

Production Control administers and monitors operational and production processing standards for all AmeriHealth Mercy Family of Companies' corporate operations, ensuring that all production cycle requirements are in accordance with individual company standards, as well as State and customer requirements.

Production Control employees provide technical support services 24 hours a day, seven days a week, 365 days a year. Production Control is responsible for executing over 3,700 processes on a daily basis, which are triggered by predetermined calendars, file events, e-mail events, job events, and by operator interaction.

QUESTION 3

What is the current capacity of your MIS/claims processing? Explain your process to readily expand your MIS/claims processing should the capacity of either be exceeded through enrollment of program members.

(Limit to two pages)

RESPONSE TO QUESTION 3

Capacity through Our Technology Platforms

One of AmeriHealth Mercy's key differentiators is our ability to scale our technology platform to meet growth demands. Our scalable and agile systems architecture, comprised of industry-proven applications and hardware infrastructures, has allowed AmeriHealth Mercy to successfully expand our capacity to cover additional Medicaid managed care enrollees in new and existing Medicaid markets.

Scalability to increase capacity is first addressed in a comprehensive approach during the design of our system enhancements and new solutions. Dedicated resources from our Architecture, Infrastructure Delivery, and Data Center Operations teams continuously monitor system utilization to ensure that our baselines and performance are within expected ranges and compliant with state contract requirements. The team looks continuously for opportunities to enhance performance and ensure availability.

A fundamental element of our success is the tight collaboration and experience we have gained with our core technology partners, including:

- TriZetto
- EMC/VMware
- Hewlett Packard (HP) Oracle
- Avaya

Through these industry leaders, AmeriHealth Mercy leverages "best in breed" technology that enables us to easily assume sizable growth. The following provides a brief description of how these technology partners support AmeriHealth Mercy's Medicaid managed care products today and position us to readily and seamlessly expand to serve additional membership.

- TriZetto's Facets system is AmeriHealth Mercy's core claims processing engine. Facets incorporates batch processing and load balancing models to readily resize and process expanded volumes of claims.
- EMC's VMware virtual server environment is the foundation of managing scheduled claim processing growth for the expansion of HealthChoices in Pennsylvania.
- Hewlett Packard's dynamic resource on demand (iCAP) technology enables instant capacity processing and populates business critical systems at maximum configuration. The agility gained allows for short-term and long-term needs to be easily addressed.
- The Oracle Data Warehouse solution is scalable commensurate with our Facets claim processing system. In anticipation of growth, we have sized the storage capacity appropriately.
- The Avaya Single Image Switch is a fully distributed IP-based phone system. This system provides feature transparency across the AmeriHealth Mercy infrastructure and also extends contact center and other telephony applications throughout the enterprise. The main Avaya Communication Manager server resides in Philadelphia, Pennsylvania and supports all AmeriHealth Mercy locations. The secondary standby server is located in a separate location to ensure continuity of service. Since we migrated to the Avaya single image switch platform, all sites are fully capable of providing contact center call handling for any type of situation.

Capability and Capacity Assessment

As a part of the Initiation and Planning phase of our systems development lifecycle, AmeriHealth Mercy reviewed the Department of Public Welfare's requirements and projected volumes in relation to our Information Systems capacity and capabilities and confirmed that our systems have the capability and capacity to exceed all the requirements. The following are the key outcomes of our system capacity and capability assessment:

AmeriHealth Mercy currently processes over 6.5 million Medicaid claims for Pennsylvania per year with >85 percent auto adjudication rate. Our existing infrastructure capacity will accommodate additional business volumes from expansion counties.

The table below shows our current Sybase configuration to support our Medicaid managed care business across the country. To ensure maximum efficiency, we have separated our current books of business into multiple regions. This reduces load times and impacts on system processing. The HP SuperDome we have is designed for instant capacity on demand – we would simply need to license the additional processors as we grow.

Table 4: Current capacity of our current Sybase (Facets) environment by region

Environment	Memory	Engines/Processor
PRD_REG_1	9GB	6
PRD_REG_2	6GB	4
PRD_REG_3	7GB	4
PRD_REG_4	7GB	4

AmeriHealth Mercy is confident in our ability to manage even larger volumes of increased data to support our future growth. We have developed and deployed clear and effective business continuity and disaster recovery procedures, which have been successfully tested in response to recent weather events impacting several of our lines of business.

Finally, we measure our success by trending solution activity, system availability, and our responsiveness to scale environments as needed. On a yearly basis, we complete a full review of the compiled system statistics as part of the organization's annual operating goal development. This information is used as the basis for setting new thresholds for performance, availability, and our ability to meet the business needs of our company and the requirements and expectations of our state regulatory partners, and the Medicaid consumers and health care providers we serve.

QUESTION 4

Explain your process for ensuring your subcontractors meet the same MIS requirements for which you are responsible.

(Limit to three pages)

RESPONSE TO QUESTION 4

Vendor and Subcontractor Management/Oversight

AmeriHealth Mercy understands that it is ultimately accountable for the performance of all services performed by subcontractors. As such, defined strict management information system requirements and related policies, procedures, and protocols, exist to ensure that all subcontractors adhere to Department of Public Welfare (DPW) and AmeriHealth Mercy compliance provisions. Our policies and procedures guide the initial selection of subcontractors and ongoing adherence performance monitoring and oversight. AmeriHealth Mercy requires all subcontractors to have completed, or provide a plan and timeline for completing, their SAS 70 audit.

AmeriHealth Mercy conducts an on-site assessment of a potential subcontractor's ability to meet performance standards prior to executing a subcontract agreement. AmeriHealth Mercy requires subcontractors and vendors to conform to the HealthChoices Management Information System and System Performance Review (SPR) Standards as set forth in the HealthChoices Agreement, including, but not limited to:

- Systems Standardization Requirements
- Data Requirements
- Systems Documentation Requirements
- Claims Processing Requirements (including claims processing support; input validation and control; edit and audit; adjudication and payment; and audit trail requirements)
- Information Retrieval Requirements for operational, program management, surveillance, and utilization review processing
- Capture of Required Data Elements

Service Level Agreements outlining performance standards are incorporated into the written contract with all subcontractors. Defined contract provisions define adherence requirements to performance standards, including provisions for auditing and oversight by AmeriHealth Mercy, corrective action plans, and assessment of penalties up to and including contract termination. Routine oversight and monitoring is performed consistent with industry standards. In addition to routine monitoring and oversight, we perform a formal annual audit of each subcontractor's performance and compliance.

MIS Service Level Agreements

The following is a sample SLA chart demonstrating standards for subcontractors as included in the contract.

Table 5: Sample SLA for Subcontractors

Performance Indicator	Definition	Performance Standard	Performance Goal	Reporting Frequency
Encounter file submission timeliness	The vendor shall submit its encounter data at least monthly, following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount ($0.00) and all encounters for capitation arrangement with a provider.	By 10th of each calendar month	100%	Monthly

Performance Indicator	Definition	Performance Standard	Performance Goal	Reporting Frequency
Encounter submission completeness & accuracy	The vendor shall provide complete and accurate encounter data for all levels of healthcare services provided to include encounter data for specific denied claims as specified by the State.	> 98%	100%	Monthly
Encounter error correction timeliness & accuracy	The vendor shall address any issues that prevent processing of an encounter. Acceptable standards shall be 90% of reported repairable errors are addressed within 30 calendar days, and 99% of reported repairable errors within sixty (60) calendar days. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan may result in monetary penalties.	100% within 60 calendar days	100% within 30 calendar days	Monthly
Encounter requests	Regulatory changes or special requests by AmeriHealth Mercy or State	60 days upon request	30 days upon request	As requested
Issue escalation	The escalation points for VENDOR issues with encounter submissions: 1) AmeriHealth Mercy Encounters Manager 2) AmeriHealth Mercy Vendor Oversight Manager	Notification of issue(s) effecting performanc e standards	Immediate	As needed

These reports are continuously reviewed to evaluate and monitor Service Level Agreement (SLA) metrics, to discover potential areas of weakness, and to target interventions.

Subcontractor Oversight Data Analysis

In addition to using the encounter data to analyze subcontractor performance, each subcontractor is required to submit a monthly performance report to measure their compliance to the contractual terms. This report is distributed to the AmeriHealth Mercy Quality of Service Committee, which is responsible for monitoring compliance and providing recommendations for corrective actions or sanctions, if documented performance goals are not met.

Some of the performance and quality reports that AmeriHealth Mercy receives from subcontractors include:

- Ongoing Monitoring of Sanctions
- Subcontractor Call Center Statistics
- Authorization Denials and Appeals
- Timeliness of Claims Paid
- Accuracy of Claims Paid
- Member Satisfaction
- Provider Satisfaction
- Credentialing Status /Network reports

Other Components of Subcontractor Agreements, Oversight, and Monitoring

File Transfer Protocols

All subcontractors are governed by contract provisions and service level agreements that require adherence to file transfer protocols (FTPs). AmeriHealth Mercy uses secure internal servers,

public external servers, and Connect: Direct for FTP connections to subcontractors. All files sent to subcontractors' FTP sites use a secure virtual private network (VPN), local area network (LAN)-to-LAN tunnel that is HIPAA compliant.

Data Validation/Error Report Handling

Our systems use industry-standard, two-level status validation of all input sources. The level one status check ensures that all inputs match record format criteria, including 1) that all mandatory/ required fields are present; 2) that all date fields contain a valid millennium-compliant date; and 3) that numeric fields contain only numerals.

The level two status check cross-validates that the input source data are what is expected within the record, utilizing defined criteria that include:

- Valid supplied data (e.g., "diagnosis code" is a valid diagnosis based on a predefined format to determine if the diagnosis provided by the PCP truly exists)
- Cross-validation within the application (e.g., the medical claim being loaded is cross-validated to a previously defined valid member)
- Cross-validation for mandatory items (e.g., the hospital/physician/provider is an active provider within the network for provided a valid service)

Encounter Data Reporting

AmeriHealth Mercy requires that all subcontractor encounter files pass Level II X12 compliance prior to submission to the DPW. If any file fails this compliance check, the subcontractor is required to return a corrected encounter file to us within four business days. To support their efforts to meet AmeriHealth Mercy's performance expectations, we provide our subcontractors' with regular updates of DPW's procedure codes, diagnosis codes, and provider data reference files. Also, AmeriHealth Mercy's Delegation Oversight Committee is responsible for monitoring our subcontractors' encounter data performance.

Information Security

We require that all subcontractors sign AmeriHealth Mercy's HIPAA and Code of Conduct agreements, which define acceptable use and policy requirements. All subcontractors are subject to the same internal audit controls as AmeriHealth Mercy employees. These internal controls include intensive LAN and wide area network (WAN) monitoring using URL filtering, intrusion detection and prevention, and native SYSLOG monitoring by the Information Security Department. Subcontractors are also restricted by global group and local policy settings within the active directory environment. Our Information Security Department staff reviews these logs, and any security conduct violations are subject to prompt disciplinary action.

Our Information Security team interrogates all access requests (for all employees, contractors, subcontractors, and other entities) to ensure access is appropriate and compliant with the policy. They track access requests in a problem management system, and access cannot be granted until the request is approved. Additionally, Information Security monitors access requests using various real-time or near real-time tools to ensure compliance with acceptable usage standards. Detailed reports and automated alerts are built in to the process to ensure a timely and systematic incident response in the event of an abnormality.

QUESTION 5

Describe the capability your management will have to access a database of service information to create ad hoc reports for both MCO management and the Department. Include a description of the system and software, an overview of the data that will be held, and the resources and the capability you will have to use large amounts of data to create ad hoc reports.

(Limit to five pages and list of reports)

RESPONSE TO QUESTION 5

AmeriHealth Mercy will leverage our comprehensive business intelligence capabilities to provide the Department of Public Welfare (DPW) and internal AmeriHealth Mercy management with accurate, complete, and timely ad hoc reports. As a long-standing Medicaid contractor in Pennsylvania and several other states, AmeriHealth Mercy brings significant knowledge and expertise to the preparation and secure delivery of such reports. The Medical Economics Department provides leadership, guidance, and support to the improvement of processes that create, disseminate, manipulate, and manage data. This dedicated team is responsible for all statutory, quality, clinical and cost analysis reporting, on both a regularly scheduled and an ad-hoc basis.

Our ad-hoc reporting capabilities include:

- Enterprise Data Management Architecture
- Data Availability for Ad Hoc reporting
- Ad-Hoc Internal and External Reporting Capabilities

Enterprise Data Management Architecture

To support our quality ad hoc reporting and timely delivery of all state management reporting, AmeriHealth Mercy maintains an Enterprise Data Management Architecture that includes a robust Business Intelligence capability. This capability will be leveraged to generate the ad hoc reports required by the internal management team for oversight purposes, as well as to support State-requested reports. Figure 1 depicts the following core components of the enterprise data management architecture

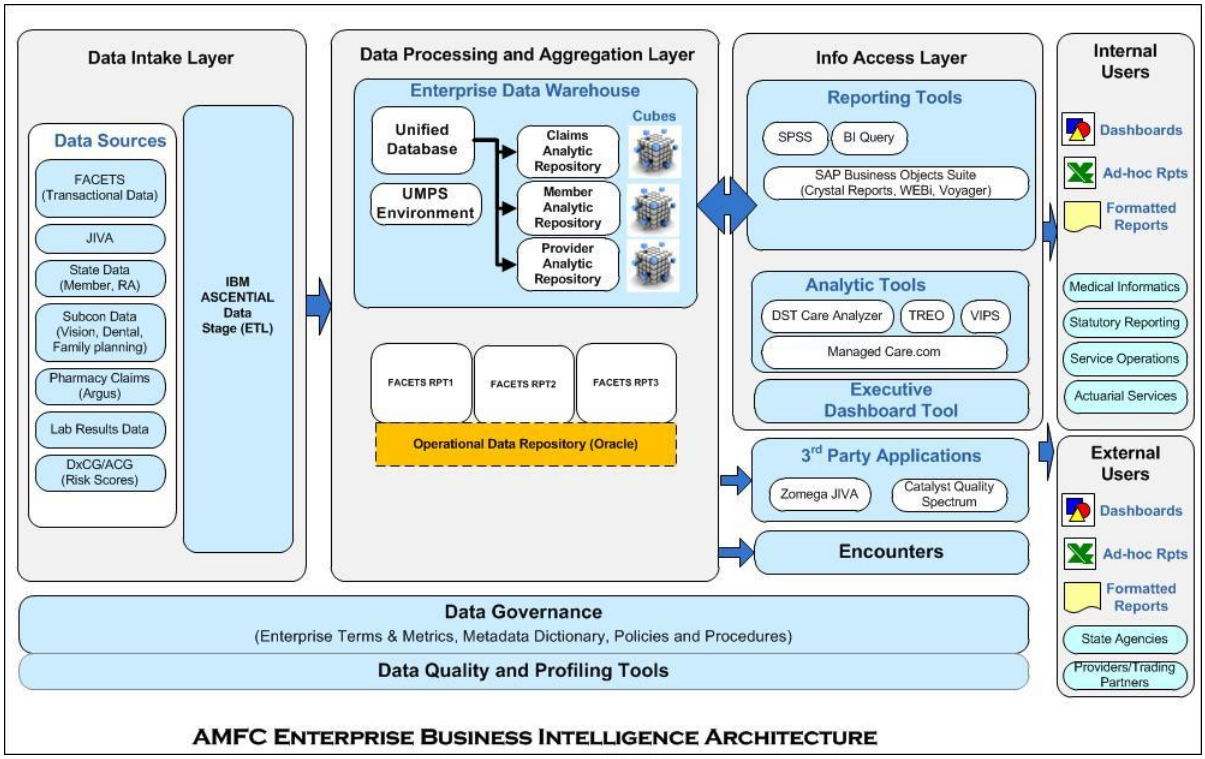

Figure 2: Enterprise Data Management Architecture

The Data Intake Layer collects and cleanses the data extracted from a number of internal and external sources including:

- Claims data from the Facets claims processing system
- Care management data from Jiva
- State data (Member eligibility, Third Party Liability, etc.)
- Subcontractor claims data (Dental, Vision, Family Planning,)
- Pharmacy claims data (Argus)
- Lab results
- DxCG/ACG risk scores

The chart below displays the data sources (production applications or data feeds), the data integration methods (real-time, or batch), and the data integration controls (compliance and validation tools) for ad hoc reporting.

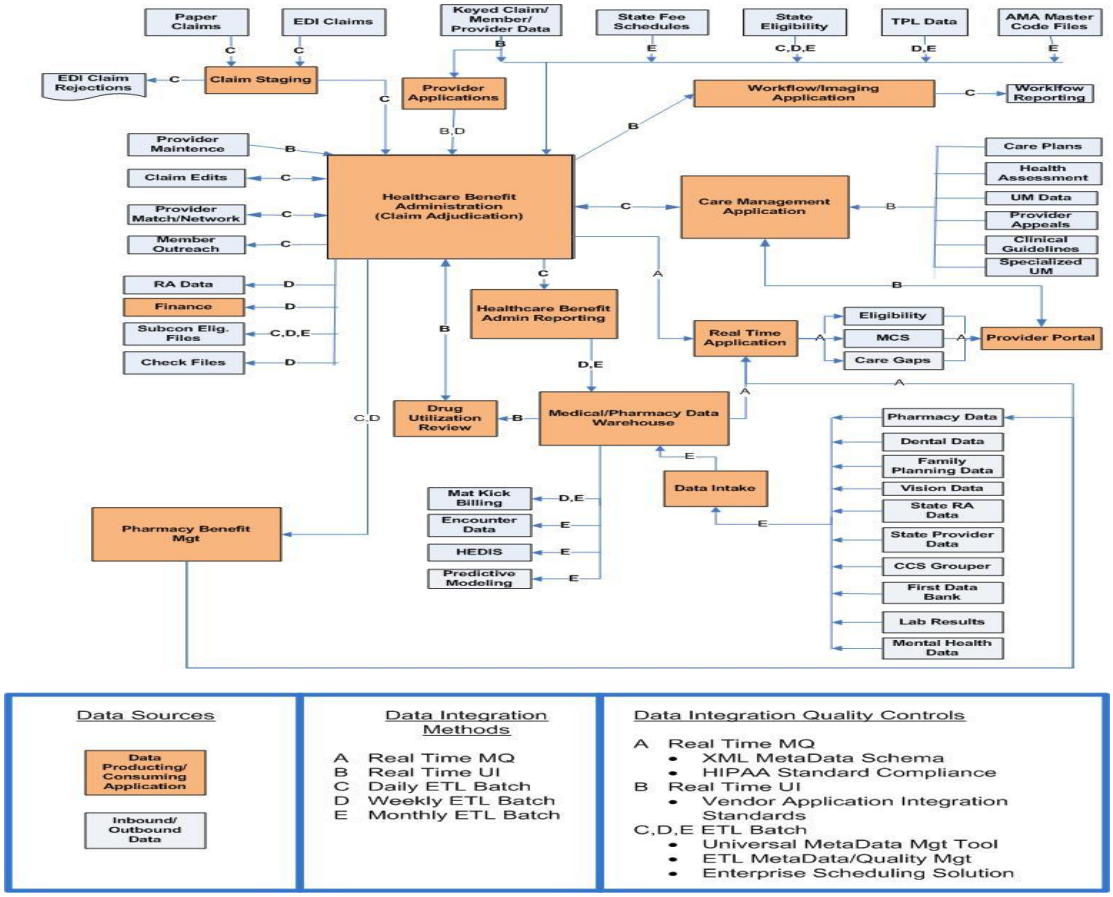

Figure 3: Data Integration

The Data Processing and Aggregation Layer unifies the data obtained from multiple data sources and organizes the data by two primary dimensions: member and provider. In addition, a number of useful business measures are aggregated to aid in analysis and reporting. This unified and integrated view of our members and providers enables us to offer accurate, complete, and timely reports to stakeholders and customers.

The Information Access Layer includes the Business Intelligence tools to transform data into actionable information. These tools are described under Ad Hoc Internal and External User Reporting Capabilities.

The Executive Dashboard capability within the Information Access Layer enables the delivery of information to stakeholders based upon customized, role-appropriate views.

Ad Hoc Internal and External Reporting

AmeriHealth Mercy will access data from our core business systems and the enterprise data warehouse to address its ad hoc reporting needs. The types of data available for reporting include, but are not limited to:

- Membership data
- Provider network data
- Care management data, including health assessments, EPSDT, lab results, care gaps, care plans, disease management and case management data
- Utilization data, authorizations, over/under-utilization
- Encounters and claims (medical, hospital, pharmacy, dental, vision, behavioral health, family planning)
- Payments
- Appeals and grievances
- Outcomes data (e.g., HEDIS, maternity)

Our data retention processes are customizable based on the specific needs of our enrollees, while maintaining compliance with applicable state and federal regulations. Our standard data retention and management practices are described below:

- Claims: The data warehouse stores all historical claims for up to 10 years. The data warehouse claim data is primarily utilized for informatics and analytical needs
- Membership and Provider Data: The data warehouse retains a complete history of all membership and provider data
- Billing and Capitation Data: The data warehouse retains all billing and capitation data for 10 years

A broad portfolio of reporting and analysis tools, robust data quality controls, and secure report delivery processes provide the foundation for us to deliver ad hoc reports upon request, with turnaround times that vary based on the complexity and urgency of the request:

Reporting and Analysis Tools

- Crystal Reports® enable rapid development of flexible, versatile reports from a number of data sources, and integrates them into Web and Windows applications. Crystal Enterprise® (Business Objects™) is used companywide for reporting information from the data warehouse, Facets, our care management system, and other sources. Crystal Reports are often used for medical management reporting on claims, membership, provider, authorization, and care management data.
- SPSS Statistical Reporting® provides statistical data analysis and graphical presentation of data. It is used to analyze survey data, utilization data, cost data, record sampling, and control group vs. test group sampling.
- SAP Business Objects Web Intelligence utilizes multi-dimensional data models to enable business users to interpret business information in order to gain valuable insights for

operational and strategic management. Users can select the business measures of interest and drill through the data at multiple levels of detail.

- HEDIS Services - Quality Spectrum This application (Catalyst Technologies, a premier NCQA-certified software vendor) is used to generate HEDIS and State Performance Measurement data and results. Monthly interim HEDIS rates and data on care gaps are generated on a monthly basis.
- Treo is a Web-based suite of applications which incorporates the 3M methodology for identifying Potentially Preventable Readmissions (PPRs). Using sophisticated algorithms, chains of admission and readmission events are linked to generate rates of PPR for any hospital or group of hospitals compared to the network, or any segment thereof. These data can be used to identify opportunities for improvement of care and for use in pay-for-performance programs. Treo also can identify Potentially Preventable Initial Admissions (PPIAs) and Potentially Preventable ER Visits. Since the basis for this content is member data, we can also report the data by primary care providers (PCP), in order to identify PCPs with the highest rates of PPRs and PPIAs so that improvement opportunities can be explored.

Data Quality Controls

AmeriHealth Mercy's reporting process ensures that reports are developed, tested, and sent as prescribed by DPW. Policies and procedures are in place to ensure that all reports: 1) use the appropriate specifications for creation of the report; 2) are quality-reviewed for data integrity and completeness; and 3) are retained in accordance with AmeriHealth Mercy policy and applicable State and Federal laws and regulations. The dedicated staff in our Reporting Department manages the ongoing reporting process to ensure timely delivery of material to the State.

Secure Delivery of Reports

AmeriHealth Mercy utilizes a secure Provider Web Portal to extend reporting access and services to external entities. We will work with the DPW to establish a safe, secure, and efficient approach to enable DPW staff to access ad hoc reports.

Sample Reports

Examples of ad hoc reports that we have prepared include, but are not limited to:

- Monthly inpatient and outpatient authorization reports
- Summary of Healthcare Activity report (claims-based cost & utilization)
- Member Demographics reports
- Maternity Outcomes report
- EPSDT gaps in care report
- HEDIS
- Over-/Under-Utilization report
- Plan Wide Indicator report
- PCP Profile report
- Case Management/Disease Management Dashboard report

Detailed reporting requirements will be developed in consultation with the DPW.

Standard Reports

Report Management

- Utilization management reporting
- Care management reporting

- Support activity regarding risk adjusted rates and encounter data improvement activities
- Support Market Expansion and new business development
- Provide data to Legal Affairs as needed
- Appeals reporting
- Plan-Wide Indicator Report
- Medical Affairs Operations Reports
- Provider Contracting reporting

Population Analysis and Outcomes

- Member population analysis
- Disease management reporting and outcomes measurement
- Support NCQA accreditation
- Coordinate and submit HEDIS
- Coordinate and submit CAHPS
- Conduct, coordinate and support other surveys and analyses-provider satisfaction
- voluntary disenrollment, PCP change, Physician after-hours accessibility
- Coordinate and support submission of quality indicators for EQRO
- Predictive Modeling
- PCP and Hospital Profiling

Reporting Accomplishments

AmeriHealth Mercy's reporting and analytical capabilities and leadership are nationally recognized:

- Presenter, 2010 National Predictive Modeling Congress
- Quality Profiles, The Leadership Series, 2009, NCQA
- Winner, 2009 Thomson Reuters Healthcare Advantage Award
- Presenter, 2009 Thomson Reuters Healthcare Conference
- Poster Presentation, 2008 Society of General Internal Medicine
- Winner, 2007 Thomson Innovator Award
- Presenter, 2006 Thomson Annual Conference
- Finalist, 2006 Thomson Innovator Award
- Poster Presentation, 2006 AHIP Meeting
- Poster Presentation, 2005 Pennsylvania Public Health Association

In addition to the above presentation and awards, members of our Information Solutions Reporting teams serve in the following capabilities:

- Board member, Pennsylvania Public Health Association
- Member, American Medical Informatics Association
- Reviewer of papers for the AMIA
- Member, American Health Information Management Association
- Member, The Data Warehouse Institute
- Member, Healthcare Financial Management Association
- Member, NCQA HEDIS Policy Panel

QUESTION 6

Describe the capability you will have to access your subcontractor's information to create ad hoc reports for subcontractor oversight and for the Department upon request.

(Limit to three pages)

RESPONSE TO QUESTION 6

AmeriHealth Mercy has service level agreements with our subcontractors defining accurate and timely two-way exchange of encounter data and monthly performance reports to ensure optimal operational performance and customer satisfaction. Subcontractor encounter data is integrated into our Data Warehouse and is available for ad hoc reporting and analysis for a variety of purposes, including but not limited to, subcontractor oversight and care management. This data can be made available to the Department of Public Welfare upon request.

Integration of Subcontractor Data into the Data Warehouse

On a monthly basis, encounter and claim data for pharmacy, dental, vision, laboratory, radiology and family planning services are received from AmeriHealth Mercy's subcontractors. Subcontractor encounter and claim files are received using Secured File Transfer Protocol (SFTP) through the inbound data interface. Results are reviewed by encounter analysts and appropriate action is taken to ensure the data is complete. Data collected from subcontractors is integrated in the AmeriHealth Mercy Enterprise Data Warehouse. The Data Integration Layer organizes and stores the subcontractor data in the Enterprise Data Warehouse. AmeriHealth Mercy's Data Warehouse hosts information from all of our major internal operating systems in addition to external data sources. Therefore, when subcontractor data is loaded to the AmeriHealth Mercy Data Warehouse, it can be readily joined to the data files downloaded from internal processing systems. As such, production and ad hoc reports at the member, provider, or program level can be generated to include data that spans across all categories of service providers.

Ad Hoc subcontractor reporting

Ad-hoc reports for subcontractor oversight are generated by our Medical Economics Department. These are based on the encounter data that subcontractors submit and are available through the Information Access Layer of the AmeriHealth Mercy Business Intelligence Architecture.

Once the data is in the Data Warehouse, we use our standard reporting tools. As shown, the Information Access Layer of the AmeriHealth Mercy Business Intelligence Architecture provides a variety of tools for ad-hoc reporting, including the following:

Crystal Reports

Enables rapid development of flexible, versatile reports against a number of data sources, and integrates them into Web and Windows applications. Crystal Enterprise, by Business Objects, is used throughout the organization for reporting from the data warehouse, Facets, our care management system, and other sources. Crystal Reports is often used for medical management reporting on claims, membership, provider, authorization, and care management data.

SPSS Statistical Reporting

SPSS Provides statistical data analysis and graphical presentation of data. It is used to analyze survey data, utilization data, cost data, record sampling and control group vs. test group sampling.

SAP Business Objects Web Intelligence

SAP Business Objects uses multi-dimensional data models to enable business users to manipulate business information in order to gain valuable insights for operational and strategic management. Users can select the business measures of interest and drill-through the data at multiple levels of detail.

Catalyst Technologies - Quality Spectrum

This application is from Catalyst Technologies, a premier NCQA-certified software vendor. It is used to generate HEDIS and state performance measurement data and results. Monthly interim HEDIS rates and data on care gaps are generated on a monthly basis.

AmeriHealth Mercy has a solid history of providing both internal management and DPW information and data sets on a special-request basis. For example, below is a summary of a recently fulfilled ad hoc request for prior authorization denial information that included data from subcontractors.

Table 6: Summary of Ad Hoc Prior Authorization Denial Information

Physical Health Managed Care Organizations Please provide the prior authorization denial information specified below for FY 2010-11		
Data requested: (Please provide the information in percentage (%) form for questions 1-4)	**KMHP MCO Response**	**AMHP MCO Response**
Overall service denial rate for prior authorization requests (including both partial and full denials)	4.18%	4.49%
Denial rates, specific to the following service types: Pharmacy, including "automatic" denials at point-of-sale based on a lack of prior authorization	47.94%	50.82%
Home health	0.63%	2.11%
Therapies (including Speech, Physical, and Occupational)	2.99%	1.88%
Dental	23.09%	23.28%
Durable medical equipment	5.69%	6.44%
3. Percentage of overall denials in which a grievance *or* fair hearing was requested	75.79%	79.49%
4. Percentage of overall denials reversed, partially or fully, after a grievance was filed or fair hearing was requested.	24.21%	20.51%
5. The total number of denials issued. (absolute number)	70,582	28,491

Subcontractor Oversight Data Analysis

In addition to using the Encounter data to analyze subcontractor performance, each subcontractor is required to submit a monthly performance report to measure their compliance to their contractual terms. This report is distributed to the business owner as well as the Quality Management Department. This information is also reported to AmeriHealth Mercy's Quality of Service Committee, which is responsible for tracking compliance/non-compliance and making a recommendation for corrective action or sanctions if documented performance goals are not met.

Some of the performance and quality reports AmeriHealth Mercy receives from subcontractors, include:

- Credentialing status /Network reports
- Ongoing Monitoring of Sanctions
- Subcontractor Call center Statistics
  - Call Volume
  - Calls per 1000 members
  - Average Speed of Answer
  - Service Level
  - Abandonment Rate
- Authorizations denials and appeals
- Timeliness of claims paid
- Accuracy of claims paid
- Member Satisfaction
- Provider Satisfaction

QUESTION 7

Describe your approach for ensuring complete encounter data is submitted accurately and timely to the Department consistent with required formats.

(Limit to two pages)

RESPONSE TO QUESTION 7

AmeriHealth Mercy has successfully submitted complete, accurate, and timely encounter data to the Department of Public Welfare (DPW) in the appropriate format for 14 years. A cross-functional review of the medical record/claims data is conducted to verify that complete data are being submitted.

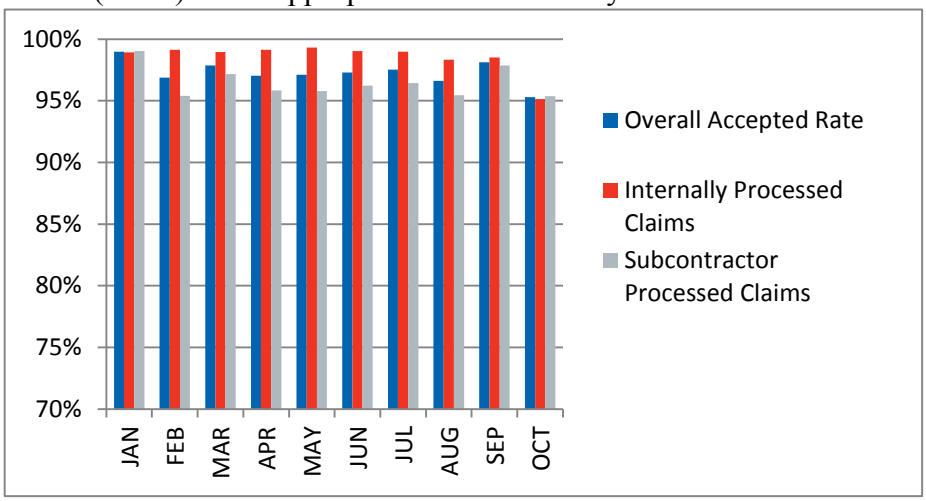

Figure 4: 2011 Encounter Data Submission

Monitoring Data Completeness

Our well-defined and reproducible encounter processes, along with our related reconciliation and operational quality reviews, provide the framework for data completeness.

Claims/encounters are submitted by providers via electronic data interface (EDI) or paper claim form (which is converted to electronic format). A clearinghouse edits specific claim data and returns claims that do not meet editing rules back to the provider. Clean claims are processed through Facets, which verifies the completeness and accuracy of provider numbers, member ID numbers, diagnosis codes, and procedure codes. Claim acknowledgements are sent to providers via the clearinghouse. Discrepancies are identified, investigated, and corrected.

Encounter files are examined for completeness and accuracy prior to submission to DPW. Claim counts and payment amounts are validated between the claims processing system and the data warehouse system. Claim counts and key claim/encounter data and HIPAA compliance validation are verified. All encounter files and claim/encounter records are logged onto an audit file.

Ensuring Accuracy

Encounter accuracy is examined on three levels: 1) when the encounter is loaded into the claims processing system; 2) when the encounter enters our encounter database; and 3) when the 837 file is created to send to the DPW. The claim processing system verifies the completeness and accuracy of the provider numbers, member ID numbers, diagnosis codes, procedure codes, ICD 9 or ICD10, HCPCS codes, and National Correct Coding Initiative standards. Our claims processing system rejects claims with missing or inaccurate information and rejected claims are returned to the providers for correction.

When encounter data are loaded from the claims processing system into the encounter database (from which we prepare encounter data submissions to the State), the data passes through a secondary pre-editing process. This process enables AmeriHealth Mercy to identify, investigate, and correct significant errors before submitting the encounters to the State in the required formats.

To assure file accuracy, all 837 professional and institutional files must pass HIPAA compliance investigations prior to submission to the State. In addition, AmeriHealth Mercy uses an encounter audit table for data validation. After encounter files are created from the data warehouse, we post encounter data at the claim line level to an encounter audit table and audit history table, and mark each encounter with the status of "sent to State." When responses from the State are received, the encounter status is updated to "accepted" or "rejected." Additionally, a monthly status report from the encounter audit table that displays claim counts categorized by each status. This report is used to resolve/resubmit encounters, and to identify non-reparable encounters, such as claims that are exact duplicates. After an update of the response files, we calculate an acceptance percentage based on claims sent and accepted by the State.

Internal Quality audits are performed monthly, and discrepancies are promptly investigated. Quality and independent audits are conducted by sampling claims and encounters processed by AmeriHealth Mercy systems. Queries are written and pre-approved by an auditor. Specific data elements may be requested (e.g., provider NPI, procedure, diagnosis codes, bill amount, payment amount, etc.). Query results are provided to the auditor to verify the samples against AmeriHealth Mercy's internal systems, and against encounter data residing in DPW's databases.

Ensuring Timeliness

Our approach to timely submissions is based on State standards for submitting encounter data on a predefined schedule (e.g. weekly, bi-weekly, or monthly). We have developed automated encounter processes to ensure encounter data is submitted on a consistent time schedule for each period.

To provide predictable and reliable processing, the Tidal Enterprise Scheduler (Cisco) is used to manage the sending and receiving of files between AmeriHealth Mercy and its subcontractors, the State or its agents. The predetermined schedules allow for alerts to be signaled in the event that: 1) a file is not received or sent when expected; 2) the file transfer is not successful; or 3) any processing step fails. These alerts are monitored (24 hours a day, 7 days a week, and 365 days a year) and appropriate steps are taken depending upon the circumstances.

Following the encounter processing by the DPW, the EDI response files received from the DPW is reconciled to the encounter audit file to determine the disposition of the claim. Should AmeriHealth Mercy not receive a response file, the disposition of the claim will be resolved in collaboration with the DPW.

QUESTION 8

The MCO will be required to have a data completeness monitoring program and submit a data completeness monitoring plan as described in the Agreement. Describe your approach to providing this data completeness monitoring plan.

(Limit to three pages)

RESPONSE TO QUESTION 8

AmeriHealth Mercy will ensure that all claims and encounters submitted to us by our providers and subcontractors for transmission to Department of Public Welfare (DPW) are both accurate and timely. Our data completeness monitoring program is realized through a combination of encounter completeness monitoring, internal audits, annual encounter data information survey, annual on-site audits performed by DPW, documented policies and procedures and reporting. In addition data completeness oversight is provided by our Encounter Data Team, Medical Economics and Delegated Oversight units.

Approach

AmeriHealth Mercy will utilize our current Completeness Monitoring Program as the foundation for the development of a plan for the New West and the New East Zones. The plan will outline how we will meet all of DPW encounter requirements. Our 14 year experience in the Southeast and Lehigh/Capital Zones with successful encounter submissions to DPW will aid in this process. We will submit the plan to DPW annually for review and approval.

Data Completeness Monitoring Program

Encounter Completeness Monitoring

Our well-defined and repeatable encounter processes, and related reconciliation and operational quality reviews, provide the framework for data completeness.

1. **Provider Claims Reconciled Upon Receipt -** Claims and encounters received either via electronic data interface (EDI) or by paper claim are edited for compliance. Claim acknowledgements are returned to providers via the clearinghouse or by ACS, our paper claims processing subcontractor. Discrepancies are identified, researched, corrected and resubmitted.
2. **Adjudication of Claims -** AmeriHealth Mercy processes claims through our claims processing system, applying all required payments rules and edits. Claims that do comply with billing requirements and encounter requirements are denied. Remittance Advices (RA) are sent to providers detailing all claims submitted, and their adjudication status. The reasons for adjustment or denial are also provided on the RA.
3. **Claims Reconciled to Encounters -** Paid and denied claims, along with provider and member demographic information, are loaded and reconciled into the data warehouse for reporting purposes. Claim counts and payment amounts are validated between the claims processing system and the Data Warehouse system.

Following encounter processing by DPW, the EDI response files received from DPW will be reconciled to the encounter audit file to determine disposition. Should AmeriHealth Mercy not receive a response file, dispositions will be resolved in collaboration with DPW.

Encounter Data Information Survey

On an annual basis, DPW sends us an Encounter Data Information Survey for completion. The survey is a list a question where we describe, in detail, our processes for submitting encounter data (including those processed by subcontractors) to DPW; reconciling reports and files; documentation for submitting adjustments to encounter data submitted; and assessment of encounter data completeness and timeliness. The survey results provided by DPW are utilized to enhance the process either through adding system controls, edits and enhancements to workflows.

Quality and Independent Audits

Internal Quality audits are performed frequently and discrepancies are investigated promptly. Quality and independent audits are conducted by sampling claims and encounters processed by AmeriHealth Mercy systems (AmeriHealth Mercy processed and Subcontractor processed encounters). Queries are written and pre-approved by an auditor. Specific data elements may be requested (i.e., provider NPI, procedure, diagnosis codes, bill amount, payment amount, etc.) Query results are provided to the auditor to verify the samples against AmeriHealth Mercy internal systems, and will be provided for verification with encounter data residing in DPW's databases.

On-Site Audit

After review of the Encounter Data Information Survey, DPW schedules an on-site audit to observe the processes and procedures outlined in the survey. Our encounter process has been improved based on the outcome of the audits to ensure that we remain compliant with DPW contract requirements.

Policies Procedures and Reports

The table below lists the policies and procedures that we follow, and the types of reports that we produce, to monitor accuracy and compliance. The reports are generated every month for reconciliation purposes and to identify claims that have errors, so that the claims can be corrected or adjusted and the encounters may be resubmitted in a timely fashion.

Table 7: Encounter Accuracy and Compliance Policies and Procedures

Policies and Procedures	Sample Reports
Encounter File BBA Cert File Process Policy	BUILD_RECON_AUG11.xls
Encounter File Submission Schedule Policy	EXT_REJECT_DROPPED_AUG11.xls
Encounter File Transfer Oversight Policy	PROVIDER_ERR_01JUL2010_30SEP2011.xls
Encounter Performance Standard & Error Corrections Policy	RA_CUMULATIVE_ERRORS_AUG11.xls
Encounter Pre-Edit Process Policy	RA_MONTHLY_ERRORS_AUG11.XLS
Encounter Production Job Authorization Forms Policy	RA_STATUS_ANALYSIS_AUG11.xls

Data Completeness Oversight

On a daily basis, our Encounter Data Team manages all aspects of encounter submissions to ensure that all encounters are complete and delivered to DPW on a monthly basis. To achieve this goal, the team:

- Meets daily to collaborate and handle any urgent issues

- Ensures the encounter files have successfully passes all completeness checks
- Review internal compliance reports
- Ensures that the encounter submissions are prepared in advance of the time they are due
- Tracks every file submitted to DPW along with pertinent data (e.g., date, record counts, etc.)
- Distributes reports to management for review of any potential files missed
- Addresses all issues on a timely basis

The Medical Economics Department monitors our Data Warehouse for data anomalies, part of which includes missing or incomplete data from subcontractors. If data anomalies are discovered, Medical Economics communicates potential issues to the Information Systems Department to be sure that the anomalies are not due to any internal processes related to loading the source data. Medical Economics also communicates with Quality Management and Provider Network Management Departments to follow-up with providers and subcontractors, when needed, to obtain complete and correct data and reports.

Our Delegated Oversight Area, managed from the Quality Management Department, in conjunction with Provider Network Management, monitors the submission of reporting from subcontractors on a monthly basis. Inadequacies are followed-up swiftly with the applicable subcontractor and corrective action plans are implemented when appropriate.

QUESTION 9

How will you ensure and verify that providers and subcontractor(s) submit timely, accurate, complete and required encounter data elements to you for subsequent transmission to the Department? How often will you verify the data?

(Limit to three pages)

RESPONSE TO QUESTION 9

AmeriHealth Mercy understands that it is ultimately accountable for the performance of all services performed by subcontractors. As such, we have defined strict management information system requirements and related policies, procedures, and protocols, to ensure all AmeriHealth Mercy subcontractors adhere to DPW and AmeriHealth Mercy compliance provisions, including the submission of timely, accurate, and complete encounter data. Our policies and procedures guide our initial selection of subcontractors and ongoing adherence performance monitoring and oversight.

Ensuring Timeliness

Providers

Providers are required to submit encounters on a standard claim form (HCFA 1500 or UB 04) to AmeriHealth Mercy within 180 calendar days from the date that services were rendered or compensable items were provided. Re-submission of previously denied claims with corrections and requests for adjustments must be made within 365 calendar days from the date that services were rendered or compensable items were provided. Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 days of the date shown on the primary insurer's EOB.

AmeriHealth Mercy's claims processing system is configured with the timely filing rules to ensure that providers submit their encounters in a timely manner. We have the capability to run reports by providers to identify any patterns of late submission of encounters. Often the provider will contact AmeriHealth Mercy via phone or in writing to dispute payment denials for timely filing. The Network Management Department is notified if a pattern of late submission is identified, and a Provider Management Account Executive contacts the provider to reinforce the claims billing guideline.

Subcontractors

AmeriHealth Mercy requires that all of its subcontractors submit encounter data on a standard 837 EDI format weekly, bi-weekly, or monthly depending on State requirements. AmeriHealth Mercy utilizes a file tracking system, which tracks the submission status of encounter files based on a defined schedule. If a file is not submitted on the day it is expected, the system will send an alert to the Encounter Managers who will in turn contact the subcontractor to alert him that his file has not been received. All file transactions are tracked and reviewed monthly to identify any negative trends in the timely submission and quality of the data. If a trend is identified, the issue is escalated to AmeriHealth Mercy's Subcontractor Oversight Manager to seek immediate resolution, including the following: the specific actions that can be taken, a request for a formal corrective action plan, and/or performance penalties assessed for non-compliance with contractual service level standards.

AmeriHealth Mercy's Quality of Service Committee annually conducts a comprehensive review of each subcontractor's ability to submit encounters in compliance with all applicable standards. These reviews are conducted by an independent auditor or by the AmeriHealth Mercy Audit department. If a subcontractor's performance falls below the threshold level stipulated in their contractual agreement with AmeriHealth Mercy or otherwise does not comply with DPW requirements, the subcontractor is required to complete and submit a corrective action plan explaining the specific reasons for underperformance. To support subcontractors' efforts to meet

performance expectations, we provide regular updates of the State's procedure codes, diagnosis codes, and provider data reference files.

Ensuring Accuracy

Providers

Provider encounters are submitted on a claim form and then processed through the claims processing system, which verifies the completeness and accuracy of provider numbers, member ID numbers, diagnosis codes, and procedure codes. The claims processing system rejects claims with missing or inaccurate information; rejected claims are returned to the providers for correction.

The claims processing system utilizes claim clinical editing functions based on valid Current Procedure Terminology, ICD-9 (or ICD-10 when implemented by the State), HCPCS codes, and National Correct Coding Initiative standards. When encounter data are loaded from the claims processing system into the encounter database (from which we prepare encounter data submissions to the State), the data passes through a secondary pre-edit process. This process enables AmeriHealth Mercy to identify, investigate, and correct significant errors before submitting the encounters to the State in the required formats.

Subcontractors

Subcontractors are required to apply claim level edits at the point of adjudication. Subcontractor 837 professional and institutional files must pass HIPAA compliance examination prior to submission to the State. In addition, AmeriHealth Mercy uses an encounter audit tables for data validation, and files are required to pass a second level of the pre edits process. This chart shows our encounter acceptance rate from our subcontractors for Calendar Year 2011.

Ensuring Completeness

Providers

We continually strive to ensure complete encounter submissions from our capitated PCPs. We have several initiatives in place to achieve this goal. We continue to offer a $1.00 incentive payment for every complete and accurate encounter form submitted by our capitated PCPs and our Primary Care Provider Incentive Program provides financial incentives for the submission of accurate and complete health data.

In April 2007, AmeriHealth Mercy implemented an initiative to ensure complete encounter reporting of all diagnosis for chronic illnesses. The PCPs receive enhanced fee-for-service reimbursement for providing outreach and comprehensive evaluation and management services to a defined member population. The target population is identified by comparing current period claim experience to a two-year historical look-back. In all cases where active members have a history of chronic illness, but no current record of claims reporting the same illness, the assigned PCP is notified and requested to validate the continued presence of the condition by providing a comprehensive evaluation and management services and submitting a claim reporting all active diagnoses.

Encounter submission rates for providers are reviewed every six months by the Provider Network Management team. An encounter submission report is generated from the Facets claims payment system that lists every provider and encounter submission rate per month. In addition, a variance field exists that indicates the percentage change from the prior reporting period.

We verify the completeness of PCPs' claims submissions through biannual medical record reviews. During these reviews, we collect data from medical records and compare them to claim encounter submissions. When encounter rates fall below a specified threshold, the provider is contacted to discuss the issue and is required to prepare a corrective action plan. Capitated PCPs who continually under-report encounter data are notified that continued non-compliance may result in the change of their reimbursement from capitation to fee-for-service, or that we may apply sanctions up to and including contract termination. This action has been every effective and we have seen an increase in our submission rates as a result.

Subcontractors

AmeriHealth Mercy monitors the number of service encounters submitted for every service that an enrollee receives. A cross-functional review of the medical record/claims data of the subcontractor is conducted by AmeriHealth Mercy departments with a stakeholder interest, such as Medical Affairs, Informatics, and Claims, to verify that complete data are being submitted.

Data are analyzed and evaluated for over/under/misutilization of medical services based on national benchmarks (such as Medicaid Quality Compass scores, HEDIS, and other nationally-accepted industry standards and measures) and in accordance with the requirements of the RFP. During our medical record review, if we determine that encounters were not submitted, the subcontractor is required to develop and implement a corrective action plan. AmeriHealth Mercy requires all subcontractor files to pass HIPAA compliance examination for all 837 files prior to submission to the State. If any file fails this compliance examination, the subcontractor is required to return a corrected encounter file to us within four business days. This process is used every time that files are received from subcontractors, typically once a month.

Encounter Transmission to the State

All encounter data received from a provider or subcontractor will undergo the same editing for completeness and accuracy required from all encounter records. A more detailed description of the process is provided in Question 7. AmeriHealth Mercy will submit multiple encounter files to the State monthly containing internally processed claims and claims processed by subcontractors. An initial file is submitted once a month; throughout the rest of the month, subsequent adjustments and corrections will be submitted as needed. By separating the file, DPW will be able to conduct any further audit and/or reviews for subcontractor encounter data.

QUESTION 10

How will you manage the non-submission of encounter data by a provider or subcontractor? Will it result in any assessment of penalties? If so, please describe.

(Limit to 2 pages)

RESPONSE TO QUESTION 10

AmeriHealth Mercy has systems and processes in place to verify and ensure that providers and subcontractors provide us with timely, accurate and complete encounter data for transmission to DPW. This combination of activities has enabled, AmeriHealth Mercy to exceed DW encounter acceptance standard.

To encourage encounter submissions by capitated PCPs, AmeriHealth Mercy makes a $1.00 incentive payment for each timely, accurate and complete capitated encounter submitted to the Plan.

Non-Submission of Encounters by Participating Providers

AmeriHealth Mercy reimburses all participating providers, with the exception of some Primary Care Providers, on a fee-for-service basis. Providers who are paid on a fee-for-service basis do not receive payment from AmeriHealth Mercy unless they submit an encounter (claim) form. Our primary focus is on ensuring the submission of encounter data from our capitated Primary Care Providers.

The first step in ensuring encounter submissions occur is appropriate provider education and communication. AmeriHealth Mercy Provider Network Representatives conduct in-service/orientation meetings with participating providers to review policies and procedures, reimbursement, billing requirements, encounter submission requirements, and performance metrics. Providers with low encounter submission rates receive additional, ongoing training and education.

The second step to ensure encounter submissions by primary care providers includes financial rewards. AmeriHealth Mercy offers a financial incentive to PCPs for each timely, accurate and completed capitated encounter submitted.

AmeriHealth Mercy monitors encounter submissions by PCP practices, whether capitated or fee-for-service, on a regular basis. The encounter submission rate is expressed in terms of an average number of encounters per member per year (PMPY). Encounter submission reports are generated from our Facets claims payment system showing the monthly encounter submission rate for every participating primary care provider, along with the percentage change from the prior reporting period. When a capitated provider's Encounter submission rates fall below a pre-determined threshold, we contact the provider to discuss the concern and inform him/her of the need for corrective action. Persistent outliers, particularly low encounter submitters that reimbursed through capitation, are converted to fee-for-service payment arrangements to encourage complete encounter submissions.

Non-Submission of Encounters by Subcontractors

AmeriHealth Mercy's contracts with subcontractors who process claims include performance standards for timely, accurate and complete encounter data submissions. Our subcontract agreements include language providing for the implementation of progressive sanctions for non-compliance, up to and including contract termination.

Encounter data performance standards are incorporated into the subcontract through written service level agreements. Our encounter data analysts monitor subcontractor encounter data submissions, volumes, and accuracy, with every data transmission and on a monthly basis. If service levels are not met, they escalate the non-performance issue to the AmeriHealth Mercy

Subcontract Oversight Manager who in turn escalates the issue to the appointed subcontractor encounter data contact. The issues are discussed jointly with the subcontractor and a corrective targeted corrective action plan is developed, documented and tracked. As discussed above, continued non-compliance will result in the application of progressive sanctions, up to an including penalties and contract termination.

On an annual basis, AmeriHealth Mercy's Quality of Service Committee conducts a comprehensive review of each subcontractor's ability to transmit timely, accurate, and complete encounter submissions in accordance with AmeriHealth Mercy and DPW requirements. This review is conducted by an independent auditor or by the AmeriHealth Mercy Audit department. If a subcontractor's performance falls below the performance threshold stipulated in their contract with AmeriHealth Mercy, or otherwise does not comply with DPW requirements, the subcontractor will be required to submit and complete a corrective action plan targeted at the specific reasons for underperformance. Again, continued non-compliance with encounter submission performance standards will result in the application of penalties, up to and including contract termination, as per AmeriHealth Mercy's subcontractor agreements.

QUESTION 11

Describe in detail your process for utilizing the daily, weekly, and monthly files to manage your membership. Include the process for resolving discrepancies between your membership data and the above files.

(Limit to four pages)

RESPONSE TO QUESTION 11

Maintaining complete and accurate membership data is critical to AmeriHealth Mercy's ability to provide high quality and cost-effective care to all enrollees. Our enrollment processes and technologies provide a solid infrastructure for the management of enrollment information, including clear documentation and tracking to resolve discrepancies. This process has been enhanced in the nearly 30 years we have served Medicaid recipients in Pennsylvania.

Process for Utilizing Daily, Weekly and Monthly Files

AmeriHealth Mercy's enrollment process is built around nationally-accepted, HIPAA-compliant transactions and file layouts that allow us to process and reconcile eligibility information effectively. We have developed and operated processes to utilize the daily, weekly, and monthly files that we receive to enroll new enrollees, disenroll enrollees, re-enroll enrollees, update enrollee demographic data, and assign PCPs in a timely and accurate manner.

AmeriHealth Mercy currently receives daily, weekly, and monthly enrollment files from DPW in an ASC X12N 834 Benefit Enrollment and Maintenance transaction. Each file is automatically processed nightly in our Facets Healthcare Application, our core eligibility and claims processing system, serving as the central repository for all enrollee data. This process loads changes to enrollment data so that the information in Facets can be reconciled with the information from the State. Any online modification of demographic information, alteration in category of assistance, change of medical assistance, eligibility, new enrollment, disenrollment or PCP change automatically updates our enrollee records. In order to effectively manage the accuracy of our enrollment data, we process files in the order in which they are received, and we process records in chronological order for each enrollee.

Weekly Eligibility File Process

AmeriHealth Mercy is required to produce a Weekly Membership Enrollment and Disenrollment Outbound File for DPW, which contains alerts and notifications consisting of newborns, returned mail, pregnancy, death notifications, TPL data and demographic changes. These alerts are a means to communicate changes in membership data to DPW for incorporation into the Pennsylvania State System.

DPW returns the enrollment/disenrollment file weekly with a disposition of each record that was sent to them on the file. Each record returned contains an edit code indicating whether the record was processed, and the type of processing that was completed. AmeriHealth Mercy's Enrollment Department manually reviews all edits codes that require additional research. Our Enrollment Department staff also loads the edit codes for each member into our Facets system for future reference.

Weekly Pending Enrollment File

DPW's Enrollment Broker Contractor generates the Weekly Pending Enrollment File. This file contains new enrollees who were recently submitted to DPW along with the members' PCP selection and special needs information. We run automated queries to compare the Weekly Pending Enrollment File information already in our system. If a match is found, the PCP information is automatically updated into the member's enrollment record. If a match cannot be made, the information is included in an error report (see below). We recycle unprocessed Weekly Pending Enrollment records for 40 days, after which they are purged.

AmeriHealth Mercy's Enrollment Department generates and reconciles the following reports:

- **Recipient Not in Healthcare System and Members with Duplicate ID Numbers** – This report identifies any member who could not be located by recipient number in the Facets system or where duplicate recipient numbers exist.
- **Unprocessed Records Report** – This report identifies members who are not an active member assigned to AmeriHealth Mercy and were never found in the Facets system. These records are purged after 40 days from their original receipt date.
- **PCP Update Error Report** – This report identifies members whose PCP assignment could not be processed automatically due to PCP panel restrictions or PCP's participation status has changed.

Monthly Eligibility File

AmeriHealth Mercy receives a Monthly Eligibility File from DPW that contains the most current record for each recipient who becomes Managed Care eligible within the next month.

Upon receiving this file, AmeriHealth Mercy completes automated comparisons to identify discrepancies with our Facets system. We accumulate this information into categories and report it to the Enrollment Department. The Enrollment Department proactively reviews, researches, and updates discrepancies to reconcile our system with the Pennsylvania State System. We make all changes within 72 hours of receipt of the file from DPW. Once the reconciliation is complete, we continue the processes for generation of PCP panel lists and PCP capitation.

Newborn Database

AmeriHealth Mercy developed a database to track and monitor all claims for newborn members who do not yet have Medicaid eligibility. This database interfaces with our Facets system, which permits daily refreshing of the data, so that all updates from DPW are captured quickly and routinely. In this way, newborn claims can be addressed on an expedited basis.

This process and database also allow our Enrollment Department to track the status of notifications to DPW about the need for newborn eligibility information and ensures that notification is timely and not redundant. This streamlines the process for assignment of Medicaid eligibility in our Facets system, reducing administrative costs for both DPW and AmeriHealth Mercy. It also ensures greater access to necessary services for newborns through timely availability of the latest eligibility information for member and provider inquiries.

Eligibility Information from Other Sources

During our process, eligibility discrepancies are identified through a number of sources: medical records, discharge planning, PCP notification, enrollee self-reports, Explanation of Benefits (EOBs), claims, and returned mail. The most common discrepancies are address changes, name spelling errors, e-mail addresses, changes to third party insurance coverage, and wrong telephone numbers. Our employees enter updates into our Facets system using Streamline, which is a custom-designed, front-end graphical user interface. Demographic changes are communicated to the State via the weekly outbound file process described above.

Resolving Discrepancies

AmeriHealth Mercy compares eligibility transactions to our existing enrollee records on a daily basis, and updates or adds them as necessary. Specifically, the enrollee data on the daily inbound file are loaded into the Facets system within 24 hours of receipt of the file.

If there is a discrepancy identified, the system is configured to default the record to an error report which is resolved by an enrollment specialist within 24 hours (for example, there may be an invalid exemption code on the record of a terminated enrollee). This information is accumulated into categories and researched by the enrollment specialist. The enrollment specialist proactively reviews the reports, researches, and updates any discrepancies to reconcile our system with the State.

Our enrollment specialist will provide the State and/or the enrollment broker with written notification of all discrepancies that are identified during the reconciliation process. We intend to utilize the file layout of the report and reconciliation file we currently produce in our Pennsylvania plans. The table below shows the error code descriptions that we will provide on the reconciliation file:

Table 8: Enrollment Error Code and Description

Frequency	Error No.	Error Description
Daily	3	INVALID EXEMPTION CODE FOR TERM MEMBERS
	4	BLANK FACILITY CODE
	9	PH CODE AND GROUP POLICY MISMATCH
	15	MATCH BETWEEN MEMBER INBOUND EFFECTIVE BEGIN AND END DATES
	18	MEMBER TERMINATED WITH INVALID CURRENT PLAN SEGMENT
	7	VALID EFFECTIVE DATE WITH A VALID MEDICAID TERMINATION DATE [MIN]
	22	ERROR IN PREGNANCY
	25	NEW EFF DATE PRIOR TO FACETS MECD EFF DATE
	26	NEW EFF DATE PRIOR TO FACETS MELC EFF DATE
	27	FACETS EFF DATE PRIOR TO NEW EFF DT FOR NON-TERMED
	28	CUTOFF DATE IS PRIOR TO ELIGIBILITY BEGIN DATE
	17	ERROR IN CURRENT PLAN AND HMO EFFECTIVE DATE SEGMENTS
	24	NEW PLAN IS NULL/BLANK/NOT VALID
	20	MIN OF MEDICAID TERM DATE NOT EQUAL TO OPEN-ENDED DATE
	20	PCP ERROR FOR RE-INSTATED MEMBERS
	45	DUPLICATES EXIST FOR MEDICAID ID

Frequency	Error No.	Error Description
	46	DUPLICATES EXIST FOR SSN
Monthly	0	TERM BY ABSENCE
	1	ELIGIBLE IN INBOUND NOT IN FACETS
	2	TERMED IN INBOUD BUT ACTIVE IN FACETS
	3	TERM DATE MISMATCH
	5	CATEGORY CODE AND PSC MISMATCH
	7	NON EXISTENCE OF CATEGORY CODE IN FACETS
	8	TERMED IN FACETS BUT ACTIVE IN INBOUND
	9	DECEASED IN INBOUND BUT ACTIVE IN FACETS
	9	PH CODE AND GROUP POLICY MISMATCH
	10	INBOUND DECEASED DATE MISMATCH WITH FACETS TERM DATE
	11	PRENANCY DATE MISMATCH
	12	PREGNANCY INDICATOR INBOUD BUT NOT IN FACETS
	13	PREGNANCY DATE MATCH BUT FACETS HEALTH PREFIX IS A
	14	PREGNANCY INDICATOR IN FACETS BUT NOT INBOUND
	45	DUPLICATES EXIST FOR MEDICAID ID

Quality Auditing Process

AmeriHealth Mercy has a very effective Quality Assurance program. The program is geared to identify errors performed by the Enrollment Representative during the reconciliation process and to identify any trends in the quality of the enrollment files sent by DPW and/or the Enrollment Broker. Through this process we have been able to reduce eligibility errors and address data quality issue early so they did not impact a member's ability to access service or a provider reimbursement.

In addition to the automated identification of enrollment discrepancies, 5 percent of the work performed manually by AmeriHealth Mercy's Enrollment Department is audited. The 5 percent is selected through a random sample of the total work completed by the Enrollment Representative during a given time period. Detailed quality reports that document overall accuracy and error trends are provided to the manager on a monthly basis. The reports are utilized for training, trending and performance monitoring purposes.

QUESTION 12

Explain in detail your process for providing membership information to each of your subcontractors (dental, vision, etc.). Include the subcontractor's name, their purpose and how often membership data is submitted.

(Limit to three pages)

RESPONSE TO QUESTION 12

AmeriHealth Mercy has processes and procedures in place to provide our subcontractors with timely and accurate membership information to support all delegated clinical and administrative functions. In addition to the processes we have service level agreements with each of our subcontractor to ensure they receive and load the eligibility file timely so not to prevent members from access services.

Our process for providing membership information to each of our subcontractors begins with our receipt of the daily, weekly and monthly enrollment files from DPW. These files are processed each night in our Facets Healthcare Administration Application. This process automatically applies changes to the membership data and updates information about members so that the information in Facets is synchronized with the information received from the State or Enrollment Broker. Any online modification of demographic information, category of assistance, change of medical assistance, eligibility, new enrollment, disenrollment or PCP change automatically updates our member records. Our Enrollment Department resolves and discrepancies and makes all updates to the members eligibility records on Facets. For a more detail description of the enrollment file reconciliation process, please refer to Question 8 of this section.

Productions and Submissions of Eligibility file to Subcontractors

AmeriHealth Mercy produces a daily change file and monthly full eligibility file for each of the subcontractors. These files are transmitted to the subcontractors using a CISCO Tidal job scheduler to initiate and manage the generation of the outbound files. The outbound file production schedule is configured with the CISCO Tidal Enterprise Scheduler, which allows for alerts to be generated and routed in the event a file is not sent as expected, if the file transfer is not successful, if any processing step fails, and under other exception conditions. AmeriHealth Mercy monitors the data exchange process twenty-four hours a day, seven days a week. In addition, we have the ability to identify which subcontractors are not retrieving their eligibility files timely. If a pattern is identified, the Subcontractor oversight manager will be notified and further action taken as needed.

Data Security

The security of all data files transferred is guaranteed via point-to-point connectivity or secures virtual private networks across the Internet. We utilize a “Lock Step” method executed with each data movement to ensure all received and outbound exchanges are archived and logged for future reference or processing. This enables us to track the status of each file and identify potential errors.

Error Reconciliation

AmeriHealth Mercy has workflows and processes to assist all Subcontracts with the reconciliation of all files. When the subcontractor loads the eligibility file into their system, on occasion they will receive errors which prevent the file or a specific member record to automatically load into their system (Example: If they receive a member with an ID number that has already been assigned to another member). The Subcontractor will contact the Enrollment department to work through the error. The error fix can result in a manual update to their system, AmeriHealth Mercy System or resubmission of a new file. All errors are tracked a logged to assist with trending.

Service Levels

We achieve superior data exchange service levels through our commitment to proven procedures and operational controls. We practice strict adherence to scheduled processing times, routine error handling/reporting and associated processes to address discrepancies through reconciliation of data between parties and audits. The audits include operational quality assurance audits, internal audits, and/or third party audits, including State and Federal regulatory audits.

The following table is the list of our subcontractors and the eligibility files they receive:

Table 9: Subcontractor Eligibility Files

Subcontractor	Purpose/Description of Services Provided	Daily Eligibility File	Monthly Eligibility File
DentaQuest	Dental	X	X
Argus	Pharmacy	X	X
Connections	Member outreach	X	X
Quest Labs	Medical Lab	X	X
Davis	Vision	X	X
ACS Commercial Solutions	Data Processing	X	X
ACS Recovery Services Inc.	Subrogation Recoveries	X	X
Healthcare Management Systems	TPL and COB identification and recovery	X	X
MedSolutions Inc.	Utilization Management for outpatient diagnostic imaging services	X	X
ProgenyHealth	Neonatal intensive care management	X	X
PerformRx LLC	Pharmacy Benefit Management	X	X

QUESTION 13

Explain your process for maintaining your provider file with detailed information on each provider sufficient to support provider payment and also meet the Department's reporting and Encounter Data Requirements. Include how you cross reference your internal provider ID number with the PROMISe provider ID and the provider's NPI number.

(Limit to two pages).

RESPONSE TO QUESTION 13

Maintaining Provider Data

AmeriHealth Mercy recognizes the importance of creating and maintaining current provider demographic information to ensure the accuracy of claims payment, state reporting, encounter data requirements, and provider directories. We coordinate our contracting, credentialing, provider file maintenance and encounter processes to ensure that provider file information is current and accurate.

Initial Provider Enrollment

Each new provider contracted with AmeriHealth Mercy completes a credentialing application and signs an agreement that defines both parties' reimbursement obligation. Provider Network Management is responsible for receipt of a completed application package that includes validation of all required provider identification numbers. This package is then forwarded to the Credentialing Department where a provider profile is created in Visual Cactus. The profile includes all necessary information: name, address, phone, fax, email, ID numbers (PROMISe and NPI), license numbers, board certifications, languages spoken, and site review information (such as handicapped accessibility). Providers are requested to review information obtained during the credentialing verification process, and, if it is substantially different from what they submitted on their application, are given the opportunity to correct erroneous information. Once approved through the credentialing process, the provider data are extracted from Visual Cactus and loaded into the Facets System by the Provider Maintenance Department. Reimbursement information from the executed provider contract is formatted into a Contracting Implementation Template and delivered to our Facets Configuration Team, which creates or updates the agreement details in the Facets System. Since many providers are paid based on the same fee schedule, this usually involves simply associating the new provider to an existing agreement. Facility agreements require specific reimbursement configuration and are routinely tested prior to implementation to ensure reimbursement at the contracted rate for various services.

Each provider record loaded into the Facets System is given a sequentially generated, unique practitioner or facility ID number, but NPI and PROMISe Provider ID (PPID) numbers are also stored on the Facets provider data table. The NPI and PPID are cross-referenced to the practitioner ID and the associated provider Group ID and Payee ID. The Facets provider platform maintains this unique link through the duration of the record's existence on the platform. The integrated NPI crosswalk table within Facets enables AmeriHealth Mercy to link all practitioner-related claims information. AmeriHealth Mercy's Encounter Analysts also monitor encounter rejection reports on a monthly basis. If any provider data errors are identified (e.g., providers with invalid data such as PROMISe ID, invalid NPI number, etc.), encounter data analysts will work with the Provider Network Management Department and Claims Operations to make corrections to provider or claims data. The provider master data are corrected as necessary to ensure that future payments are accurate.

Routine Monitoring

The on-going accuracy of our provider database is monitored through multiple processes:

- Daily audit of the manual updates performed by our Provider Maintenance employees
- Quarterly review by Provider Network Management representatives through a combination of provider office visits, telephonic, electronic media, and facsimile-based confirmation

- During the routine re-credentialing cycle

Updates from provider data can also come from external sources. We perform State and federal file comparisons that reconcile data elements such as name, address, license, DEA, office locations, NPI and State ID numbers. Corrections to provider data are also made on an ad hoc basis whenever reported to us directly by the provider or identified as the result of a claim investigation. As a final monitoring effort, AmeriHealth Mercy performs a complete provider data validation annually. Through this process, all providers are required to validate and edit the data stored in our provider database. This process has proven to be very effective as a means to ensure accuracy of provider directories. Provider Services or Provider Network Management staff submits change requests to Provider Maintenance. All such requests are completed within two business days.

QUESTION 14

Explain your process for ensuring that providers are enrolled in MA and have a valid PROMISe Provider ID number and NPI. Include how you will monitor your subcontractors to ensure their providers are enrolled in MA and have a valid PROMISe provider ID number and NPI.

(Limit to two pages)

RESPONSE TO QUESTION 14

AmeriHealth Mercy Health Plan provider enrollment procedures have been established to maintain compliance with the requirement that prospective and participating providers are enrolled in the Pennsylvania Medical Assistance (Medicaid) Program and have valid PROMISe ID (PPID) and National Provider Identifier (NPI) numbers prior to being added to our provider database.

Participating Provider Enrollment

For those providers who must be credentialed by AmeriHealth Mercy as a condition of participation in our network, we verify enrollment in the Pennsylvania Medical Assistance Program and the existence of a valid PPID number and NPI number during the initial provider credentialing process and during re-credentialing. If we receive an application that does not include the PPID or NPI number, we contact the provider's office to verify that they have submitted an application to receive a PPID and/or an NPI number. Providers who have not submitted an application for a PROMISe ID or NPI number are directed to do so. More often, we find that the request for the PPID or NPI number has been made, but is still pending review by the DPW. In these instances, we proceed with the credentialing process, but pend the final credentialing approval upon receipt of the valid PROMISe ID or NPI number. Upon notification that the provider has been enrolled by DPW and/or has received the NPI number, the credentialing process is completed. AmeriHealth Mercy verifies the validity of the PPID and/or NPI number prior to entering it into the Facets System by checking Pennsylvania PROMISe database. The PPID and NPI numbers are both stored on the Facets provider data tables and cross-referenced to the system-generated Facets ID number.

Subcontracted Provider Enrollment

Our sub-contractor agreements also require that all subcontractor providers are enrolled in the Pennsylvania Medical Assistance Program and have a valid PROMISe Provider ID and NPI number. Our subcontractors follow similar processes to those outlined above to verify that a provider in their network has a valid PPID number.

AmeriHealth Mercy also shares its PVR 415 files with all subcontractors. Additionally, we conduct a secondary review of the PPIDs and NPIs submitted by our subcontractors through the encounter process. Prior to submission to DPW, all encounters are run through a pre-editing process that verifies the existence of a PPID and NPI number.

Non-Participating Providers verification

AmeriHealth Mercy submits a request to add a non-participating provider who do not exist in our Facets database to our Provider Maintenance Department to obtain an internal provider identification number. Providers who do not have a valid PPID and/or NPI may be entered into the Facets System as a non-participating provider only. Each non-participating provider addition is researched on the PROMISe system to validate their participation in the Pennsylvania Medicaid Program, and to obtain or validate the PPID number and NPI number.

Maintenance

We investigate missing and invalid PPIDs and NPIs on a monthly basis via a query comparing the 415 file received from DPW against our Facets database. This report identifies any provider (participating and non-participating) in our Facets database who does not have a valid PPID or NPI. AmeriHealth Mercy investigates missing and invalid PPID and NPI numbers in the

PROMISe database and corrects the information in the Facets database if the valid information is found. If we find a provider without a valid PPID or NPI, AmeriHealth Mercy contacts the provider to educate and assist him/her in obtaining a PPID or NPI number.

If AmeriHealth Mercy receives claims and/or work requests that require changes and updates to provider data for subcontractors, we use the PROMISe system to validate the PPID and NPI number. If the provider is not in the PROMISe system, we do not set up a provider record. Instead, the request is pended and assistance is requested from our Provider Contracting Department. Once the PPID and NPI is obtained and provided, a provider record is set up for the subcontractor in the provider database. If a subcontracted provider is found to be without a valid PPID or NPI number, AmeriHealth Mercy notifies the subcontractor to contact the provider for education and assistance in obtaining a PPID and/or NPI. We re-educate the subcontractor about their responsibility to ensure that all providers in their network have a valid PPID and NPI number. If a pattern of problems is noted through the encounter edit process, the subcontractor would be subject to sanctions.

QUESTION 15

What is your plan to ensure that claims timeliness standards are met and that providers are paid timely?

(Limit to two pages)

RESPONSE TO QUESTION 15

AmeriHealth Mercy has achieved high standards for timely and accurate claims processing and provider payment by using state-of-the-art technology, well-trained staff, and a rigorous quality assurance process. As shown in the table below, we far exceeded DPW payment timeliness standards for time to pay within 30 days of receipt, and our performance at the 45- and 90-day mark materially complies with DPW's requirements over the past year (DPW has a threshold for compliance for 45 and 90 days of 99.5% or greater).

Table 10: AmeriHealth Mercy Health Plan Clean Claim Payment Results

Time to Pay Requirement AmeriHealth Mercy 90% of Clean Claims in 30 days											
Nov-10	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**
99.9%	99.9%	95.6%	99.9%	98.9%	98.0%	94.0%	96.1%	98.1%	97.7%	97.1%	99.5%
Time to Pay Requirement for AmeriHealth Mercy 100% of all Clean Claims in 45 days											
Nov-10	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**
99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	98.5%	99.8%	99.9%
Time to Pay Requirement for AmeriHealth Mercy 100% of all Claims in 90 days											
Nov-10	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**
100.0%	99.9%	99.9%	100.0%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%

Adherence to claims payment standards and requirements is achieved through daily monitoring of the claims inventory by the AmeriHealth Mercy claims management team. Specifically, our 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 processing and payment performance 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.

Facets offers a high degree of automation and data capture, achieving fast, accurate claims processing and high auto-adjudication rates. AmeriHealth Mercy affiliate has achieved a yearly average of an 87 percent claims payment auto-adjudication rate. These high rates have been achieved by utilizing standard provider agreements and pricing methodology (such as percentage of fee schedule and DRGs). 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.

Of the 18 million claims we receive annually across our family of companies, over 89 percent are electronically submitted.

Facets' electronic auto adjudication allows us to process claims faster and more accurately than paper claims. AmeriHealth Mercy employees can adjudicate all medical and hospital claims that are submitted electronically in a batch mode. The batch mode capability allows us to process a large amount of claims at one time automatically. We can also adjudicate pended claims that have been mass-released for re-adjudication as a batch process. 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.

Table 11: AmeriHealth Mercy Health Plan Auto Adjudication Rates

Auto Adjudication Rates for AmeriHealth Mercy											
Nov-10	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**
92.2%	88.9%	85.3%	88.9%	87.4%	90.3%	85.9%	87.3%	80.9%	89.2%	87.1%	88.1%

AmeriHealth Mercy utilizes SunGard EXP Macess imaging-based operations management, workflow management, enterprise content management and customer service solution. EXP Macess 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 claims workflow, helping managers identify bottlenecks and increase efficiency. EXP Macess offers solutions for document management, content management and business process management that help organizations automate workflow and improve productivity. Some of the documents we capture include:

- Incoming correspondence from members or providers
- Claims
- Medical records
- Detail invoices
- Prior authorization records
- Letters of medical necessity (electronic and scanned images)
- Outgoing correspondence to an enrollee or provider (such as letters to request additional information, notice of action, notice of appeal resolution)
- Electronic documents

EXP's Doc Flow module enables records/documents to be processed into work queues for efficient work assignment and management. EXP Macess enables queue-based work distribution. Users can use a graphical design component to create electronic workflow and routing flows to match a predefined workflow process. The system will perform automatic searches for supporting documents, in order to complete tasks in the queue. 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. Together, these integrated systems provide for accurate and prompt claims payment to our providers.

PHARMACY

CONTENTS

QUESTION 1

Describe your approach to control pharmacy costs. Describe programs/initiatives that have been successful at controlling costs.

(Limit to three pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy controls pharmacy costs within the broader context of reducing the overall cost of care for our members. Our pharmacy programs are designed to improve the comprehensive health needs of our members through optimal use of medication therapy. By ensuring that our members receive the right medication, at the right time, at the lowest possible cost, we are able to achieve the highest quality care in the most cost effective manner.

Our programs have successfully controlled costs. The six key drivers of our pharmacy cost containment efforts are:

- Effective use of clinical pharmacy utilization protocols
- Maximizing the use of generic medications through strategic formulary design
- Driving prescribing patterns through targeted member and provider interventions
- Negotiating competitive reimbursement policies
- Effectively managing a robust rebate management program, and specialty drug program; and
- Application of dose optimization criteria to minimize member tablet burden and daily medication costs

Some of these components are described in detail in the following questions, but a brief summary is below.

Pharmacy Utilization Management

AmeriHealth Mercy's pharmacy utilization management program is the foundation of our approach to controlling pharmacy costs. Although the DUR program is explained more in Question 2, and prior authorization is explained more in Question 3, a quick example of the effectiveness of our program involves the drug Synagis.

Peer reviewed clinical literature as well as national guidelines have clearly demonstrated that treatment with Synagis, an extremely high cost medication, is cost effective when administered only to a specific set of newborns with particular risk factors. Accordingly, we developed stringent prior authorization guidelines for Synagis to reduce its inappropriate use and aid providers in determining which members will benefit most from this therapy. When paired with physician and member education, our Synagis management program has achieved a 40% reduction in inappropriate utilization over the past year.

Additionally, the use of step therapy protocols, quantity limits, age limits, and prior authorization criteria drive favorable utilization patterns. Step therapy protocols ensure that all members try at least one of the three mainstays of treatment prior to obtaining newer, more expensive therapies. Similarly, quantity limits restrict the number of doses members can receive without prior authorization to reserve their use for their indication. Lastly, age limits restrict the use of certain medications to only those members who are determined to be age-appropriate users.

Drug Formulary

Through careful consideration of both clinical effectiveness as well as pharmacoeconomic data, AmeriHealth Mercy has been able to design and maintain a formulary that offers our members and providers a wide array of clinically appropriate therapeutic options while driving utilization toward cost effective first-line therapies. This results in a formulary that meets all of the requirements as described in Exhibit BBB (1) of the draft HealthChoices Agreement, and serves as the cornerstone for maintaining pharmacy cost trends. Maximizing the use of generic

medications, which often cost up to 90% less than their brand-name counterparts, is a key factor to our success in "bending" the pharmacy cost trend. Over the past four years our generic dispensing rate has increased 10% to our current average of 80%. To encourage continued growth of generic medications in the future, AmeriHealth Mercy has maintained its zero copay for generic initiative which waives the copay for all generic medications.

In addition, we monitor for upcoming patent expirations to ensure our formulary design will serve us well in the future. For example, the brand-named medication Plavix is anticipated to become generically available in mid-2012. While in the current market, Plavix and its competitors are similar in both price and efficacy, we have maintained Plavix as our sole formulary option so we can achieve the maximum cost savings when the generic product is introduced.

In 2011, we implemented a 90-day program for select generic medications where the dispense fee paid to the pharmacy for months two and three exceed the cost of the medication provided. By providing all of the medication for a single dispensing fee we are able to save these two dispensing fees. This program is especially advantageous for our members with limited means of transportation because it allows them to make fewer trips to the pharmacy for their medication. Since the program began in September 2011, nearly 14,000 claims have been filled for a 90-day supply with an anticipated savings of approximately $57,000 in pharmacy dispensing fees.

Targeted Interventions

Our targeted physician and pharmacist interventions promote medically appropriate and cost effective use of prescription drugs for specific members.

When targeted interventions are required to quickly transition a large number of members to a different medication, we generate and distribute pre-populated prescription templates to the prescribing physicians. These pre-populated prescription templates contain the member and provider information as well as information on the member's current therapy and our recommended cost-effective alternative therapy. By reducing the administrative burden of transitioning members, prescribers are more apt to accept our recommendation resulting in improved cost trends.

Since our members are ultimately taking the medications prescribed for them, providing education to ensure them of the safety and clinical equivalence of a different medication product is an important part of improving member utilization rates.

Competitive Pharmacy Reimbursement

In addition to the rigorous formulary management methods discussed previously, AmeriHealth Mercy also pursues opportunities to achieve unit cost price reductions through pharmacy contract negotiations. We routinely assess our reimbursement for brand name medications against national and regional reimbursement levels to ensure our contracted rates are aggressive, yet equitable. For generic medications, we use a Maximum Allowable Cost (MAC) program which covers approximately 95% of our generic prescription drug claims, and 90% of our generic drug expenditures. Our MAC list is maintained on a monthly basis to accommodate the frequent price fluctuations of generic products.

Specialty Pharmacy Program and Rebate Management Program

AmeriHealth Mercy's in-house specialty pharmacy program fosters appropriate use of self-administered injectables and physician-administered specialty drug products, while controlling the cost of these very high-cost medications. Our program has achieved significant per-member-per-month cost reductions over the past few years, despite rising drug prices and, in some cases, increasing utilization. More information about AmeriHealth Mercy's specialty pharmacy program is provided in our response to Question 5.

Our national pharmacy benefit management program enables us to negotiate our rebate agreements based on approximately 3.2 million members nationwide. We currently have rebate agreements with 55 drug manufacturers covering 630 NDC level products. These rebate-eligible products accounted 62% of all brand prescriptions, filled for AmeriHealth Mercy members.

Dose Optimization

AmeriHealth Mercy's Dose Optimization programs have been successful from both a quality perspective, and a financial perspective. Through point of sale edits and prescriber education, AmeriHealth Mercy has been successful in converting members from multiple daily dosing drug regimens to single daily dosing. For example, some physicians may prescribe Pulmicort 0.25mg Respules twice a day when clinical literature supports the use of Pulmicort 0.5mg once a day with similar outcomes. By consolidating this regimen, medication adherence and satisfaction is increased because therapy can now be completed once a day. In addition, the daily cost of this medication regimen is decreased because only 30 vials are required instead of 60 vials.

QUESTION 2

Describe your policies, procedures or processes for conducting both retrospective and prospective drug utilization review within the MA Program's Drug Utilization Review guidelines. Provide evidence of success. Describe your strategy moving forward to improve performance in this area.

(Limit to four pages)

RESPONSE TO QUESTION 2

AmeriHealth Mercy's pharmacy drug utilization review (DUR) program is designed to monitor medication prescribing and dispensing activities both proactively and retrospectively with the goals of identifying and correcting potentially harmful prescribing patterns, enhancing community-prescribing standards, and detecting patterns of fraud and abuse. Our program and our policies and procedures comply with federal and state statutes and regulations, DPW guidelines, URAC standards, and NCQA guidelines.

Prospective Drug Utilization Review

AmeriHealth Mercy conducts prospective DUR online through a central repository for capturing, storing and updating prospective DUR data. The DUR occurs in real-time at the point-of-sale through the Argus claims adjudication system. Onscreen messages immediately notify pharmacies of potential concurrent or prospective DUR issues for their review and consideration. By generating alerts to the fulfilling pharmacies during the claims adjudication process we are able to minimize the risk of adverse outcomes as a result of improper medication utilization. The system achieves this objective by:

- Reviewing prescription drug claims for therapeutic appropriateness prior to medication dispensing
- Using criteria that include the member's medical history and clinical parameters
- Focusing on those members with conditions that place them at the highest level of risk for potentially harmful outcomes

When a pharmacy submits an online claim for adjudication, the information from the prescription request is automatically compared to the member's drug and medical history in addition to the therapeutic criteria file catalogues containing approximately 228 American Hospital Formulary Service (AHFS) primary classes of drugs and other clinical algorithms. The criteria address disease categories that may predispose patients to inappropriate and potentially harmful drug use situations. When drug therapy problems are identified, the pharmacist receives an on-line alert, and takes additional steps to evaluate the order. Steps may include contacting the prescriber, or discussing the issue with the member. The file also incorporates the following drug therapy problem types:

- Therapeutic duplications
- Therapeutic overlap
- Drug to drug interactions (such as allergy and cross-sensitivity reactions)
- Drug age contraindications
- Early refill (over-utilization)
- Late refill (under-utilization)
- Excessive drug dosage (age-specific)
- Insufficient drug dosage (age-specific)
- Drug pregnancy contraindications
- Excessive quantity dispensed
- Generic product availability

Each problem type is rated using the following severity indicators:

- Cause serious harm to relatively few people (high risk and low incidence)
- Cause relatively minor harm to a large number of people (low risk and high incidence)
- Significantly increase the cost of health care by increasing hospitalizations or the use of other treatment modalities

Pharmacist counseling to our membership regarding appropriate medication use, as well as any of the prospective DUR elements listed above, is part of our contractual agreement with our pharmacy network. Through our pharmacy network, we are able to educate members about the potential risks associated with using two different medications within the same therapeutic class, which is categorized as a therapeutic duplication DUR edit. To resolve a possible therapeutic duplication DUR edit, the pharmacist can collaborate with the prescriber and the member to determine if the member should transition from one agent to another, or take a short-acting medication in the daytime and a long-acting medication in the evening.

Other edits, such as late refill or generic product availability, provide additional opportunities for the pharmacist to educate the member regarding the importance of complying with their prescribed medication regimen or the clinical equivalence of generic medications to their brand-name equivalents.

Similarly, our pharmacy network can use the prospective DUR edits to identify potential cases of fraud and abuse. As an example, a member may be alternating pharmacies in an attempt to obtain duplicate prescriptions for controlled substances. Through our prospective DUR edits, the second pharmacy would be alerted that the member had recently filled a similar controlled substance at different pharmacy, providing the second pharmacist the ability to investigate and determine if the prescription is appropriate to dispense.

Pharmacy claims are subject to post-payment audit and recoupment in the following situations:

- When a claim that has been approved for payment includes DUR messages and written documentation that pertains to the message is not returned with the claim
- When a message is returned saying that the approved claim has a dosage exceeding standards developed by a national database company, and there is no documentation of a discussion between the pharmacist and the prescriber verifying the high dose
- When a duplicate therapy message is returned on an approved claim, and there is no documentation demonstrating that the prescriber spoke with the dispensing pharmacist and approved the concurrent administration of both drugs involved

Retrospective Drug Utilization Review

AmeriHealth Mercy's Retrospective DUR program includes review of member's pharmacy claims data to determine the presence and/or frequency of the following:

- Drug-drug interactions
- Poly-pharmacy
- Over dosing and under dosing
- Aggravation of disease states
- Excessive duration of therapy
- Potential therapeutic failures
- Duplicate therapy
- Fraud and abuse

- Failure to substitute generic drugs
- Over-utilization and under-utilization
- Compliance

Our pharmacy claims processing system electronically captures and stores member prescription data in member profiles, in the NCPDP format. AmeriHealth Mercy has immediate access to the member profiles for a period of 13 months. The data is stored in archives after 13 months and may be retrieved if necessary. AmeriHealth Mercy clinical pharmacists continually review claims history in the member profiles to evaluate drug utilization and prepare retrospective review reports. These reports provide screening and trending of prescription claims data, using therapeutic criteria standards, to identify patterns of inappropriate drug utilization and to evaluate the total cost of care.

The clinical pharmacist analyzes practitioner-prescribing patterns, network pharmacist dispensing patterns, and member utilization to detect episodes of drug-related problems, target therapeutic categories for intervention, and identify inappropriate and/or unnecessary usage patterns.

AmeriHealth Mercy shares the retrospective review reports with our Pharmacy and Therapeutics Committee for review and development of quality improvement programs, such as outcomes research activities, provider education and member education programs. Recent interventions have included targeted provider mailings on patient medication compliance for members with HIV, diabetes, or asthma.

Pharmacy Audits

AmeriHealth Mercy uses a Pennsylvania contractor, ACS, Audit & Compliance Solutions, to conduct audits of participating pharmacies. The objective of our Pharmacy Auditing Program is to educate pharmacy personnel in the proper use of procedures for transmitting claims. AmeriHealth Mercy provides pharmacy paid claims data to ACS monthly. ACS runs the paid claims through its audit criteria to identify unusual or questionable patterns. The results of this analysis are used to identify pharmacies for on-site audits.

Each year, approximately eight percent of AmeriHealth Mercy's participating pharmacies are audited through a combination of desktop audits and on-site audits. Audits are scheduled by either a routine audit of network pharmacies, upon DPW's request, or due to poor compliance to a previous audit. We report the number of audits performed on network pharmacies on a monthly basis and summarize the findings on a quarterly basis after pharmacies have been allowed a period to provide any required documentation.

Evidence of Success

AmeriHealth Mercy has been able to produce sustainable prescribing pattern changes resulting in approximately $100,000 in annual savings through our Therapeutic Interchange program. By evaluating members receiving a brand-name medication and encouraging prescribers to switch these members to its generic equivalent, we were able to transition over seven percent of these members to our preferred product. It is important to note that this transition occurred without implementing any official formulary changes. Instead, we educated our providers regarding the similarities of the two agents and the dramatic cost difference between them.

We have also had success in asthma management through retrospective DUR activities. Through the combination of an educational member mailing, encouraging members to speak with their

physician about whether a controller medication was right for them, and a targeted provider mailing, using pre-populated prescription templates, we were able to increase prescription fill rates of controller medications in this population by 43 percent. Accurate identification of the appropriate member population, reduction of provider administrative burden, and targeted mailings to both providers and members allowed us to achieve this high success rate in a single intervention.

Looking Ahead

AmeriHealth Mercy has many plans for moving forward and improving its existing successful programs. We routinely examine new and existing drug therapies to ensure our drug utilization techniques follow best practices. Our clinical pharmacists, with expertise in clinical drug review, pharmacoeconomics, and outcomes research, review all pertinent evidence-based medical literature related to the particular pharmaceuticals in question. We will continue to monitor member drug utilization, standard of care guidelines, and biopharmaceutical sources to identify opportunities to improve the quality of care and achieve cost savings.

QUESTION 3

Describe your pharmacy prior authorization process, including the following:

- *How are prior authorization criteria developed?*
- *How are requests for prior authorization made?*
- *How do providers (pharmacies and prescribers) and consumers learn about the authorization process and criteria?*

(Limit to four pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy's strategic use of pharmacy prior authorization policies and criteria enables us to ensure that our members receive the care they need, while being good stewards of the limited resources available to the Medical Assistance Program. We use prior authorization processes to ensure that prescribing patterns are supported in the medical literature, that members receive the appropriate medication for their diagnosis, and to promote cost-effective first-line therapies through step therapy protocols. Currently our pharmacy benefit manager has 390 prior authorization and 170 step therapy protocols for oral medications.

Developing Prior Authorization Criteria

AmeriHealth Mercy uses various clinical and biopharmaceutical sources to make recommendations to our Pharmacy and Therapeutics (P&T) Committee regarding prior authorization criteria and treatment algorithms. Upon completion of an exhaustive literature review, drug formulary monographs and medication class summaries including comparative cost data are prepared as appropriate for presentation to the P&T Committee.

AmeriHealth Mercy's P&T committee is comprised of both internal and external pharmacists and physicians with expertise in a variety of disciplines. As required by the P&T Committee our committee consists of, at minimum, one practicing physician and one practicing pharmacist who are experts regarding care of elderly or disabled individuals, one practicing physician specializing in internal medicine, one practicing physician specializing in pediatrics, and one practicing physician specializing in psychiatry. Additional members may be added to the committee to provide expertise in other specialties. After receiving the approval of our P&T Committee, we submit our policies and criteria to DPW for approval. New policies and criteria are implemented only after receiving DPW approval, and providing the required advance notice to members and providers.

Making a Request for Prior Authorization

AmeriHealth Mercy's Pharmacy Department accepts requests for prior authorization from prescribing providers by the web, phone, fax or U.S. Mail. While our Pharmacy Department is staffed 24 hours a day, 365 days a year for questions, prior authorization determinations are only made during business hours.

To ensure our members have adequate access to medication during the submission and review time of prior authorization requests, we use these following temporary supply procedures. In the event that a pharmacy claim rejects at the point-of-sale because a prior authorization is required, and an approval cannot be obtained immediately by calling AmeriHealth Mercy's Pharmacy Department, the pharmacy is directed to dispense a 5-day temporary supply of the medication if the prescription is for a new medication, or a 15-day temporary supply if the prescription is for an ongoing, chronic medication. To facilitate compliance with this requirement, AmeriHealth Mercy has automated the process for participating pharmacies to dispense temporary supplies and receive payment from AmeriHealth Mercy through the online pharmacy claims adjudication system with on-screen messaging for our pharmacy network.

The information that must be supplied by the prescribing provider to obtain prior authorization approval varies based on the drug that is being requested, and whether any other point-of-sale edits were triggered in the process. Most oral medications may be submitted on our "Universal Pharmacy Oral Prior Authorization Form." In addition to the name, strength, and dosing of the

requested medication, the requestor must submit a history of formulary alternatives that the member has tried and failed leading up to the request for the current medication. Specific prior authorization forms have been developed for our most commonly requested injectable and specialty items that require detailed information, such as liver function test values, blood counts, patient's weight, and kidney function test values.

Determinations are made for all prior authorization requests within 24 hours of receipt, excluding weekends and holidays. When the prior authorization request meets medical necessity criteria for approval, authorization is issued for a period of up to 12 months, or for the length of the physician's request, whichever is shorter. We then generate a fax notification to the requesting practitioner and the member's PCP as well as a letter that is mailed to the member informing them of the approval.

If the request does not meet criteria for approval by the reviewing pharmacist, it is forwarded to an AmeriHealth Mercy Medical Director for review. In evaluating the request, the Medical Director relies on information supplied by the prescriber, guidelines published in the Physicians' Desk Reference, accepted clinical practice guidelines, federal and state laws, and DPW requirements. In the event of insufficient information provided by the prescriber, an AmeriHealth Mercy Pharmacist attempts to contact the prescriber to obtain the necessary clinical information for review.

If the Medical Director determines that medical necessity criteria have not been met, a denial is issued within 24 hours of receiving the request, using the denial notice template in Exhibit BBB(3) of the draft HealthChoices Agreement. When requests for a minor (under 21 years old) cannot be approved, an AmeriHealth Mercy clinical pharmacist attempts to contact the prescriber by phone to discuss the case and obtain additional information that may aid the request in meeting medical necessity criteria for an approval. If we are unable to issue a written denial notice within the 24-hour period, we continue to authorize a temporary supply of the requested medication until the member is notified of our decision. The prescribing physician may contact us to request a reconsideration or a peer-to-peer discussion regarding our decision with either an AmeriHealth Mercy Clinical Pharmacist or Medical Director during regular business hours. Prescribers and members may also obtain prior authorization criteria related to a specific denial determination by submitting a written request for the criteria.

In 2012, we will launch the E-Telligent PA system which will provide sophisticated, real-time prior authorization information to our providers. Through this system, providers will not only be able to submit prior authorization requests online but will have the opportunity, for selected medications, to enter clinical information that may yield an automatic approval with an instant authorization entry into Argus for claims payment purposes. For more complex cases, where responses cannot be evaluated automatically, the provider will have the opportunity to attach additional supporting documentation and then submit the request to our clinical pharmacy team for review. Future enhancements will also allow the system to suggest formulary alternatives for the medication the provider is requesting that may alleviate the need to complete the prior authorization entirely.

Member and Provider Education about Prior Authorization Procedures and Criteria

AmeriHealth Mercy educates members and our participating providers and pharmacies about our prior authorization procedures and criteria via the methods described below.

Member Handbook and Provider Manuals

Our Member Handbook and Provider Manuals are mailed to all new members and new providers and are also available on our website. The handbook and manual provide comprehensive information about member pharmacy benefits and currently covers pharmacy topics such as:

- FDA approved medications
- Formulary medications
- No copayment policy for generic medications
- Non-formulary medications that require prior authorization
- Temporary supply procedures
- Examples of covered over-the-counter medications and covered vitamins
- How to request a written copy of the formulary
- How to obtain reimbursement for out-of-pocket payments

Member Websites and Provider Portal

The health education section of our Member Website and the Pharmacy section of the Provider Portal highlight important pharmacy benefit information. Members can view their co-pay schedule and benefits grid, a searchable formulary, and review the Member Handbook. Providers can access a searchable formulary, information on generic medications that require a 90-day supply, and download prior authorization and specialty injectable request forms.

Online Searchable Formulary

Our recently enhanced searchable formulary tool allows members and providers to complete an online formulary search of a particular drug or drug class, prior authorization criteria, and other formulary requirements.

Member Newsletter

All members receive our Member Newsletter by mail at least three times a year. The newsletter is sent as a single document printed in English and Spanish and can be translated into other languages of choice. Formulary updates are provided, as necessary, to inform members when medications are being added or removed from the formulary. The newsletter also contains pharmacy information about benefit changes and other important topics. Past topics have included the safety and efficacy of herbal supplements, how to use an asthma inhaler, and smoking cessation products.

Member Mailings

When new programs only affects a targeted subset of the membership, such as our Dose Optimization Program and our new 90-day generic program, a direct member mailing is sent to the affected members. This is the most efficient way to communicate with members whose regimen may need to be modified as a result of the new program. Members are also educated by their provider and/or pharmacist who receive separate detailed communications on the program.

Provider ScriptNotes Newsletter

Physicians and pharmacies receive a quarterly ScriptNotes newsletter that provides updates on new and deleted prior authorization protocols, formulary additions and deletions, changes from preferred to non-preferred status, therapy guidelines, contraindications, new indications, new products, and safety alerts.

Provider Fax Blasts and Targeted Mailings

Specific formulary materials such as prior authorization criteria, step therapy protocols, and formulary updates are sometimes sent to the entire provider network via a fax blast, or to an individual provider via a targeted mailing or by fax, upon request.

Pharmacy Call Center

Our pharmacy call center currently answers approximately 35,750 calls per month from members and providers about the pharmacy benefit. Our staff is able to answer a multitude of member questions, including questions about covered medications, copays, and the status of prior authorization requests.

QUESTION 4

In regard to pharmacy point of sale, explain:

- *Who adjudicates your pharmacy claims?*
- *How do you ensure adequate oversight and monitoring of the pharmacy claims processor, including fraud and abuse and encounter data?*
- *Are all outpatient medications processed through pharmacy claims? If not, what other method of claims processing is used (e.g., professional claim with HCPCs codes)?*

(Limit to three pages)

RESPONSE TO QUESTION 4

Claims Adjudication

AmeriHealth Mercy contracts with Argus Health Systems to process and adjudicate pharmacy claims. Founded in 1983, Argus is a leading independent prescription claims processor for pharmacy benefit administration. One of the largest providers of independent data processing and related services for the pharmacy benefit administration industry, Argus processed 510 million claims for 26 million recipients throughout the country in 2010. Argus serves a wide variety of customers, including large insurance carriers, managed care organizations, and chain drug stores.

Argus provides a direct point-of-sale interface at AmeriHealth Mercy's participating pharmacies for real-time claims processing and adjudication. This claims processing system facilitates and supports concurrent drug utilization review (DUR) functions that allow for the review and monitoring of the cost-effectiveness, interaction and resulting therapeutic implications of various drugs. By incorporating AmeriHealth Mercy's formulary guidelines and parameters into the Argus system, AmeriHealth Mercy is better able to effectively administer the formulary, and to ensure appropriate pharmaceutical products and services are being provided to our members.

Oversight and Monitoring of the Pharmacy Claims Processing Vendor

AmeriHealth Mercy's oversight and monitoring of Argus begins with the agreement between the parties. Our agreement with Argus describes the scope of services to be performed, performance expectations, reporting responsibilities, and consequences for failure to meet the contract requirements, which include corrective action and/or sanctions, up to and including contract termination. AmeriHealth Mercy conducts an annual review of Argus' policies and procedures and documentation of quality activities, as well as an annual review of Argus' compliance with contractual requirements and policies and procedures. Argus also provides routine monitoring and oversight reports. Weekly and ad hoc meetings are conducted to review and monitor the current state of claims processing and address requested changes or updates to the system.

Encounter Data Oversight

Argus submits monthly encounter files in the NCPDP format by the fifth business day of each month for claims adjudicated in the prior month. Like all subcontractor encounter files, the Argus encounter files must pass the internal pre-edit process prior to our submission of the files to the Department of Public Welfare/EDS. Our pre-edit process validates that header control totals match claim detail counts in the file, and that the file was not previously sent to DPW. In addition, pre-edits validate that all required segments are preset, as well as the Submitter ID, NPI number, and other critical data elements. Any files that fail the validation process are returned to Argus for correction and resubmission within four business days.

Following submission of the encounter files, we forward the NCPDP response file returned by EDS to Argus. Argus documents all encounter rejections and reports this information by error code, rejection counts, and dollar value. AmeriHealth Mercy then works with Argus to discuss a plan of action to correct and resubmit the rejected encounters to DPW.

AmeriHealth Mercy's agreement with Argus includes performance metrics for the timely, accurate and complete submission of encounter data. The agreement also provides for the

submission of corrective action plans, and/or the application of sanctions, up to and including contract termination, if we identify problems with the quality of their encounter submissions. AmeriHealth Mercy has not imposed sanctions on Argus related to encounter data submission at any time during our eight-year contractual relationship. Each month, AmeriHealth Mercy tracks the total claims sent to DPW/EDS, and the total accepted and total rejected, to calculate an acceptance ratio. We monitor this information to verify that the volume of submissions is consistent from month to month, and the acceptance rate does not fall below standards. For 2010, the Argus monthly average acceptance rate was 99%.

We currently have a process to retain and submit PROMISe ICNs for previously submitted encounters that require correction or resubmission. We have been providing reports for PROMISe ICNs pharmacy encounters since 2009.

Fraud and Abuse Oversight

As indicated above, AmeriHealth Mercy conducts an annual review of Argus' policies and procedures and documentation of quality activities, as well as an annual review of Argus' compliance with contractual requirements and policies and procedures. Argus also provides a set of standard monitoring reports that, together with our annual reviews, would help to alert us of possible fraud or abuse.

Additionally, AmeriHealth Mercy has direct 24/7 web-based connectivity to the Argus claims processing system. This allows us to monitor Argus' work remotely and interface with their real-time claim adjudication system. This interface also provides AmeriHealth Mercy with access to the near real-time data in the Argus data warehouse, from which we can perform our own ad hoc claim reviews, run queries and export data to other applications, and generates reports. AmeriHealth Mercy also has the ability to make real-time adjustments or changes in the Argus claims processing system to assist pharmacies in processing point-of-sale transactions.

In addition to our oversight of Argus' performance, AmeriHealth Mercy carefully monitors member prescription patterns, prescribing patterns of physicians, and dispensing practices of network pharmacies, to identify potential circumstances of fraud, waste, or abuse. All potential issues are shared with our Special Investigations Unit for investigation and appropriate follow-up action. Our Fraud, Waste, and Abuse Identification and Prevention program is comprised of the following programs: Drug Utilization Review, Pharmacy Network Auditing, and Recipient Restriction.

- **Retrospective DUR -** Retrospective drug utilization review program provides systematic review of drug utilization and prescribing patterns to ensure member prescriptions are appropriate, medically necessary, and unlikely to result in adverse medical effects.
- **Pharmacy Network Auditing Program** - Our pharmacy claims auditing program is designed to protect against fraud, misuse and abuse at the pharmacy level. Aside from the educating of pharmacy personnel on the proper use and implementation of correct procedures for claims submission, the goal of the process is the identification and verification of aberrant claims and patterns leading to the recovery of funds and the prevention of future Fraud, Waste and Abuse. Pharmacies are selected for auditing by a combination of paid claims data analysis, exchanged or gathered tip information, and our on-site pharmacy audit programs
- **Recipient Restriction Program** - Under this program, identified members must obtain prescriptions from a specific physician or pharmacy to ensure proper prescription

compliance. We offer real-time capability to change a member's physician and/or pharmacy if necessary.

Outpatient Pharmacy Claims Processed Through the Medical Benefit

A small number of outpatient pharmacy claims are billed and adjudicated under the medical benefit using HCPC codes. The types of outpatient pharmacy claims processed through the medical benefit include: oncology infusions, including blood cell stimulator agents, hemophilia treatments, and intravenous agents administered in conjunction with home nursing care such as antibiotics.

Currently, medications billed in this manner by participating providers do not require authorization for payment. However, many of these medications are submitted in conjunction with other medical services, such as home nursing care, that do require authorization. In these instances, our utilization management department reviews the request for the medical service and an approval of the medical service is considered to be a proxy approval of the medication.

QUESTION 5

Describe your specialty pharmacy program. Describe your future plans, including plans to purchase and effectively manage specialty drugs.

(Limit to three pages)

RESPONSE TO QUESTION 5

AmeriHealth Mercy's in-house specialty pharmacy program is designed to foster appropriate utilization of self-administered injectables and physician-administered specialty drug products, while controlling the cost of these high-cost medications. Our program has achieved significant cost reductions on a per-member-per-month basis over the past few years, despite rising drug prices and, in some cases, increasing utilization. These cost reductions have been achieved by implementing the following:

- Competitive drug acquisition price negotiation
- Oversight of office-based injectable prescribing
- Specialty network management
- Dedicated specialty injectable staff
- Effective utilization management programs
- Inventory management at the patient level
- Detailed policies to scrutinize billing

Our specialty pharmacy unit is comprised of individuals trained in specialty medication utilization management techniques. The unit includes pharmacists, nurse case managers and certified pharmacy technicians.

Unlike many specialty pharmacy programs, we do not generate profit or revenue, other than rebates, from the distribution or sale of specialty/biotechnology drugs. Because we manage our specialty pharmacy program in-house, all savings generated from our program result from appropriate utilization, competitive drug acquisition price negotiation, and inventory management.

Our focus is on assertive price negotiation, careful oversight of office-based injectable prescribing, effective network management, and staff dedicated to specialty injectables and effective policies put in place to scrutinize billing.

Evidence of our success in this area is demonstrated through:

- Comprehensive utilization management and checks for patient safety and compliance, plus cost-effectiveness
- Rigorous clinical review based on approved usage protocols
- Measurable waste reduction through stringent Prior Authorization screening
- Expert specialty network management
- Highly capable electronic claims adjudication

In addition, AmeriHealth Mercy has implemented carve-out programs to review high-cost specialty medication use in the hospital and/or physician office setting. One such program monitors the off-label use of the hemophilia agent, NovoSeven. This product is often used off-label for many conditions where there is little or no clinical data to support such use, generating considerable, inappropriate expenditures. Through this program, each claim is reviewed by a medical professional based on criteria that was developed by reviewing the medical literature and practice guidelines, virtually eliminating inappropriate utilization patterns.

The following is an outline of our major action steps that have aided in the creation of a successful specialty pharmacy program and will continue to provide value into the future:

- Re-crafted reimbursement process
  - Mandated claims submission through the pharmacy benefit
  - Required use of J-codes
- Formulated a cost-effective supply chain distribution system
  - Negotiated discounts/rebates
  - Channeled distribution through lowest cost specialty vendor
  - Pre-determined reimbursement or injectable drug replacement program options for physicians
- Implemented rigorous point-of-service 'hard' edits and prior authorization criteria across several products
  - Reduced inappropriate length of therapy and utilization
  - Developed hundreds of evidenced-based and clinically appropriate specialty injectable prior authorization protocols
  - Incorporated evidenced-based clinical studies and guidelines
- Staffing Upgrades and Training
  - Upgraded the specialty pharmacy team which is now comprised of pharmacists, technicians, nurse, and support staff experienced with biopharmaceuticals and injectable products in key therapeutic areas
  - Integrated Pharmacy/Nurse case management oversight
  - Continued education ranging from new biopharmaceuticals to system applications

AmeriHealth Mercy's approach emphasizes the involvement of care management departments, disease management teams, and providers (medical and pharmacy) to engage members in care management. This approach has enabled us to overcome barriers to care such as medication adherence issues, difficulty in locating members, inappropriate use of the emergency room, and cultural differences.

Future Plans - Pay for Performance

We implemented pay for performance programs specifically for specialty management in the Southeast Zone that may be applicable in the new zones. This innovative program incorporates medical and pharmacy resources to provide a seamless management strategy that promotes clinically appropriate and cost effective treatment. Participating providers are encouraged to follow agreed upon treatment pathways that are designed using best practice guidelines. These providers would then be eligible to earn incentives for achieving adherence to the pathways. This program has the potential to generate cost savings while ensuring that members are treated safely and effectively.

QUESTION 6

Describe how your pharmacy claim information is coordinated with medical claim data to provide comprehensive care management.

(Limit to two pages)

RESPONSE TO QUESTION 6

Our integrated care management strategy is data driven and relies on all available data streams including medical, pharmacy, vision, dental, and lab to ensure the best possible member outcomes. This integration is for our care managers and prior authorization staff to access on a case-by-case basis as well as in our backend data reporting systems where we monitor cost and utilization trends as well as generate quality and cost containment initiatives.

Desktop Applications

One of the best examples of this interaction is the AmeriHealth Mercy Desktop Pharmacy Application. This comprehensive resource was built internally to support our care coordination efforts and is refreshed on a weekly basis to ensure access to the latest claims information. Associates are able to use this application to generate a six month medication profiles including the medication possession ratio compliance calculation for either internal use or distribution to a provider. In addition there are direct links to formulary information, prior authorization criteria, third-party patient assistance programs, drug information resources, searchable tables of DME products billable via Argus for hard to find items, and finally pharmacy gaps in care.

Currently, our application identifies eleven pharmacy care gaps that can be accessed in a variety of ways for individual case management or population management through provider and member notifications. Below are some brief details of each of the care gaps. In order to provide broad notification of these pharmacy care gaps to our providers and members, four of the eleven pharmacy care gaps have been integrated with our medical care gaps for provider and Member Services. In 2010, we loaded the ACEI or ARB for diabetics, lipid lowering therapy for members with high cholesterol and the asthma monotherapy measure. In 2011, the test strip measures as well as the acute coronary syndrome measures discussed below were added.

Outreach

In 2009, AmeriHealth Mercy began a member and provider outreach to increase the percentage of our members with recent acute coronary syndrome (ACS) events (heart attack or severe, heart related chest pain) receiving the five medication categories recommended by the ACC/AHA guidelines for secondary prevention. Since the greatest risk for a second event is shortly after the primary event, we identify these members through data captured by our concurrent review nurses rather than waiting for paid claims data. Medication fills for these members are then evaluated for usage of the five recommended medication categories. Members who are missing one or more of these categories receive a letter educating them about the importance of receiving all components of this regimen to decrease the risk of another event and encouraging them to speak with their provider. Simultaneously, the member's provider receives a letter informing them that the member is missing one of the guideline recommended medications as well as a pre-populated prescription template displaying both the most recent fill dates of medications the member is receiving and our covered formulary options for those the member is not.

As a result of this program we have seen the number of members diagnosed with an ACS event receiving none of the recommended therapies decrease from 24% to 11% while the number of members receiving all five medications has increased from zero to 14%.

We have also successfully combined our medical and pharmacy data for our automated telephonic refill reminder program. This program identifies members receiving medications to treat asthma or behavioral health conditions who have a proven history of filling their

medications late. To further identify the members at highest risk of experiencing and adverse outcome due to their non-compliance we then evaluate this list of members for those who have had three or more emergency room visits in the past twelve months. This list of high risk members is then enrolled into a proactive automated telephone outreach program which contacts the member when their prescription is due to be refilled and provides the option to warm transfer them to their pharmacy to place a refill request.

Finally, we are launching a pilot with NaviNet Mobile Connect to display both medical and pharmacy gaps in care directly to the clinician on a hand-held PDA during their office visit with a patient. The NaviNet Mobile Connect gives providers e-prescribing software as well as PDAs to aid them in creating operational efficiencies in their office while being able to access pertinent patient and medical information available through NaviNet. By moving care gap information from the front office staff into the hands of the clinician, we can more effectively convey our care gap information at the most appropriate time during the clinical decision making process.

Looking Ahead

Looking to the future, technology will enable us to make our integrated data "powerful" enough to reduce administrative burden and improve member care. For example, as we make further strides in acquiring and integrating lab data we may be able to streamline the prior authorization process by auto approving requests where a lab value is the main determining criteria (e.g. Hepatitis C viral loads) and is already known in our claims database. In addition, as we explore the development of quality-based pharmacy, provider and facility contracting, where reimbursement is variable based upon the quality of the care provided, pharmacy metrics such as formulary compliance, generic utilization rate, and medication adherence may be key elements in the scoring and ranking system.

QUESTION 7

Describe how you will use the CMS Drug File to ensure access to all drugs covered under the MA Program and compliance with data reporting requirements for the Federal Drug Rebate Program.

(Limit to four pages)

RESPONSE TO QUESTION 7

As a current managed care organization, AmeriHealth Mercy is already in compliance with the Department's requirements regarding the CMS Drug File and the Federal Drug Rebate Program data reporting. On a quarterly basis, we obtain and process the CMS Drug File. In 2011, we began submitting monthly supplemental rebate files to DPW with an encounter acceptance rate that exceeded, and continues to surpass, 96%. Our rebate and encounter data submission team remains committed to meeting all requirements for reporting of Federal Rebate Program data as required by DPW and CMS now and in the future.

CMS Drug File

In order to ensure access to all drugs covered under the MA Program, and compliance with data reporting requirements for the Federal Drug Rebate Program, AmeriHealth Mercy downloads the CMS Drug File quarterly and supplemental rebate reporting file as soon as it is made available. In addition, we receive regular systems notices from DPW regarding updates to the Participating Drug Company List for the Medicaid Drug Rebate Program and MCO Pharmacy Encounter Data NDC Updates. As detailed below, we created a two-stage internal process to expeditiously review and address these changes.

Stage One

AmeriHealth Mercy identifies any medications that are no longer covered by the MA program. Claims history of these medications is analyzed to determine the impact to our existing membership. When the analysis has been completed, a recommendation is made to our clinical team and chief medical officer for their review. Upon acceptance of the recommendation, the proposed formulary changes are prepared and presented at the next Pharmacy and Therapeutics (P&T) Committee for approval. As per our policies and procedures, as well as DPW requirements, affected members are informed via mail of the impending formulary change and provided a 60-day grandfather period before their medication therapy is discontinued. Affected members are encouraged to speak to their provider about alternative medication therapies to use.

Often, a medication is removed from the drug file because the manufacturer no longer participates in the Federal Drug Rebate Program. In this instance, a different manufacturer's medication product of the same ingredient and strength generally remains available on the drug file, allowing members to make a nearly seamless transition.

Stage Two

AmeriHealth Mercy identifies any medications that have been added to the MA Program. These products are immediately available to our members via the prior authorization process. The new medications are reviewed by our clinical pharmacy team and their recommendations to exclude or include the medications from the formulary are presented to our P&T Committee for approval. Once reviewed by the P&T Committee, medications recommended for inclusion on the formulary are made available to members with no prior authorization. Medications that were not recommended for formulary inclusion will continue to be available through the prior authorization process.

Federal Drug Rebate File

AmeriHealth Mercy's pharmacy benefit manager provides rebate contracting services to commercial, Medicaid, and Medicare clients. They are experienced in supporting a wide range of

rebate data, reporting standards and regulations to ensure timely and accurate compliance to all federal and state requirements.

AmeriHealth Mercy's current supplemental rebate encounter files meet all requirements for NCPDP 5.1 standards, including the updates released in the fourth quarter of 2010. We are confident that our staff is able to generate file formats and create production and delivery schedules that will meet all future federal and state rebate reporting requirements. We continually strive to increase automation and generate operational efficiencies, and are working towards streamlining these processes in the future.

PLANNED APPROACH

CONTENTS

QUESTION 1

Describe in detail how you will develop your network and set up operations capable of supporting membership and meeting requirements of the RFP and draft Agreement, no later than three months prior to the anticipated implementation date of 9/1/12 in the NW Zone and/or no later than three months prior to the anticipated implementation date of 3/1/13 in the NE Zone.

Describe your approach for meeting the requirements and include:

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

(Limit to five pages)

RESPONSE TO QUESTION 1

As a longtime Pennsylvania HealthChoices Managed Care Organization, AmeriHealth Mercy Health Plan (AmeriHealth Mercy) has a proven track record for developing provider networks and implementing operations that provide quality service to Pennsylvania Medicaid consumers. We serve as a partner to the provider community and an advocate for our members, and will expand these roles to meet the unique needs of the New West and New East Zones. Using our established provider networks and health plan operations as the foundation for the new zones, we will build on that base to support the membership and meet state requirements prior to June 1, 2012, for the New West Zone, and prior to December 1, 2012, for the New East Zone. This will allow us to quickly expand our existing reach and execute the unique needs of the new zones.

Our project management methodology has proven successful in previous network development and business activation projects and will be described in detail after our network and operations overview. This methodology has most recently been utilized in an expansion opportunity in Louisiana, in which AmeriHealth Mercy successfully completed a readiness review and met 100% of the 906 operational requirements of that state's regulatory agency. In addition, the network development team for that state has built a solid network of over 6700 rural and urban provider locations in only six months.

Network Development Plan

AmeriHealth Mercy's approach to network development is inclusive rather than exclusive. We strive to contract with all available hospitals and physicians who meet our credentialing standards. As part of our mission to build healthy communities, we contract with community-based providers, with particular attention to those who are culturally competent and understand the backgrounds and needs of our members. Our network management staff is working throughout Pennsylvania, meeting, educating and recruiting physicians, hospitals, FQHCs, RHCs and ancillary providers. We are aggressively implementing our provider network development plan and will continue to add providers to the network to ensure the best possible access for our future members.

AmeriHealth Mercy's implementation plan for the development of the network in the New West and New East Zones is included in the response to Question 2 of this section. The plan details our approach to the contracting, education, and ongoing management of a robust provider network prepared to meet the needs of Pennsylvania's Medicaid members, providers and communities, as well as what is required for the Readiness Review. Highlights of the Provider Network Development Plan are identified in Table 1, including the individuals responsible for the activities.

Table 1: Provider Network Development Plan

Actions	Party Responsible	Due Date (NW/NE)
Identify Medicaid Providers	Steve Orndorff	Complete
Obtain LOI's and Provider Contracts	Steve Orndorff	Ongoing
Finalize Provider Manual	Denise Kirkham	In progress
Finalize Policies	Benetta Rapier	In progress
Create Provider Directory	Scott Stroman	July 2012/January 2013
Host Provider Workshops	Benetta Rapier	October 2012/April 2013

In anticipation of being awarded an agreement for both the New West and New East Zones, we formed a cross-functional team with employees from our existing AmeriHealth Mercy Health Plan, located in Harrisburg. Our goal is to assure access to care in rural Pennsylvania and identify opportunities to reduce the administrative burden on our providers during both the recruitment phase and ongoing operations. We were able to launch our provider network recruitment with relative ease because of our strong relationships with providers in our existing 15 county service area.

Operation Set-Up

As an existing HealthChoices managed care organization in the Lehigh/Capital Zone, AmeriHealth Mercy currently has a fully-functional operational model that encompasses all back office services, including but not limited to: call centers, claims processing, auditing, and technology infrastructure, as well as all policies, procedures, processes and staff to perform the full set of HealthChoices requirements. Our focus for the New West and New East Zones will be to expand the capacity of existing operations to serve additional membership and meet any and all unique requirements for these zones. Our existing AmeriHealth Mercy management team will partner with our New Business Activation (NBA) team to identify and implement all necessary work for this expansion. The NBA team is a group of subject matter experts from every discipline within the company that works with the business leaders and the enterprise project management office to ensure the flawless execution of each new business opportunity. Using the project management methodology described below, the team will coordinate all activities necessary for successful implementation of these new Pennsylvania contracts.

Project Management Methodology

AmeriHealth Mercy's project management methodology provides a framework for the project deliverables for the New West and New East Zones, ensuring consistency and completeness. It provides a structure for an efficient, effective, and predictable quality outcome. AmeriHealth Mercy's Enterprise Project Management Office's (EPMO's) methodology is based on industry standards of best practices and an established project management methodology made up of eight individual phases, see Figure 1:

Figure 1: Project Management Methodology

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

Our Project Management Methodology is built on the following principles:

- Consistent utilization of industry standards of best practices in project management methodologies
- A dedicated project management team with more than 250 collective years of project management experience
- A stable and predictable implementation staffing model
- Effective and accurate communications focused on building strong relationships with the Department of Public Welfare's (DPW) personnel
- Management of a comprehensive communication plan (see Attachment 1)
- Execution of a detailed implementation work plan
- Rapid identification, quantification, and resolution of project issues
- Development of comprehensive contingency plans to address project risks

The New West and New East Zone project team, with support from the EPMO, has developed a detailed implementation plan governed by leaders representing key functional areas. The project team and local management are led by:

- **Dr. Jay Feldstein**, who has had a distinguished, two-decade career in health plan administration and clinical leadership and is the Regional President responsible for Pennsylvania health plans
- **Marge Angello**, AMHP's current Executive Director, who is based in the Harrisburg area and has over 25 years of clinical and operational experience serving Pennsylvania residents
- **Joanne McFall**, VP and Chief of Staff for the AmeriHealth Mercy Family of Companies, who has 20 years of experience in project execution, technology application, and implementation of AmeriHealth Mercy's strategic plan.

In addition, our project team and the EPMO have begun executing itemized tasks in our comprehensive work plan (see Question 2), which covers all aspects of the implementation, including preparation for the Readiness Review.

Issue Identification, Assessment, Alternatives and Resolution

Throughout the lifecycle of each implementation project, AmeriHealth Mercy utilizes an issue resolution process that dictates how issues are identified, documented, assigned, and resolved during the course of the implementation. This process defines the level of information that must be captured for each issue in each step of the process. Issues are prioritized based on the level of potential impact and magnitude of the issue as it relates to the schedule, a specific state

requirement, or level of functionality. Throughout the life of the project, issues are identified by various members of the implementation team. These issues are identified and captured in an issue log.

As issues are identified, the Project Management Team performs an impact assessment and analysis of each identified issue to determine its downstream effects and severity on the implementation. All issues that impact the project are addressed in a timely manner using the following guidelines:

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

In the event that the resolution of an issue results in a change to the project scope, schedule, and/or budget, a formal change management process is followed. The change request includes documentation of a detailed reason for the change, associated costs, resources needs, internal and/or external impact to the project or other projects, and any new dependencies or assumptions. The request must be accompanied by a realistic contingency plan. The Governance Team performs a preliminary review of the request and, if approved, forwards the request to the appropriate member of senior management for final approval.

Resource Allocation and Deployment

Our EPMO has a well-defined, enterprise-wide, demand management process that enables us to analyze the complete enterprise portfolio of project work including an assessment of our resources and a deployment of those resources across all of our lines of business. This includes projects already in progress as well as new requests to determine the value and impact across the organization.

As business needs and priorities change, the demand management process provides the framework for comparing new requests against the existing body of work based on strategic value, risk assessment, cost/benefit, net gain, and resource impacts to staff and infrastructure.

Each new project requires a documented business justification and resource analysis. The process ensures that there is an adequate supply of subject matter experts from across our business and operations areas, as well as technical experts available when needed during the course of the implementation.

Reporting of Status and Ensuring Accuracy of Information

AmeriHealth Mercy believes that effective communication is the cornerstone to maintaining and growing our strong collaborative relationship with the Commonwealth of Pennsylvania. If awarded additional contracts, we will utilize our existing relationships with DPW and build new implementation-specific relationships to establish a regular communication and reporting plan. Components of this plan will include twice-weekly conference calls with DPW, written status reports, and other reporting mechanisms as established by the team.

In addition to the conference calls and written status reports recommended above, we suggest other reporting mechanisms such as regularly scheduled and ad-hoc reports as well as live,

interactive meetings and site visits. Examples of such reporting mechanisms include, but are not limited to:

- Detailed Implementation Plan Reporting - The work plan will be used to create a comprehensive management report, detailing project scope, status, staffing, and timelines.
- Risk Management & Issue Reporting - This proactive process will be used to identify critical issues needing to be addressed in an escalated or expedited manner. Using a proprietary, custom-made database, AmeriHealth Mercy will be able to provide real-time updates to both internal and State staff.
- Site Visits and Meetings - The Executive Director and Implementation Project Manager will meet with DPW as necessary to facilitate effective communications.
- Ongoing Operational Reporting – Upon timely completion of the New West and New East implementations, we will continue our regular reporting to DPW based on the reporting structure that is in place for our current contracts.

Assuring Accuracy

Our success in completing accurate reports is due largely to the front-end work of our Statutory Reporting unit and the quality assurance mechanisms it has established. Our Statutory Reporting unit works very closely with other internal departments to develop report specifications that identify supporting systems, data requirements, reporting periods, and appropriate coding documentation needed to meet all reporting requirements. Based on the outcome of that research, a technical solution is developed to extract the required information from the most appropriate data source for the particular report. The Statutory Reporting unit audits each report for accuracy and to ensure that the report is in the exact format specified.

Prior to submission, all reports are subject to review and approval by Statutory Reporting/Finance management and the appropriate internal business owner(s). Once the report generation process is stabilized and verified, detailed report documentation is created and subsequently tested by the Statutory Reporting unit. This documentation serves to ensure consistency and continuity between reporting periods and to support the cross-training of staff. Hard copies of all report submissions and supporting documentation are maintained in central files and copies of all computer files are stored under discrete directories on a network drive that is backed up each evening.

QUESTION 2

Provide a work plan for implementation. At a minimum, the work plan should include:

- *A description of all activities necessary to obtain required contracts for your provider network as specified in the draft Agreement; and*
- *An itemization of activities that you will undertake during the period between notification of selection to proceed to Readiness Review and the implementation date of 9/1/12 in the NW Zone and/or the implementation date of 3/1/13 in the NE Zone. The activities shall have established deadlines and timeframes.*

(Limit to four pages)

RESPONSE TO QUESTION 2

Overview

Detailed project planning and execution are the keys to the successful implementation of a program of this magnitude. AmeriHealth Mercy's comprehensive implementation plan lists all tasks, timelines and resources necessary to meet the State's implementation requirements and timelines for each zone and is included as Attachment 2. In addition, we will work closely with the State and partners throughout the implementation to ensure a smooth transition for all impacted members, providers, and other stakeholders.

AmeriHealth Mercy has a standard work plan and implementation structure, which we have successfully used in other markets. The plan will be tailored to integrate the New West and the New East into our existing operations in the Lehigh/Capital Zone. This plan and structure have been refined after each implementation from our lessons learned and feedback we received from the States. Based on the RFP requirements and timelines, a separate work plan will be created for each zone, although the tasks will be essentially the same for both. Throughout the implementation, AmeriHealth Mercy will also involve consumers, providers, and other stakeholders in this important effort. Our goal is to implement the program in a manner that is sensitive to the local needs and not simply a "cookie-cutter" managed care approach.

The work plan identifies all tasks necessary to meet the RFP requirements, with associated timelines and key personnel. Each task has a specified owner who is accountable for ensuring timely completion of the task, communication with other task owners and project teams, and escalation of issues as needed. The work plan also outlines the specific tasks that will be performed to contract and configure the Provider Network as well as all activities needed to certify readiness.

Network Management Development

As described in Question 1, AmeriHealth Mercy has a robust plan in place for the identification, recruitment, contracting and education of the comprehensive provider network necessary for providing access to all members in the New West and New East Zones. The activities listed in the Provider Network Management section of the Work Plan have already begun, and will continue throughout the implementation.

The provider network development activities began in the fall of 2011 with outreach to key providers known to AmeriHealth Mercy throughout the area and identification of all other providers necessary to form a comprehensive network to support member access to care. The AmeriHealth Mercy contracting team then began contacting providers via letters, telephone outreach and in-person office visits to introduce the organization and begin contracting activities.

See Table 2 for key components of the provider network management section of the work plan:

Table 2: Key Provider Network Management Components

Task	Start Date	NW End Date	NE End Date
Establish team and document network strategy	October 2011	November 2011	November 2011
Develop provider outreach list	November 2011	December 2011	December 2011
Create and distribute provider recruitment materials	December 2011	December 2011	February 2012
Establish data collection and credentialing workflow	December 2011	January 2012	January 2012
Conduct outreach activities and obtain signed contracts	December 2011	August 2012	February 2013
Produce regular Geo Access and status reports to monitor adequacy as network is developed	February 2012	August 2012	February 2013
Finalize New West and New East provider network management policies and procedures, based on existing materials	March 2012	May 2012	May 2012
Finalize Provider Manual, including DPW review component	March 2012	May 2012	May 2012
Configure batch processes, interfaces and workflows that will be used to share data with DPW and the enrollment broker	March 2012	June 2012	December 2012
Conduct provider education sessions	May 2012	October 2012	April 2013
Implement ongoing provider relationship management process	July 2012	August 2012	February 2013

Project Activities through Readiness Review

Each zone has its own implementation plan. The management processes and tasks are similar and each accommodates their respective anticipated timelines. Table 3 provides a brief overview:

Table 3: Implementation Plan Overview

Zone	Estimated Start	Implementation Date	Estimated Duration
New West	3/5/2012	9/1/2012	< 6 months
New East	9/1/2012	3/1/2013	6 months

In order to meet the New West implementation date of September 1, 2012 and to ensure high quality, AmeriHealth Mercy has already begun our pre-planning process as part of this RPF response. We are confident in our ability to meet the aggressive timeline for the New West Zone implementation because of our experience in Pennsylvania and the quality of our proven project management processes and experiences.

AmeriHealth Mercy's detailed work plan was developed utilizing a standard project mythology. The specific phases include: pre-initiate, initiate, planning, design, development, testing, stabilization and monitoring. Table 4 below highlights phases, timelines and major milestones for this implementation:

Table 4: Milestones for Implementation

Phase	Milestone	NW Timeline	NE Timeline
Pre Initiate	Initiate network development activities (including subcontractors) Implement project management structure and develop Work Plan Submit RFP response	10/1/11 – 3/5/12	10/1/11 – 3/5/12
Initiate	Receive RFP award Activate Project Team Receive State approval of Work Plan Schedule ongoing State meetings (Core Team, enrollment broker, financial intermediary, etc.) Begin employee recruitment	3/5/12 – 4/2/12	3/512 – 4/2/12
Planning	Finalize business and system functional requirements Initiate marketing and member outreach campaign	3/15/12 – 4/15/12	3/15/12 – 8/15/12
Design	Complete network development activities Finalize system design (Architecture) Complete policy, procedure and workflow design	4/15/12 – 5/15/12	8/15/12 – 9/17/12
Development	Complete all system configuration	5/15/12 – 6/1/12	9/17/12 – 12/1/12
Testing	Finalize all system integration and user acceptance testing Complete testing with subcontractors and State agencies Complete State readiness review (system and operational)	6/1/12 – 9/1/12	12/3/12 – 3/1/13
Stabilization	**Go Live**	9/1/12 – 10/31/12	3/1/13 – 4/30/13

Phase	Milestone	NW Timeline	NE Timeline
	Repair all defects and address any open issues Begin member mailings, welcome calls, outreach efforts and transition planning		
Monitoring	Review all key performance indicators	11/1/12 – 12/31/12	5/1/13 – 6/30/13

Operational and System Readiness Review

AmeriHealth Mercy has a strong, stable and proven Readiness Review process that encompasses all organizational functions, as seen in Attachment 3. This process includes the review of the following components and artifacts to ensure they meet state requirements and federal regulations:

- Operational policies, procedures and workflows
- Network adequacy reports and provider listing, as well as periodic network status reports
- Member materials (handbook, marketing materials, disease management materials, phone scripts, and sample ID card) and outreach processes
- Provider materials and communication strategies, including the Provider Handbook
- Marketing strategy
- Staffing models and proposed staffing levels
- Member, provider and staff training approach and materials
- Medical management protocols, policies and procedures
- System applications to support key functions and associated testing plans
- System security and control processes , as well as results of recent audits
- Disaster recovery and business continuity plans, as well as results of recent tests

In the spring of 2011 AmeriHealth Mercy was awarded the statewide physical health MCO contract for the State of Louisiana. Readiness review activities began 30-days post contract award and we recently received notification that we have completed 100% of the readiness review requirements ahead of schedule. Of over 900 requirements, 99% were certified complete at the initial submission.

As a result of our current experience in the Pennsylvania HealthChoices program, a majority of the required materials have already been developed and will only need to be modified to meet the specific needs of the New West and New East Zones.

Our process includes the following steps: document development, internal review and editing, document revisions and formatting, functional leader approval, submission to DPW, edits and revisions per DPW comments and resubmission for approval. In addition, we will enhance our standard system and functional presentation and system demonstrations for an onsite review. Although our process is simple, the keys to our success are the direct results of having the appropriate version control process in place, proven processes and procedures, appropriate management oversight at the right level, adequate resources and ability to respond to any defects quickly.

Provider Network Composition and Network Management

Contents

QUESTION 1

Explain your plan to ensure that your provider network meets the network and access requirements in the draft Agreement. Specifically include:

- *The method you plan to use on an ongoing basis to assess and ensure that network standards outlined in the draft Agreement are maintained for all provider types.*
- *Describe your process for continuous improvement in your network over and above contract compliance.*
- *Describe how you will ensure that appointment access standards are met when members cannot access care within your provider network and must go to an out-of-network provider?*
- *Describe how you will collect and record language needs for those consumers with limited English proficiency and how you will ensure all written notices are language appropriate.*
- *Describe how you will educate and coordinate interpreter services with your network providers.*

(Limit to six pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy's experience with serving Medicaid enrollees in Pennsylvania for nearly 30 years makes it uniquely qualified to build an expansive provider network and to ensure that its provider network meets all of the State's network and access requirements. We have developed a proven process to ensure we can quickly implement a comprehensive provider network that not only meets – but exceeds – DPW's requirements. Our plan for the New West and New East network was established based on the following critical elements:

- The anticipated Medicaid enrollment and expected utilization of services, considering the characteristics and health care needs of particular Medicaid populations
- The numbers and types of providers required to supply the contracted Medicaid services
- The numbers of network providers who are not accepting new Medicaid patients
- The geographic location of providers and members, considering distance, travel time, and commonly used means of transportation, and provisions for physical access for members with special health care needs

Assessment of Network Adequacy

AmeriHealth Mercy monitors network adequacy against the State's access to care standards on a frequent basis in the months prior to and after program implementation. Minimum network adequacy is determined by utilizing Geo Access mapping. Geo Access mapping is used to define our statewide comprehensive networks for: hospitals, including children's, tertiary care and critical access hospitals, PCPs, specialists, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as well as other providers as necessary to meet Exhibit AAA(1) requirements for Network Composition/Service Access.

After the network has been stabilized, PCP networks are monitored on a monthly basis. Specialty networks and other provider networks are monitored at least quarterly thereafter, using Geo Access mapping. In addition to the regularly scheduled assessments, we also prepare Geo Access reports any time there is a significant change in the provider network that could negatively impact access to care. Should a gap be found or predicted based on expected provider changes or membership growth, an outreach plan is created that includes targeted provider recruitment, or as appropriate, outreach to currently contracted providers to ask them to accept more members.

Continuous Improvement of Our Network

Continuous improvement in the New West and New East provider networks will be critical to assuring adequate access in rural areas. We have several initiatives we are considering as strategies to drive continuous improvements of our network if necessary.

Provider Incentive Programs

These programs will be tailored to incent the providers to improve access and/or improve specific health outcomes. As part of the incentive programs, we give information to the providers, in individualized reports, regarding how they compare to their peers on a variety of measures. For example, the report may compare how the physician compares to other physicians with regard to prescribing generic medications, or on specific HEDIS measures.

Mobile Services

AmeriHealth Mercy will continue our practice of going into the community where our members reside, to offer mobile services. For example, we have an existing contract with a mobile

mammography company, Lackawanna Mobile Diagnostic Services. We have already reserved dates to offer mammograms to our members in the New West and New East.

Telehealth Programs

Telehealth programs are necessary to expand access. For example, we have a telehealth program for members with heart failure. Participating members monitor their daily weight fluctuations - a key indicator of heart failure - and blood pressure using a digital weight scale and a blood pressure monitor. The wireless telemedicine device easily and automatically stores and sends health information to designated medical professionals, enabling them to make timely decisions that can prevent unnecessary hospital stays. Home Agency staff utilizes these opportunities as "teachable moments" with our members, especially when symptoms are most acute.

Health Navigators

We will also use Health Navigators in the rural counties. Nurses, specially trained outreach coordinators and other professionals serve as Health Navigators and act as a liaison between the member, provider and health plan. Our Health Navigators are poised to conduct health education sessions at locations in each county. In the rural communities of Luzerne, Lackawanna, Monroe, Carbon and Pike counties that we currently serve, AmeriHealth Mercy conducts this type of educational programs at a variety of community locations such as Friends of the Poor, Salvation Army and the Community Intervention Center.

Meeting Appointment Access Standards

Providers are contractually required to meet standards for timely access to care and services, taking into account the urgency of the need for the services. In a practitioner's absence, the patient must be instructed, via an answering service or a telephone answering machine, on how to reach their PCP or an approved practitioner providing 24-hour coverage. In addition to the standards being communicated in a provider's contract, access and appointment availability standards are routinely communicated via the provider manual (also available on line), provider website, on-site orientation of new providers, ongoing training and the provider newsletter.

Once the accessibility standards have been communicated to providers, follow-up contact with the providers ensures that the member's experience is consistent with these standards. Compliance with the accessibility standards is monitored through a number of tracking and reporting vehicles. We track calls from members related to dissatisfaction with appointment and wait times. Individual complaints are forwarded to the Provider Contracting Representative assigned to the provider for investigation and resolution. In addition, aggregate complaint data related to dissatisfaction with appointments and wait times is trended to identify physician offices with repeated problems.

We also conduct assessments via "Secret Shopper" surveys, as well as provider audits. "Secret Shopper" calls allow us to directly experience the response from the physician's office that our members receive. For this assessment, we call physician offices after normal business hours to verify whether members who call at this time are able to reach a physician, if necessary. We also audit provider scheduling records to determine the availability of the next appointment for preventive, routine, and urgent care. During on-site visits, we monitor office wait times.

Providers who are non-compliant with any of the accessibility standards are notified of our findings by their Provider Contracting Representative and re-instructed regarding the standards. The assigned Provider Contracting Representative schedules another monitoring event, either an

on-site visit to monitor office wait times, a "Secret Shopper" call to check appointment availability, or an after-hours call to verify the availability of the practitioner.

Offices that are non-compliant during repeated monitoring attempts are required to prepare and implement a corrective action plan. The Provider Contracting Representative monitors the implementation of any correction action and reports the results to the Quality Service Committee. Non-compliant offices are also automatically included in the provider list for the next monitoring session.

Our Provider Contracting Representatives work with provider offices to assist them in implementing creative solutions and adjusting their processes to become more compliant. For example, one of our providers in central Pennsylvania implemented walk-in hours from 7:00 a.m. to 9:00 a.m. on Monday through Thursday, providing the practice with greater flexibility in meeting standards for urgent appointments.

Appointments by Non-Participating Providers

If services cannot be provided by participating providers within the required mileage radius, AmeriHealth Mercy allows members to seek care from a non-participating provider. An authorization will be entered into our medical management system authorizing the services to be rendered by the non-participating provider as long as a participating provider is unavailable to provide such services.

Our Provider Contracting Representatives will assist all authorized, non-participating providers in obtaining the necessary information to assure their claims are paid timely. We will also discuss the possibility of the non-participating provider's participation in our network in the future.

In some areas of rural Pennsylvania, the specific type of provider may not be located within the required mileage radius. In such cases, we will identify the nearest provider available to expedite the delivery of care.

Capturing Our Members Language Needs

AmeriHealth Mercy is a national leader in recognizing the diversity in our member population and the need to understand the various cultures, ethnicities, languages and races in our communities. We design our programs to incorporate the cultural and language needs of our members. In addition to the key topics covered in our standard orientation, AmeriHealth Mercy offers educational programs to providers on numerous topics, some of which are CME-accredited, including:

- Cultural Competency Training
- Patient Centered Medical Homes
- Health Literacy

Within the AmeriHealth Mercy affiliated plans, three of our companies have been awarded the Distinguished Multicultural Health Care Distinction award from the National Committee for Quality Assurance (NCQA).

Our approach incorporates the collection of race, ethnicity, and language data provided by state agencies using the Federal Office of Management and Budget (OMB) guidelines. We recently enhanced our information systems and customer service processes to further expand the information we received from the state to improve the race and ethnicity data about our

members. We are able, without over-writing the state data, to capture up to five additional categories of race and ethnicity, and preferred written and spoken language. We are able to retain over 300 distinct levels of racial, ethnic, and language groups, and have the capacity to roll up to the OMB standard categories.

Our Member Services representatives and Care Managers actively collect data on race, ethnicity and language from members. As we collect this information, we enter it into our information system. This information serves as a powerful driver to assure that we send language appropriate written materials, and also helps drive future initiatives to reduce health care disparities. We analyze our health outcome data to identify health issues among specific populations and design programs to address those issues. We also leverage race, ethnicity and language data to ensure that the cultures prevalent in our membership are reflected to the extent possible in our provider network, and provide translation services to assist members to bridge language barriers. We also provide member's spoken language to our PCPs via their patient rosters. In the future, we will add this information to the provider portal and it will be available when providers verify eligibility.

To promote understanding of written materials, we maintain information on the enrollee's preferred language as part of our enrollee demographic data set (if the information is provided). All written materials are routinely printed in English and Spanish. We advise members that materials can be translated in other languages through a tagline in English, Russian, Cambodian, Vietnamese, Spanish, Chinese and any other language as required by DPW. For enrollees where a language other than English or Spanish is identified as the preferred language, written notices and materials will be translated into the enrollee's preferred language prior to mailing. AmeriHealth Mercy will use currently contracted translation vendors to serve individuals in the New West and New East Zones. Through these translators, we are able to translate materials in over 170 languages and into large print, braille and audio-tape formats.

Examples of written materials that can be translated include our new enrollee welcome packages, member handbook, member newsletter, educational materials supporting our care management programs, and our health education and outreach materials. We also translate all materials related to appeals and grievances. For example, for appeals and grievances, a system flag will alert the appeal coordinator that translation or an alternative medium is needed. Based on the flag, the system automatically creates a workflow record requesting the translation and setting a reminder for the coordinator to verify that translation was received and sent.

We also request our providers submit information regarding race, ethnicity and language of the provider, office staff, and language services available at the practice site into the Provider Validation Process. By asking all participating providers to check the information in our system on an annual basis, we have the most current race, ethnicity, and language data on our provider network. This information is used to monitor that we have enough providers available to service our members in their preferred language. We also provide this information to members as part of the provider directory, allowing them to choose providers who match their language preferences.

Interpreter Services

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. AmeriHealth Mercy is accustomed to 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.

We assist callers who require other language assistance through the services of Language Services Associates (LSA). LSA offers Interpreting by Telephone (IBT), Instant Communication, Total Understanding as well as Face-to-Face Interpreting when there is a need for an interpreter to be physically present. These services enable us to communicate with members in more than 170 languages. The Member Service representative can facilitate a three-way call between the members and LSA. This service is available at no charge to our members. LSA employees understand the specific needs of the Medicaid population which helps to facilitate the call to meet the members' needs.

Additionally, Member Services has the technology to respond to Deaf/Teletypewriter (TTY/TDD) calls. A desktop application is loaded on the representative's desktop, where the representative logs into a TTY/TDD serve, "sharing" central TTY modems over a network. When a call is received an alert will appear on the desktop notifying them of a call waiting. This optimizes call-handling procedures because the representative is equipped to handle an incoming TTY/TDD call without the need for additional equipment.

Under the Americans with Disability Act (ADA), health care providers have an independent obligation to provide reasonable accommodations to care for members with sensory impairments and to provide translation services when necessary. We recognize that many providers participating in the Medicaid program are not equipped to provide oral interpretation services for their patients; therefore, AmeriHealth Mercy provides a toll-free service which providers can utilize in order to provide the necessary access to members who require interpretation services and to reduce their administrative costs.

QUESTION 2

How will you use Geo Access mapping to ensure network adequacy?

(Limit to two pages)

RESPONSE TO QUESTION 2

AmeriHealth Mercy seeks to maximize access to care for our members and therefore we take an inclusive approach to provider contracting using Geo Access mapping to ensure network adequacy. We strive to contract with all available providers who meet our credentialing standards and will refine the network over time, as needed, to ensure we retain providers who meet our network requirements. While establishing and maintaining the AmeriHealth Mercy network, we considered several aspects of access including, but not limited to, the following:

- Our anticipated enrollment and the expected utilization of services, considering the characteristics and health care needs of the Medicaid populations
- The numbers and types of providers required to supply the contracted Medicaid services;
- The numbers of network providers who are not accepting new Medicaid patients
- The geographic location of providers and members, considering distance, travel time, commonly used means of transportation, and provisions for physical access for members with disabilities

Geo Access mapping will be used to define our statewide comprehensive networks for: Hospitals, PCPs, Specialists, Urgent Care Centers, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Our ability to partner effectively with providers enables us to meet the required Geo Access standards. We will make certain we meet the following State-mandated Geographic Access-Standards:

- Two (2) PCPs within 30 miles of members in urban counties and 60 miles in rural counties;
- Two (2) high-volume specialists within 30 miles of members in urban counties and 60 miles in rural counties for the following specialties: General Surgery, Cardiology, Obstetrics & Gynecology, Pharmacy and General Dentistry, Oncology, Orthopedic Surgery, Physical Therapy, Radiology
- At least one (1) hospital within 30 minutes in urban counties and 60 minutes in rural counties and a second choice within the Managed Care service area

AmeriHealth Mercy monitors network adequacy against the State's access to care standards on a frequent basis in the months prior to and after program implementation and at least quarterly thereafter, using Geo Access mapping. In addition to quarterly assessments, we also prepare Geo Access reports any time there is a significant change in the provider network that could negatively impact access to care.

The following information is included in the quarterly Geo Access reports:

- Geographic Overview Maps that display the provider locations in the geographical area requested
- Provider and Member Location Maps showing an overlay of the provider network against the enrollee base
- Potential Member Accessibility Summary that provides an overview of the entire analysis displayed in the report showing number and percentages of potential enrollees with or without access
- Accessibility Detail Data Sheet that provides an in-depth summary of the information contained on the Accessibility Summary Page

Should a gap be found or predicted based on expected provider changes or membership growth, an outreach plan is created that includes targeted provider recruitment, or as appropriate, outreach to currently contracted providers to ask them to accept more members.

As our provider network grows daily during the recruitment process, we continue to evaluate access to care and to develop a robust network of high quality providers.

While the Geo Access reports are a tool to determine availability of providers for our members, we utilize other tools and resources to ensure access to care for our members. Demonstrating coverage on a map is the beginning of the evaluation process, but we conduct additional analyses to ensure that providers are accepting new patients and scheduling timely appointments. We also monitor customer complaints about access and understand that a dot on the map does not translate into care for our members, so we are always attuned to member, advocate, and community input. Ensuring that health care services are available requires special relationships with hospitals, primary care physicians, specialists and others.

QUESTION 3

Explain the policy and procedure utilized to insure your provider directories are accurate and up to date. Please describe how policies are applied to both hard-copy and on-line or electronic versions.

(Limit to three pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy recognizes the importance of creating and maintaining current provider demographic information to ensure the accuracy of provider directories, claims payment, encounter data and statutory reporting to DPW. Over the years, AmeriHealth Mercy has developed a detailed process with control points to ensure the provider data is reviewed, validated and updated regularly.

We coordinate our contracting, credentialing and provider setup processes to ensure that provider file information is accurate, current and audited. Detailed provider data is routinely integrated into our Facets system, and is therefore directly tied to provider directories, claims payment, and encounter data submission.

Audits

We ensure that our provider directories are accurate and updated by regularly reviewing and auditing the provider information on file. The Provider Directory is pulled directly from Facets, our claims processing system, which serves as the official source for all provider data. The accuracy of our provider database is regularly monitored through a quality auditing process that evaluates transactional activity associated with updating and maintaining it. We conduct a daily audit of the manual updates performed by our Provider Maintenance Management staff 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. Provider Contracting Representatives validate provider demographic data, at least quarterly, to ensure the accuracy of that information. Validation will occur through a combination of personal visits, telephonic outreach, electronic media and faxed confirmation.

Additionally, we run monthly reports which identify any possible discrepancies in the system that would result in directory errors. Queries search for basic information, such as:

- Phone numbers, for the correct number of digits
- Invalid/duplicate office hours
- Practitioner/group address/phone number disconnect
- Missing county on service site
- Missing or invalid phone number
- CRNPs listed as having board certification
- Missing or invalid gender code
- Directory print conflict within group
- Invalid panel restrictions
- Missing hospital affiliations

Discrepancy reports are distributed to Provider Contracting Representatives for investigation and correction, if necessary. All changes are submitted to the Quality Auditing Department for audit selection.

Quarterly Provider Profile Validation for Health Systems

On a quarterly basis, AmeriHealth Mercy generates a provider data profile report for large health systems that is sent to the health system's contact for review and validation. This profile contains a snapshot of the health system providers' demographic information contained in the Facets system. The health system contact is asked to carefully review the information, update as necessary and return the report to the Provider Contracting Representative. Once approved by the

Provider Contracting Representative, the changes are sent to the Provider Maintenance Management team to update the Facets system. This process is well received by the large health system providers.

Data Validation

Annually, AmeriHealth Mercy performs a full network provider data 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 very effective as a means to ensure accuracy of provider directories. Additional validations are as follows:

- State and federal file comparisons that reconcile data elements such as name, address, license, DEA, office locations, NPI, and Pennsylvania PROMISe Provider ID
- Provider office visits at least once a year (and in some cases quarterly) by the Provider Contracting Representative to verify demographic data
- Receipt of claims and/or demographic change requests that require changes and updates to provider data
- Provider self-reporting to update to update any information
- Provider Contracting Representative inquiries about provider changes, such as new providers, anticipated changes and other demographic modifications on a recurring basis during provider visits

Accuracy of Provider Directories

AmeriHealth Mercy maintains a searchable online provider directory that queries the Facets system for participating network providers. The online provider directory is refreshed daily, incorporating all manual updates that are performed by the Provider Maintenance Management team. This daily update ensures that the online provider directory displays the most up to date information available about participating network providers. Members are encouraged to utilize the online provider directory to obtain the most accurate information about AmeriHealth Mercy network providers.

AmeriHealth Mercy produces two types of paper provider directories yearly. The Provider Directory includes primary care physicians, specialists, hospitals, nursing facilities, ancillary providers and diagnostic laboratory drawing stations. The Dental/Vision and Pharmacy Provider Directory lists participating dental and vision providers and pharmacies. The data used to create the provider directories is pulled from the Facets system, extensively reviewed and subsequently validated by the Provider Network Management team, and is accurate at the time of printing. The paper provider directories are mailed to members and providers upon request, though we always recommend that the requestor consult the online provider directory or Member Services for the most up to date information.

QUESTION 4

Explain your plan to manage contracted skilled nursing and home health providers to meet members' growing needs for access to home and community based services for medically complex cases.

(Limit to two pages)

RESPONSE TO QUESTION 4

There is a growing need for skilled nurses and home health providers in the Pennsylvania market. This demand is further exacerbated in rural counties where there are fewer skilled employees and the expansive geography limits the number of visits possible per day. AmeriHealth Mercy has been successful in managing these challenges by working collaboratively with contracted skilled nursing and home health providers to both increase the bandwidth of each provider and by increasing the number of providers. The following strategies are reviewed in greater detailed below:

1. Ensuring provider shift adherence
2. Incentives for remote locations
3. Supporting the hiring effort
4. Enabling telehealth functionality
5. Supporting back-up staffing models
6. Ensuring other member safeguards

Ensuring Provider Shift Adherence

To ensure that Providers meet their scheduled requirements, all missed shifts are reviewed on a monthly basis via the Missed Shift Report. The report contains a list of all members who were scheduled for a skilled nursing or home health visit that was not completed due to a provider missed shift. The report is submitted monthly by AmeriHealth Mercy to the Department and reviewed via conference call.

Incentives for Remote Locations

In working within Pennsylvania, AmeriHealth Mercy knows that it is harder to secure skilled nursing and home health aide visits for members located in more remote locations, as providers are not always fairly compensated for the additional travel expenses. AmeriHealth Mercy believes that to keep members healthy they need access to the right type of care at the right time; this includes skilled nursing and home health aides. To that end, AmeriHealth Mercy works with their contracted providers to offer travel incentives to increase the range that providers are willing to travel to provide care to our members.

We also work with contracted agencies to negotiate special rates for to care for multiple members living in the same household and on occasion for cases that are difficult to staff.

Supporting the Hiring Effort

AmeriHealth Mercy has learned that recruiting and hiring top talent can be a challenge, especially for smaller organizations who have limited resources to invest. This is of even greater challenge in areas with a smaller talent pools to draw from. As a result, AmeriHealth Mercy partners with their contracted skilled nursing and home health providers to help them hire. More specifically, AmeriHealth Mercy sponsors their contracted providers' participation in on campus recruiting events and actively refers local, known candidates to these organizations. These strategies have placed a significant number of employees - just this year - with contracted skilled nursing and home health providers.

Telehealth Functionality

To enhance access, AmeriHealth Mercy partners with home health providers to offer telehealth programs to members with heart disease, diabetes and members who are categorized as being a

high-risk pregnancy. These programs allow members to be remotely monitored for things like blood pressure levels, weight gain or loss and daily blood glucose levels. High-risk pregnant members, who participate with the program, have their contractions monitored remotely by a tocometer. Wireless telemedicine devices easily stores and sends health information to designated medical professionals, enabling them to make timely decisions that can prevent unnecessary hospital stays. This also allows home health aides and skilled nursing providers to triage which members need immediate care and when.

Back-up Staffing Model

AmeriHealth Mercy strives to work collaboratively with home health and skilled nursing providers. AmeriHealth Mercy wants these providers to see AmeriHealth Mercy as an ally. As such, AmeriHealth Mercy's home health agencies are requested to contact us if they are not able to complete a home visit for any reason. With prior notification, there is no retribution to these home health and skilled nursing providers for requesting support from AmeriHealth Mercy.

Upon such notification, AmeriHealth Mercy immediately locates another agency to provide coverage and will orchestrate communication between the relevant parties to ensure clear communication and documentation of care. In some cases this means that AmeriHealth Mercy will authorize home nursing services to be delivered by non-participating providers.

Additional Safeguards

As mentioned above, AmeriHealth Mercy's goal is to ensure that members stay healthy. We believe this requires members to have access to the right care at the right time. Even with the strategies noted above, AmeriHealth Mercy is sensitive to the scenarios when home health care or skilled nursing care is not available. In these rare instances, AmeriHealth Mercy is willing to offer a number of contingency plans including moving a member to a skilled nursing facility or rehabilitation facility until the appropriate level of home healthcare can be offered. In some instances, AmeriHealth Mercy has authorized services to be provided in a Medical Day Care Program setting, when that level of care was medically appropriate.

Our Discharge Planners and Care Managers work directly with hospitals to ensure that the correct step-down care is always identified and in place to support the member upon discharge.

QUESTION 5

What risk adjustment strategies and/or provider incentives do you employ in PCP contracting to ensure members with complex medical needs have adequate access to primary care and care coordination services? How do you measure and assure that these members have adequate access to care?

(Limit to two pages)

RESPONSE TO QUESTION 5

Access is one of the primary needs of Medicaid recipients in Pennsylvania, and AmeriHealth Mercy will enhance its payment structure to Primary Care Providers to increase access for members with complex medical needs and coordinated care services utilizing two strategies: provider incentives and monitoring and enforcing adherence to access standards.

Provider Incentives

Quality Enhancement Program

The Quality Enhancement Program (QEP) rewards PCPs for high-quality and cost-effective care. The program provides additional reimbursement to providers who care for members with complex medical needs. In the most recent cycle of the QEP program, a total of 1,165 unique PCPs qualified to receive incentives based on their performance caring for over 104,000 members.

The Quality Enhancement Program contains four performance metrics: quality, illness severity, cost efficiency, and non-emergent emergency room utilization. Focusing on our members with complex medical needs, the severity of illness metric rewards practices (on a risk-adjusted basis) for treating higher risk panels relative to their peers.

Practice performance is evaluated every six months (based on a rolling 12 months of encounter data). The measure and ranking are combined in an overall report card which is shared with the practice. Provider Contracting Representatives use the data to support and encourage high performing practices. In the case of poor performing practices, Provider Contracting Representatives work with these groups to collaboratively develop performance action plans.

PCP groups contracted to receive capitation reimbursement may be moved to a fee-for-service reimbursement method if claim submission volume remains low or coding accuracy has not improved after education and re-evaluation.

Intensive Case Management Reimbursement Program

The Intensive Case Management (ICM) Reimbursement Program provides PCP practices additional reimbursement for delivering care to chronically ill patients. Over a recent span of 12 months, the ICM Reimbursement Program has identified over 38,000 members with chronic and/or complex illnesses being evaluated and managed by almost 700 providers.

Program goals are as follows:

1. Assist practices by identifying members with chronic and/or complex medical needs
2. Assure chronically ill members are routinely accessing primary care services
3. Improve appointment compliance through member outreach
4. Report complete and accurate diagnosis and disease acuity information to the Department of Public Welfare

The ICM Reimbursement Program is continuously monitored to assure PCPs are submitting claims for evaluation and management services that include the chronic and associated episodic diagnoses of their identified members. Provider Contracting Representatives receive monthly reports enumerating the volume of ICM Reimbursement Program members by PCP group and the number of claims with chronic diagnoses that have been received from the PCP group within the previous six months. The Provider Contracting Representative will visit low performing PCPs to educate them about the goals of the ICM Reimbursement Program and offer additional

assistance with member outreach, appointment scheduling and/or medical record review by AmeriHealth Mercy Certified Professional Coders to determine if the practice is correctly coding diagnosis data.

All ICM Reimbursement Program data is available to PCPs via the NaviNet.

Integrated Care Management

All AmeriHealth Mercy members are considered for our Complex Integrated Care Management (ICM) program, discussed in greater detail in the Coordination of Care section. The ICM program provides member with a single point-of-contact for all of their healthcare needs. Members are selected for ICM through our data stratification process – which electronically analyses every single member's need - or though provider referrals. Members may also self-refer for ICM.

Appointment Access

AmeriHealth Mercy network providers are required to meet and treat members according to the standards for timely access – appointment and wait times – established by the Department.

Monitoring of Standards

Once the accessibility standards have been communicated to providers, follow-up contact with the providers ensures that the member's experience is consistent with these standards, and is a critical component of assessing access to care.

Review and Analysis of Findings

Providers who are non-compliant with any of the accessibility standards receive written notification of our findings and are re-instructed regarding the standards. The assigned provider network management representative schedules another monitoring event, either an on-site visit to monitor office wait times, a "Secret Shopper" call to check appointment availability, or an after-hours call to verify the availability of the practitioner.

QUESTION 6

How do you monitor and evaluate PCP compliance with availability and scheduling requirements outlined in the draft Agreement? What is your plan to ensure PCP-to-member ratio requirements are maintained throughout the term of the Agreement?

(Limit to two pages)

RESPONSE TO QUESTION 6

PCP Availability

AmeriHealth Mercy provides geographic access to two PCPs within 30 minutes travel time in urban/suburban areas and 60 minutes travel time in rural areas. Contracted Federally Qualified Health Center Facilities (FQHCs) are considered PCP sites and are available for member selection in the provider directory. On an annual and/or an "as needed" basis, AmeriHealth Mercy monitors the geographic availability of its participating providers to ensure that members have timely access to health care services, as well as to comply with the Availability Standards outlined by DPW.

Appointment Scheduling Access

AmeriHealth Mercy network providers, including PCPs, are required by contract to meet standards for timely access to care and services, taking into account the urgency of the need for the services. Appointment scheduling standards have been established and are communicated to PCPs and Specialists in the Provider Manual and discussed in orientation meetings. After normal business hours, AmeriHealth Mercy PCPs are required to instruct members on how to reach their PCP or an approved practitioner providing 24-hour coverage.

Monitoring and Evaluating Compliance

AmeriHealth Mercy has implemented the following procedures to monitor its PCP network to evaluate compliance with availability and appointment scheduling standards.

Geographic Distribution and Provider Availability – Annual Assessment

Annually, Provider Network Management utilizes the GeoNetworks® software program to generate number and geographic distribution of provider sites in relation to membership to assure that the established standard is met. The goal is to have a 98% compliance rate or better. If gaps are identified, AmeriHealth Mercy implements interventions and other corrective measures, such as recruitment of necessary service providers, in order to ensure compliance. Results are reported annually to the Quality Service Committee, which monitors compliance and issues recommendations for improvement. The Quality Service Committee compares the following year's annual assessment of the geographic distribution of providers and number of providers to members to determine whether the previous year's interventions had the desired effect.

Education and Communication of Standards

AmeriHealth Mercy uses all available methods to educate and communicate provider appointment scheduling standards with the aim of ensuring providers have a clear understanding of expectations. Appointment scheduling standards will be routinely communicated via on-site orientation of new providers, ongoing training, the provider manual (available online), provider website, and the provider newsletter.

Evaluating Compliance

Follow-up contact with the providers ensures that the member's experience is consistent with these standards. Compliance is monitored through a number of tracking and reporting vehicles, including tracking calls from members related to dissatisfaction with appointment and wait times. Complaints are forwarded to a Provider Contracting Representative for investigation and resolution. Aggregate complaint data is trended to identify physician offices with repeated problems.

AmeriHealth Mercy also conducts assessments via "Secret Shopper" surveys, and provider audits. "Secret Shopper" calls allow us to directly experience the response from the physician's office that our members receive. We call physician offices after normal business hours to verify access. We also audit provider scheduling records to determine appointment availability and monitor wait times during on-site visits.

Non-compliant providers are notified of findings by their Provider Contracting Representative and re-instructed regarding the standards. The Provider Contracting Representative then schedules another monitoring event to check appointment availability.

Corrective Measures

Offices that are non-compliant during repeated monitoring attempts are required to prepare and implement a corrective action plan. The Provider Contracting Representative monitors implementation and reports the results to a Quality Service Committee. Non-compliant offices are also automatically included in the provider list for the next monitoring session to make certain the providers have corrected their procedures and are now meeting AmeriHealth Mercy standards.

Results of our monitoring activities are combined with select Consumer Assessment of Healthcare Providers and Systems (CAHPS) responses and AmeriHealth Mercy Health Plan phone access performance evaluations to create a global picture of Appointment Scheduling Access and Geographic Availability. The findings are reported to the Quality Service Committee where, as appropriate, corrective action plans are recommended and monitored to make certain the providers are meeting Plan standards.

PCP to Member Ratio

All member and provider data are stored in the Facets system. Facets functionality supports setting a maximum panel count value on each practitioner record. We set a maximum value that preserves the 1000 recipient per full time equivalent PCP ratio and prevents additional assignment of members when the value will be exceeded. Daily panel count reports are delivered to both Member Services and Provider Network Management to monitor "open panel" status. Through use of this functionality, daily reports and on-going evaluation of Geo Access data, PCP to member ratios are consistently monitored and used to define provider recruitment needs.

QUESTION 7

How do you ensure that members have access to medical care for needs that arise after hours and for urgent, non-emergency situations? How do you monitor providers to ensure that follow-up is done with the member and the member's PCP to facilitate transfer of information from the after-hours provider? Describe any incentive programs you have in place to improve access to care by rewarding providers who provide extended and/or after hours care.

(Limit to two pages)

RESPONSE TO QUESTION 7

AmeriHealth Mercy has several complementary strategies to improve access to after-hours care and urgent care. We have long been aware of the problem, as well as its consequences in terms of discontinuity of care, member and provider inconvenience, and misuse of healthcare dollars. AmeriHealth Mercy recognizes the importance of good communication with both providers and members, especially when related to follow-up of the diagnosis or treatment of a condition, including emergency care, post-stabilization care, or acute or chronic condition management.

AmeriHealth Mercy offers enhanced compensation to PCPs for extended office hours on weekdays and on weekends. Additionally, we offer additional compensation to providers for opening their offices outside of their normal business hours to address an urgent patient need. AmeriHealth Mercy is working to improve access to after-hours care and urgent care through contracts with urgent care centers and by encouraging area health systems to offer increased urgent care centers and "walk-in" clinics for routine care. We provide a 24/7 Nurse Call Line for members to call if they need advice related to an urgent medical need. In a practitioner's absence, the patient must be instructed, via an answering service or a telephone answering machine, on how to reach their PCP or an approved practitioner providing 24-hour coverage.

Care managers work to proactively facilitate PCP appointments for members as appropriate following after-hours and emergency care or post-stabilization care, as well as for enrollees who are in need of such assistance due to an acute or chronic condition. Our Care Management team ensures that all key/current providers, including specialists and behavioral health clinicians, who are involved with the enrollee's care are kept informed of relevant medical events and treatments to identify areas for care coordination and participation in the development of the plan of care. The frequency and extent of communication following the diagnosis and treatment of a condition, emergency care, or post-stabilization care will be provided in accordance with the guidelines of our Intensive Care Management (ICM) program.

If the member is admitted to the hospital following the ER visit, our Medical Director or utilization management staff notifies the PCP and works with them to assure continuity of care. In addition, the PCP has access to the full history of health care delivered to the member through the Clinical Patient Summary via the NaviNet system. This data includes care rendered in the ER or after hours care provided by another practitioner. Accessing this data allows the PCP to be aware of all healthcare services provided to his/her patients.

Follow-up contact by the providers ensures that the member's experience is consistent, and is a critical component of assessing access to care.

Providers who are non-compliant with any of the accessibility standards are notified of our findings by their Provider Contracting Representative and re-instructed regarding the standards.

Offices that are non-compliant during repeated monitoring attempts are required to prepare and implement a corrective action plan. The Provider Contracting Representative monitors the implementation of any corrective action and reports the results to the Quality Service Committee. Non-compliant offices are also automatically included in the provider list for the next monitoring session.

Our Provider Contracting Representatives work with provider offices to assist them in implementing creative solutions and adjusting their processes to become compliant.

In 2010, AmeriHealth Mercy ER utilization rates increased from the previous year. Since then, our provider incentive programs have become effective in reducing our members' non-emergent ER usage. As mentioned in question 5, one of the performance metrics for AmeriHealth Mercy's primary care provider incentive program (Quality Enhancement Program) rewards PCPs for improving the management of members who frequently use the ER. In the most recent cycle of the program, a total of 1,165 PCPs qualified to receive incentives based on their performance in caring for 104,000 members. Additionally, we offer enhanced compensation to PCPs for extended office hours and compensation to providers for opening their offices outside of their normal business hours to address an urgent patient need.

QUESTION 8

Describe the policies and procedures followed in response to the network termination or loss of a large-scale provider group or health system. Please develop the response taking the following areas into consideration:

- *System utilized for identification and notification of members affected by the provider loss;*
- *The automated systems and membership supports utilized in assisting affected members with provider transitions;*
- *Systems and policies utilized for continuity of care of members experiencing provider transition; and*
- *Outcomes experienced in coverage of the membership with existing network resources following the terminations.*

(Limit to five pages)

RESPONSE TO QUESTION 8

Overview

AmeriHealth Mercy's processes require us to take all necessary steps to work with a provider to address any concerns, and take necessary steps to prevent the termination of providers from our network. In instances when we have to terminate a provider from our network, such as if a provider no longer meets our credentialing standards, AmeriHealth Mercy has an effective process in place for minimizing the impact to and communicating with the member.

When faced with a possible termination of a provider, particularly one whose loss would adversely impact care to a significant number of members, we will first and foremost take all reasonable measures to prevent such a termination. If the termination is being initiated by the provider, we will immediately contact the provider to ascertain the reasons for the termination notice. Regardless of the reason the provider initiated the termination notice, we will explore whether there are administrative modifications we can make to improve provider satisfaction to prevent the loss of the provider to our network.

While we will exhaust all reasonable options to retain the provider**,** AmeriHealth Mercy also has detailed contingency plans to ensure a network provider termination is managed effectively and efficiently and to assure that the continuity of care for our members is not compromised.

Whenever a provider's contract is terminated, all affected members will be notified in writing by AmeriHealth Mercy. In the case of a member who received his or her primary care from, or was seen on a regular basis by the terminated provider, we will make a good faith effort to give written notice of termination of a contracted primary care provider at least 30 days before the termination effective date, to each such member.

In the case of terminated primary care physicians, "affected members" are defined as those who have designated the terminating provider as their primary care practitioner. In the case of terminating specialty physicians, utilization data will be used to identify those members who had seen the terminating specialist for specialty services during the preceding 12 months. In the case of a terminating hospital, utilization data will be used to identify members who had been treated at the terminating hospital for services during the preceding 12 months.

Critical to a smooth provider termination is proper identification and notification of the members and providers affected by the termination as well as proper and timely notification to DPW and related agencies. The contingency planning process includes the following activities when a large-scale provider group or health system is terminating.

Identification of Members and Providers

- Identify all providers owned (employees of the provider group or health system) by the provider group or health system
- Determine community providers (not employed by the provider group or health system) with admitting privileges only at terminating facilities
- List community providers (not employed by the provider group or health system) with admitting privileges at terminating facilities and who also can admit to other hospitals in the network
- Identify members who within the past 12 months received health care services from a terminating facility or provider or whose primary care practitioner (PCP) is terminating

- Identify those members with special needs or who will have continuity of care issues for immediate outreach – especially pregnant women, members in care management programs, members with HIV/AIDS, children in foster care or in children and youth custody

Analysis of Network Adequacy

- Analyze member health care access issues caused by facility and practitioner termination through a Geo Access Survey
- Develop strategies to mitigate access to care issues, e.g., recruitment of additional providers and practitioners to fill gaps in care

Timely DPW/Related Agency Notification

- Inform the state and benefits counselor and other relevant parties of the potential for a termination
- Provide DPW written notice of any material change to the provider network at least 60 days prior to the effective date of the termination. Notice will include the reason(s) for the proposed action
- Draft and obtain DPW's approval of member and provider notification letters, scripts for associates who will outreach to and receive calls from affected members, and related materials
- Submit to DPW a termination work plan and supporting documentation within 10 days of notification to DPW of the termination

Continuing Care/Transition to Alternative Providers

- Manage all open authorizations at a terminating provider so continuity of care arrangements can start for members in an active course of treatment
- Create a member strategy and identify and outreach to physicians to whom members will be transitioned

Notification to affected members will include information regarding assistance in choosing another contracted practitioner and referral to the AmeriHealth Mercy website for a list of network providers in the member's area. The member may also call Member Services for assistance in selecting a new PCP, specialist or hospital provider.

Once the termination notification has been mailed, members with terminating PCPs are given at least 10 days from the letter's date to choose a new PCP. Once the time period ends, the members are automatically assigned to a new PCP through a process algorithm, which places the member with a geographically accessible PCP. Members will also receive information on how to change the assigned PCP if they are not happy with the assignment.

A strong communication plan details steps taken to ensure that AmeriHealth Mercy is not only complying with DPW requirements, but also ensuring that we are assisting all affected members in transitioning to new providers. Communication plans will include updates to the provider directories as required by Section V.F.16 of the agreement with DPW.

Automated Systems and Membership Supports

AmeriHealth Mercy employs various types of additional notification strategies which are used as needed to supplement the written notification and to ensure that members receive timely information. These strategies are implemented if we are unsuccessful in reaching members or for any reason the traditional methods are not successful. These strategies include phone calls, "on hold" messages, and automated and interactive phone calls. Special effort is made to contact

members with special needs so that the health care services they receive continue without interruption. Members with special needs receive repeated phone calls and/or home visits arranged by our Rapid Response staff until our Case Managers have successfully transitioned or arranged for continuation of their care.

Geo Access maps are prepared to determine network composition and access with, and without, the provider in question. This allows the development of a recruitment plan to replace the needed provider specialty, if possible. Additionally, we take steps to ensure early identification of members with special needs. Early outreach to all affected members enables the arrangement of appropriate, quality alternative health care services and mitigates disruption to both members and the provider network. If alternative providers and practitioners cannot be located, early outreach allows AmeriHealth Mercy to arrange continuation of care with the terminating provider for as long as medically necessary, without disrupting care for the member.

Continuity of Care Policies

AmeriHealth Mercy allows members to continue ongoing treatment with a health care provider whose contract terminates, except when the provider's contract is terminated "for cause" reasons. "For cause" includes quality of care issues, the provider is not a Medical Assistance provider, or the provider did not comply with regulations or contract requirements. AmeriHealth Mercy can approve requests for ongoing treatment or services when the request is made by the provider or by the member. Continuing care requests are reviewed on a case-by-case basis. AmeriHealth Mercy considers treatment "ongoing" if the member was treated during the past 12 months for a condition that requires follow up care or additional treatment. Services are also considered "ongoing" if they have been prior authorized. Once AmeriHealth Mercy has received the request for continuing care with a terminating provider, the case is reviewed. AmeriHealth Mercy notifies the member and provider by telephone if the request is approved. If the request is not approved, AmeriHealth Mercy will call the provider and the member and will also send a letter explaining the decision and describing the member's appeal rights.

When continuing care is approved, members may continue to see the terminated provider for 90 days beyond the date the member was initially notified. If the member is pregnant, continuing care will be approved with that obstetrician or midwife and hospital provider through the end of the postpartum care period.

Outcomes experienced in coverage of the membership with existing network resources following the terminations

AmeriHealth Mercy has an excellent record in transitioning members to other network providers when a provider termination necessitates initiation of contingency plans. An example of this occurred in April 2010, when AmeriHealth Mercy terminated its relationship with Milton S. Hershey Medical Center and the University Physicians Group. AmeriHealth Mercy successfully transitioned all PCP panel members to other PCPs near the members' homes. AmeriHealth Mercy entered into a contract with an alternative health care provider (Pinnacle Health System) and has not had enduring network access issues due to the loss of the Hershey providers.

TRANSPARENCY

CONTENTS

QUESTION 1

Describe how you currently use or how you would in the future create and use a tool that includes a graphical interface that allows users to track costs for specific medical procedures across the network of providers. Describe how this tool has been or could be adapted for shared use by Department staff, and whether this tool currently does or will in the future allow the Department to determine the population of providers who will accept a certain payment rate and the associated savings if the Department paid no more than a set payment rate which becomes a defined benefit maximum payment?

(Limit to two pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy has a long history of using actionable data and benchmarks to assess the quality of our provider networks. We believe that providing actionable data to members and providers, along with compelling incentives, can drive behavioral changes, thereby creating a more efficient and higher quality network.

This section will briefly outline our current PerformPLUS provider profiling system and how we believe this system can be expanded to track costs for specific medical procedures, store provider current and potential contract rates and be diverse, secure and flexible enough for ad hoc reports to be run and analyzed by both AmeriHealth Mercy and the Department.

PerformPLUS

Developed by AmeriHealth Mercy, PerformPLUS is a data repository and analytics tool that supports our methodology for profiling and reporting provider performance. PerformPLUS currently allows us to provide network providers with actionable and benchmark data by compiling all sources of data, such as claims, encounter, membership, provider contract rates, and utilization data, into a single data repository. Reports are then prepared from this database and shared with providers monthly, quarterly, and annually so that providers may review key information on their performance relative to their peers.

Our PerformPLUS tool tracks HEDIS measures, member Care Gaps and key cost metrics for hospitals and specialists. Physician incentives are aligned with key metrics to promote the efficient use of resources. Please see Attachment 1 for a sample PCP and Hospital Profile.

AmeriHealth Mercy PCPs receive bonuses based on the quality of care they deliver. Top-tier providers are segmented within each respective category and supplemental bonus opportunities are available for statistically significant achievement relative to the baseline.

Current performance metrics include:

- Inpatient admissions
- Quality reporting measures*
- Average Length of Stay (by DRG)**
- Ambulatory care sensitive conditions*
- Emergency room utilization
- Potentially preventable readmission rates*
- Average cost per admission (by DRG)**

** Relative to the practitioner's specialty*

***Hospital specific metric*

Future State

AmeriHealth Mercy's partner in the New East Zone, Blue Cross of Northeastern Pennsylvania (BCNEPA), currently allows its members to review and compare a variety of costs for specific hospital and outpatient services using BCNEPA's secure member portal. This tool would enable members to identify providers willing to accept a certain payment rate. The associated savings to the Department of Public Welfare, if it paid no more than a set payment rate, could be calculated if the member receives services beyond the defined benefit maximum. AmeriHealth Mercy and BCNEPA will collaborate on efforts to enable AmeriHealth Mercy to leverage the existing BCNEPA tools and infrastructure to support AmeriHealth Mercy's Medicaid program.

As needed, AmeriHealth Mercy would potentially secure its own contract with a "front-end" graphical interface vendor. Today, a leading vendor is this market space is SAP and their *Crystal Reports*. A tool such as *Crystal Reports* would allow a user to 'slice-and-dice' the data held by PerformPLUS by any predefined metric. For example, a very simple report could be prepared

that would show inpatient rates categorized by provider, region, or primary diagnosis. Additional examples include reviewing the average length of stay by diagnosis-related group (DRG) by hospital, and the average cost of DRGs by specialist. All variances, trends, and benchmarks could be assessed with the support of a front-end analytics tool. The analysis available to a user would be unlimited.

For data to be actionable, it also must be timely. As such, we will work towards refreshing the available data as close to real-time as possible. As claims are submitted and adjudicated regularly, PerformPLUS could be updated in tandem.

Department Access

AmeriHealth Mercy also understands the importance that this data and analytics ability would have to the Department. As such, AmeriHealth Mercy would ensure that the Department would have their own secure log-in to the graphical interface. As the data would only flow from PerformPLUS to the interface — and not the other way around — there would be no risk to the integrity of the underlying data source. We would also ensure that the Department's log-in was supported by all modern security to ensure protection of members' private health information. All State and Federal regulations around data safety would be followed at all times.

Timeline

There are currently two limiting factors to going live with this process. The first is the implementation of a front-end analytics tool such as *Crystal Reports*. Again, should we seek support from SAP, the generally proposed timeline for implementation for this process is six months to one year. This includes an allowance for end-user training. This model would be scalable to be applied to additional populations and geographic regions.

An additional limiting factor would be the collection of data that does not currently exist within PerformPLUS. For example, we do not currently store data concerning which providers are willing to accept a certain payment rate. However, if our Provider Contracting Representatives were to collect this information during their monthly meetings with providers, we could surely create a field for such data in PerformPLUS, which would then be available in our graphical interface for an end-user to run analytics. AmeriHealth Mercy would welcome a dialogue with the Department on additional metrics that they would like to be made available in the PerformPLUS database.

QUESTION 2

Describe how you currently or would in the future provide cost transparency information to Medicaid consumers through a call center and over the Internet using a secure web portal. Describe whether and how this call center and/or web portal currently allows or would in the future allow the consumers to shop for required medical services by selecting the most cost-effective healthcare settings, locations and providers, while continuing to ensure appropriate access to high quality, medically necessary healthcare services and procedures.

(Limit to two pages)

RESPONSE TO QUESTION 2

As discussed in Question 1 above, AmeriHealth Mercy believes that providing actionable data to members and providers, along with compelling incentives, can drive behavioral changes that create a more efficient and higher quality network. As such, AmeriHealth Mercy has invested heavily in providing data to Members through telephonic outreach, mail campaigns, health education materials, community outreach programs, and many more avenues. However, our Member Portal provides the most efficient way to deliver valuable data.

This section will briefly discuss the current state of our Member Portal; its interface with our Member Services team; and how we believe that cost transparency data can be added to support members in the selection of cost-effective and high quality healthcare settings and providers.

Member Portal

The objective of the Member Portal is to provide members with efficient and secure interactive tools to help them develop a clear picture of their medical care. By giving members access to such information, clinical outcomes improve through better medication adherence and a reduction in Care Gaps.

The Portal allows members and guardians to establish a user ID and password for secure access. To date, the following options available to members via this secure environment:

- PCP Information
- Medication List
- Care Gap Report
- Member Clinical Summary
- EPSDT Clinical Summary
- Request an ID Card
- Request a Handbook
- Send secure email
- Health and Wellness Library
- Complete a Health Risk Assessment

Once a member is connected to the Portal, the Portal supports good member decision-making by emailing the member reminders for office visits and for upcoming Care Gaps and/or EPSDT needs. These reminders are also supported by health education materials available via the Health Library.

Call Center Support

Make Every Member Contact Count

Care Gaps are integrated with all internal information systems. This integration provides an alert to any AmeriHealth Mercy employee who enters the member's ID number into the system. These alerts enable staff to address gaps in services during every member encounter. As such, should a member call our call center for any reason, the Member Services Representative is informed of the member's Care Gaps and reminds the member of the gap as part of their standard script. Additionally, the Member Services Representative offers to assist the member in scheduling an appointment, should that be required, and will also connect the member to our Rapid Response team, should additional barriers to care be identified.

Future State

As discussed above, AmeriHealth Mercy has a strong infrastructure in place to direct valuable information to members to improve their health outcomes. Looking towards the future, we will collaborate with our partner in this proposal, Blue Cross of Northeastern Pennsylvania (BCNEPA), on efforts to enable AmeriHealth Mercy to leverage the existing BCNEPA tools and infrastructure to support AmeriHealth Mercy's Medicaid program. As discussed in our response

to Question 1, BCNEPA members can view and compare specific procedure costs at hospitals and outpatient facilities using BCNEPA's secure member portal. Physician cost and quality transparency data will be available through this same member portal beginning in the first quarter of 2012.

As discussed in Question 1, AmeriHealth Mercy also has a strong, supportive data foundation. With the addition of stronger data analytics, such information could also be directed to members through the Member Portal. Such analytics could be similar to the web page that the member now views when selecting a primary care provider (PCP). When a member completes this process, they first enter their zip code, and the system filters the data by location. The member is also able to enter a number of selections including physician gender, language, and specialty. The system then filters the data by these selections and provides the member with the respective matches.

In this future state, when a member is selecting a PCP, they could also be prompted to select a high-efficiency provider, as defined by average cost of procedure or visit and quality performance. The member could also be prompted to select a provider with the highest Healthcare Effectiveness Data and Information Set (HEDIS) adherence rates. Furthermore, when a member is prompted to follow-up on a Care Gap or EPSDT screening for a child, they could also be prompted to use a number of cost- and quality-related filters. For example, should a member need a procedure, they could search for the providers and locations with the highest quality, as measured by health outcomes.

Should a member call into our Contact Center, the Member Services Representative could guide the member through this selection process verbally. As discussed above, the Member Services Representative would be alerted to the potential need for services by the member's ID and simply direct the member through the analytic process to aid in his/her selection of the appropriate care location and provider.

Cost transparency data will also be made available to the member in the explanation of benefits (EOB) statement and the member's landing page on the Member Portal. The EOB explains what medical treatments and services were reimbursed on the member's behalf, describing: the service performed (including the date and description of the service, as well as the name and location of the service provider); the provider's fee and the MCO's contribution; and the amount for which the patient is responsible, if any, and directions for filing an appeal. The member's landing page on the Member Portal will contain the same information in an electronic format.

Timeline

The greatest limiting factor in providing members access to such cost transparency data is defining the data definitions. AmeriHealth Mercy would look to partner with the Department on setting these definitions, so that when communicating to a member that a certain PCP is a high-quality provider, all parties are in agreement as to the precise definition. As noted in Question 1, the analytics should be up and running 6–12 months after vendor selection. AmeriHealth Mercy estimates that an additional year of research and discussions will be required to roll out the additional analytics to members. The Member Portal build-out and education of Member Services staff could be completed in-house and in parallel to the definition finalization. This model would be scalable to additional populations and geographic regions.

QUESTION 3

Describe any methods and strategies you currently or would in the future employ to encourage Medicaid consumers to utilize the most cost-effective healthcare settings, locations and providers, while continuing to ensure appropriate access to high quality, medically necessary healthcare services and procedures. In particular, describe how you currently or would in the future reward or incent Medicaid consumers who utilize a cost-effective location identified by shopping through the call center or member web portal described above.

(Limit to two pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy believes that providing actionable data to members and providers, along with compelling incentives, can drive behavioral changes, thereby creating a more efficient and higher quality network.

This section will briefly outline our current education and incentive programs and how we believe that these programs can be expanded to encourage members to utilize cost effective health care locations and providers.

Member Incentives

AmeriHealth Mercy has a history of successfully leveraging actionable information with member incentives to change behavior. For example, our affiliated South Carolina plan was faced with poor adherence to Prenatal Care guidelines and was subsequently experiencing poor birth outcomes. AmeriHealth Mercy set out, and achieved, the NCQA 90th percentile on these measures.

To achieve this goal, AmeriHealth Mercy pursued a number of interventions including:

- Better identification of at-risk members
- Better education of at-risk members, leveraging technology for reminding and tracking purposes, literature, and community outreach
- Better incentives for mothers who achieved certain care goals, via our Baby Shower program through a partnership with March of Dimes

For a complete review of this Case Study, including a review of the results, please see Attachment 2. We also have a similar program in our Pennsylvania market, where moms receive gift cards after reaching certain milestones with their pre- and postnatal care:

- First prenatal visit during the first trimester or within 42 days of joining the plan
- Completion of over 80% of expected prenatal visits (calculated by using a combination of data from eligibility date, delivery date, and gestational age)
- Upon completion of a postpartum visit within 45 days of the delivery

Information concerning these benefits is communicated through the Member Handbook, Member Portal, as well as through pregnancy-related educational materials and prenatal care improvement initiatives coordinated by AmeriHealth Mercy's WeeCare (Maternity) program. The WeeCare staff educate and reinforce the benefits during their interactions with pregnant members. Additionally, AmeriHealth Mercy conducts targeted communication campaigns (electronic, text, telephone, mail) to the pregnant population to inform them of the benefit.

AmeriHealth Mercy believes that the incentive program, described above is the best-in-class and the structure — member identification, education and incentives — can be used to direct members to leverage the provider cost and quality shopping tool in the Member Portal.

Future State

AmeriHealth Mercy believes that it already possesses a strong base of usable data and an excellent methodology for sharing relevant information with members. Our software, either internally or externally developed as discussed in greater detail in Question 4, will allow us to know the lowest cost provider or site of service for certain procedures that maintain quality standards. As also discussed above, we will then direct members via the Member Portal, or

through telephonic interactions with our Member Services Representatives to those providers and locations.

With the addition of a member incentive to the other elements of the program, AmeriHealth Mercy feels that it would be successful in driving utilization towards this resource. Members will receive financial incentives and support services, such as transportation, to ensure that barriers to cost effective and high quality care are removed.

To that end, AmeriHealth Mercy recommends a similar incentive for members who seek care in the more cost effective health settings and locations. Of course, all member incentives would also be in accordance with all local, State, and Federal laws and with the approval of the Department. Potential incented behaviors could be:

- First selection of a provider or care location from the Member Portal selection tool or via a telephonic interaction with a Member Services Representative verbally guiding them through the process
- Completion of over 80% of care interactions with high-quality providers, as defined by AmeriHealth Mercy
- Upon completion of a procedure at a high quality and preferred location, as defined by AmeriHealth Mercy

The definitions of these settings and their correlation to quality would need to be well-defined and supported. The priority is always in directing members to the most efficient and highest quality care resources available.

Once an incentive is clearly defined, member education would be provided through the Member Handbook, Member Portal, and related educational materials, as well as through more targeted outreach efforts initiated from our Integrated Care Management team. Additionally, we would conduct targeted communication campaigns (electronic, text, telephone, mail) to the population known to be high utilizers or more likely to seek a medical procedure in the near future.

Also as discussed in Question 2 above, our Member Services Representatives would be instructed on the details of this program, and would remind a member of the rewards while aiding them in scheduling appointments.

Timeline

The metrics to be incented would be defined and refined through collaboration between AmeriHealth Mercy and the Department. We commit to partnering with the Department in the preparation of any waivers to CMS in order to gain approval for these programs for their successful future implementation. We believe that such incentive programs will be beneficial for both members and taxpayers. These conversations could occur in parallel to the implementation and build-out, and would be operational at the time that the Member Portal is able to go live. This model would be scalable to additional populations and geographic regions as needed.

QUESTION 4

Describe how you currently (or would in the future) perform detailed analysis of claims and/or encounter data, including Medicaid claims data provided by the Department, to generate total average costs for specific medical procedures or tests at various provider locations across the provider network. Describe how you would present and incorporate the results of such analysis both within the shopping tool and as part of the defined benefit maximum tool for use by the Department.

(Limit to two pages)

RESPONSE TO QUESTION 4

AmeriHealth Mercy has much experience in analyzing data to extract actionable information for members and providers. As discussed in Question 1, we have sifted through these numbers for many years to provide direction to providers via our Provider Profiles.

This section will briefly outline our current analysis of claims and encounter data and how we would look to leverage that data to refine the statistics on average costs per procedure or test to share that information with members and the Department.

PerformPLUS

As discussed in Question 1, AmeriHealth Mercy designed PerformPLUS as a data repository tool that supports our methodology for profiling and reporting provider performance. PerformPLUS currently allows us to offer network providers actionable and benchmark data by compiling all sources of data, such as claims, encounter, membership, provider contract rates, and utilization data, into a single data repository.

With the addition of stronger data analytics, also discussed as part of Question 1 above, such information could be available via a graphical interface and 'sliced-and-diced' in numerous ways. Given the aforementioned functionality, AmeriHealth Mercy would be required to review average costs of procedures or tests via a consistent data field. The fields that are in use today are DRG codes, current procedural terminology (CPT) codes, and average length of stay. As such, we are able to assess the cost of a DRG by admission, and then further dissect the data by location, provider, or even by a specific time period. AmeriHealth Mercy does not currently have a grouper beyond such building blocks.

Future

The greatest value of the current PerformPLUS tool is the extensive data that it stores and with which it is updated at regular intervals. Looking towards the future, we will collaborate with our partner in this proposal, Blue Cross of Northeastern Pennsylvania (BCNEPA), to leverage BCNEPA's existing tools and infrastructure used to group medical and pharmacy claims and encounters into episodes of care for use with AmeriHealth Mercy's Medicaid Program.

BCNEPA calculates an average cost per episode by service categories within specific medical conditions. The results are presented for a provider or for various facilities. Similar results are generated for hospitals and outpatient facilities, so that BCNEPA members can select the most cost-efficient provider. These results are currently presented for hospitals and outpatient facilities through BCNEPA's secure member portal, and cost and quality results will be available for physicians beginning in the first quarter of 2012.

As needed, AmeriHealth Mercy would potentially secure a contract with a vendor that has been developing a grouper agent that examines Episodes of Care. Today, two leading vendors in this market space are Cave Consulting Group and Compass Healthcare Advisers. Both vendors provide tools offering existing, internally validated groupers that create Episodes of Care and correlations to health outcomes. The Compass shopping tool (Compass Choice Rewards) can incorporate additional information alongside cost rankings, for example, combining both cost and quality measures into an amalgamated provider ranking model that is provided to members.

Member Portal

Once the aforementioned grouper information is secured, a member selecting a PCP could also be prompted to select a provider with the highest quality outcomes, as defined by a quality grouper. Furthermore, when a member is prompted to follow-up on a Care Gap or EPSDT screening for a child, he/she could also be prompted with a number of cost- and quality-based filters. For example, should a member need a procedure, they could search for the providers and locations with the highest quality, as measured by health outcomes.

Should a member call into our Contact Center, the Member Services Representative could also guide the member through this selection process verbally. As discussed above, the Member Services representative would be alerted to the care need by the member's ID and simply directs the member through the analytic process to aid in their selection of the appropriate care location and provider.

Department Access

AmeriHealth Mercy also understands the importance that this data and analytics ability would have for the Department. As such, AmeriHealth Mercy would ensure that the Department would have its own secure log-in to the graphical interface, including this grouping data. As the data would only flow from PerformPLUS to the interface — and not the other way around — there would be no risk to the integrity of the underlying data source. We would also ensure that the Department's log-in was supported by all modern security measures to ensure protection of members' private health information. All State and Federal regulations concerning data safety would be followed at all times.

Timeline

Cave Group Consulting and Compass Healthcare Advisers usually propose a 6 month to 1 year implementation period, including end-user training. This could be done in parallel with the installation of *Crystal Reports* analytics software. This model would be scalable to additional populations and geographic regions as needed.

QUESTION 5

Describe how your current systems provides and how you use, or how you would in the future create and use, (and how you are or will be able to share the Department) the following:

- *Reports that capture consumer program activity/utilization for both the shopping service and defined benefit maximum service, including consumer interactions, incentives delivered and corresponding claim savings attributable to consumers selecting cost-effective locations.*
- *Geographic reports that capture total cost by medical procedure, allowing users to understand cost variation across the network and to analyze the impact of maximum allowed reimbursement rates on cost savings?*
- *Listings of all in-network providers within specific geographic areas that provide specific medical procedures and the cost for those procedures (or denoting high cost users from low cost users).*

(Limit to two pages)

RESPONSE TO QUESTION 5

AmeriHealth Mercy has a long history of using data and benchmarks to assess the quality of our provider networks. Additionally, AmeriHealth Mercy has a strong history of directing relevant information to members. We believe that providing actionable data to members and providers, along with compelling incentives, can drive behavioral changes, thereby creating a more efficient and higher quality network.

This section will briefly outline our current data sharing protocols and how we believe that they can be expanded in the future to better track member activity/utilization of relevant tools, and to educate members on cost variation across the network as well as the impact that it has on the overall cost of healthcare.

Tracking Consumer Program Activity/Utilization

As discussed in greater detail in Question 2, AmeriHealth Mercy is very proud of its Member Portal and its integrated care system that allows our staff to see a member's current condition, simply by entering the member's ID into the system.

As the shopping service and defined benefit maximum services do not currently exist, there is no current reporting. However, as the Member Portal requires a user to create a username and password, it would be simple for us to track member activity and utilization of the tools. For nonmembers or members who choose to not create a password, we would simply track the number of 'hits' on the website. These data are of limited value due to their lack of detail, but would still be a usable statistic that could directionally express the tools' popularity.

Furthermore, should we implement a member incentive, we would store the member's utilization history within the Portal, and also make this information available to the Department through its associated site, as discussed in Question 3. The availability of this information would allow the member to see their incentive history and provider choice. It would also graphically display the cost savings associated with the member's provider and his/her care location selection. Member cost savings and utilization would require an annual review at minimum to assess the impact of the member incentive, and to modify it, as appropriate.

Geographic and Provider Cost Reporting

As discussed in Question 2, AmeriHealth Mercy has a strong infrastructure and supportive data foundation in place to direct valuable information to members to improve their health outcomes. With the addition of stronger data analytics, also discussed as part of Question1 above, such information could also be pushed to members as part of the member portal.

Such analytics could be similar to the web page that the member now views when selecting a PCP. When a member completes this process, they first enter their zip code, and the system filters the data by location. The member is also able to enter a number of selections including physician gender, language, and specialty. The system then filters the data by these selections and provides the member with the respective matches.

In this future state, when a member is selecting a provider, he/she could also be prompted to select a high-efficiency provider. This could be associated with a graphic demonstrating the overall cost to the Medicaid program if the member were to select one provider over another. This information would also be made available to the Department for further analysis.

WASTE, FRAUD, AND ABUSE

CONTENTS

QUESTION 1

Describe the internal controls you will implement to detect potential waste, fraud and abuse within your own organization.

(Limit to two pages)

RESPONSE TO QUESTION 1

AmeriHealth Mercy has a comprehensive system of internal controls for detecting potential fraud, waste and abuse (FWA). These controls exist in the various systems and processes of the organization including a Corporate Compliance Program, Fraud Hot Line, and internal detection strategies.

Corporate Compliance Program

AmeriHealth Mercy has implemented and continually enforces policies and procedures to detect and prevent FWA and to provide protections for those who suspect and report wrongdoing through our Corporate Compliance Program. The Compliance Program serves as the universal platform for how we internally control the detection of FWA, and includes a written plan that contains the elements required by CMS and found at www.cms.hhs.gov/states/fraud.

AmeriHealth Mercy educates its employees, contractors and agents about:

1) Its policies and procedures for detecting and preventing FWA
2) Its Associate Guidebook and Code of Ethics and Conduct, including compliance with of the Federal and State False Claims Acts
3) The right of employees to be protected as whistleblowers
4) Compliance with the False Claims Act

Well publicized disciplinary procedures apply to all employees. AmeriHealth Mercy has, and will continue to communicate to employees, its zero tolerance of employees violating any law, including failing to report violations, such as FWA.

Fraud Hot Line and Tip Form

AmeriHealth Mercy has a confidential, toll-free telephone line for all members, providers, employees, contractors, and consultants to report suspected FWA activity. The Fraud Hotline number is promoted to vendors, provider, employees and members through newsletters, handbooks, websites, and contracts. Employees, contractors, consultants, members or providers will not be subject to retaliation or reprisal for reporting, in good faith, actions that they feel violate our Standards of Conduct.

AmeriHealth Mercy also has a “Fraud Investigation Tip Form” and a Corporate Compliance intake form on our intranet that permits employees to submit concerns related to FWA.

Internal Detection Strategies

Departments across the organization support FWA prevention and detection through a system of internal controls, including the following:

- **Claims Clinical Editing -** Upcoding, unbundling, and correct coding is identified through the prospective claims clinical editing. For example, rules are used to define what constitutes a definite or possible duplicate claim. We contract with a vendor, iHealth Technologies, to enhance the clinical editing capabilities of our Facets claims processing system to assist in the detection of FWA.
- **Prior Authorization Review -** We use InterQual guidelines to evaluate medical necessity and appropriate level of care for high cost services and services that are known to be over-utilized. We routinely administer inter-rater reliability testing to ensure consistent application of utilization criteria across all reviewers.

- **High-Dollar Claim Pre-Payment Review -** Security edits in our claims system are set at the individual employee level. This prevents claims processors from releasing payment above established dollar amounts without management approval. Payment for high dollar claims cannot be released without senior management approval. For example, an inter-disciplinary group routinely reviews all high-dollar claims above established thresholds to ensure claims are billed accurately and paid correctly.
- **Medical Record Review -** We conduct medical record chart reviews to ensure that the medical record is consistent with billed services.
- **Credentialing and Re-credentialing -** During the initial credentialing and re-credentialing process, we ensure that providers seeking to become or remain part of our network are in good standing and are not precluded from participation in state and federal programs.
- **Accounts Payable Controls -** We use industry-standard software to manage all accounts payable activity outside of our claims processing system. Security is set at the individual employee level so that employees cannot process payments without appropriate management approval.
- **Information System Controls -** We have comprehensive internal security controls governing access to our information systems. Security is set at the individual employee level to prevent access into systems that are not related to the employee's individual job responsibilities. We prohibit our employees from sharing passwords and require each employee to change his/her password every 45 days. Each employee knows that the company retains the right to monitor, inspect, or search any information system with or without the consent of the employee.

Looking Ahead

In keeping with our dedication to continuous improvement of our FWA detection abilities, AmeriHealth Mercy recently expanded its contract with Health Management Systems (HMS) to augment our FWA activities. A national leader in cost containment solutions for government-funded programs, HMS has a strong track record of FWA identification and intervention.

Our extended partnership with HMS will include retrospective data mining services and forensic editing post adjudication, as well as pre-payment fraud, waste and abuse support.

HMS's subsidiary, IntegriGuard, recently won the Investigation of the Year Award from the National Health Care Anti-Fraud Association for its work in the following case:

Dr. Stephen Schneider and his wife Linda were operating a pain management clinic in Kansas. They were found guilty of healthcare fraud resulting in death, conspiracy, money laundering and illegally prescribing narcotics. Each was sentenced to 30 years in prison. Over an eight year period, investigators found the Schneider's had dispensed potent and addictive medications to hundreds of patients. Many of these patients were later determined to be addicts, who had not exhibited symptoms of pain, and who received little monitoring or follow up. The pill mill resulted in over 100 drug overdoses and 68 deaths.

This case was brought to closure by a collection of agencies working in collaboration for the benefit of the Medicaid and Medicare programs. Together, they detected patterns of fraud and abuse, conducted medical reviews, and pooled their resources to ensure the investigation was airtight.

QUESTION 2

Describe the types of fraud detection methods you will use to detect potential waste, fraud and abuse.

(Limit to two pages)

RESPONSE TO QUESTION 2

AmeriHealth Mercy has implemented various methods to detect fraud, waste, and abuse (FWA) by providers, members, and employees, while providing protection for those who suspect and report wrongdoing. These include confidential reporting, data analytics, periodic sampling and internal audits, and follow-up of suspicious activity. Clinical editing during claims processing and the use of prepayment correct coding edits (which can lead to claims cost avoidance) supports our data analytics method.

Confidential Reporting

AmeriHealth Mercy maintains a toll-free Fraud Hotline for internal and external use. The hotline is solely for the purpose of receiving reports of suspected improper/illegal activities or misconduct on a confidential basis. All incoming referrals are recorded in the case tracking tool. The Corporate and Financial Investigations (CFI) department investigates each potential FWA activity.

Data Analytics

The CFI department utilizes automated applications to assist in detecting and preventing potential fraud, as well as access to public records and industry-wide databases. These efforts are supported by industry-leading clinical editing during prepayment claim processing. Our prepayment correct-coding edits have led to claim cost avoidance that supports reduction of FWA for a savings of more than two percent of payments. For post-payment efforts, the anti-fraud software package provides analytics, case tracking, data manipulation and visualization tools, as well as ad hoc and scheduled analyses. The department also uses an internal data warehouse to identify patterns that may be indicative of FWA. When combined, these tools are used to identify potential cases of member FWA, including, but not limited to:

- Overutilization
- Up-coding
- High-dollar claims
- Unusual patterns by subscribers, providers or facilities
- Unusual dates of service
- Excessive time units for time-based codes
- Unusual claims volume by providers or subscribers
- Unbundling services
- Incorrect reimbursement to providers, subscribers, facilities and/or pharmacies
- Incongruous procedure code, prescription, and diagnostic code combinations

The CFI utilizes the following tools:

- ***ViPS STAR Sentinel™*** - This data analysis system is used for the purposes of healthcare fraud detection, investigation, documentation, and case coordination. Using this tool, the CFI department is able to identify patterns of behavior and potential impact.
- ***Facets Claims System Edit*** - The NCCI edits are applied in a pre-payment manner to all medical claims that are processed through the Facets claims system.

Periodic Sampling and Internal Audits

Detection of FWA is facilitated through the use of data analysis from many areas of the organization, including Informatics, Claims Cost Management, and other departments that routinely perform data analysis.

The CFI department proactively identifies potential incidents of FWA as part of its program for ongoing monitoring and auditing. The procedures that CFI has in place to safeguard AmeriHealth Mercy against provider or member fraud and abuse includes the following:

- Periodic evaluation of claims data to detect apparent abnormalities in provider billing or member utilization patterns
- Periodic sampling of bills/claims to determine propriety of payments
- Sampling of services through member contact to ascertain that billed services were rendered for provider cases
- Contractual provisions for providers and subcontractors requiring compliance with FWA program standards as a condition of contracting
- Dissemination of information to members and providers concerning FWA

For example, in reviewing one of our reports, we noted a participating orthopedic group had billed an X-ray procedure with nearly every office visit. After review of the information with the group, the level of x-ray testing decreased noticeably.

The CFI Department conducts audits/investigations in response to referrals suggesting that claims are being paid inappropriately. Referrals are received from a variety of internal and external sources that are critical in monitoring and detecting potential cases of FWA.

QUESTION 3

Describe the activities you will undertake to safeguard against potential member fraud.

(Limit to two pages)

RESPONSE TO QUESTION 3

AmeriHealth Mercy's Corporate Compliance Program includes a comprehensive program to prevent, detect, and investigate potential member fraud.

Training and Education

Effective training is an integral part of the compliance plan. We routinely educate members on awareness and prevention of fraud and abuse through member newsletters, the Member Handbook, and the member website.

Coordination for fraud, waste and abuse (FWA) complaints received by AmeriHealth Mercy will be handled in accordance with State requirements. This includes complaints about a member's eligibility, a member's utilization of benefits, and health care provider's or contractor's conduct in the network. An investigator obtains necessary data for making a determination as to whether to investigate the case. Corporate and Financial Investigations (CFI) 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.

Confidential Reporting

Confidential reporting is available to all of our members. Several independent paths for reporting FWA are available. Confidential reporting may occur either through the Compliance Hotline, a telephone line to be used solely for the purpose of receiving reports of suspected improper/illegal activities or misconduct on a confidential basis or the Fraud Hotline. The Fraud Hotline is intended to be dedicated to fraud tips, concentrating on member and provider fraud; however, both Hotlines may be used to report infractions of AmeriHealth Mercy's Code of Ethics and Conduct or FWA concerns.

Data Analytics

The CFI department proactively identifies potential incidents of FWA as part of its program for ongoing monitoring and auditing. For example, CFI conducts periodic evaluation of claims data to detect apparent abnormalities in member utilization patterns. The CFI efforts are supported by industry-leading, anti-fraud technology. The anti-fraud software package provides analytics, case tracking, data manipulation and visualization tools, as well as ad hoc and scheduled analyses. The department also uses an internal data warehouse to identify patterns that may be indicative of FWA. When combined, these tools are used to identify potential cases of member FWA, such as:

- Overutilization
- Unusual patterns by subscribers, providers or facilities
- Excessive time units for time-based codes
- Unusual claims volume by providers or subscribers

Follow-up of Suspicious Activity

Upon suspicion of FWA activity, the CFI Manager will request a suspension of payment for all claims processed for the provider and/or member under investigation, and all claims payments for the provider and/or member will accordingly be suspended or withheld. Relevant departments — including, but not limited to, Operations, Provider Contracting, Medical Management and Finance — are notified of the suspension. The suspension is released upon completion of the investigation.

AmeriHealth Mercy reports substantiated instances of member fraud to appropriate regulatory, governmental oversight, and/or law enforcement agencies within the required time frame as defined by DPW. When the determination has been made that an external referral is warranted, CFI consults with Corporate Compliance and Legal Affairs to review case-specific information and complete the referral. Corrective action will be implemented if appropriate.

Pharmacy Detection

Our pharmacy network utilizes its prospective Drug Utilization Review (DUR) edits to identify potential cases of fraud and abuse. For example, a member may be alternating pharmacies in an attempt to obtain duplicate prescriptions for controlled substances. Through our prospective DUR edits, the pharmacies would be alerted that the member had recently filled a similar controlled substance at different pharmacy, providing the pharmacist the ability to investigate and determine if the prescription is appropriate to dispense.

Recipient Restriction

AmeriHealth Mercy's Recipient Restriction Committee evaluates members at risk for fraud, waste and abuse of their health benefits.Referrals for restriction are received from internal and external sources. We review six months of pharmacy claims and one year of medical claims to identify members for restriction to a specific pharmacy or medical provider. We also identify any instances of suspected fraudulent prescriptions.

Candidates for restriction are presented monthly at the Recipient Restriction Committee and recommendations for restriction are then sent to DPW for review and approval.

Upon approval from DPW, members are restricted to a combination of a PCP, a pharmacy or a facility (hospital). In accordance with DPW requirements, members are not restricted in their selection of an ER.

QUESTION 4

Describe how you use consumer verification techniques regarding the cost of inpatient and outpatient services to detect provider waste, fraud and abuse.

(Limit to two pages)

RESPONSE TO QUESTION 4

Minimum Sampling Criteria

In an effort to enhance our fraud, waste and abuse activities, AmeriHealth Mercy will provide individual notices to a sample group of the enrollees who received services, and who will be selected based on a statistically valid sample size. The enrollees will be asked to review the information provided and if they do not believe the service listed was provided, they will be instructed to contact our Member Services department. The required notice will include:

- The service furnished
- The name of the provider furnishing the service
- The date on which the service was furnished
- The exact amount of the payment made for the service

The number of enrollees to contact will be determined based on a statistically valid sample size and the enrollees will be randomly selected based on claims paid.